Welcome

Professor Mark Pietroni, Director of Public Health for South Gloucestershire Council, has been Chair of the Sexual Health Programme Board, and leading the Office for Sexual Health South West since the 1st of March 2014. The Programme Board is made up of representatives from NHS England, Public Health England, Local Authorities, Acute Trusts, General Practice, Universities, BASHH, The Terence Higgins Trust, Eddystone Trust and Brook. Administration for the Office is provided by the South Gloucestershire Council Public Health & Wellbeing Team.

The Office continues to develop and implement innovative and meaningful programmes of work that support the sexual health priorities of the South West Directors of Public Health and sexual health commissioning, influencing practice across the South West and nationally. Following a recent review of the work of the Office and its achievements over the past three years I am pleased to report that funding has been secured from the South West Directors of Public Health and Public Health England to enable the work of the Office to continue for the next three years. A strategic review is currently underway to establish the key priorities for the Office and inform the development of the new work plan.

My thanks go to all those who have contributed to the achievements and developments during 2016-17 and to the production of this annual report.

Professor Mark Pietroni
Chair
South West Sexual Health Programme Board
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1. SEXUAL HEALTH COMMISSIONING

Sexual Health Commissioners Network Feedback
Laura Juett (Sexual Health Commissioners Network Chair), Public Health Specialist, Plymouth City Council

The Sexual Health Network continues to meet quarterly and is well attended. There are active discussions and communications between members outside of the meetings that provide great peer support and learning.

Much of the focus over the last twelve months has been around procurement and re-commissioning issues. Many areas have been working through the complexities of these processes and I think we all agree they are just the start of longer term system transformation programmes. Some of the main challenges discussed have been the need to achieve financial efficiencies, managing increasing demand, making best use of new treatments and technologies including online services and maintaining constructive relationships with service providers. It has been really interesting hearing about how different areas are meeting these challenges and seeing the different local services taking shape.

The Network also provides an opportunity to touch base with Public Health England (PHE) with Norah O’Brien providing useful national and regional updates and Meda Sandu guiding us through the various data.

We have benefited from some external speakers including a representative from the Faculty of Sexual and Reproductive Health who linked with the Network around developing the Faculty’s vision for sexual health services. The meetings are also an opportunity to check in with broader system issues such as linking with NHSE around cervical screening, HIV treatment and care and the forthcoming case for change for Sexual Assault Referral Centres.

For me the Network is a chance to connect with colleagues who appreciate and understand the detail of the sexual and reproductive health world. It provides the space for shared learning and problem solving and mutual support around some of the everyday challenges and opportunities.

Integrated Commissioning: partnership working across Bristol, North Somerset and South Gloucestershire (BNSSG) Local Authorities and Clinical Commissioning Groups (CCGs)
Becky Pollard, Director of Public Health, Bristol Public Health
Thara Raj, Consultant in Public Health, Bristol Public Health
Annette Billing, Public Health Principal (Sexual Health), Bristol Public Health
Lindsey Thomas, Specialist Public Health Manager, South Gloucestershire Public Health
Lottie Lawson, Health & Wellbeing Partnership Officer (Sexual Health), South Gloucestershire Public Health
Matt Lenny, Public Health Service Leader, North Somerset Public Health
Paul Sheehan, B&NES Public Health
Inge Shepherd, Clinical Commissioning Group(s)

During 2016/17 a new integrated sexual health service was successfully procured as a collaboration between Bristol, North Somerset and South Gloucestershire local authorities and the accompanying Clinical Commissioning Groups. Bath and North East Somerset Council joined the collaboration for the chlamydia screening programme only.
A competitive tender was advertised in 2016, following an extensive consultation exercise. The contract was awarded to University Hospitals Bristol (UHB) NHS Foundation Trust as lead provider, with UHB subcontracting to a number of local NHS trusts and national voluntary sector providers, including Brook and Terrence Higgins Trust. The contract started on 1 April 2017. The service will operate under the brand name ‘Unity’.

It was important that the Clinical Commissioning Groups joined the collaborative commissioning process with the local authorities to include termination of pregnancies, as this gives the new service a real incentive to reduce unwanted pregnancies as part of an overall system of improving sexual health outcomes.

**Young People Friendly**
The office continues to support Young People Friendly (YPF) accreditation of services by funding the YPF leads network which provides opportunities for training, sharing practice and peer assessment of services seeking or renewing accreditation. To review the South West YPF documentation please see: https://www.4ypbristol.co.uk/for-professionals/young-people-friendly/

The national ‘You’re Welcome’ standards are currently being revised and piloted and the South West will review its position once they have been formally published. For further information please see the link http://www.youngpeopleshealth.org.uk/yourewelcome/

**Commissioning Sexual Dysfunction**
The South West Sexual Dysfunction Expert Advisory Group, established by and reporting to the South West Sexual Health Board, met from 2014 until early 2016 with the aim of informing and supporting equitable access to high quality services for sexual dysfunction across the South West. The context of the establishment of this group was the change introduced from April 2013 to commissioning responsibility for sexual dysfunction being split between Local Authorities (to be responsible for commissioning “sexual health aspects of psychosexual counselling”) and Clinical Commissioning Groups, (to be responsible for commissioning “non-sexual health elements of psychosexual health services”). There was no national explanation of these commissioning responsibilities, resulting in considerable lack of clarity amongst commissioners across England.

The Sexual Dysfunction Expert Advisory Group believed that it was not feasible to split commissioning responsibilities for sexual dysfunction in this way, recommending a single, consistent definition of sexual dysfunction supported by the relevant national bodies, eg The Institute of Psychosexual Medicine (IPM) and the College of Sexual and Relationship Therapists (COSRT) and a single commissioning pathway. The group produced a paper (attached), describing the meaning, definitions, classifications, causes and treatment models of sexual dysfunction, and offered an expanded description of the split commissioning responsibilities for these services with national and south west recommendations for action. The paper outlines patient pathways using a series of case studies to illustrate the complexities and common service inter-dependencies.

A structured consultation process on the paper was undertaken to gain feedback from within the south west and from national organisations and bodies. All responses were reviewed by the SW Sexual Dysfunction Expert Advisory Group and amendments agreed. The responses received were numerous and varied, giving some clear insights into the needs of commissioners and the views of clinicians.

Please forward this paper to organisations, groups and individuals as you feel appropriate.
PrEP
Sarah Fuhrmann, Regional Manager, Terence Higgins Trust

What is PrEP?
PrEP (Pre-Exposure Prophylaxis) is a course of drugs taken by HIV negative people before sex to reduce the chance of getting HIV. The medication used for PrEP is a tablet called Truvada, which contains tenofovir and emtricitabine (which are drugs commonly used to treat HIV). PrEP can be taken once a day, and, when taken correctly, is stunningly effective in preventing HIV. Results in trials have been very successful, with PrEP significantly lowering the risk of becoming HIV positive and without major side effects. When used alongside condoms, regular testing and early treatment, PrEP can be the vital piece of the puzzle to help end HIV transmissions and the HIV epidemic for good.

How do you take it?
In clinical trials PrEP has been used in two different ways: taken regularly (one tablet per day); only taken when needed (two tablets 2-24 hours before sex, one tablet 24 hours after sex and a further tablet 48 hours after sex). The latter is often called ‘on-demand’ or ‘event based’ dosing. Both methods have been shown to be very effective, although on-demand dosing has only been studied in gay and bisexual men.

Who is PrEP for?
PrEP is a game-changer for communities who have been hit hardest by the epidemic and as such PrEP will be targeted to those at risk of HIV. This includes gay and bisexual men, black Africans, trans people and those in a relationship with an HIV positive partner who is not on successful treatment.

Is it cost-effective?
The average lifetime cost to the NHS of treating someone with HIV is £360,000. In the long-term it will be far more cost-effective for the NHS to prevent people from getting HIV while they’re at risk, than to fund a lifetime of treatment for them.

Why can’t people just use condoms?
Condoms will always be a cornerstone of HIV prevention, however, perfect condom use is not a reality for everyone, despite years of promotion. Not everyone is able to negotiate condom use. Condoms alone will not win the fight against HIV. PrEP is not about replacing condoms, it is about making full use of all the tools we have to stop the HIV epidemic once and for all. Together we now have a powerful arsenal with which to end HIV: condom use, regular testing, early treatment, and – vitally - PrEP. PrEP could be the last piece of the puzzle to help end HIV transmissions.

Will this encourage risk-taking or other STIs?
The reality is that people who are already taking PrEP are acting responsibly to protect themselves and others against HIV. They are aware of other STIs and their overall sexual health has improved, as they more regularly attend sexual health clinics.

This is supported by World Health Organisation guidelines which say that PrEP increases opportunities for access to other sexual health services, and by the NICE review which pointed to reassuring evidence from major trials, showing PrEP did not lead to increased sexual risk taking. In the PROUD trial, there was no statistically significant increase in other STIs.
**PrEP – The Current Situation**

**England**
In November 2016 the Court of Appeal upheld a ruling that NHS England has the legal power to fund PrEP. In December 2016 NHS England announced they would fund a trial of PrEP, with at least 10,000 participants over the next three years. Whilst this is a welcome step, a trial is only ever a temporary answer. In order to end the epidemic, the government must commit to making PrEP routinely available in England for those at risk, as Scotland has already done.

People in England are still waiting to access PrEP, six months after the court of appeal ruled that NHS England was responsible for its funding.

There are a lot of questions still to be answered about the trial: when exactly it will begin (current estimates are July 2017), who will have access to it and there is still no information about how to take part. It is also pivotal that the NHS will retain responsibility for PrEP when the trial comes to an end.

**Scotland**
In April 2017, it was announced that people at risk of HIV in Scotland will be able to access PrEP through the NHS making Scotland the first country in the UK to routinely commission PrEP on the NHS.

**Wales**
Also in April 2017, the Welsh Government went against advice from the All Wales Medicines Strategy Group and announced an all Wales PrEP trial. The health secretary, Vaughan Gething has since described the trial as a ‘3 year study’, beginning in July, and will make PrEP available to all those for whom the drug is clinically appropriate. The study will help illustrate how best to provide the preventative treatment to reduce risks of HIV transmission in Wales and answer some of the questions raised by the All Wales Medicines Strategy Group around incidence rates.

By framing the trial as a ‘study’ into behaviour, the need for ethical approval has been avoided. In addition, there is no cap on the numbers of people who can access PrEP unlike in England. Despite this, to ensure cost effectiveness, robust eligibility criteria must be established.

**Concerns:**

- Delays and uncertainty in England:
  - Lack of clarity around which approach will be used.
  - Eligibility criteria.
  - Postcode Lottery?
- Accessibility in rural areas not within easy reach of GUM clinics.
- Accessibility in marginalized communities and vulnerable adults.
- Clinical uptake – not all clinicians support the use of PrEP.
- Stigma.
- Lack of education.
- ‘Black market PrEP’:
  - Buying of cheap, unregulated pills.
  - Selling of Truvada by HIV positive patients.
  - Lack of access to screening services.
Summary
The momentum regarding PrEP in Wales and Scotland further highlights the comparatively underwhelming response in England, which is home to eight out of ten people living with HIV in the UK. The long-awaited PrEP trial in England is still yet to materialise, and there’s still no guarantee that PrEP will be funded on the NHS after the trial. With delays and uncertainty in England, access to PrEP could become a postcode lottery. PrEP is something that should be available to all those at risk, regardless of where they live.

A number of groups including ‘I want PrEP now’, Prepster and Terrence Higgins Trust continue to lobby tirelessly to ensure that PrEP is made accessible and a reality for all.

Outbreak Management
Mags Davies, Director and Andrew Evans, Director of Operations and Finance, Eddystone Trust

Hepatitis B
In conjunction with Public Health England, The Eddystone Trust delivered the Hepatitis B campaign ‘Get Tested, Get the Shots’ throughout the South West of England following a number of related ‘prison variant’ cases. The cases were primarily identified in males not presenting as gay or bisexual, but were attending public sex environments (PSEs) such as Haldon Hill. A multi-pronged campaign was initiated, covering all areas across the South West where men who have sex with men (MSM) attend. The areas were sex on premises venues such as saunas, all of the outdoor PSEs and the LGBT bars and clubs. The campaign materials depicted a range of pictures from torsos and saunas for use in the saunas to simple wording on business cards, acknowledging that MSMs in PSEs were more likely to accept a non-identifiable card. The campaign was successful in directing individuals to the local sexual health clinics or GPs to get tested and vaccinated. The numbers of those diagnosed did not increase any further following the campaign.

Hepatitis A
Again in conjunction with Public Health England, The Eddystone Trust delivered a campaign for Hepatitis A. This time the activity had been identified as mainly contracted by individuals using sex apps. A campaign was distributed through Grindr and on the Trusts website. Narrative for the campaign was utilised from the national PHE/HIV Prevention England factsheets and the poster that had been used in Portsmouth. The wording was slightly different so that it was not dismissed by those who were men who have sex with other men and do not present as gay or bi-sexual. A further section was also added to explain what to do if you were also HIV+.

The message delivered aimed to encourage people to either contact the Eddystone Trust to discuss the issues further, ask about vaccination at their next sexual health appointment or if they had the symptoms identified then they should see a health professional as soon as possible. Approximately 1,000 people have accessed the web page via the link available through the sex app.

British Association for Sexual Health and HIV (BASHH)
Indrajith Karunaratne, BASHH Regional Chair

The BASHH South West Branch Chair, Dr Indrajith Karunaratne, has reported to the Board on a number of areas of interest over the past twelve months including guidance, clinical standards and health promotion. Work has been carried out by BASHH on guidance around FGM reporting, online testing for STIs and has issued guidance on the Retention and Disposal of Clinical records.
Outreach clinic standards guidelines were presented at the BASHH Spring Conference and discussions have been held around clinical standards for social media, safeguarding and the adverse consequences of using social media. A review of STI management standards has also taken place. A mystery shopper exercise has been carried out to gather information on standards of services. Promotion of HIV testing took place along with the introduction of HIV testing as part of GP screening and a poster campaign was held to promote chlamydia testing. A BASHH re-audit on syphilis management has been carried out and a survey on chaperoning is being planned.

Education and training courses are held regularly; eHIV-STI courses are being updated and new pathways developed for select groups such as medical students, a microscopy app and a new certificate in the history of venereology is also being developed. During June BASHH is organising a high-profile event in Parliament to commemorate the centenary of the VD Act 1917, marking 100 years of high quality sexual health services across the UK.

More recently the King’s Fund report was discussed at both BASHH Board and Clinical Governance meetings. BASHH continues to support services during tender procedures through their approved advisers, sharing best practice knowledge in cost reductions and gathering information on disruption to services through its branch network. As described in the report there is a huge variation in funding cuts across the country. The South West Branch is planning a political campaign to educate their local parliamentarians on sexual health budget cuts and its impact on service provision. Sarah Wollaston MP for Totnes and Chair of the Health Select Committee has kindly agreed to attend and speak at the South West BASHH in November and prior to that branch reps are planning to meet her to explain the current situation in sexual health services.

Further information can be found on the BASHH website.

**Relationships and Sex Education Hub**

The RSE Hub has been working with Public Health England (PHE) and the Sex Education Forum to update the briefing for councillors on the importance of relationships and sex education (RSE) for children and young people. The new briefing will be co-badged with the Local Government Association (LGA) and PHE and will be launched in the autumn to coincide with the LGA conference. The RSE Hub continues to use emailers as a way of advocating for the quality provision of RSE, raising awareness and promoting the resources available through the Hub to schools.

Over the past year we have delivered a workshop on the RSE Quality Review Framework for schools at Torbay Council’s excellent Emotional Health and Wellbeing event and continued our partnership with Exeter University on the Sex and History workshops and resource development. We have also supplied the RSE Quality Review Framework to the Durex funded ‘DO…SRE for schools’ programme as well as individual purchases from the website. The website continues to be used with 74% of users in the past year being new to the site and over 3,000 page views which is encouraging.

Further information can be found on their website: RSE Hub
Chlamydia Testing

Chlamydia is a common bacterial sexually transmitted infection which is frequently asymptomatic. Infection risk is higher for young people under the age of 25. If left untreated, chlamydia infection can result in serious long-term consequences, particularly for women where it might lead to pelvic inflammatory disease (PID), ectopic pregnancy or infertility.

Chlamydia testing can help prevent and control chlamydia through early detection and the treatment of infection, reducing onward transmission to sexual partners and the prevention of the consequences of untreated infection. The National Chlamydia Screening Programme (NCSP) in England was established in 2003 and recommends that all sexually active men and women aged under 25 are tested for chlamydia annually or on change of sexual partner (whichever is more frequent). The programme advises that testing should be delivered opportunistically, by embedding it within existing services. However, the costs of delivering a chlamydia testing programme across the southwest are high.

The Office carried out a project to look at the costs, benefits and evidence for improving value for money in the delivery of chlamydia testing in the southwest. The final report on the southwest programme of chlamydia testing was completed in October 2016. It presents an analysis of the current issues, a summary of recent trends, costs, benefits and evidence for improving value for money. It also makes recommendations for ensuring optimum delivery of chlamydia testing including improvements in effectiveness, integration, collective working and further research at a local level.

The recommendations listed for enhancing the existing chlamydia testing programme included:

1. **Improve effectiveness**
   Chlamydia testing could be more effective by ensuring that there is a stronger focus on:
   - encouraging repeat testing at the time of partner change
   - maintaining good quality treatment and partner notification pathways
   - encouraging retesting of those with a positive test result
   - targeting high risk population groups and areas of high social deprivation
   - expanding on-line testing
   - improving the uptake of testing by young people through offering appropriate testing options
   - utilising the Public Health England chlamydia care pathway tools to improve effective delivery

2. **Integration**
   By continuing to integrate chlamydia testing into broader health services for young adults, local authorities can ensure that testing remains widely available. There does not appear to be strong evidence to support a standalone programme of chlamydia testing with its associated additional running costs. Integration will also help the development of positive relationships with services, enabling young people to develop and maintain good sexual health throughout their lives.
3. Working together
It would be valuable to explore options for collective working. Where local authorities are working together, costs can be reduced. Collective working is likely to achieve better value through economies of scale or as a result of negotiating lower cost options with providers.

4. Further research at a local level
Analysis of local data would provide useful information about current arrangements and costs. Generalisation across the south west has not been shown to be viable across such a diverse range of provision. It is therefore recommended that this analysis is carried out at a local level.

Late HIV Diagnosis
Late and very late diagnosis of HIV is detrimental to the individual patient’s well-being and impacts on public health via the onward transmission of HIV. Continuing our commitment to advocate for further reductions in late diagnosis of HIV in the south west we launched the revised Serious Incidence Protocol for late diagnosis prior to HIV testing week 2016. The protocol has been shared with commissioners and providers across the south west and at a national level, with local authorities and providers using it as a tool to stimulate local discussions whilst also providing a framework for action.

3. REPRODUCTIVE HEALTH

Abortion

Update on the South West Late and Complex Abortion Data Review and Recommendations
The original South West Late Gestation and Complex Abortion Project Report has been reviewed and checked by Public Health England South West (PHE SW) for the South West Abortion Expert Advisory Group, and has been revised to include the most recently published abortion data to provide some degree of trend.

The current ‘very late’ abortion data have recently been obtained by PHE SW via a Freedom of Information request from the Department of Health Sexual Health Team. However this data is collated and provided differently from that used in the original report, meaning direct comparison is not possible.

Following the period of purdah prior to the General Election, a follow-up request will be made to the Department of Health in an attempt to access usable comparative data. PHE SW will then complete the revised report for the Expert Advisory Group. After review by the group, the updated recommendations will be submitted to the SW Sexual Health Board for approval and further action. The recommendations will include:

- provision of a central south west late abortion service up to 24 weeks gestation,
- equitable access to high standard abortion services for complex medical comorbidity cases (eg obesity and heart conditions).
Sexual Health Outcome Indicators for Abortion

The South West Abortion Expert Advisory Group, in liaison with a wider regional and national network of clinicians, reviewed and made recommendation for revision of the Abortion Outcome Indicators in the Quarterly Reports. These recommendations were approved by the SW Sexual Health Board and the new indicators introduced.

Progress against the Public Health Outcome Indicators for Sexual and Reproductive Health

What we have done well:
All areas of the south west have shown a reduction in the under-18 conception rate from 1998 to 2015. For eight local authorities this reduction was greater than the England reduction of 53.6%. For 11 out of the 15 local authorities in the south west the reduction over the last 17 years was more than 50%.

Under 18 conceptions:

Conceptions to women aged under 18 years, 1998-2015, percentage change
All new STIs excluding chlamydia under 25:
The rate of new STIs (excluding chlamydia under 25 year olds) has been consistently lower in the south west than England from 2013 to 2016. Although bigger cities such as Bournemouth, Bristol and Plymouth had higher rates than England over the same time period. Bristol was the only local authority of the three experiencing an increasing trend in the last four years.

What we need to continue improving:
Nine local authorities increased their chlamydia detection rate from 2015 to 2016. However, five local authorities have shown a constant decrease from 2013 to 2016. Only Bournemouth, Plymouth and Swindon were above the detection rate of 2300 in 2016.

Chlamydia detection rate in 15-24 year olds:

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<tr>
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What else we need to improve:
Progress with HIV late diagnosis has been made in many areas of the south west, with ten local authorities reporting reduction of HIV late diagnosis in 2013 to 2015, compared with 2012 to 2014. However other areas have seen an increase in HIV late diagnosis over the same time period. All areas of the south west have a late HIV diagnosis proportion of at least 25%, with four areas having a proportion over 50%.

HIV late diagnosis:

<table>
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<td>40.0</td>
<td>50.0</td>
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<td>63.2</td>
<td>58.3</td>
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<td>52.9</td>
<td>54.1</td>
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<td>Swindon</td>
<td>57.5</td>
<td>56.8</td>
<td>62.3</td>
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<td>Torbay</td>
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<td>41.7</td>
<td>38.5</td>
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<td>47.5</td>
<td>45.5</td>
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</table>

Sexual and Reproductive Health Data Sources

Sexual and Reproductive Health Profiles (publicly available)
http://fingertips.phe.org.uk/profile/sexualhealth

The profiles have been developed by Public Health England (PHE) to support local authorities, public health leads and other stakeholders to monitor the sexual and reproductive health of their population and the contribution of local public health related systems.

The profiles are publicly available and presented as interactive maps, charts and tables that provide a snapshot and trends across a range of topics. The tool allows for comparison between local authorities and benchmarking against the England average or nationally advised goals or thresholds where available.

PHE HIV and STI web portal (not publicly available)
Access is for those working within level three sexual health services; this includes local authorities, clinical commissioning groups and trusts.

Standardised reports are available for both GUMCAD (GUM clinic activity dataset) and CTAD (chlamydia testing activity dataset), based on the quarterly submissions of data. Reports can be created for local authorities (upper and lower tier), by service attended and by date of attendance. Types of report include: service provision, STI trends and epidemiology, performance monitoring, data completion and quality.
Local Authority Sexual Health Epidemiology Reports (LASERs) (not publicly available)
LASERs are produced by PHE on an annual basis. The LASERs bring together a range of sexual and reproductive health and HIV intelligence in one document for local authorities to identify burden, trends and population groups and geographical areas of greater need. These reports are available through the HIV and STI Web Portal and are intended for internal local authority use only.

HIV Data Tables
HIV data tables at lower tier local authority level are produced by PHE annually. The tables show HIV cases accessing care by:

- survey year
- sex
- risk group
- geographical area (MSOA)
- age group
- index of multiple deprivation
- infants born to HIV diagnosed women
- CD4 count

The tables are intended for internal local authority use only.

Further Links:
PHE has produced a guide to local and national sexual and reproductive health data, updated in December 2014. This guide can be found here: sexual and reproductive health in England local and national data

Please note all use of sexual health data should follow the guidance set out in the PHE HIV and STI Data Sharing Policy, found here: HIV and STI data sharing policy

For help, advice, useful links, or further information about sexual health data sources, please contact your local PHE Field Epidemiology Service (fes.southwest@phe.gov.uk)

Outbreak guidance can be found via the following link: https://www.gov.uk/government/publications/sexually-transmitted-infections-stis-managing-outbreaks

Topics of interest brought to the attention of the Board during the last year

STIs in all persons and Non-MSM

- New STI diagnosis rate: 629 diagnoses per 100,000 population
- 15-24 year olds accounted for 57% of new STI diagnoses
- 1% of new STI diagnoses are in black Caribbeans who also have the highest rate (2,327 per 100,000 population)
- Gonorrhoea and genital herpes increased between 2014 and 2015 in all persons.
- Gonorrhoea has decreased by 5% in non-MSM in the south west but increased in Dorset by 120%
- Herpes increased by 3.6% in non-MSM, Somerset and Plymouth experiencing the highest increase (27%)
- Plymouth, Bournemouth and Bristol had higher rates than England in all new STIs and all STIs (excluding chlamydia in 15-24) in 15-64
- Plymouth, Torbay and Bournemouth had chlamydia detection rates of over 2,300 in 2015
Table 1: Percentage change in new STI diagnoses. South West residents

<table>
<thead>
<tr>
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<tr>
<td>New STIs</td>
<td>34,095</td>
<td>-</td>
<td>-2%</td>
</tr>
<tr>
<td>Syphilis</td>
<td>154</td>
<td>54%</td>
<td>-2%</td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>1,736</td>
<td>139%</td>
<td>9%</td>
</tr>
<tr>
<td>Chlamydia</td>
<td>16,206</td>
<td>-</td>
<td>-3%</td>
</tr>
<tr>
<td>Genital Herpes</td>
<td>2,755</td>
<td>13%</td>
<td>3%</td>
</tr>
<tr>
<td>Genital Warts</td>
<td>6,489</td>
<td>-5%</td>
<td>-3%</td>
</tr>
</tbody>
</table>

STI in MSM

- All STIs have increased from 2014 to 2015 in MSM
- Highest increases in MSM from 2014 to 2015 were in gonorrhoea, chlamydia and genital herpes
- Highest increases in MSM from 2011 to 2015 were in gonorrhoea, syphilis and genital herpes

Table 2: Percentage change in new STI diagnoses in men who have sex with men (MSM) diagnosed in GUM clinics. South West residents

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>New STIs</td>
<td>2,476</td>
<td>77%</td>
<td>13%</td>
</tr>
<tr>
<td>Syphilis</td>
<td>112</td>
<td>44%</td>
<td>2%</td>
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<tr>
<td>Gonorrhoea</td>
<td>882</td>
<td>254%</td>
<td>25%</td>
</tr>
<tr>
<td>Chlamydia</td>
<td>586</td>
<td>57%</td>
<td>26%</td>
</tr>
<tr>
<td>Genital Herpes</td>
<td>87</td>
<td>81%</td>
<td>13%</td>
</tr>
<tr>
<td>Genital Warts</td>
<td>273</td>
<td>40%</td>
<td>9%</td>
</tr>
</tbody>
</table>

Gonorrhoea in MSM

- Between 2008 and 2016 (Q2) 40.1% of those diagnosed with gonorrhoea were also diagnosed with chlamydia, syphilis, genital warts or herpes
- Of all those diagnosed with gonorrhoea:
  - 30.8% were diagnosed with one of the 4 STIs at or within 12 months of their gonorrhoea diagnosis
  - 34.3% were diagnosed with one of the 4 STIs 12 months before or after their gonorrhoea diagnosis

4. ACADEMIC UPDATE

Dr Patrick Horner, Consultant Senior Lecturer, School of Social and Community Medicine, University of Bristol

Research on the following areas was brought to the attention of the Board:

- Making every contact count – risky alcohol consumption in sexual health clinic attendees
  "Assessing feasibility and acceptability of a brief intervention for risky alcohol consumption in sexual health clinic attendees: a randomised controlled trial."
Interpretation: Alcohol misuse is common in sexual health clinic attendees. Systematic assessment and brief intervention for alcohol misuse was feasible and acceptable to staff and patients. Identification and provision of standard information alone appeared to influence drinking and sexual behaviour. "The clinical effectiveness and cost-effectiveness of brief intervention for excessive alcohol consumption among people attending sexual health clinics: a randomised controlled trial (SHEAR)."

Interpretation: Introduction of universal screening and brief intervention for excessive alcohol use among people who attend sexual health clinics does not result in clinically important reductions in alcohol consumption or provide a cost-effective use of resources. While people attending sexual health clinics may want to achieve better sexual health, attempts to reduce alcohol consumption may not be seen by them as a necessary means of trying to achieve this aim.


Interpretation: Geographical regions with less available condoms were associated with higher gonorrhoea/chlamydia and HIV infection rates.

Medicated sex in Britain: evidence from the third National Survey of Sexual Attitudes and Lifestyles "Medicated sex in Britain: evidence from the third National Survey of Sexual Attitudes and Lifestyles."

Interpretation: Because medication is increasingly easy to access without prescription, there is a need for better professional and patient education on this phenomenon.

Quadrivalent HPV vaccination in heterosexual men a retrospective study from Australia "Quadrivalent vaccine-targeted human papillomavirus genotypes in heterosexual men after the Australian female human papillomavirus vaccination programme: a retrospective observational study"

Interpretation: The marked reduction in prevalence of 4vHPV genotypes among mainly unvaccinated Australian-born men suggests herd protection has occurred from the female vaccination programme. These reductions could translate to reductions in HPV-related malignant conditions in men, even in countries with female-only vaccination programmes. Adds to the evidence of reduction in genital warts in heterosexual males in Australia following female vaccination. A female vaccination only programme is of no benefit to men who have sex with men (MSM).
• **Pre-exposure prophylaxis for HIV-1 infection**
  - **Interpretation:** PrEP for HIV prevention among MSM in the Netherlands is likely to be cost-effective. The use of PrEP is most cost-effective when the price of PrEP is reduced through on-demand use or through availability of generic PrEP, and can quickly be considered cost-saving.

• **MSM prescribed HIV post-exposure prophylaxis: characteristics and outcomes**
  “What are the characteristics of, and clinical outcomes in men who have sex with men prescribed HIV post-exposure prophylaxis following sexual exposure (PEPSE) at sexual health clinics in England?”
  Mitchell H, et al *Sex Transm Infect* DOI: [http://dx.doi.org/10.1136/sextrans-2016-052806](http://dx.doi.org/10.1136/sextrans-2016-052806)
  - **Interpretation:** MSM prescribed PEPSE are at high risk of subsequent HIV acquisition and the data show further risk stratification by clinical and PEPSE prescribing history is possible.
    - This group is also at high risk of STIs
    - Likely to benefit from PrEP

• **ACCEPt Chlamydia Screening Trial Australia**
  “Chlamydia control – where to from here? Results from the Australian Chlamydia Control Effectiveness Pilot (ACCEPt)”
  - **Interpretation:** No evidence from this large well conducted RCT in men and women that chlamydia screening reduces chlamydia prevalence. However coverage was lower than the NCSP: 8.1% at baseline increasing to 20% in the intervention arm vs 12.7% in control arm. A reduction in prevalence was noted in both arms – why this occurred in the control arm is unclear.

• **The emergence and spread of gonorrhoea with reduced susceptibility to ceftriaxone seems a realistic prospect!**
  “Drifting towards ceftriaxone treatment failure in gonorrhoea: risk factor analysis of data from the Gonococcal Resistance to Antimicrobials Surveillance Programme in England and Wales.”
  Town et al., (2017) *Sex Trans Infect* DOI: [https://doi.org/10.1136/sextrans-2016-052583](https://doi.org/10.1136/sextrans-2016-052583)
  - **Key message:** Highlights the importance of continued surveillance, promotion and availability of accessible services for high risk networks, adherence to the recommended guidelines, vigilance for possible treatment failure and test of cure to help preserve existing treatment options.

• **Can antiseptic mouthwash reduce risk of transmission of gonorrhoea from oral sex?**
  “Antiseptic mouthwash against pharyngeal Neisseria gonorrhoeae: a randomised controlled trial and an in vitro study.”
  Chow EO et al. (2017) DOI: [http://sti.bmj.com/content/sextrans/93/2/88.full.pdf](http://sti.bmj.com/content/sextrans/93/2/88.full.pdf)
• **Results and interpretation:** After gargling the allocated solution, men in the Listerine group were significantly less likely to be culture positive on the pharyngeal surface (52%) compared with men in the saline group (84%) \((p=0.013)\). This small study suggests antiseptic mouthwash has potential to reduce oral transmission but this needs to be confirmed in a clinical trial.

• **Overseas travel and new sexual relationships**
  “Forming new sex partnerships while overseas: findings from the third British National Survey of Sexual Attitudes and Lifestyles (Natsal-3).”
  Tanton C et al. (2016) *Sex trans Infect* DOI: [http://sti.bmj.com/content/sextrans/92/6/415.full.pdf](http://sti.bmj.com/content/sextrans/92/6/415.full.pdf)

• **Key messages:** Men and women reporting new partner(s) while overseas were more likely to report a range of harmful health behaviours, including sexual risk and substance use. With international travel on the increase, and people travelling for many reasons, sexual health advice should be included as part of holistic health advice for all travellers.

5. CURRENT AND FUTURE OPPORTUNITIES

**Sexual Violence**

An act of sexual violence is any unwanted sexual activity. It includes rape, sexual assault, sexual abuse, incest, sexual domestic violence, trafficking, sexual exploitation, female genital mutilation, ritual abuse, forced marriage, crimes in the name of honour, sexual intimidation, coercion or harassment.

A sexual assault is any sexual act that a person did not consent to, or is forced into against their will. It is a form of sexual violence and includes rape. In the south west it is estimated that 42,900 people over the age of 16 experience some kind of sexual assault every year.

The Crime Survey for England and Wales for the year ending March 2015 showed that police recorded 88,219 sexual offences, encompassing rape (29,265 cases) and sexual assault, and also sexual activity with children. This is a steep rise on previous years. Sexual violence or assault can happen to anyone of any age: men, women and children.

Many support services exist for the victims of sexual violence, but the identification of the appropriate service for the individual is sometimes very complex and confusing. This project aims to simplify the process.

The support accessed by victims of sexual violence will vary, depending on what is available locally as well as personal preference, age and the length of delay in making the initial contact with services. It is increasingly recognised that identifying appropriate and legitimate services is not easy and that for young victims particularly, the internet is the key signposting resource.

The Office for Sexual Health South West is therefore developing an online map of services and pathways available for the victims of sexual violence. It will ensure that all victims of sexual violence in the south west have easy access to the information that will help identify the most appropriate support organisation.
Somerset and Avon Rape and Sexual Abuse Support (SARSAS) already provides an online resource that covers part of the south west, but outside this catchment area, the access to referral information and service details is variable.

The new online directory will help victims and professionals to identify appropriate information and support. Information about the services in each local area will be collated and uploaded to the shared website. Ultimately the full map of services and the links between them will provide a region-wide resource.

The web developers are currently designing and building the new website, based on the effective Survivor Pathway hosted by SARSAS. The new website will be formatted to allow for maximum responsiveness and improved accessibility on both tablets and smartphones. The rebuild will improve the website’s Google rankings, ensuring that users can access the site as quickly and easily as possible.

Marketing, training and promotional activities are being agreed and will take place over the summer of 2017 in preparation for the full website launch in September.

**Workforce Development**

The sexual health workforce is diverse and includes specialists and generalists. There are specialist doctors and nurses in community sexual and reproductive health (CSRH) and genitourinary (GU) medicine and HIV. The generalist workforce includes GPs, practice nurses, pharmacists, school teachers, school nurses and college tutors.

Due to the many different and varied professionals involved in the delivery of sexual health, establishing a clear picture of the workforce is not straightforward. In many cases, the main focus of an individual's work may actually be in the provision of another service, such as school nursing, health visiting or midwifery.

Recently there has also been a significant shift in the delivery of sexual health services, with a move to deliver integrated services which provide a comprehensive sexual health offer across the patient pathway. The new models of working include an increased focus on nurse-led provision so nurses are taking on pivotal positions involving an emphasis on leadership. Consultant roles within GU medicine are shifting focus, expanding into other areas of sexual health including the provision of contraception and the management of sexual dysfunction. At the same time, the new specialty of Community Sexual and Reproductive Health (CSRH) is gradually becoming established with consultants taking on lead roles in the emerging integrated sexual health services.

The majority of the sexual health specialist workforce is employed on NHS contracts, but sexual health services are funded through local authorities. As a result, responsibility for the oversight of the full sexual health workforce is at risk of falling between organisational bodies.

In addition, educational courses and training opportunities in sexual health vary. The range of courses on offer includes some that are academically accredited, whilst others are not; some containing a clinical practice component, whilst others do not; and the level of theoretical content included varies considerably. This lack of uniformity, coordination and availability confuses the recognition of knowledge and skills, and makes it difficult to plan or ensure appropriate training for carrying out roles competently and safely.
The Office for Sexual Health South West is therefore working with Health Education England to establish and accurately understand the current composition of the workforce within the specialist sexual health and contraception services and then going on to consider the individual and collective training needs.

A preliminary piece of work has been completed to scope the parameters and clear objectives of the sexual health workforce project. The work has now begun by establishing a basic list of the sexual health workforce, coordinating a directory of the currently available training opportunities for the sexual health workforce and considering the training and development requirements of the workforce.
Members of the South West Sexual Health Programme Board are:

<table>
<thead>
<tr>
<th>Name</th>
<th>Position/Role</th>
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<tbody>
<tr>
<td>Ann Steele-Nicholson</td>
<td>Nurse Manager Bristol Sexual Health Services</td>
</tr>
<tr>
<td>Debbie Harvey</td>
<td>Sexual Health Advisor</td>
</tr>
<tr>
<td>Debbie Stark</td>
<td>Deputy Centre Director Public Health England South West</td>
</tr>
<tr>
<td>Debra Lapthorne</td>
<td>Centre Director Public Health England South West</td>
</tr>
<tr>
<td>Frances Keane</td>
<td>Consultant Sexual Health/HIV Royal Cornwall Hospital Trust</td>
</tr>
<tr>
<td>Indra Karunaratne</td>
<td>BASHH Regional Chair</td>
</tr>
<tr>
<td>Julia Loveluck</td>
<td>Senior Public Health Officer – Sexual Health</td>
</tr>
<tr>
<td>Julia Nibloe</td>
<td>Service Manager, Brook, Bristol</td>
</tr>
<tr>
<td>Kay Rundle</td>
<td>Operations Manager, Brook, Cornwall</td>
</tr>
<tr>
<td>Lindsey Thomas</td>
<td>Specialist Public Health Manager</td>
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<tr>
<td>Mags Davies &amp; Andrew Evans</td>
<td>Eddystone Trust</td>
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<tr>
<td>Mark Pietroni</td>
<td>Director of Public Health</td>
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<tr>
<td>Michelle Hawkes</td>
<td>Public Health Specialist</td>
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<tr>
<td>Norah O’Brien</td>
<td>Sexual Health Facilitator Public Health England South West</td>
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<tr>
<td>Paddy Horner</td>
<td>Consultant Senior Lecturer University of Bristol</td>
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<tr>
<td>Paul Sheehan</td>
<td>Public Health Development and Commissioning Manager</td>
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<tr>
<td>Phil Kell</td>
<td>Consultant Physician in Sexual Health South Devon Healthcare NHS Trust</td>
</tr>
<tr>
<td>Rachel Campbell</td>
<td>Public Health England Public Health Specialist Health and Justice South West</td>
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<tr>
<td>Rebecca Marsh</td>
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<td>Ruth Woolley</td>
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<td>Sarah Fuhrmann</td>
<td>Terrence Higgins Trust</td>
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<td>Sarah Scott</td>
<td>Director of Public Health</td>
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<tr>
<td>Selena Gray</td>
<td>Professor of Public Health</td>
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For more information on any aspect of the Directors of Public Health Network and Office for Sexual Health South West please contact: wendy.lawton@southglos.gov.uk