Hammersmith and Fulham, Kensington and Chelsea and Westminster Tri-borough

Sexual Health Joint Strategic Needs Assessment

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Summary

Hammersmith and Fulham

- Hammersmith and Fulham is ranked 4 (out of 326 local authorities, first in the rank has highest rates) in England for rates of STIs in 2011. 3330 acute STIs were diagnosed in residents of Hammersmith and Fulham, a rate of 1962.2 per 100,000 residents.
- 34% diagnoses of acute STIs were in young people aged 15-24 years old.
- The rate of chlamydia diagnoses per 100,000 young people aged 15-24 years old in Hammersmith and Fulham was 2226.
- The proportion of Hammersmith and Fulham residents attending genitourinary medicine (GUM) clinics who received an HIV test was 67%.
- Hammersmith and Fulham under 18 conception rates are higher than London, with 42.6% per 1000 15-17 year old teenage girls in 2010.

Kensington and Chelsea

- Kensington and Chelsea is ranked 14 (out of 326 local authorities, first in the rank has highest rates) in England for rates of STIs in 2011. 2492 acute STIs were diagnosed in residents of Kensington and Chelsea, a rate of 1470.3 per 100,000 residents.
- 33% diagnoses of acute STIs were in young people aged 15-24 years old.
- The rate of chlamydia diagnoses per 100,000 young people aged 15-24 years old in Kensington and Chelsea was 2031.1.
- The proportion of Kensington and Chelsea residents attending genitourinary medicine (GUM) clinics who received an HIV test was 67%.
- HPV vaccine coverage is 65% during 2010/11, compared with London is nearly 90%.
- Kensington & Chelsea have the lowest rates of GP-prescribed LARC in London.

Westminster

- Westminster is ranked 10 (out of 326 local authorities, first in the rank has highest rates) in England for rates of STIs in 2011. 4154 acute STIs were diagnosed in residents of Westminster, a rate of 1641.2 per 100,000 residents.
- 31% diagnoses of acute STIs were in young people aged 15-24 years old.
- The rate of chlamydia diagnoses per 100,000 young people aged 15-24 years old in Westminster was 1646.9.
- The proportion of Westminster residents attending genitourinary medicine (GUM) clinics who received an HIV test was 69%.
- Westminster has the 2nd lowest rates of GP-prescribed LARC in London.

Limitations and potential data requirements

(This section will include future data improvements for further analysis)

- Estimates indicate a significant Lesbian, Gay, Bisexual and Transgender people who live, work and visit the tri-borough. However, accurate population size remains unknown. In addition, more understanding is required of the needs of these communities to ensure that accessible and appropriate services are available.

- Estimates further indicate a significant number of sex workers living or working in the tri-borough area. More work is required to understand the size and demographics of this population. Again, further understanding of the complex needs of this population needs to be gained over time. Work to deliver appropriate services to this population should link with recommendations which will be made by a specific Task Group looking at Sex Work within Westminster City Council.

Introduction

The World Health Organisation describes sexual health as:

'The state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction and infirmity. Sexual health requires a positive, respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all people must be respected, protected and fulfilled.' (WHO, 2006)

The consequences of poor sexual health can be serious. Many sexual infections have long-term impacts on health such as:

- Pelvic inflammatory disease (which can cause ectopic pregnancies and infertility);
- Cervical and other genital cancers;
- Hepatitis, chronic liver disease and liver cancer;
- Recurrent genital herpes;
- Bacterial vaginosis and premature delivery;
- Psychological consequences of sexual coercion and abuse;
- Poor educational, social and economic opportunities for teenage mothers;
- Requirement for lifelong adherence to Highly Active Anti-Retroviral Therapy (HAART) for HIV;
- Earlier onset of conditions normally seen in older age amongst people living with HIV.

Furthermore, sexual health contributes to health inequalities – there is a clear link between social deprivation and poor sexual health. Women, gay men, young people and people from Black and Minority Ethnic (BME) groups are disproportionately affected by poor sexual health.

The financial impact of poor sexually health is also far reaching. The average lifetime treatment costs for a person living with HIV is between £135,000 and £181,000. The value of preventing a single onward transmission of HIV is estimated to be between £500,000 and £1m including health benefits and treatment costs. In other words if a patient infected with HIV transmits the disease to another person that will cost health and social services an extra £500,000 to £1 million per patient for their treatments and social care. (Department of Health, 2001). Furthermore, the prevention of unintended pregnancies through the delivery of effective contraceptive services is thought to save the NHS over £2.5billion per year.

'Healthy Lives, Healthy People: the strategy for Public Health in England' (Department of Health, 2010) references sexual health throughout. It confirms commitment to increase local government and community leadership of all public health issues including sexual health.

In 2011 the Health Protection Agency (HPA, 2011) highlighted several national recommendations.

- Local areas should be working towards achieving a chlamydia diagnosis rate of at least 2,400 per 100,000 (Public Health Outcome Framework Indicator). Areas that are achieving at or above this level should aim to sustain or increase diagnosis rates, with areas achieving below it aiming to increase their diagnosis rate incrementally, for example by 10% from the previous year.
- Local areas should focus on embedding chlamydia screening in primary care and sexual health services, emphasise the need for repeat screening annually and on change of sexual partner, and ensure treatment and partner notification standards are met.
- Prevention efforts, such as greater STI screening coverage and easier access to sexual health services, should be sustained and continue to focus on groups at highest risk.
- Men who have sex with men (MSM) having unprotected sex with casual or new partners should have an HIV-STI screen at least annually, and every 3 months if changing partners regularly.
- Health promotion and education are important interventions for the prevention of STIs and HIV through improving public awareness and encouraging safer sexual behaviour. Consistent condom use, reducing the number of sexual partners and the avoidance of overlapping sexual relationships all reduce the risk of being infected with an STI.

'The 'Framework for Sexual Health Improvement in England' (Department of Health, March 2013) aspires to improve the sexual health of the whole population through the following specific ambitions:

- Reducing inequalities and improving sexual health outcomes;
- Building an open and honest culture where everyone is able to make informed and responsible choices about relationships and sex;
- Recognising that sexual ill health can affect all parts of society, often when it is least expected.

The framework also lists a number of specific objectives that are crucial to achieving these ambitions. These are:

- Build knowledge and resilience of young people;
- Rapid access to high quality services;
- People remain healthy as they age;
- Prioritise prevention;
- Reduce rates of STIs amongst people of all ages;
- Reduce onward transmission of HIV and avoidable deaths from it;
- Reduce unintended pregnancies among women of all ages;
- Continue to reduce the rate of under 16 and under 18 conceptions

Improving outcomes and supporting transparency: A public health outcomes framework for England 2013- 2016' (Department of Health, 2012) has identified a number of sexual health related indicators including:

- Under 18 conceptions
- Violent crime (including sexual violence)
- Non-cancer screening including screening for HIV during pregnancy
- Chlamydia diagnoses (15-24 year olds)

- Population vaccination coverage
- People presenting with HIV at a late stage of infection

Commissioning of sexual health services will largely be the responsibility of Public Health from April 2013. Public Health will become a Local Authority responsibility at this time. However, some sexual health services will also be commissioned by Clinical Commissioning Groups and the NHS Commissioning Board.

Robust relationships will be required between the commissioning organisations to ensure that sexual health pathways do not become disjointed and that sexual health outcomes are maintained and improved at a population level.

The London Borough of Hammersmith and Fulham, Royal Borough of Kensington and Chelsea and City of Westminster will operate a tri-borough Public Health service. To describe this footprint, this document will hereon in refer to 'the tri-borough' as covering these three boroughs.

Aims of the Joint Strategic Needs Assessment

This sexual health needs assessment supports the tri-borough Sexual Health and HIV Strategy. It specifically aims to:

- Describe the picture of sexual health in the tri-borough, examining trends in STIs and HIV as well as teenage conceptions and abortions;
- Describe current service provision with regards to prevention, testing and management of sexual and reproductive health in the tri-borough – this will include services in primary care, the National Chlamydia Screening Programme, Genito-Urinary Medicine services and community contraceptive services;
- Determine whether existing services are meeting the needs of residents in the tri-borough and identify gaps in services and areas of unmet need;
- Identify key prevention groups in greater need of services locally;

Data sources

1. Genitourinary Medicine Clinic Activity Dataset (GUMCAD) returns

2. National Chlamydia Screening Programme (NCSP) returns for chlamydia diagnoses and tests in those 15-24 years old only

3. Non-NCSP / Non-GUM returns from laboratories for chlamydia diagnoses and tests in those 15-24 years old only.

4. Data presented are compiled from a combination of sources and reflect diagnoses made in GUM clinics and include chlamydia diagnoses made in other community healthcare and non-healthcare settings such as general practice.

5. Data presented are the number of diagnoses reported and not the number of people diagnosed

6. ONS 2010 population data has been used for calculation of 2011 rates

7. Survey of Prevalent HIV Infections Diagnosed (SOPHID) from Health Protection Services - Colindale, Health Protection Agency, August 2012

8. Population data are from Office of National statistics census 2011.

9. Where there is no ONS census 2011 available other data sources were used such as 2001 ONS census data, population estimations from ONS and GLA population data.

Methodology

Data in this report is presented either as numbers or rates. Rates will be compared with London and England as a standard comparison. Statistical neighbours for the tri-boroughs are Camden, Wandsworth, Islington and Greenwich. Comparisons will be made against statistical neighbours in some of the analysis. Statistical neighbour

models provide one method for benchmarking progress. For each local authority, these models designate a number of other local authorities deemed to have similar characteristics. These designated local authorities are known as statistical neighbours. Any local authority may compare its performance (as measured by various indicators) against its statistical neighbours to provide an initial guide as to whether their performance is above or below the level that might be expected.'

The Local Population

Current population

According to the 2011 Census

- Hammersmith and Fulham had a total population of 184,500 people; the fourth smallest borough population in London
- Kensington and Chelsea had a total population of 158,700; the smallest borough population in London excluding City of London
- Westminster had a total population of 219,400 people; the 10th smallest borough population of in London.

In April 2012:

- NHS Hammersmith and Fulham Clinical Commissioning Group (CCG) comprised 31 GP practices with a total patient list of £206,061. The CCG boundary is co-terminus with the London Borough of Hammersmith and Fulham boundary.
- NHS West London CCG comprised 57 GP practices with a total patient list of 228,779. The CCG boundary is not co-terminus with the Royal Borough of Kensington and Chelsea boundary. It also includes a number of GP practices located in the Queen's Park and Paddington area of the City of Westminster.
- NHS Central London CCG comprised 36 GP practices with a total patient list of 188,986. The CCG boundary is not co-terminus with the City of Westminster boundary and excludes those practices in the Queen's Park and Paddington area.
- According to latest ONS census, 2011, tri-borough population is 560,600.

Patients do not have to register with a GP practice within their borough of residence. As such patients in General Practices may be drawn from a number of neighbouring boroughs. This will have a bearing on the development of sexual health services in Primary Care in future.

The CCG patient list figures demonstrate some immediate differences between the size of the populations living in a borough and those access Primary Care services in the same area. Any difference in commissioning for a population registered with a GP in a CCG area as opposed to a population resident in a borough area will need to be considered.

Table 1: Tri-borough population by area of residence and boundary comparison with Clinial commission groups

Local authority	Local authority resident Population	PCT GP registered population*	CCG GP registered population*
Hammersmith & Fulham	182,500	202,368	202,368
Kensington & Chelsea	158,700	178,421	226,198
Westminster	219,400	232,584	185,651

*GP registered population as at 31st December 2012.

Age structure

The age structure in each of the three boroughs is very different to England, with a much larger working age population and a much smaller proportion of children and older people.

Figure 1: Proportion of resident population by age-band, 2011, Hammersmith and Fulham (Data source, ONS census 2011)

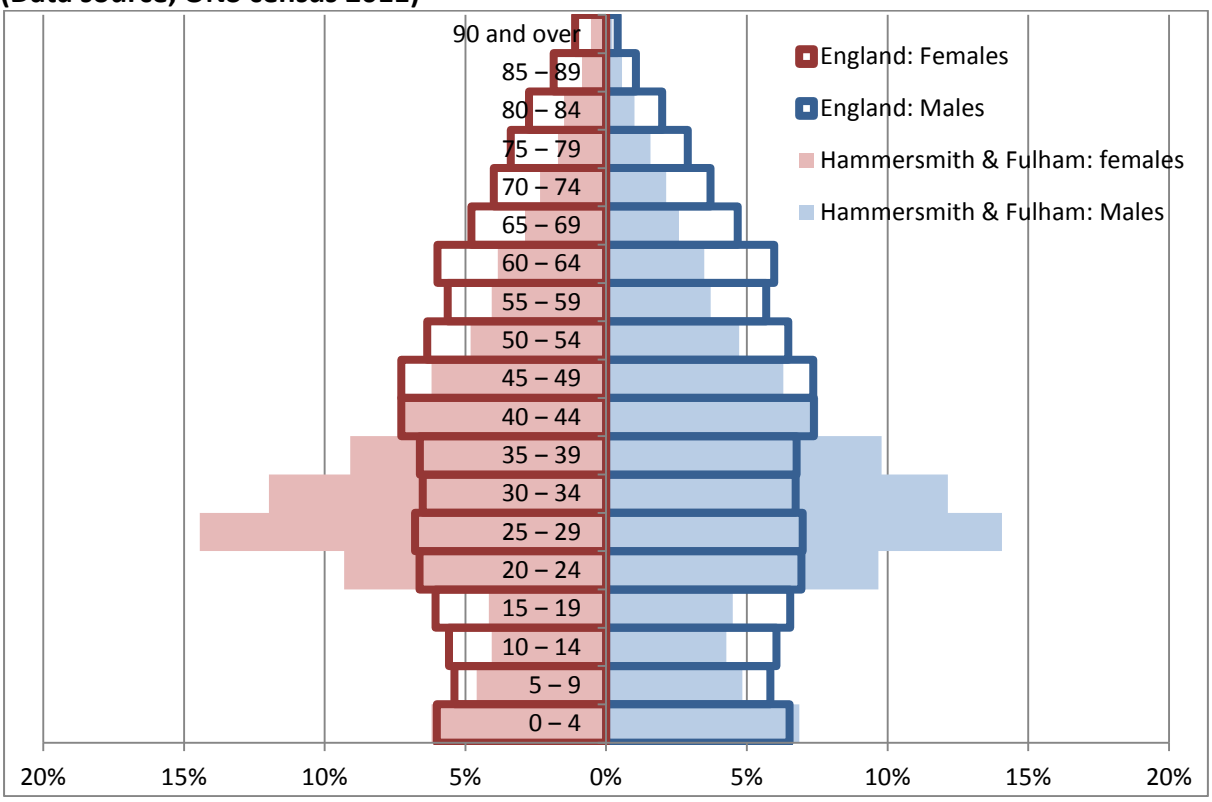


Figure 2: Proportion of resident population by age-band, 2011, Kensington and Chelsea (Data source, ONS census 2011)

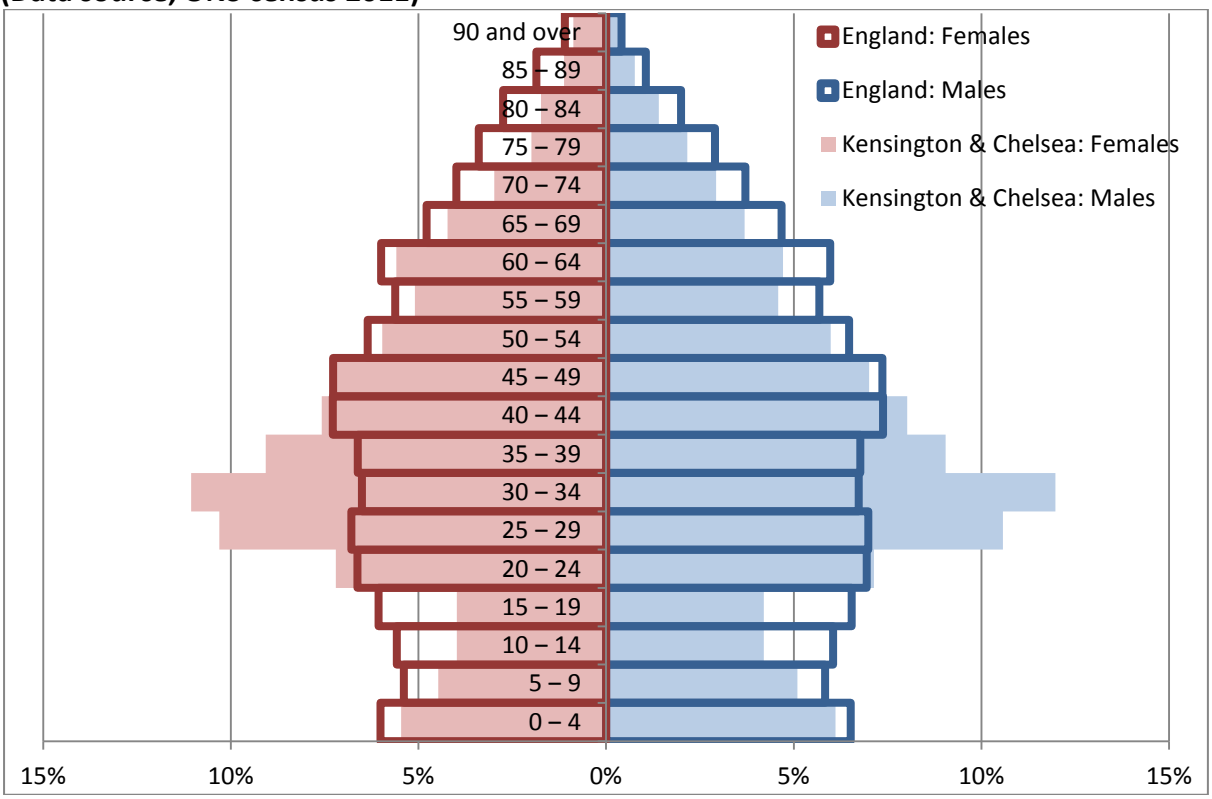
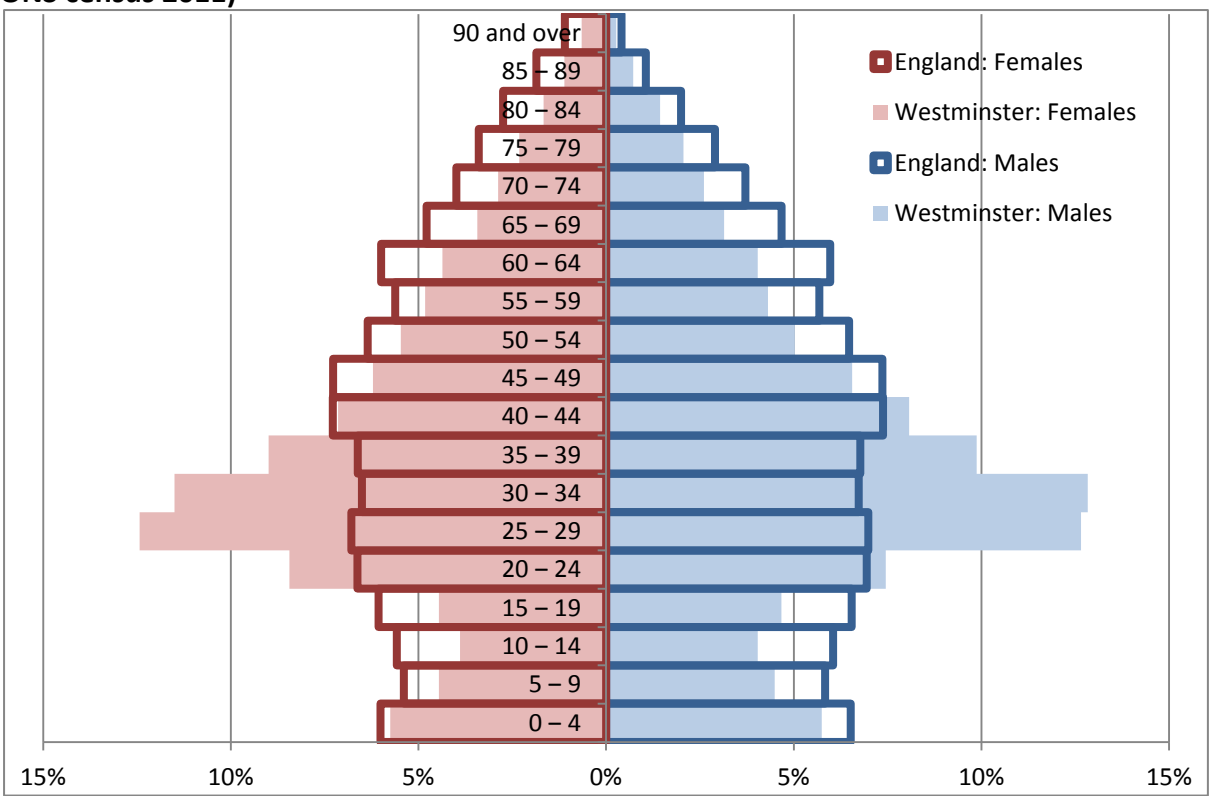


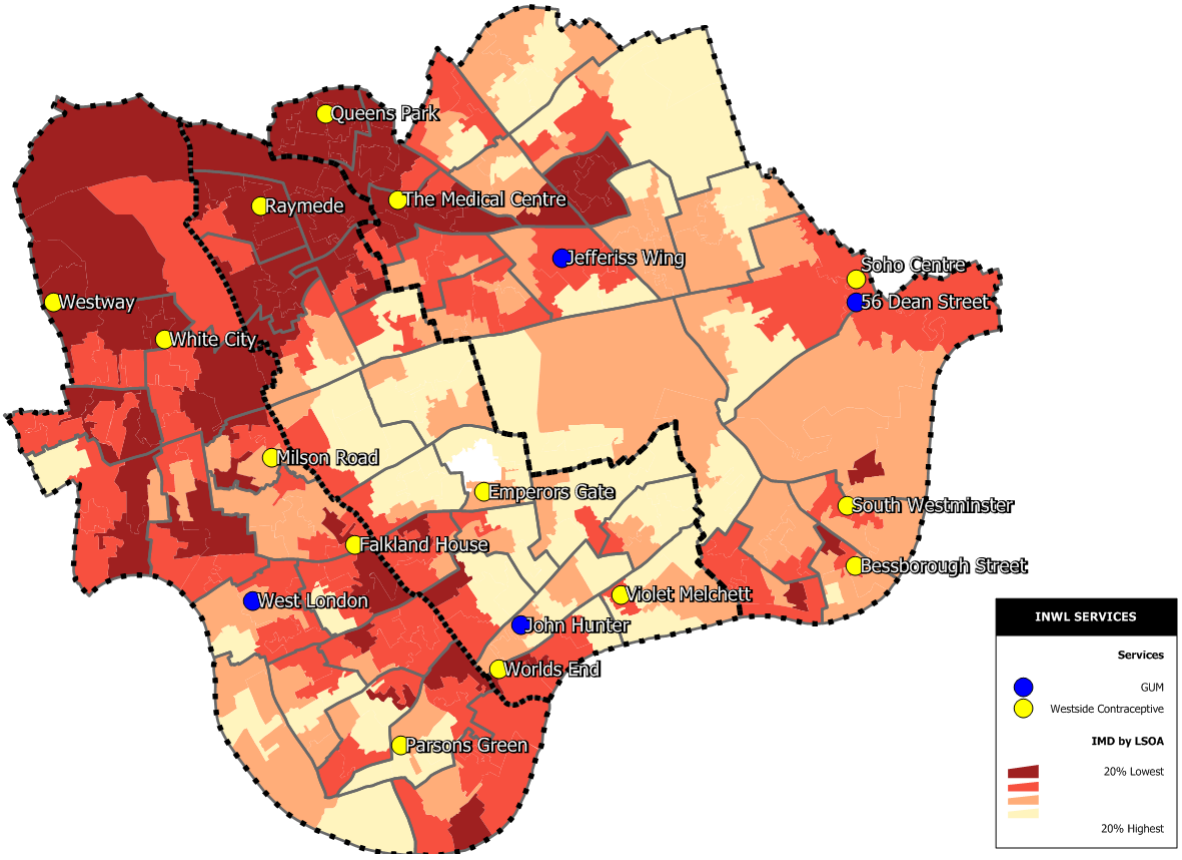
Figure 3: Proportion of resident population by age-band, 2011, Westminster (Data source, ONS census 2011)



Overall, all three boroughs have fewer children and older people than England. Populations are heavily weighted in the 20 - 44 age bracket. Hammersmith and Fulham has the highest population in this bracket by proportion and when compared to the other two boroughs

Deprivation

Figure 4: Map showing highly deprived areas (Data source, Index of multiple deprivation at LSOA level, ONS 2010) and sexual health services within the Tri-borough.



Many wards in the north of the three boroughs score highly on the Index of Multiple Deprivation. Some parts of the northern areas belong to the most deprived deciles in England. Four wards in Westminster are in the highest quintile of deprivation. There are contraceptive services in Northern wards of tri-borough. However, there are no GUM services available in the North of the boroughs.

Key population groups

Given the inequalities in sexual health outlined in the introduction, it is also useful to look at those groups who are known to experience inequalities with regards to sexual health. Nationally, young people, men who have sex with men (MSM) and Black African and Black Caribbean populations have been shown to have higher rates of acute STIs.

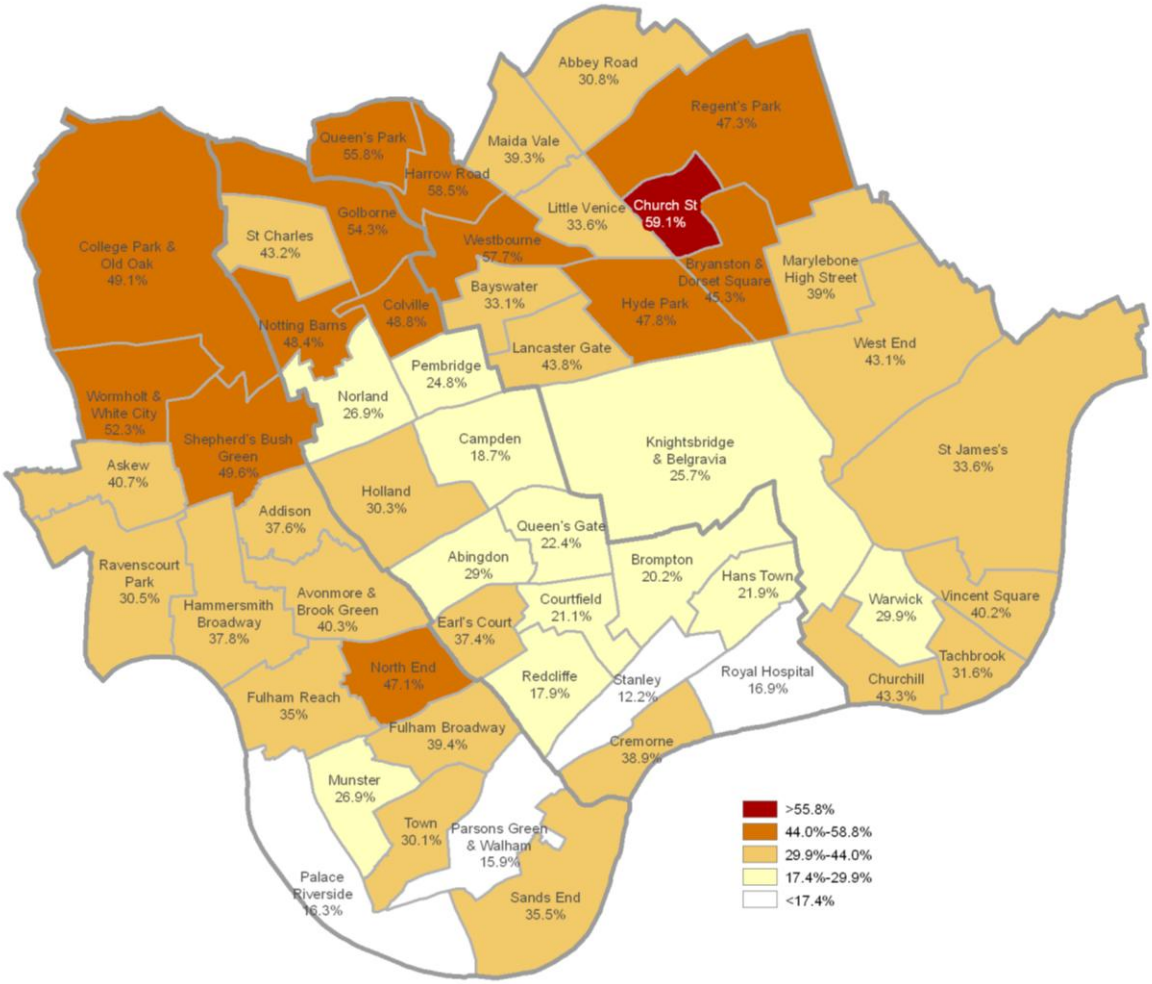
Young people

There are an estimated 98,800 young people aged 15 - 24 resident in the tri-borough (ONS Census Data, 2011). When compared with 2001 data, an upward trend in the number of 15 - 24 year olds is noted leading to an expectation of further increase in the future.

Overall, the tri-borough population is highly mobile with the highest population turnover rate of any London borough and this is particularly true of the younger population aged 18-34. Westminster has highest rates of international migration in England while Hammersmith and Fulham have the highest rates of migration within England.

The 0-17year old population in the tri-borough is also extremely diverse; 36% of children and young people are from BME groups as compared to 30% of the tri-borough population as a whole and 12% of the England population. (ONS, 2010). This diversity of children is expected to increase in the future with an increase in international migration into the tri-borough area.

Figure 5: Percentage of residents aged 0-17 years from Black and Minority Ethnic groups, 2001 (ONS census 2001)



When looking at this map in conjunction with the deprivation map, there are strong similarities between wards with higher BME populations and wards with higher levels of deprivation.

There are several universities and colleges based within the tri-borough area which have halls of residence, accommodating large numbers of students.

Young people experience the highest rates of STIs by age. Of all diagnoses of acute STIs in 2011, 34% in Hammersmith and Fulham, 33% in Kensington and Chelsea and 31% in Westminster were in 15 to 24 year olds.

Lesbian, gay, bisexual and transgender (LGBT) people

It is difficult to accurately assess the size of the local LGBT population as no data is captured on sexual orientation in any survey, including the Census. Sigma Research carried out a needs assessment of LGBT people in Lambeth, and to estimate the size of the population used an estimate of 5% (Keogh *et al*, 2006). This took into account the National Survey of Sexual Attitudes and Lifestyles (Johnson et al. 2001) which found that 3.9% of women and 5.5% of men aged 16-44 and living in London had had a same gender sex partner in the previous 5 years. The figures were lower in the rest of the UK for both women (2.4%) and men (2.1%), confirming that sexual minorities migrate to large cities, especially London. Within London, sexual minorities are concentrated in inner rather than outer London. Hickman et al. (1997) found that 8.6% of the male population of Inner London had a male sex partner in the last five years. This figure may apply to some areas of Central London but does not apply to the bulk of the UK. This demonstrates that across the tri-boroughs the consideration of the needs of LGBT people has to be greater than in the rest of the UK.

Using the 5% estimate and applying this to the population over 15 years old in the tri-borough area the resident LGBT population is of at least 22,800. This is likely to be a conservative estimate as it does not consider the large LGBT population who work or socialise in the area, particularly given the facilities in the West End and Soho areas of Westminster. This suggests that LGBT people represent a sizeable proportion of the resident and visiting population.

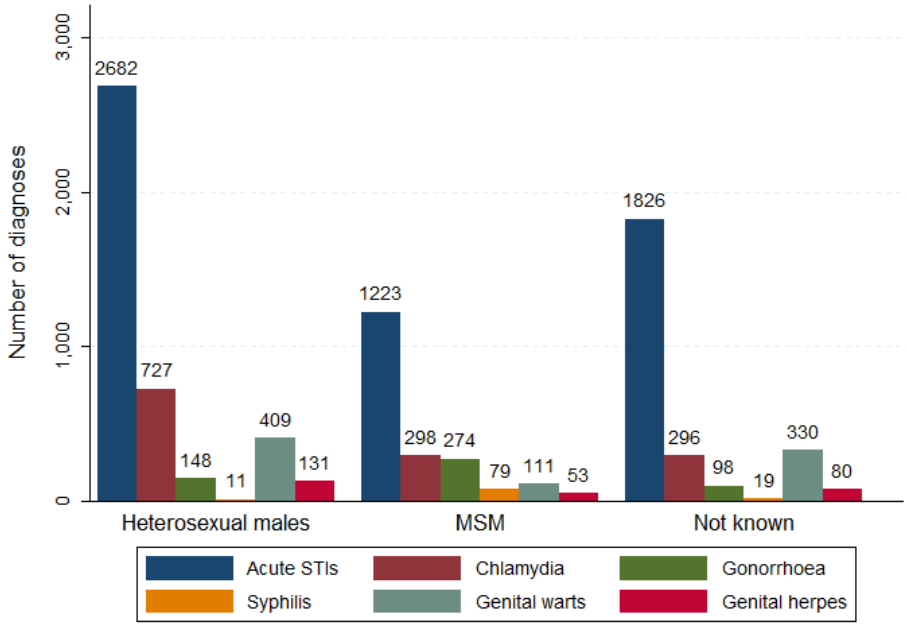
Between January 2009 and December 2011 and considering the GP registered population, for STI diagnoses in men where sexual orientation was recorded, MSM accounted for:

- 31.3% of acute STIs in Hammersmith and Fulham
- 48.1% of acute STIs in Kensington and Chelsea
- 59.3% of acute STIs in Westminster.

As these figures are only for diagnoses where sexual orientation was recorded, the actual proportion may be higher.

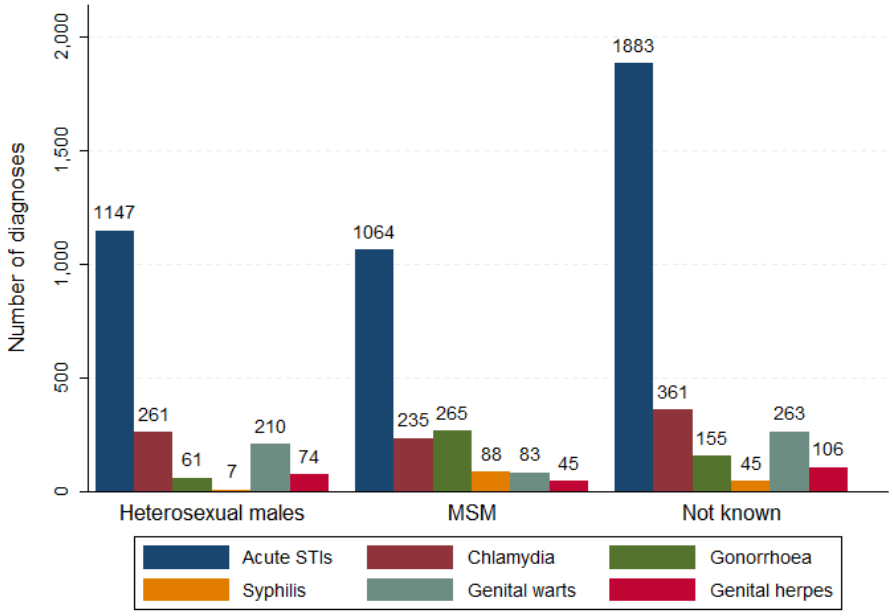
Overall very little is known about the LGBT population in the tri-borough. Further work is needed to better understand both the size of the LGBT population (both residents and visitors to the borough) and also the characteristics of this population – for example, age, ethnicity and deprivation experienced.

Figure 6: Number of acute STIs, chlamydia, syphilis, gonorrhoea, genital warts and genital herpes in men by their sexual orientation from January 2009 to December2011, Hammersmith & Fulham



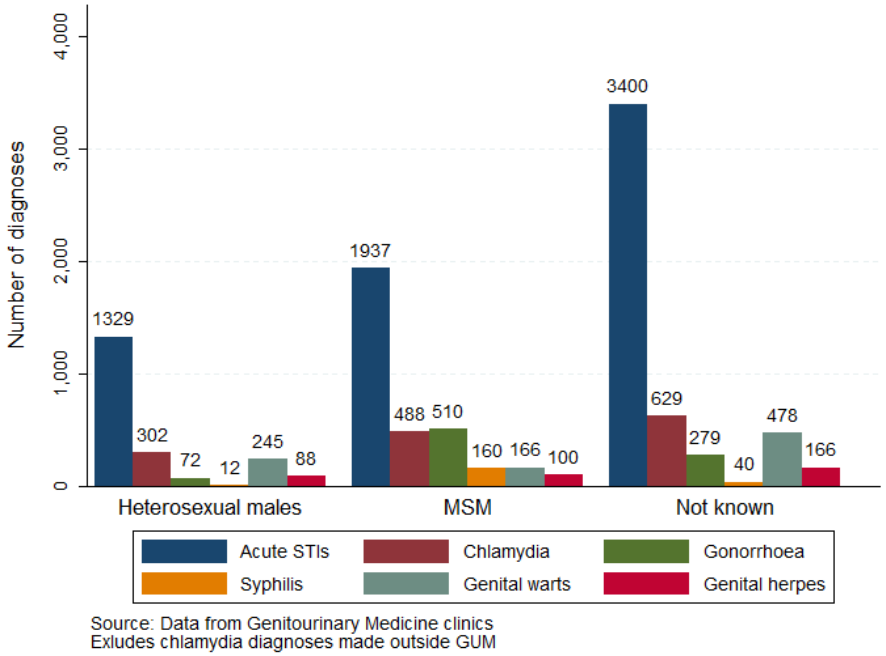
Source: Data from Genitourinary Medicine clinics
Exludes chlamydia diagnoses made outside GUM

Figure 7: Number of acute STIs, chlamydia, syphilis, gonorrhoea, genital warts and genital herpes in men by their sexual orientation from January 2009 to December2011, Kensington & Chelsea



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

Figure 8: Number of acute STIs, chlamydia, syphilis, gonorrhoea, genital warts and genital herpes in men by their sexual orientation from January 2009 to December 2011, Westminster



According to figure 6, 7 and 8, for those diagnosed with STIs, large number of patients were not recorded their sexual orientation. Sexual orientation was not recorded among 2619, 2813 and 4992 patients in Hammersmith and Fulham, Kensington & Chelsea and Westminster respectively and had a diagnosis of a sexually transmitted infection.

The Health Protection Agency (2011b) identifies an increase of 178% in diagnoses of Lymphogranuloma Venereum (LGV) in England from 2009- 2010. Actual numbers of diagnoses remain small at 530 in 2010. However, 99% of LGV diagnoses since 2003 were in MSM. 80% of those diagnosed were also HIV positive. Two thirds of men diagnosed in England live in London. In addition, since 2001, MSM are much more likely than the whole population of men to have been diagnosed with Syphilis. Such evidence points to a disproportionate impact of relatively unknown or resurgent STIs amongst MSM

In addition to acute STIs, HIV also considerably and disproportionately impacts MSM in the tri-borough. According to 2011 SOPHID data, of all those diagnosed with HIV where a probable route of infection was recorded, MSM accounted for the following proportions of people accessing treatment and care:

- 65% in Hammersmith and Fulham
- 74% in Kensington and Chelsea
- 71% in Westminster

By comparison, this route of infection accounts for 47% of all people accessing treatment and care in London and 43% in England in England as a whole. This demonstrates that HIV

remains a significant Public Health issue for men who have sex with men in the tri-borough area.

Black and Minority Ethnic people

Latest available data from ONS population estimations 2011, suggests that 23% of the resident tri-borough population belong to BME groups – this is equivalent to 139,185 people. This number is expected to increase in the future when compared against the previous ONS census and estimated historical BME population and increase in international migration recent years.

Table 2: Population by ethnicity 2001 and 2011 census, all ages (Data source: ONS census 2001 and 2011)

	Hammersmith & Fulham		Kensington & Chelsea		Westminster		London		England	
	2001	2011	2001	2011	2001	2011	2001	2011	2001	2011
White British	58%	45%	50%	39%	49%	35%	60%	45%	87%	80%
White Other	20%	23%	29%	31%	25%	26%	11%	15%	4%	6%
Black	11%	12%	7%	7%	7%	8%	11%	13%	5%	3%
Asian	4%	9%	5%	10%	9%	15%	12%	18%	2%	8%
Other/ Mixed	7%	11%	10%	13%	10%	16%	6%	8%	2%	3%
White	**78%**	**68%**	**79%**	**71%**	**74%**	**62%**	**71%**	**60%**	**91%**	**86%**
BME	**22%**	**32%**	**21%**	**29%**	**26%**	**38%**	**29%**	**40%**	**9%**	**15%**

(Highlighted areas show high proportions population from those ethnic groups compared with London and England)

White other including Eastern European, other ethnic groups including middle eastern and mixed groups are over represented in the tri-borough as compared with London and England.

57.3%, 51.6% and 43.4% of acute STIs diagnosed in Westminster, Kensington and Chelsea and Hammersmith and Fulham respectively were in people born overseas during 2011.

In addition to acute STIs, BME populations in the tri-borough are over-represented in respect of HIV. According to 2011 SOPHID data, of all of those diagnosed with HIV where ethnicity is recorded, Black Caribbean and Black African populations accounted for the following proportions of people diagnosed and accessing treatment and care:

- 20% in Hammersmith and Fulham
- 13% in Kensington and Chelsea
- 15% in Westminster

By comparison these populations account for 39% of all people accessing treatment and care in both London and England as a whole. However, given that Black ethnic populations account for no more than 11% of the total population of any of the three boroughs, despite the lower comparative local rates, HIV remains a significant Public Health issue for Black African and Black Caribbean populations across the tri-borough.

The 'Other' ethnic group accounted for the following proportions of people diagnosed and accessing treatment and care:

- 14% in Hammersmith and Fulham
- 16% in Kensington and Chelsea
- 17% in Westminster

By comparison these populations accounted for 12% of all people diagnosed and accessing treatment and care in London and only 8% in England as a whole. This further demonstrates that HIV remains a significant Public Health issue for a range of BME populations in the tri-borough.

Sex workers

There are significant numbers of men and women who either sell sex or who work in the sex industry living and/or working across the tri-boroughs especially in Westminster. It is difficult to provide robust estimates of the numbers living/working locally, however, data from specialist sexual health services show that in 2011/12, there were 2,731 contacts at the Praed Street Project across clinical, drop-in and outreach services. 498 individuals were recorded as using clinical services.

In the same period, there were 947 contacts in clinical services at the Working Men's Project, although the number of individual contacts has not been specified.

Praed Street Project also collects Country of Birth data of their clients and this shows that women working in London come from all over the world. The highest proportions are shown to be:

- 25.1% from South America
- 24.6% from Eastern Europe / Russian / Baltic states
- 16.1% from the United Kingdom
- 12.5% from China / SE Asia

Smaller but notable proportions come from Western Europe, Africa and Asia (other). 10.8% were of unknown country of birth

The age range of clients recorded across both Praed Street Project and Working Men's Project were 17 – 82.

Further work is required to build a more comprehensive picture of the sexual health needs of sex workers across the tri-borough. It is however well documented that wider determinants of health including experiences of violence and crime have a significant impact on this population.

Prison population

Wormwood Scrubs (a category B male prison) Is located in Hammersmith and Fulham. The prevalence of infectious communicable diseases (particularly HIV and AIDS, hepatitis and tuberculosis) is often much higher in prisons than outside, often related to injecting drug use, MSM and other lifestyle behaviours.

There are no direct estimates of prevalence of sexually transmitted infections (excluding Hep B, C and HIV / AIDS) in the UK prison population however there are some studies with

rates of newly diagnosed STIs. The incidence of sexually transmitted disease has continued to increase in the UK over the past decade, particularly among young people.

With regards to risk factors for STIs, 55% of those under 24 in prisons are expected to have unprotected sex in the past year with two or more partners according to research carried out by Prison reform trust and national AIDS trust (Elkins et al, 2005).
Prisoners are therefore likely to have a higher incidence of these infections than the wider population.

All prisoners under 24 are routinely offered a urine screen for Chlamydia in HMP Wormwood Scrubs. Since April 2011, 124 prisoners out of 1,133 admitted to the prison in this age group have undertaken the test, approx. 12% of prisoners. This level of uptake is fairly low and may be a result of an unwillingness of prisoners to disclose health need, the transitory nature of prison life in HMP Wormwood Scrubs, or personal / cultural issues. Many STIs may therefore remain undiagnosed and untreated.

Diagnosis rates are particularly low from the cohorts who are willing to provide a sample. Prevalence of HIV amongst adult male prisoners in the prison is estimated to be at 0.3%. Nationally the incidence of HIV in prisons increased during the 1990's. However, it is believed that this observation was exaggerated by improved detection of these diseases and has since levelled off. In the past ten years (2002-2011) there have been a total of 13 individuals who received their first UK HIV diagnosis while at HMP Wormwood Scrubs. No new diagnoses have been reported to the Health protection Agency since 2006.

Geography and deprivation

Socio-economic deprivation (SED) is a known determinant of poor health outcomes and data from GUM clinics show a strong positive correlation between rates of STI and the index of multiple deprivation across England. The relationship between STIs and SED is probably influenced by a range of factors such as the provision of and access to health services, education, health awareness, health-care seeking behaviour and sexual behaviour. This relationship between STIs and deprivation initially documented in Department of Health (2001): The National Strategy for Sexual Health and HIV.
Recently there is more evidence for this relationship, published by MRC Social and Public Health Sciences Unit (McDaid et al, 2012).

Epidemiology of Sexually transmitted infections (STIs)

Key messages

- **3330 acute STIs were diagnosed in residents of Hammersmith and Fulham in 2011 (2116 in males and 1213 in females), a rate of 1962.2 per 100,000 residents (males 2471.9 and females 1442.3).**
- **2492 acute STIs were diagnosed in residents of Kensington and Chelsea in 2011 (1540 in males and 951 in females), a rate of 1470.3 per 100,000 residents (males 1851.3 and females 1101.9).**
- **4154 acute STIs were diagnosed in residents of Westminster in 2011 (2605 in males and 1549 in females), a rate of 1641.2 per 100,000 residents (males 2031.6 and females 1240.3).**

As shown in figure 9, Westminster, Hammersmith and Fulham and Kensington and Chelsea had the 4th, 6th and 9th highest rates of acute STIs during 2011 out of 31 PCTs in London.

Figure 9: Rate of acute STIs per 100,000 resident, 2011 in London PCTs (Data source: GUMCAD)

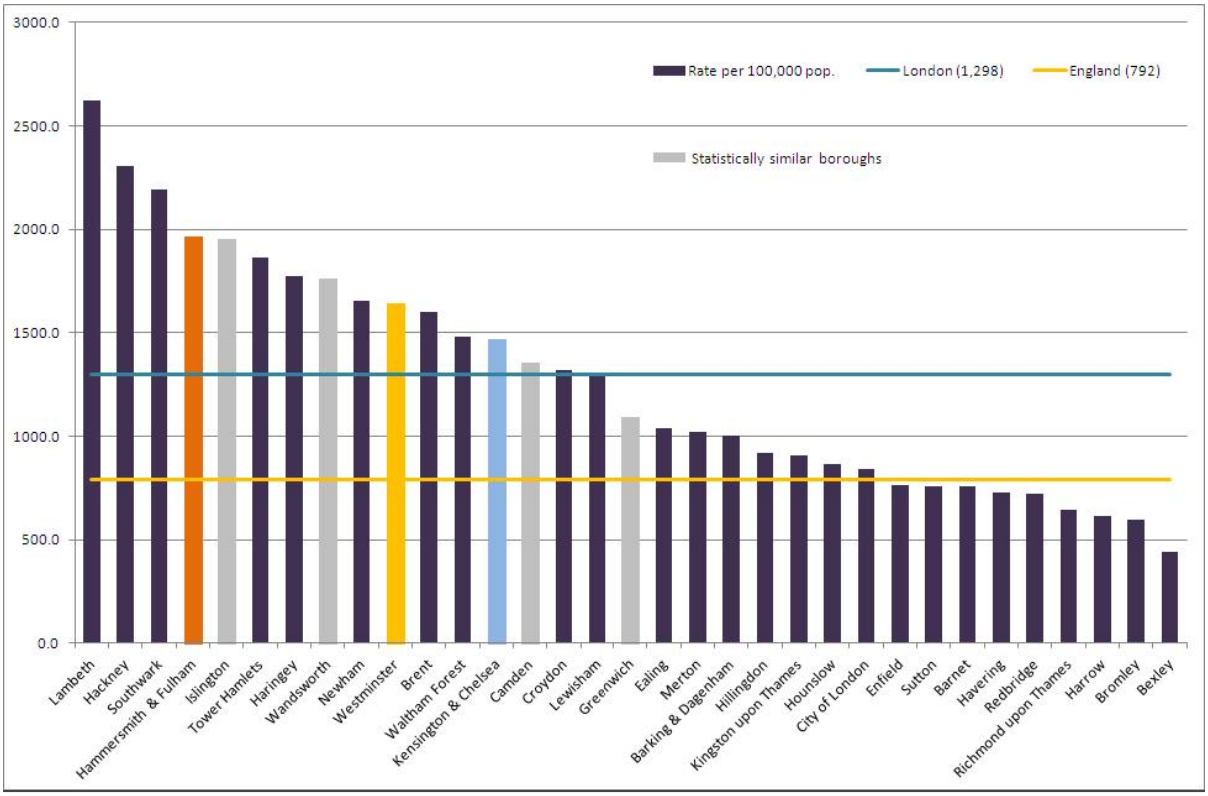


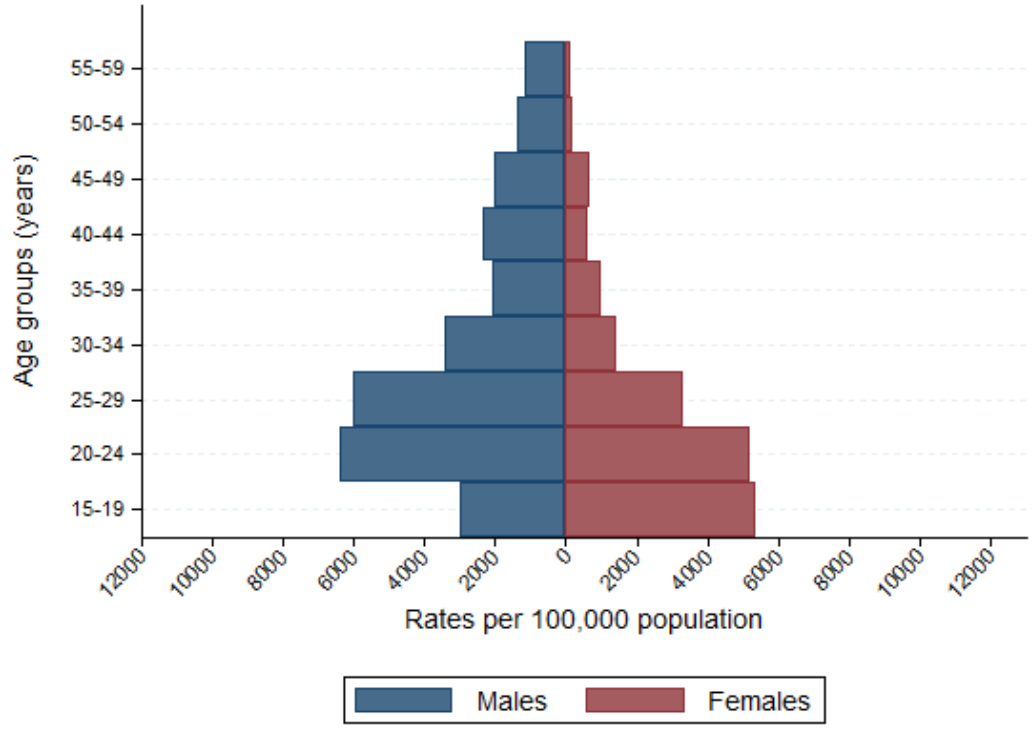
Figure 10: Trends in rates of acute STIs per 100000 population (Data source: GUM clinics and community settings only)

As shown in figure 10, rates of STIs are generally higher in three boroughs compared with London and England. While the annual trend in STIs for London and England is fairly constant from 2009 to 2011, increase rates of STIs were observed across the tri-borough. Upward trends in diagnosis may be due to improved access to GUM access. As shown in table 3, those who attended their first appointment to GUM clinics have increased by 26%, 33% and 45% in Hammersmith & Fulham, Kensington & Chelsea and Westminster respectively from 2008 to 2011.

Table 3: Number of GUM clinic clients attended their first appointment, 2008 to 2011

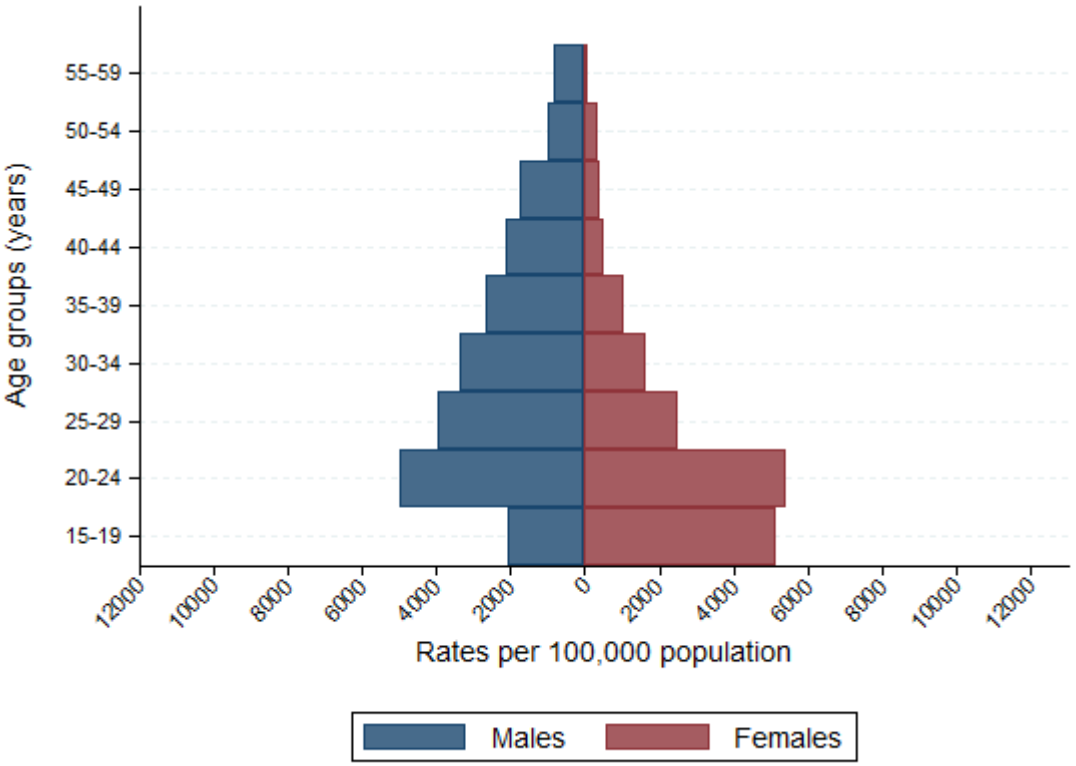
	2008	2009	2010	2011
Hammersmith & Fulham	13,709	16,138	16,662	17,285
Kensington & Chelsea	9,521	11,179	11,849	12,662
Westminster	13,701	16,854	18,808	19,901

Figure 11: Age group and gender of cases of acute STIs in Hammersmith and Fulham: 2011



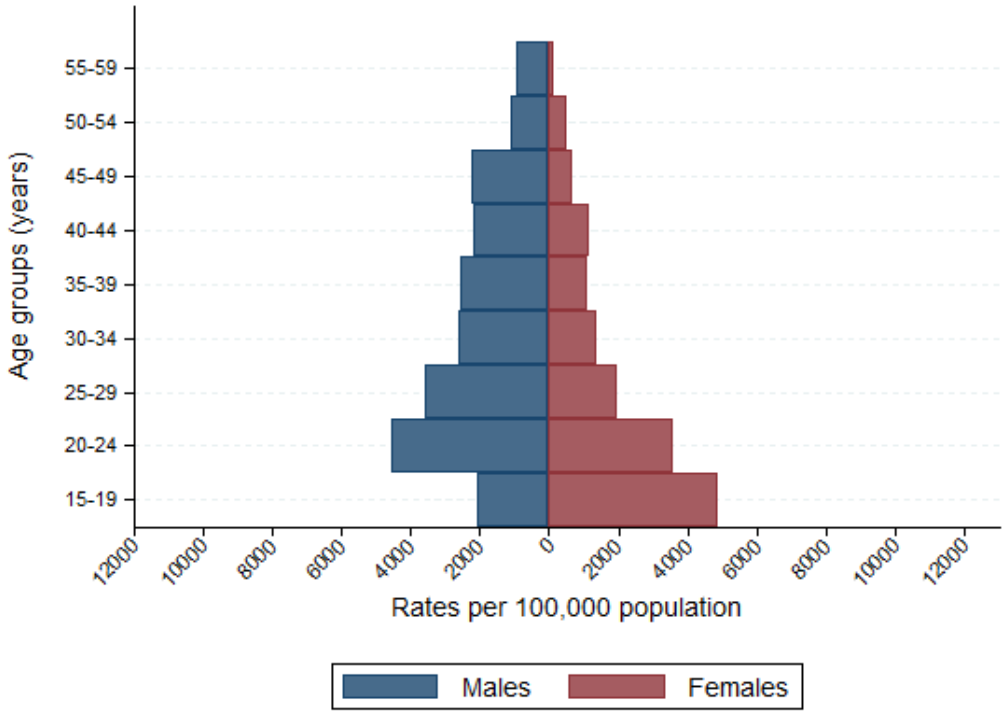
Source: Data from Genitourinary Medicine Clinics and community settings (for Chlamydia only)

Figure 12: Age group and gender of cases of acute STIs in Kensington and Chelsea: 2011



Source: Data from Genitourinary Medicine Clinics and community settings (for Chlamydia only)

Figure 13: Age group and gender of cases of acute STIs in Westminster: 2011



Source: Data from Genitourinary Medicine Clinics and community settings (for Chlamydia only)

Figure 11, 12, 13 demonstrate the rates of acute STIs by age and gender by borough. In all three boroughs, the highest rates of acute STIs were observed among 20- 29 men and 15-24 women.

Table 4: Number and proportion of acute STIs* diagnosed in GUM clinics by ethnic group: 2011 (Data source: GUMCAD)

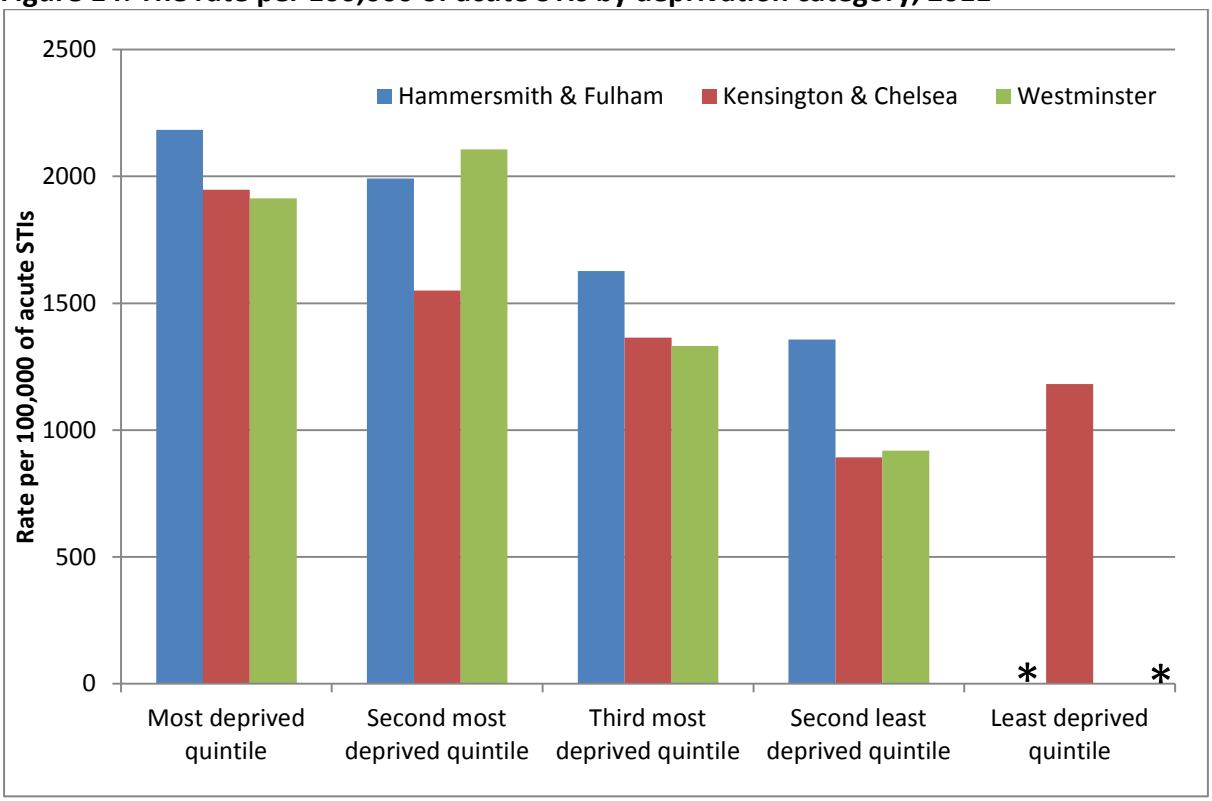
	Hammersmith & Fulham		Kensington & Chelsea		Westminster		England		London	
Ethnic group	Number	%	Number	%	Number	%	Number	%	Number	%
White	2007	61.9	1455	62.1	2366	59.6	171,716	55.2	31,029	46.1
Black or Black British	638	19.7	319	13.6	537	13.5	19,488	6.3	11,995	17.8
Asian or Asian British	114	3.5	106	4.5	212	5.3	6,663	2.1	3,078	4.6
Mixed	260	8	209	8.9	324	8.2	8,252	2.7	3,687	5.5

	Hammersmith & Fulham		Kensington & Chelsea		Westminster		England		London	
Ethnic group	Number	%	Number	%	Number	%	Number	%	Number	%
Other ethnic groups	57	1.8	49	2.1	407	10.2	4,592	1.5	2,656	3.9
Not specified	168	5.2	205	8.7	127	3.2	100,489	32.3	14,834	22.0

*Excludes diagnoses made outside GUM

The number of acute STIs diagnosed among other ethnic groups (Middle Eastern) is high in Westminster compared with other two boroughs. Generally, there is high proportion of Black population groups diagnosed with STIs in GUM clinics in London and the tri-borough compared with England. Proportion of mixed ethnic groups with acute STIs diagnosed in GUM clinics during 2011 was higher in the tri-borough compared with London and England.

Figure 14: The rate per 100,000 of acute STIs by deprivation category, 2011



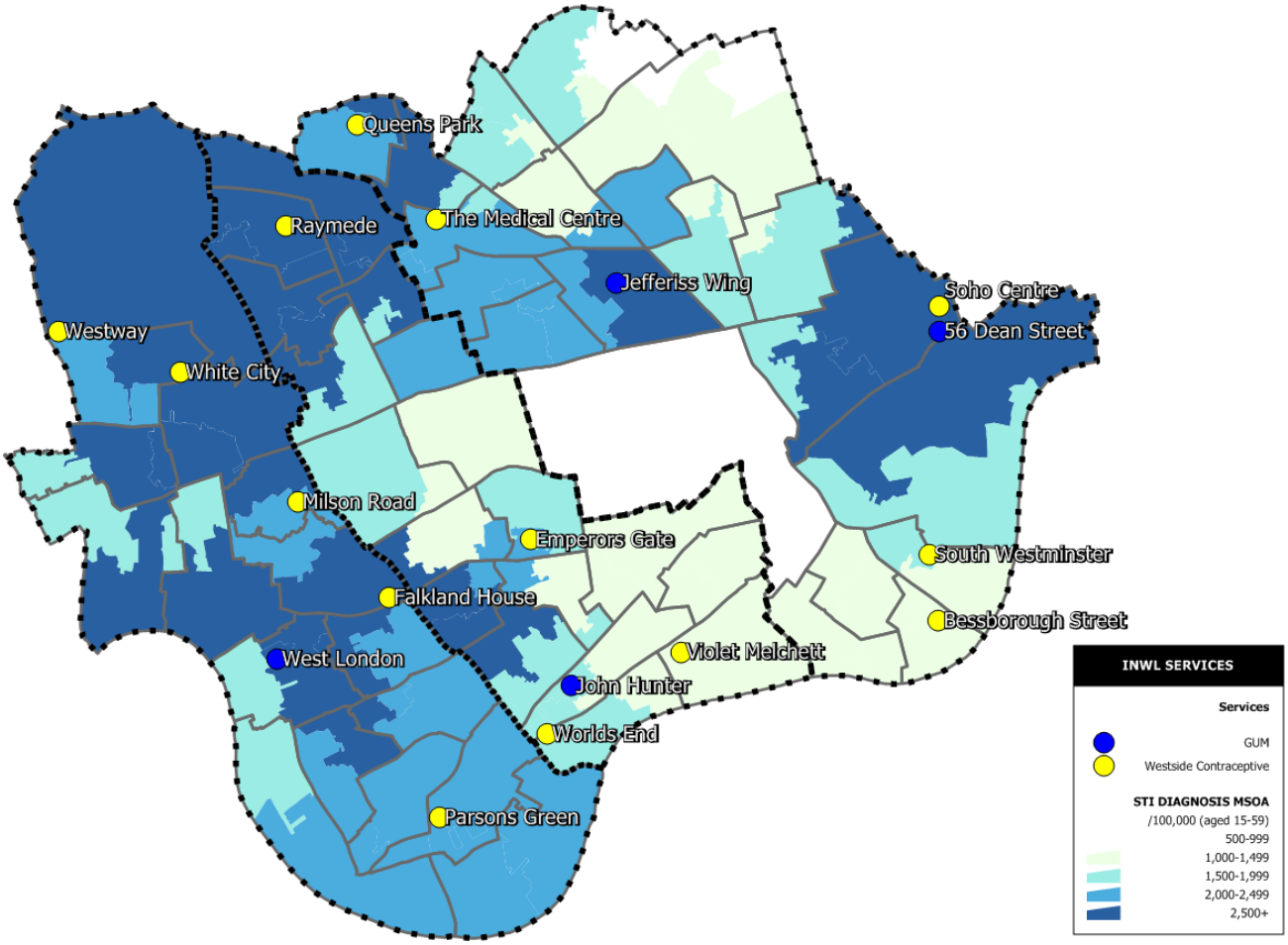
* None of the Westminster and H&F LSOAs belong to national least deprived quintile.

As shown in figure 14, generally the rate of acute STIs increases with deprivation. The most and second most deprived wards in the tri-borough have the highest rates of acute STIs. There are no wards that fall in the least deprived quintile in either Hammersmith and Fulham or Westminster.

Acute STIs: Geography and deprivation

Generally northern middle super output areas (MSOAs) in the three boroughs are amongst the most deprived areas in England. Figure 16 shows that the rates of acute STIs are highest in the most deprived MSOAs of the tri-borough. A Middle Layer Super Output Area (MSOA) is a geographical area. Middle Layer Super Output Areas are a geographic hierarchy designed to improve the reporting of small area statistics in England and Wales. They are built from groups of contiguous Lower Layer Super Output Areas (LSOA). For MSOA, the minimum population is 5000 and the mean is 7200. Collection of postcodes forms a LSOA with similar socio-demographic characteristics.

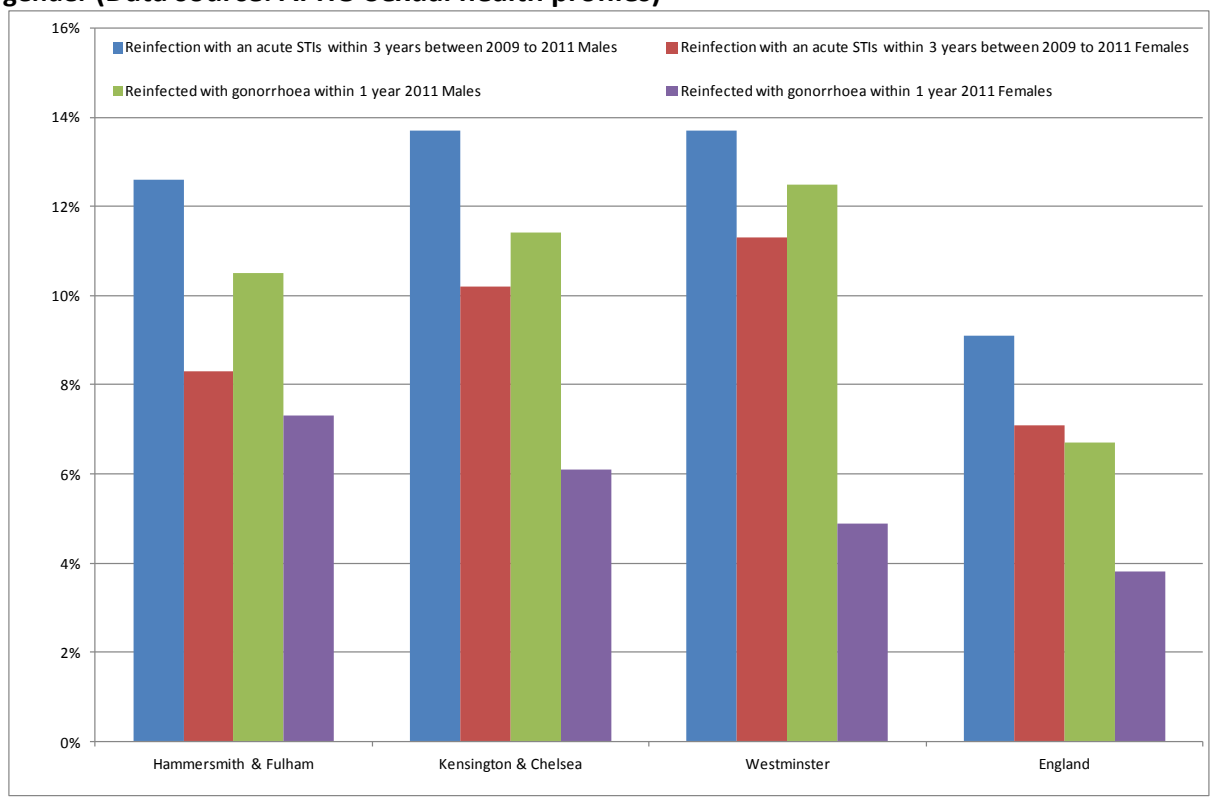
Figure 15: Rates of acute STIs by MSOA (Middle layer super output area)



Re-infections of STIs

Young people are also more likely to become re-infected with STIs, contributing to infection persistence and health service workload.

Figure 16: Percentage of re-infections with acute STIs within 3 years between 2009 and 2011 by gender (Data source: APHO Sexual health profiles)



Of those presenting with an acute STI at a GUM clinic during the three year period form 2009 – 2011, estimates on the proportion becoming re-infected within 12 months were:

- 20.1% of 16 – 19 year old women and 14.9% of 16 to 19 year old men in Hammersmith and Fulham
- 18.5% of 16 – 19 year old women and 18.4% of 16 – 19 year old men in Kensington and Chelsea
- 19.4% of 16 – 19 year old women and 12.7% of 16 to 19 year old men in Westminster

Sexually transmitted infections

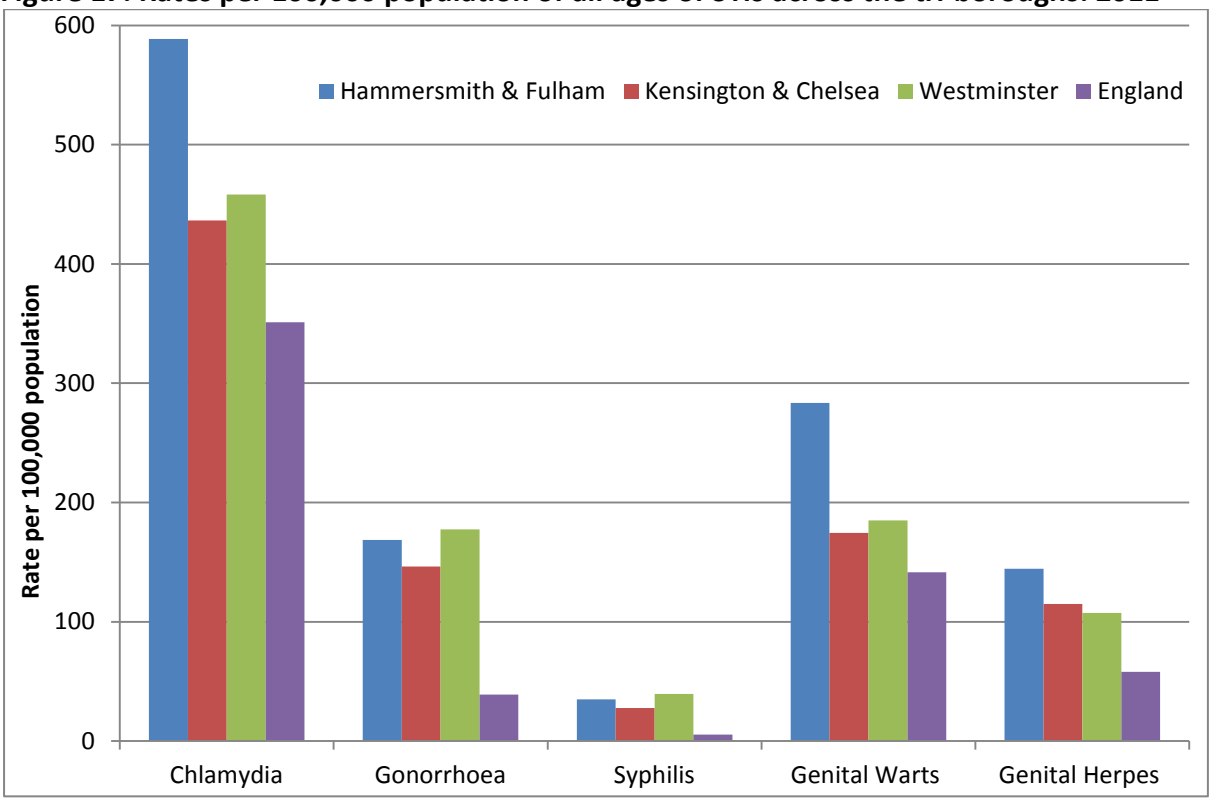
Key Messages:

- **STIs are an important public health problem across the tri-boroughs – an estimated 15,500 cases a year are diagnosed by local GUM clinics;**
- **Many STIs are asymptomatic, facilitating the spread of infection;**
- **The numbers of STIs diagnosed locally have remained constant over the last five years with the exception of 2007 in which there was an increase;**
- **Amongst men, the most common STIs diagnosed include chlamydia, anogenital warts and gonorrhoea, whilst in women the most common STIs diagnosed are chlamydia, anogenital warts and herpes simplex;**
- **Locally, STI infections are predominantly concentrated in men and young people, with the age profile of men affected slightly older than that of women;**
- **Men who have sex with men and Black African and Black Caribbean ethnic groups are also disproportionately affected by STIs, particularly gonorrhoea and syphilis;**

Sexually transmitted infections (STIs) are diseases that can be transmitted by unprotected sex between two people. Some STIs are symptomatic and may result in increased discharge, pain and ulcers, whilst others are asymptomatic and often remain undiagnosed. If STIs remain undiagnosed they can lead to serious complications and have long term health implications such as pelvic inflammatory disease and infertility.

Ascertaining the number of STIs diagnosed annually amongst tri-borough residents is complex, as diagnoses occur in a range of settings. Most data on STIs is derived from Korner (KC60) activity reports from GUM clinics in England. However, such data is not available by place of residence (data is currently available at clinic level only which includes residents and non-residents). Therefore, local GUM data should not be used as a definitive number of cases of STIs diagnosed amongst tri-borough residents, but instead serve as a guide to local trends.

Figure 17: Rates per 100,000 population of all ages of STIs across the tri-boroughs: 2011



(Data source: HPA STI report 2012)

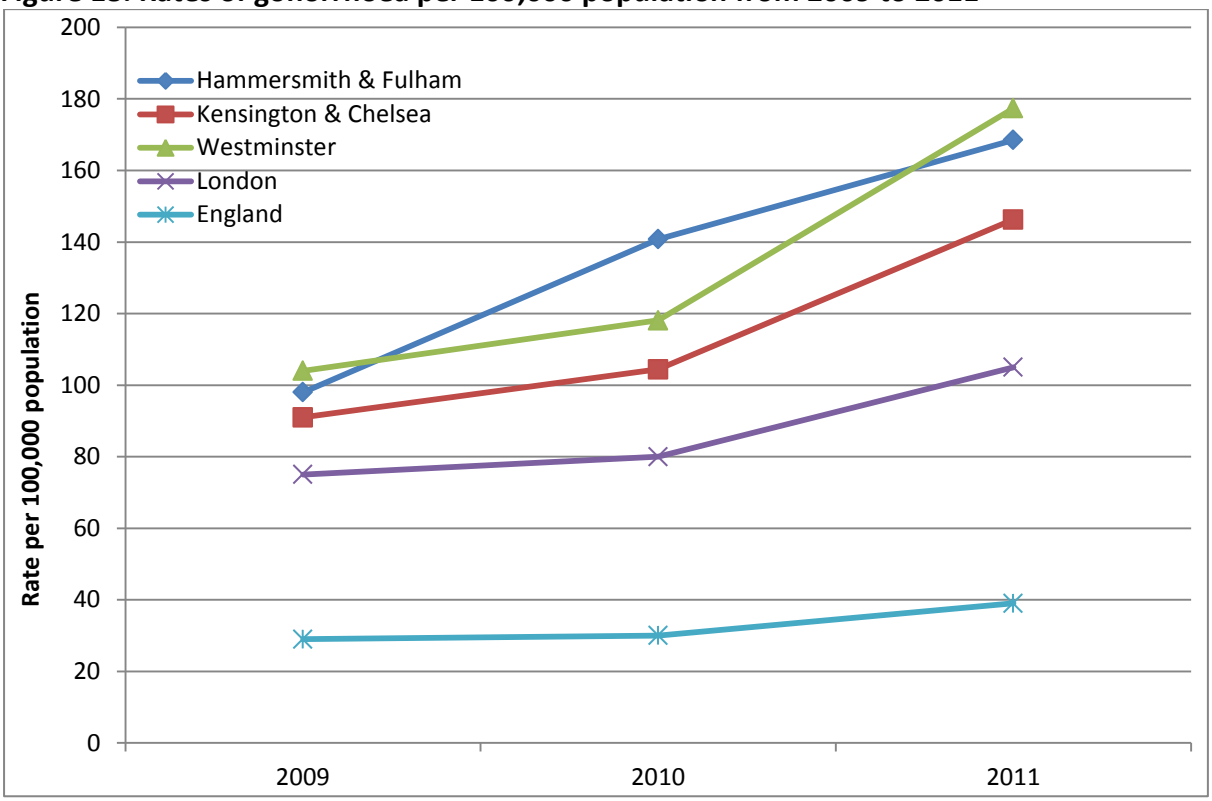
Rates of diagnosis for STIs including Gonorrhoea, Syphilis, Genital Warts and Genital Herpes are significantly higher across the tri-borough compared with England. This could be due to better diagnosis rather than real prevalence.

The HPA has reported that of all cases of infectious syphilis diagnosed between 1999 and 2008, 78% were in MSM. Higher rates of syphilis across the tri-borough are likely to be associated with greater numbers of MSM living, working and socialising in the area.

Gonorrhoea

Gonorrhoea is a bacterial STI caused by the bacteria *Neisseria gonorrhoea* and is the second most common bacterial STI diagnosed in England. If infection is not treated, gonorrhoeal infection may lead to complications such as chronic pelvic pain, pelvic inflammatory disease, ectopic pregnancy and infertility in women. Furthermore, the effective treatment of gonorrhoea has been complicated by the development of antimicrobial resistance; the prevalence of ciprofloxacin resistance has risen significantly in recent years.

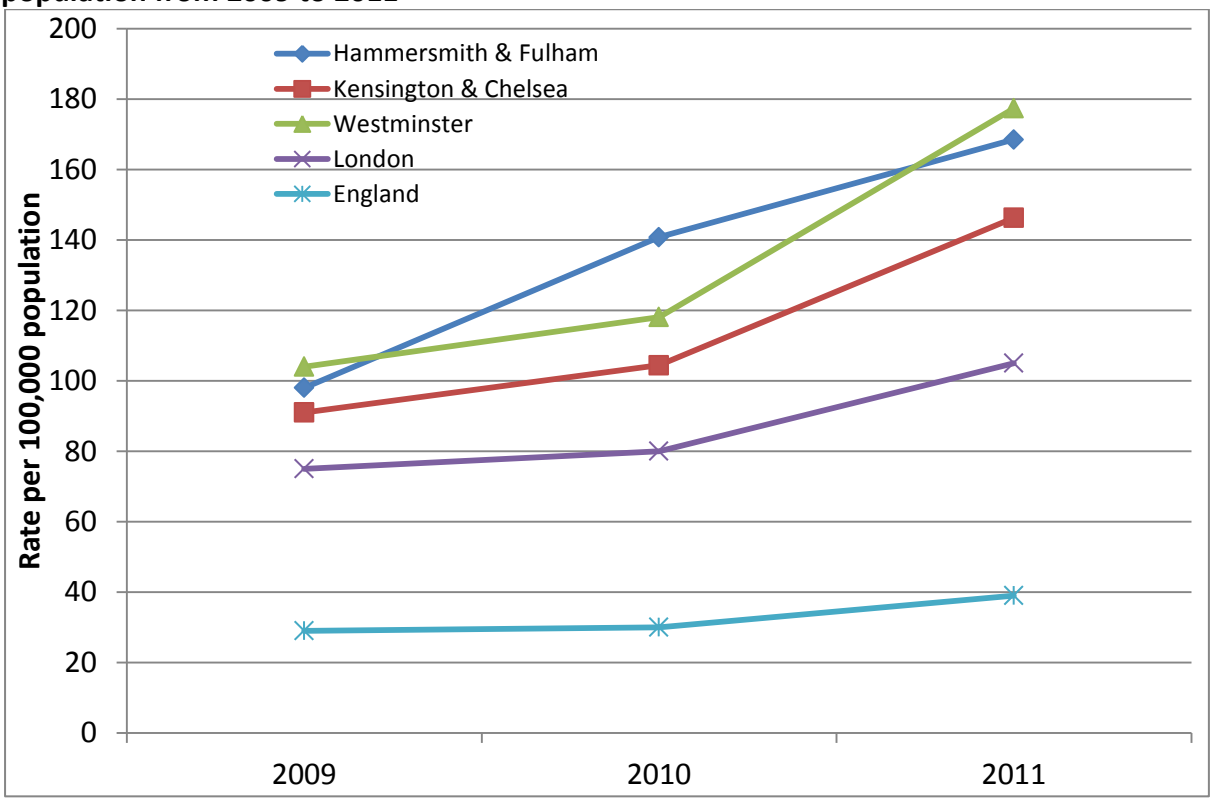
Figure 18: Rates of gonorrhoea per 100,000 population from 2009 to 2011



(Data source: HPA STI report 2012)

983 patients with gonorrhoea were seen in the tri-borough during 2011 (286, 248 and 449 patients from Hammersmith and Fulham, Kensington and Chelsea and Westminster respectively). Trends in gonorrhoea diagnosis rates have increased from 2009 to 2011 for all three boroughs. Gonorrhoea diagnosis rates are nearly 5 times higher across the tri-borough compared with England.

Figure 19: Rate of diagnosis of Gonorrhoea infection in GUM clinics, Rate per 100,000 population from 2009 to 2011



Rates of diagnosis of gonorrhoea infection in GUM clinics in 2010 are significantly higher in the tri-borough compared with London and England.
The presence of STIs such as gonorrhoea alongside HIV can increase the possibility of HIV transmission.

Genital human papilloma virus

There are over 100 types of human papilloma virus (HPV) of which 40 are known to infect the genital tract and be acquired sexually. Most HPV infections are asymptomatic and resolve without causing disease, however types 6 and 11 are associated with genital warts. HPV types 16 and 18 are associated with cervical cancer.

Genital warts are one of the most commonly diagnosed STIs in England and the lifetime risk of infection with genital HPV is high amongst sexually active people. HPV infections can often be difficult to treat and some patients may experience frequent reoccurrences.

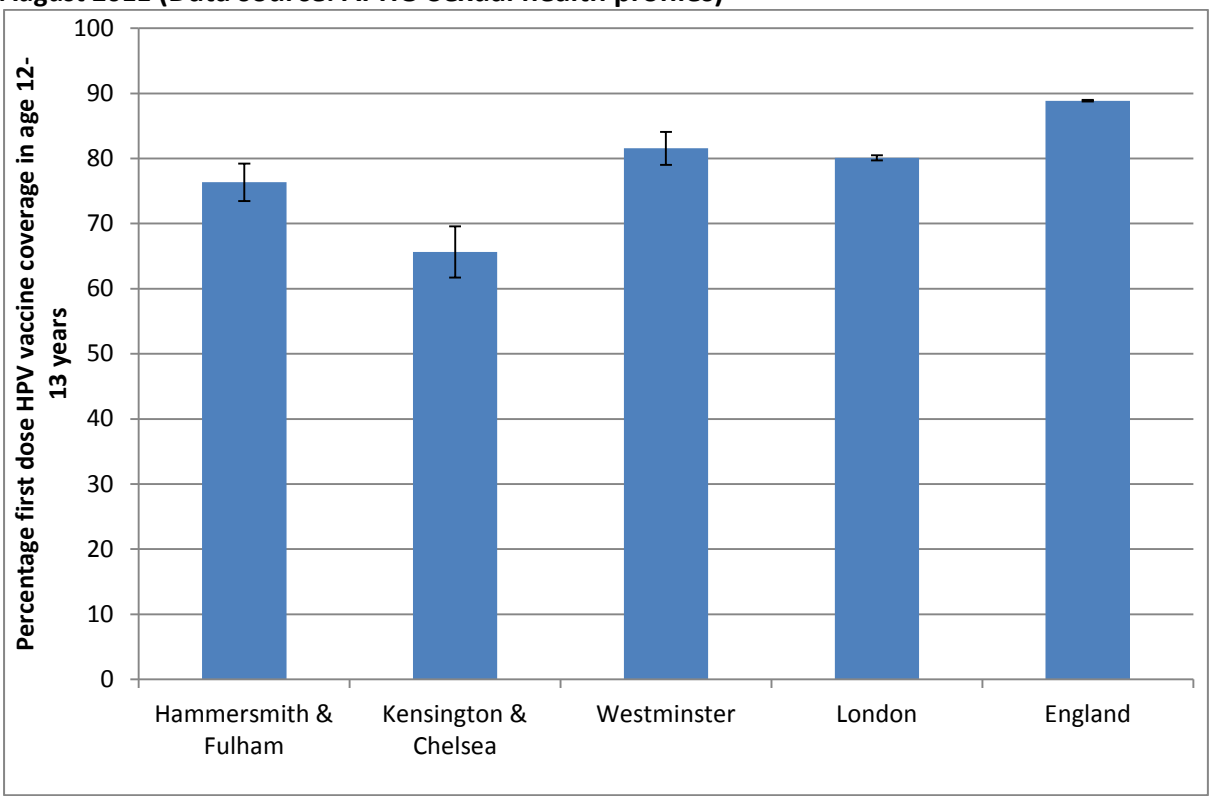
HPA Vaccination

Some types of HPV can increase the risk of developing cervical cancer. Almost 3,400 women are diagnosed with this type of cancer every year in the UK. Most women infected with HPV don't go on to develop cervical cancer. But for some, infection with HPV can go on to cause, genital warts, changes in the cervix, which may develop into cervical cancer and changes in the vaginal tissues, which may develop into vaginal cancer. In the UK, girls in year 8 at school (aged 12 to 13) are offered the HPV vaccine. Girls have three injections over 6 months. If girls take up the vaccination at school, the programme will prevent at least 7 out of 10 cancers of the cervix (70%) and possibly even more in the future. But it takes between

10 and 20 years for a cancer to develop after HPV infection. So any benefits in reducing cervical cancer won't be seen for quite a long time. But the number of cases of pre cancerous changes in the cervix (CIN) will fall quite rapidly.

As shown in figure 20, HPV vaccine coverage is nearly 90% in England. However, tri-borough HPV vaccine coverage is lower than average England rate, with lowest in Kensington & Chelsea with just over 65% coverage among girls 12-13 year olds.

Figure 20: Percentage first dose HPV vaccine coverage in age 12-13 years, 1 Sept 2010 to 31 August 2011 (Data source: APHO Sexual health profiles)



Genital warts

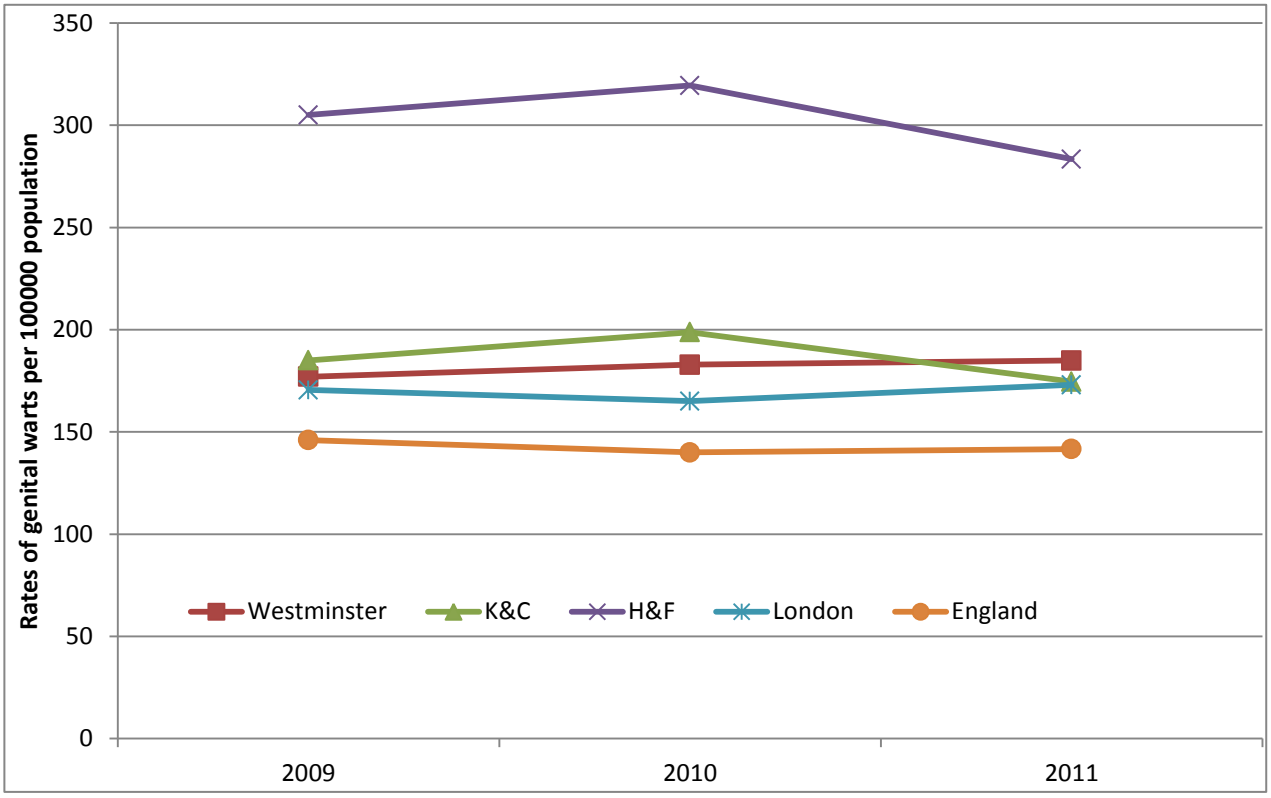
In England the number of diagnoses of first attack genital warts increased from 61,157 in 1999 to 74,083 in 2011. This represents an increase of 21%. Cases of recurrent genital warts have also increased; in 1999 there were 34,434 cases identified in GUM clinics compared to 46,086 in 2011.

Between 1999 and 2011 the number of cases of first attack genital warts in heterosexual men and women increased by 21% and 20% respectively, however, the largest proportional increase was amongst MSM (34% increase).

National evidence suggests that a significant number of cases of genital warts are also identified in general practice. Rates of new diagnosis of genital warts in the registered general practice population in 2006 were 68 per 100,000 population in men and 58 per 100,000 in women.

Nationally, genital wart infections are predominantly found in young adults. Rates of newly diagnosed genital wart infections are highest among men aged 20-24 and among women aged 16-19.

Figure 21: Trends in rates of genital warts per 100000 population from 2009 to 2011



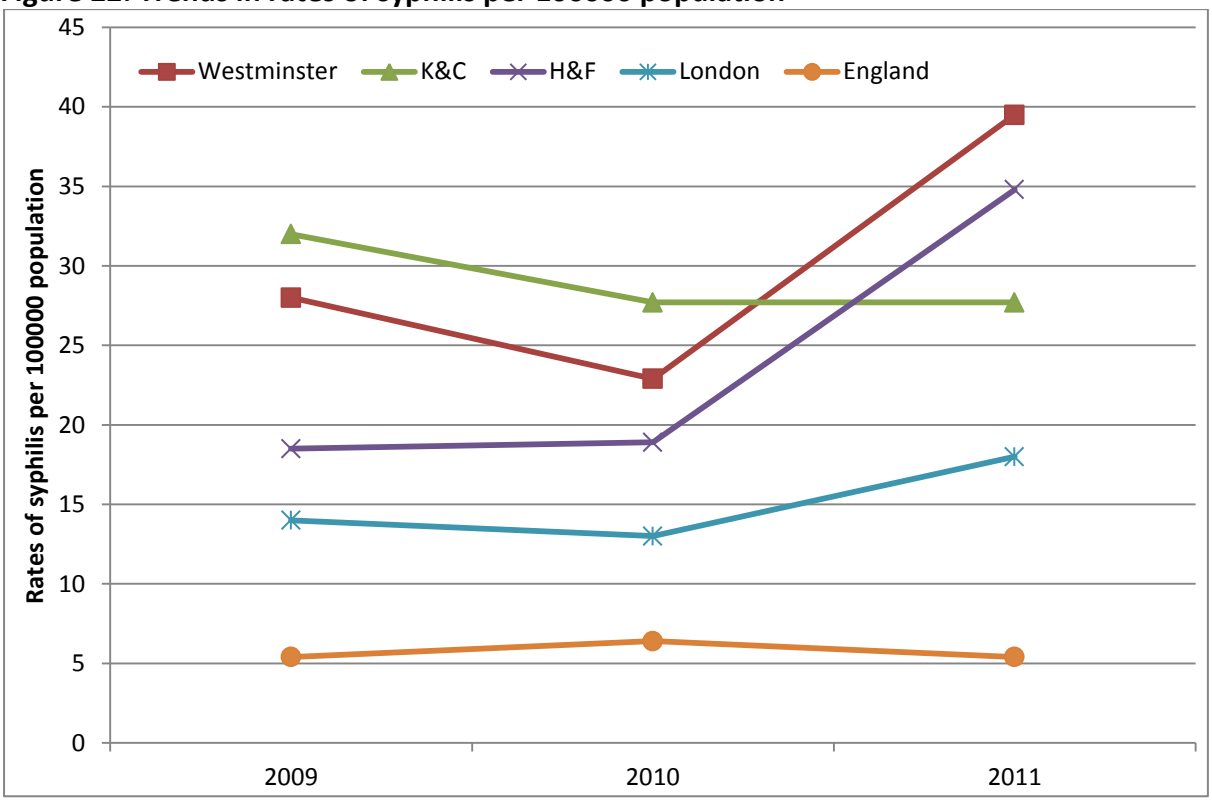
(Data source: HPA STI report 2012)

1245 patients with genital warts were diagnosed across the tri-borough during 2011 (481, 296 and 468 patients from Hammersmith and Fulham, Kensington and Chelsea and Westminster respectively). The rate of diagnosis of genital warts increased in Westminster while rates decreased in Hammersmith and Fulham and Kensington and Chelsea from 2009 to 2011. However, genital warts diagnosis rates were higher in all three boroughs than London and England rates. Hammersmith and Fulham, had the highest genital warts diagnosis rates - nearly twice that of London.

Syphilis

Syphilis is a relatively rare infection caused by the spirochete, Treponema pallidum. The disease has different stages: an early infectious stage (primary, secondary and early latent infection in the first two years of infection) and late non-infectious syphilis (late latent infection and tertiary syphilis). The clinical manifestations associated with syphilis are varied, but the primary and secondary stages are characterised by mucocutaneous lesions – almost any organ of the body can be affected. Syphilis infection in pregnant women may result in foetal death, prematurity or congenital syphilis.

Figure 22: Trends in rates of syphilis per 100000 population



(Data source: HPA STI report 2012)

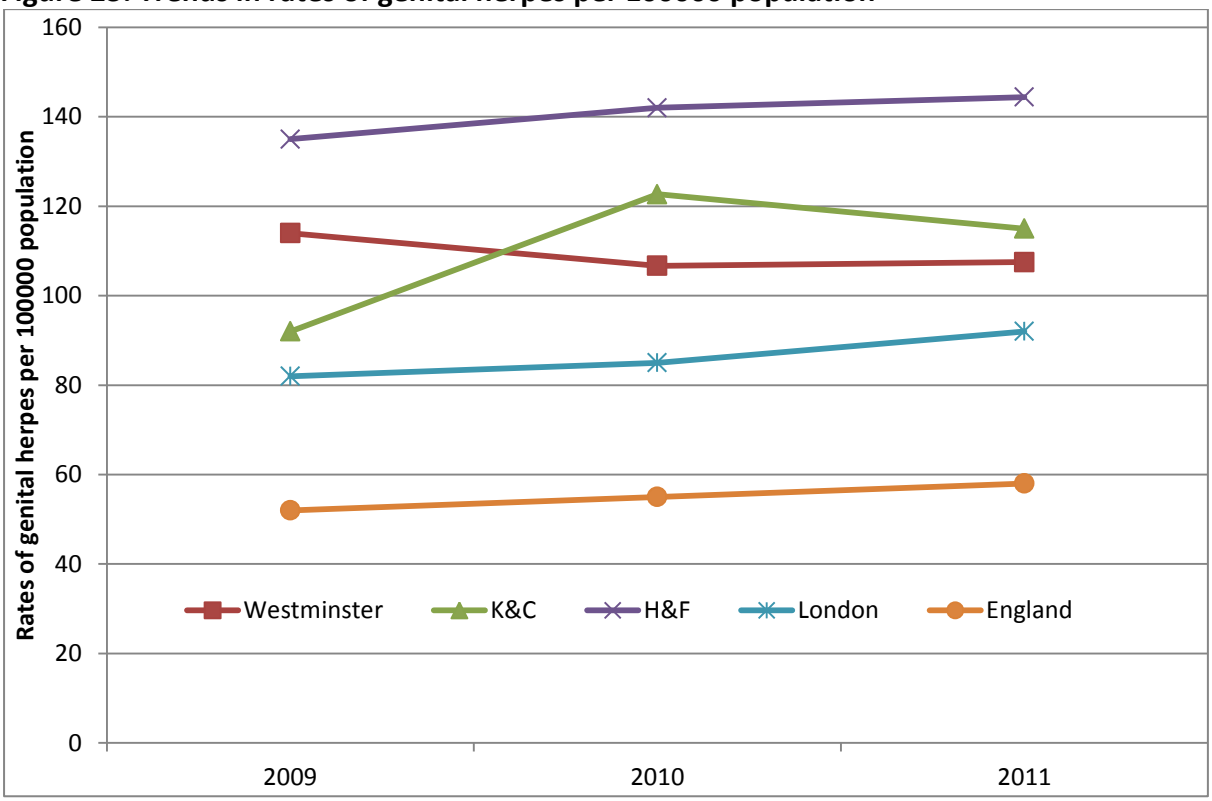
206 patients with syphilis were diagnosed within the tri-borough area during 2011 (59, 47, 100 patients from Hammersmith and Fulham, Kensington and Chelsea and Westminster respectively). Syphilis diagnosis rates declined in Kensington and Chelsea whilst rates in Hammersmith and Fulham and Westminster increased from 2009 to 2011. England rates remained static for the same period, and there was a slight increase in rates in London.

Genital herpes (herpes simplex)

Genital herpes is a sexually transmitted infection caused by the herpes simplex virus (HSV). The virus is the most common ulcerative sexually transmitted infection in the UK, and is associated with physical and psychological morbidity. It can cause severe systemic disease in newborn infants and the immuno-suppressed; it may also facilitate HIV transmission.

Genital HSV is a chronic infection with many people experiencing frequent reoccurrences. There are two subtypes of HSV; type 1 typically causes oral herpes commonly known as cold sores whilst type 2 HSV is typically associated with genital infection. The virus is highly contagious and can be passed on easily from person to person, from direct close contact. However, many infections are asymptomatic, as a consequence approximately 80% of people infected with HSV are unaware that they have been infected.

Figure 23: Trends in rates of genital herpes per 100000 population



(Data source: HPA STI report 2012)

712 patients with genital warts were diagnosed within the tri-borough area during 2011 (245, 195 and 272 patients from Hammersmith and Fulham, Kensington and Chelsea and Westminster respectively). There was a slight decrease in the rate in Westminster whilst rates in Kensington and Chelsea, Hammersmith and Fulham, London and England rates have all decreased between 2009 and 2011. Hammersmith and Fulham had the highest rate of diagnosis for genital herpes - nearly three times that of England.

Chlamydia

Key Messages:

- **Chlamydia is the most common bacterial STI in the UK and is associated with significant morbidity if untreated;**
- **Often infection is asymptomatic and so a significant proportion of those infected are undiagnosed;**
- **Young people are disproportionately affected by chlamydia;**
- **The profile of men diagnosed with chlamydia is slightly older than that of women.**
- **Nationally, 30% of 15 to 24 year olds were tested for Chlamydia with a 7% positivity rate.**
- **The Chlamydia diagnosis rate per 100,000 population for 15-24 year olds in 2011 was:**
    - **2226 in Hammersmith and Fulham. 35% of 15 – 24 year olds were tested with a 6% positivity rate.**
    - **2031 in Kensington and Chelsea. 41% of 15 – 24 year olds were tested with a 5% positivity rate.**
    - **1647 in Westminster. 35% of 15 – 24 year olds were tested with a 5% positivity rate.**

Chlamydia trachomatis is the most common bacterial STI in the UK. Infection is asymptomatic in at least 70% of women and 50% of men and as a result the majority of infections remain undiagnosed (The UK Collaborative Group for HIV and STI Surveillance, 2007).

Untreated Chlamydia infection is associated with considerable reproductive morbidity in women including pelvic inflammatory disease, ectopic pregnancy and tubal factor infertility. In men complications include urethritis, epididymytis and Reiter's syndrome (The UK Collaborative Group for HIV and STI Surveillance, 2007).

Table 5: Rates (number) of Chlamydia patients per 100000 population

Year	Hammersmith & Fulham	Kensington & Chelsea	Westminster	London	England
2009	555 (1405)	367 (622)	368 (625)	435	363
2010	535.6 (1356)	391.8 (664)	429.5 (729)	450	360
2011	588.7 (1490)	436.6 (740)	458.3 (778)	465	351.2

Data Source: The Genitourinary Medicine Clinic Activity Dataset (GUMCAD) and community settings (National Chlamydia Screening Programme (NCSP) and non-GUM, non-NCSP returns)

Trends in the rates of Chlamydia per 100,000 population increased across the tri-borough from 2009 to 2011. However, the rate in England slightly decreased during the same period.

The new Public Health Outcome Framework includes an indicator to assess progress in controlling chlamydia in sexually active young adults under 25 years old by looking at the annual diagnostic rate amongst the resident 15-24 year old population. The diagnosis rate reflects both coverage and the proportion testing positive at all sites, including

Genitourinary Medicine (GUM) diagnoses as well as those made outside of GUM.

Since chlamydia is most often asymptomatic, a high diagnosis rate reflects success at identifying infections that are left untreated, may lead to serious reproductive health consequences.

The HPA recommends that local areas achieve a rate of at least 2,400 per 100,000 resident 15-24 year olds, a level which is expected to produce falls in chlamydia prevalence. Areas already achieving this rate should aim to maintain or increase it, other areas should work towards it. Such a level can only be achieved through the ongoing commissioning of high-volume, good quality screening services across primary care and sexual health services.

Figure 24: Chlamydia diagnoses in London residents aged 15-24 yrs by London local authority (2011/2) rate per 100,000 (Data source: HPA STI report 2012)

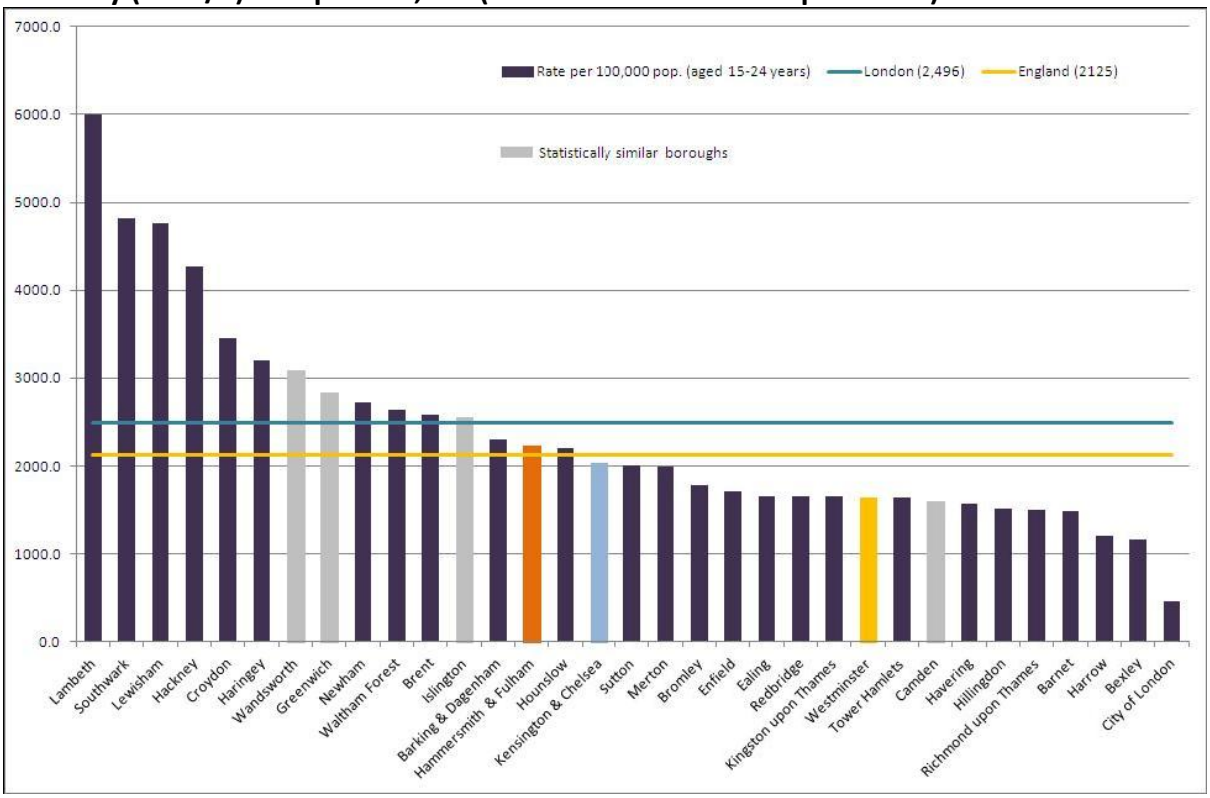


Table 6: Chlamydia testing data in 15-24 year olds across the tri-boroughs: 2011

	Number of Chlamydia tests in GUM	*Number of Chlamydia tests in other settings*	*Total number of tests*	*Number (percentage) of positives in all settings*	*Percentage of population tested (all settings)**
Hammersmith and Fulham	5011	2523	7534	474 (6.3%)	35
Kensington and Chelsea	3017	4373	7390	370 (5.0%)	41
Westminster	4474	6234	10708	550 (5.1%)	32

***Repeat tests are not excluded, Source: Data from Genitourinary Medicine Clinics and community settings**

Across the tri-borough, Kensington and Chelsea had the highest percentage of Chlamydia testing for 15-24 year olds whilst Westminster had the lowest percentage tested for this age group.

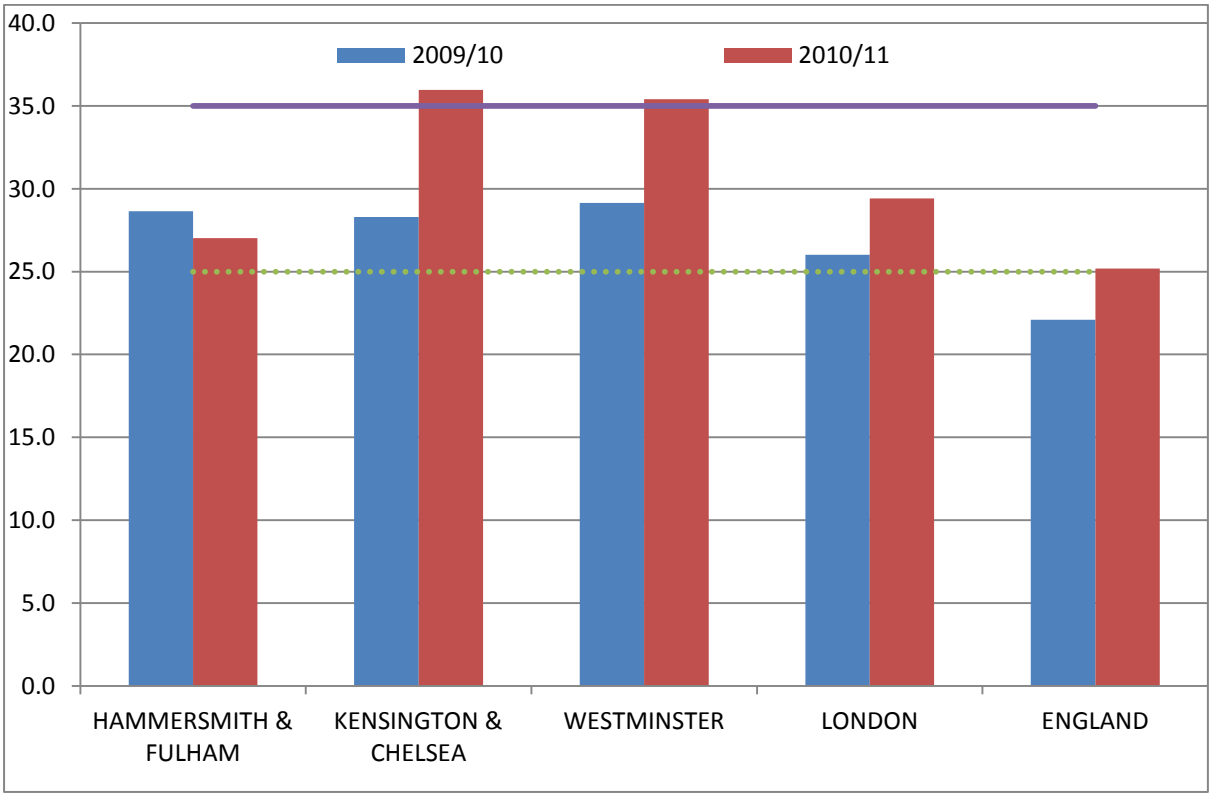
Table 7: Rates per 100,000 of Chlamydia diagnosis in 15-24 year olds: 2011

Local authority	*Rates of diagnosis*	*Rank within region**	*Rank within England**
Hammersmith and Fulham	2226	14	100
Kensington and Chelsea	2031.1	16	129
Westminster	1646.9	24	223

Source: Data from Genitourinary Medicine Clinics and community settings, * *Out of 326 local authorities, 1st rank has the highest rates

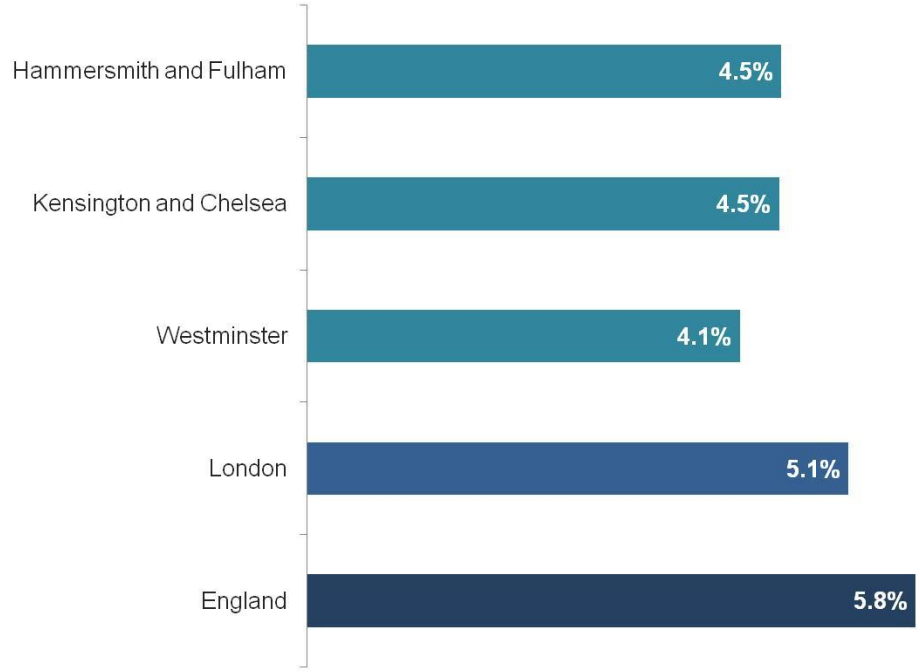
Westminster had one of the worst rates of Chlamydia diagnosis among 15-24 year olds in England.

Figure 25: Percentage age 15-24 tested for Chlamydia in non-GUM settings by PCT, 2009/10 and 2010/11 (Data source: APHO sexual health profiles)



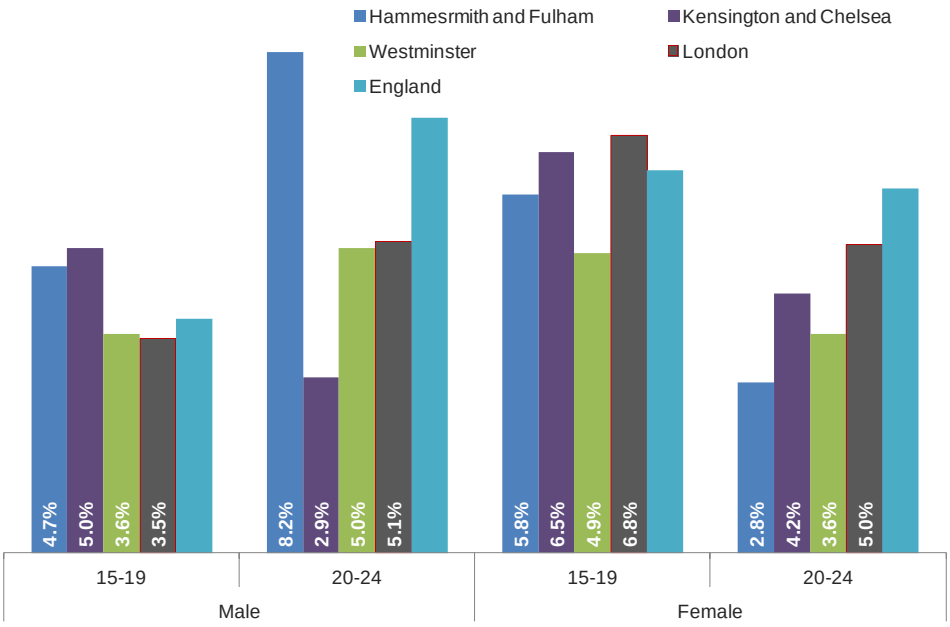
Out of those 15-24 year olds tested for Chlamydia in non-GUM settings the tri-borough performed better than London and England during 2009/10. However, during 2010/11 Hammersmith and Fulham had a lower average.

Figure 26: Chlamydia screening programme - % tested positive (Source: Chlamydia Screening Programme 2011/12)



It can be noted that since April 2011, the rate and number of screens has declined. However, the positivity rate has generally increased in the same period.

Figure 27: Chlamydia screening programme - % tested positive by age and gender group 2011/12 (Source: Chlamydia Screening Programme 2011/12)



Human Immunodeficiency Virus (HIV)

Key Messages:

- **According to SOPHID 2011, 3604 people across the tri-boroughs (1076, 1053 and 1475 in Hammersmith and Fulham, Kensington and Chelsea and Westminster respectively) have been diagnosed with HIV and are accessing care**
- **Universal HIV testing in general medical settings is recommended in areas with a prevalence rate greater than 2 per 1,000 population. The rates for the tri-borough in 2011 were:**
    - **7.38 per 1,000 in Hammersmith and Fulham; the 11th highest in England**
    - **8.83 per 1,000 in Kensington and Chelsea; the 4th highest in England**
    - **8.70 per 1,000 in Westminster; the 5th highest in England;**
- **Across the tri-borough, HIV infection is predominantly concentrated in MSM and Black African ethnic groups particularly amongst people aged 35-54 years old;**
- **Sex between men is the most common mode of transmission across the tri-borough;**
- **The population of people living with HIV is ageing - the number of people living with HIV aged over 55 has increased by 71% in Hammersmith and Fulham, 43% in Kensington and Chelsea and 50% in Westminster between 2007 and 2011.**
- **There has been little change in the overall incidence of HIV, however, an increasing number of new diagnoses are in older people and MSM, with a decreasing number of new diagnoses in African born heterosexual contacts**

Human immunodeficiency virus (HIV) is an immunosuppressant viral infection, primarily spread in the UK through sexual contact. HIV infection can lead to the development of opportunistic infections, collectively known as acquired immunodeficiency syndrome (AIDS). Accordingly, HIV is associated with significant morbidity, mortality and high treatment costs.

Highly active antiretroviral therapy (HAART) is the current treatment of choice for HIV and is very effective at suppressing HIV infection, thus adding years to life for people with HIV. Treatment with HAART can, however, exacerbate other morbidities such as premature onset of coronary heart disease.

Evidence is increasingly available of the efficacy of treatment as helping with prevention of transmission. Key clinical indicators of successful treatment are a high CD4 blood-cell count and undetectable viral load. Evidence indicates that an undetectable viral load substantially reduces the likelihood of HIV transmission occurring.

Prevalence of HIV

Prevalence refers to the proportion of individuals within a defined population who are infected at a given time. Ascertaining the prevalence of HIV is problematic because not everyone with HIV will be diagnosed. In 2011, the HPA estimated that about 25% of people infected with HIV were unaware of their infection.

The main data source that has been drawn upon to understand the prevalence of HIV in the tri-borough is the Survey of Prevalent HIV Infections Diagnosed (SOPHID), which refers to those people diagnosed with HIV and accessing care. However, data from the Unlinked Anonymous Prevalence Monitoring Programme (UAPMP) has also been considered as it

provides information not only on those people diagnosed but on those with undiagnosed infection in disproportionately affected population groups.

Figure 28: Rate of people living with HIV per 1,000 adults (2010) (Data Source: SOPHID, HPA)

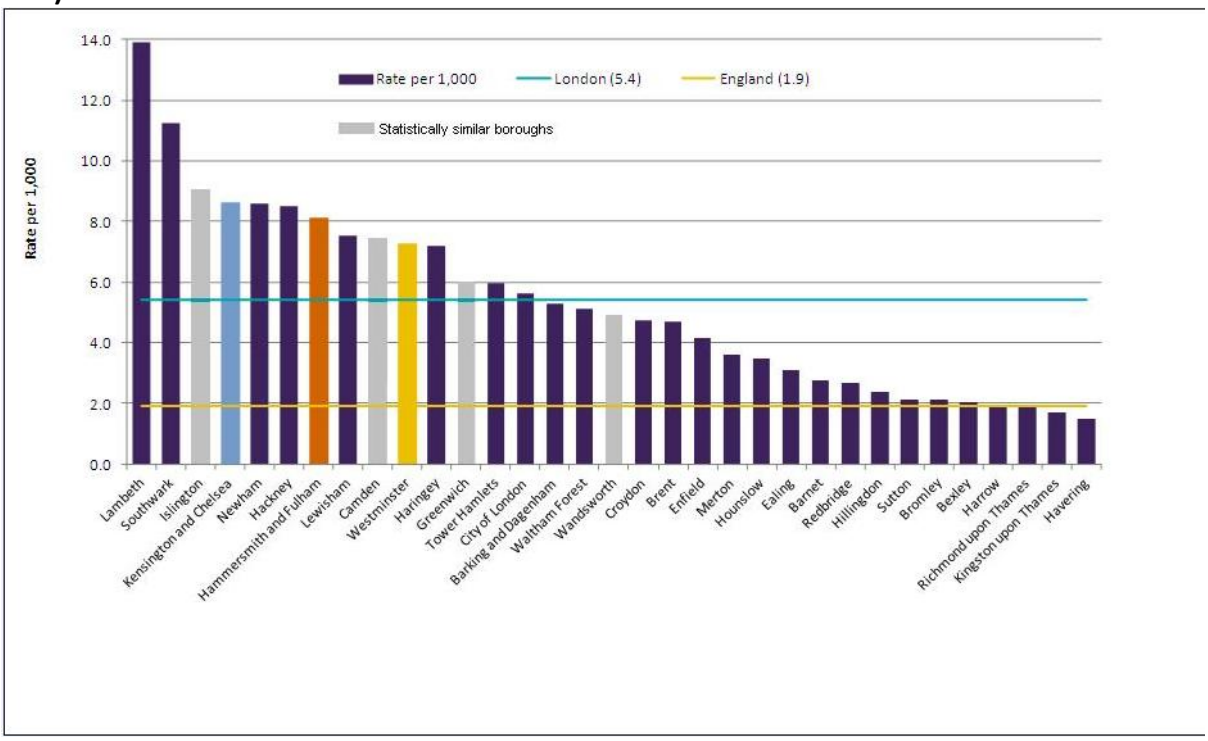
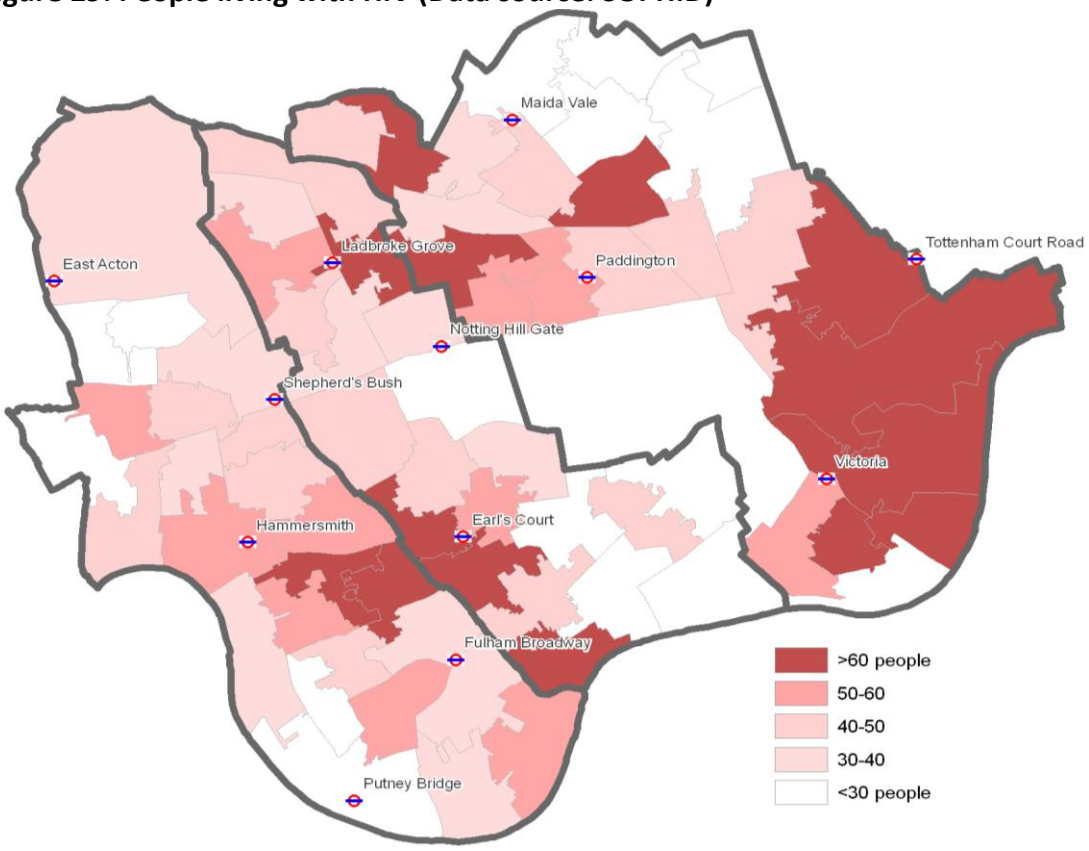


Figure 29: People living with HIV (Data source: SOPHID)



It can be noted that the areas of the three boroughs that have the highest prevalence do not always coincide with the areas with the highest levels of deprivation.

Table 8: Numbers of HIV diagnosed people by age group

Local authority	0- 15	16- 34	35- 44	45- 54	55+
Hammersmith & Fulham	<10	184	316	382	186
Kensington and Chelsea	<10	133	330	399	186
Westminster	<10	261	515	492	199

Table 9: Numbers of HIV diagnosed people by ethnic group, 2011

Local authority	White	Black-Caribbean	Black-African	Indian/ Pakistani/ Bangladeshi	Other	Not known
Westminster	967	29	186	16	252	25
Kensington and Chelsea	718	24	114	<10	169	19
Hammersmith & Fulham	692	32	181	<10	148	14

Table 10: Numbers of HIV diagnosed people by deprivation quintile

Local Authority	Most deprived	Second most deprived	Third most deprived	Second least deprived	Least deprived
Kensington and Chelsea	328	349	181	179	10
Hammersmith and Fulham	270	595	139	65	*
Westminster	269	602	476	120	*

*None of the Hammersmith & Fulham and Westminster LSOAs belong national least deprived quintiles.

Generally there is high prevalence of HIV in the most deprived parts of the tri-borough. The highest prevalence of HIV is to be found in the two highest quintiles of deprivation in all three boroughs.

Figure 30: People living with HIV over time (Data source: SOPHID)

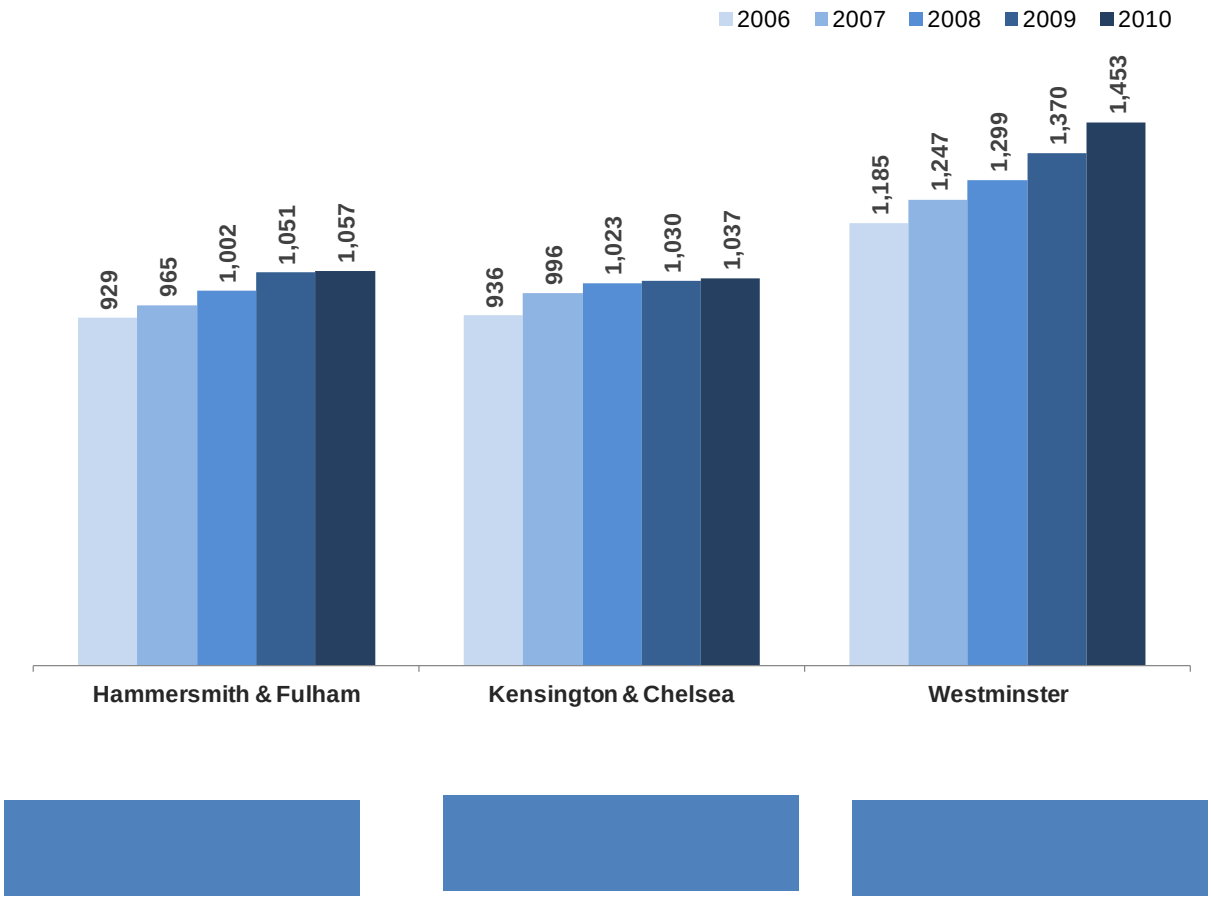


Table 11: Numbers of HIV diagnosed people by probable route of HIV infection during 2011 (Data source: SOPHID)

Local authority	Sex between men	Injecting drug use	Sex between men and women	Mother-to-child transmission
Westminster	1045	30	322	13
Kensington and Chelsea	776	10	203	<10
Hammersmith & Fulham	697	35	288	15

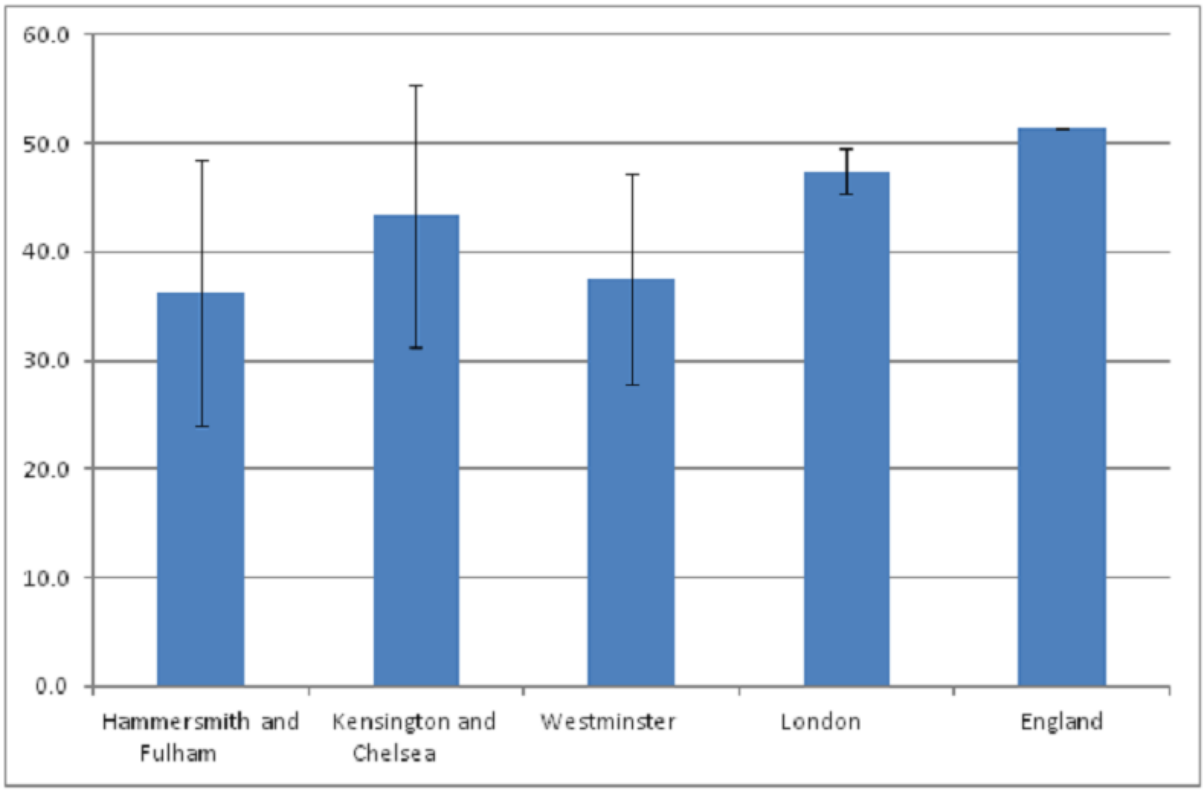
Table 12: HIV test uptake in London LAs, 2009 – 2011, Data type: residence data (residence data are unavailable prior to 2009) (Data source: SOPHID)

	LA of residence	Hammersmith & Fulham	Kensington & Chelsea	Westminster
New GUM episode	2009	17123	11828	18679
	2010	17338	12187	18691
	2011	16959	12038	19296
Offered (% offered)	2009	13671 (80%)	8905 (75%)	13927 (75%)
	2010	13833 (80%)	9788 (80%)	15230 (82%)
	2011	13556 (80%)	9767 (81%)	16027 (83%)
Tested (% uptake)	2009	10945 (80%)	7359 (83%)	11437 (82%)
	2010	11453 (83%)	8104 (83%)	12417 (82%)
	2011	11301 (83%)	8094 (83%)	13239 (83%)

(Increases in HIV test uptake may be the result of improved LA data completeness)

The uptake of HIV testing in GUM clinics (that is, the number of people who accept an HIV test as a percentage of all individuals who are offered an HIV test in GUM clinics) was higher than the England average (80%) in the tri-borough.

Figure 31: Percentage HIV diagnoses with CD4 cell count < 350mm^3 at time of diagnoses, 2011 (Data source: SOPHID)



Level of late diagnosis of HIV is better in the tri-borough compared with London and England.

Table 13: HIV/AIDS late diagnosis (Data source HPA analysis 2011)

	CD4<350				CD4 <200			
PCT	**Diagnosed**	**<350**	**%late**	**Rank in London***	**Diagnosed**	**<200**	**%late**	**Rank in London***
Hammersmith and Fulham	43	17	40%	6	43	<10	19%	5
Kensington and Chelsea	52	17	33%	1	52	<10	13%	3
Westminster	93	36	39%	5	93	18	19%	7

*There were 31 PCTs in London.

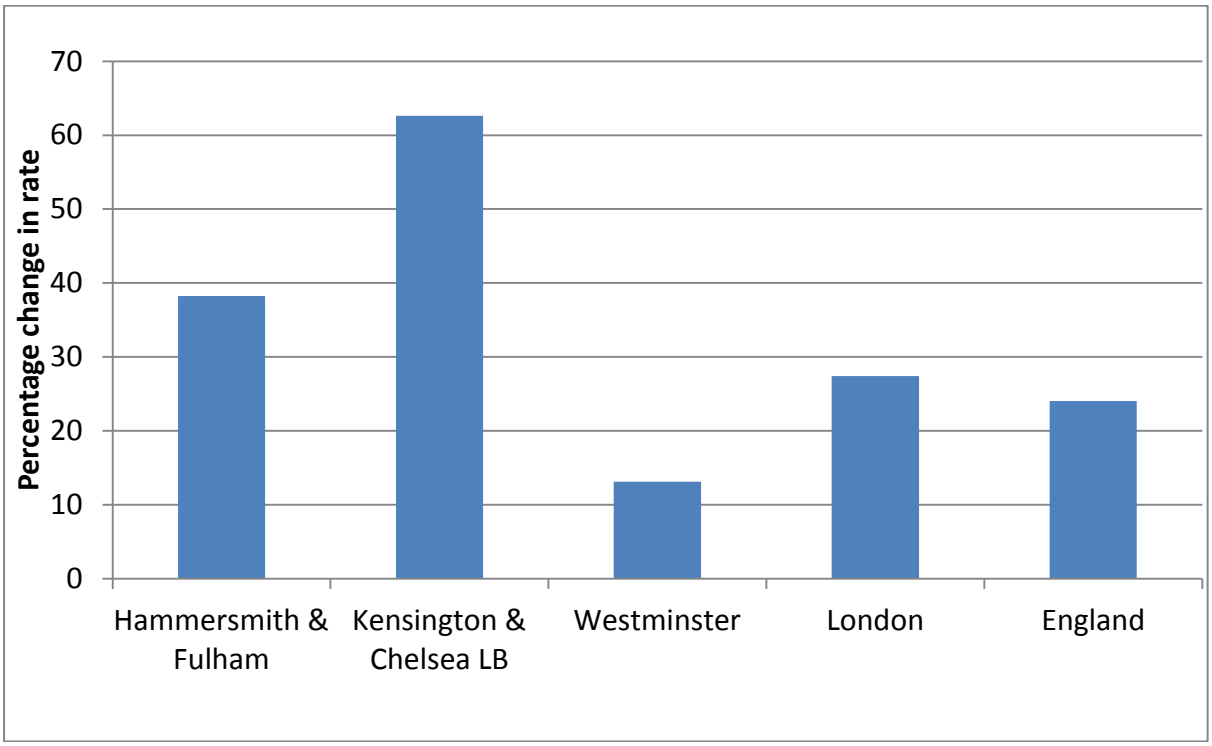
As shown in table above late diagnosis is lower (better) than London average in 2010 (where rank 1 is the best).

Teenage Pregnancy

Key Messages:

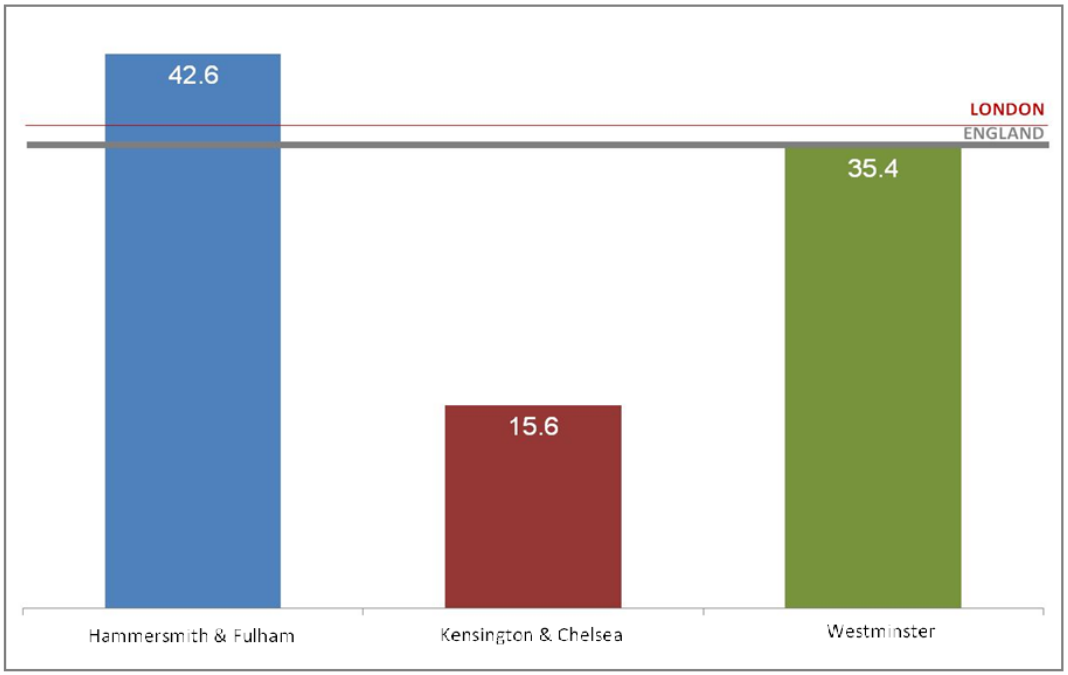
- **Teenage pregnancy is commonly associated with poor health and social care outcomes for both the teenage parent and the child;**
- **There has been a decline in the rates of teenage conceptions across the tri-borough over the last decade. There has been over a 60% reduction in Kensington and Chelsea teenage pregnancy rates while only 13% reduction was observed in Westminster from 1998 to 2010.**
- **The teenage conception rate in the tri-borough area is 31.2 per 1,000 females aged 15-17 years old- this is lower than the London and England rates; with highest rate was observed in Hammersmith and Fulham (42.6) and lowest was observed in Kensington and Chelsea (15.6) per 1000 15-17 year old teenage girls.**

Figure 32: Percentage decrease in conception rates between 1998 and 2010 in age under 18, by PCT (LA Partners) (Data source: APHO Sexual health profiles)



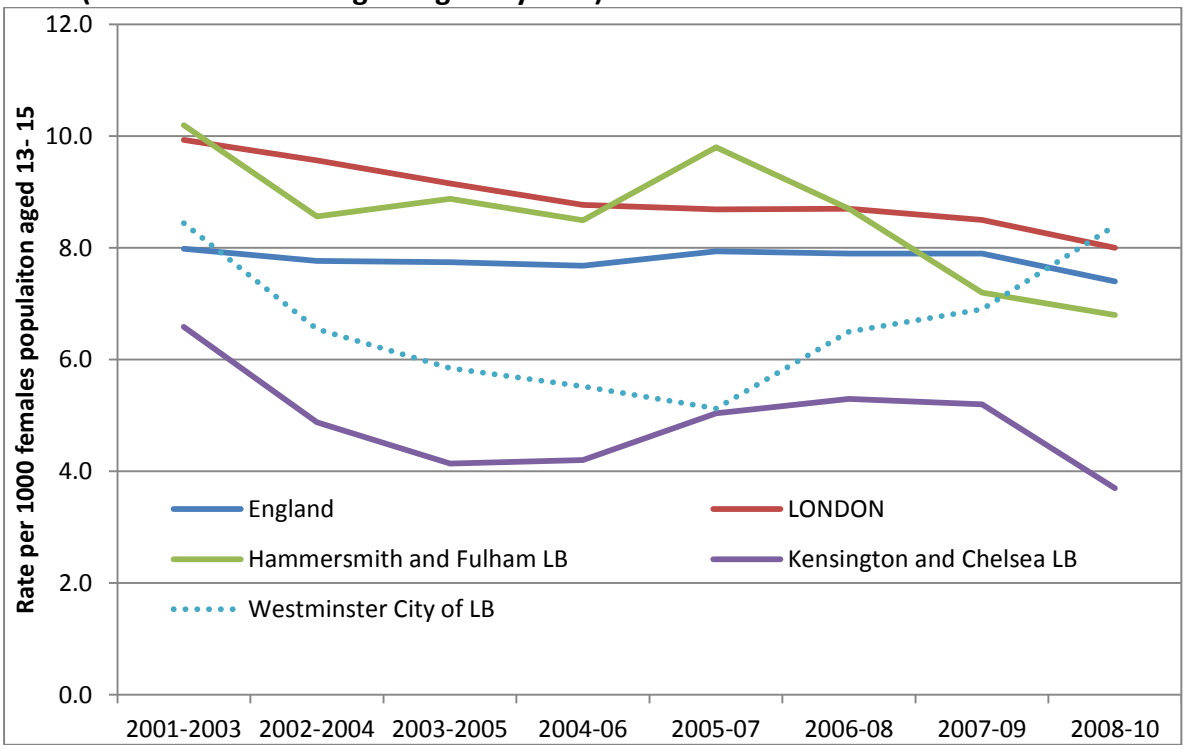
Kensington and Chelsea had a 62.6% decrease in under 18 teenage conception rate from 1998 to 2010 and had a greater percentage reduction compared with London and England. However, the Westminster percentage decrease in teenage pregnancy rate from 1998 to 2010 was 13.1% which was lower than London and England Hammersmith and Fulham under 18 conception rates are higher than London and England.

Figure 33: Under 18 conception rate, 2010: Rate per 1,000 women aged 15-17 (Data source: Teenage Pregnancy Unit)



Teenage conception rates among 15-17 are lower in Kensington and Chelsea compared with the rest of the tri-borough and London and England. However, Hammersmith and Fulham 15-17 year old conception rates were higher than London and England rates.

Figure 34: Under 16 conception rates are per 1000 female population aged 13-15, 3 year trend (Data source: Teenage Pregnancy Unit)



The conception rate in under 16s (13-15) decreased between 1998 and 2010 with Kensington and Chelsea having the largest decrease (-63%). However, Westminster rates have been increasing since 2005-07 to 2008-10.

Abortions

Key Messages:

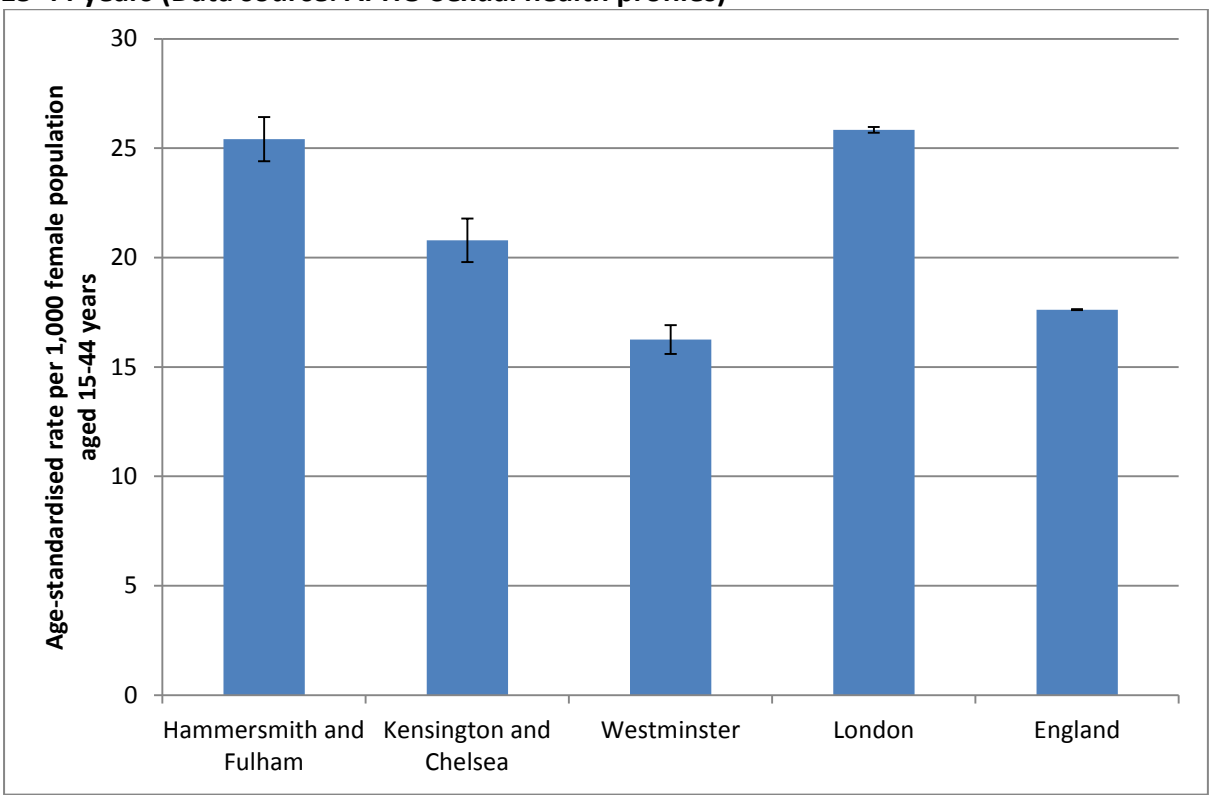
- **There has been little change in the abortion rate across the tri-boroughs in recent years;**
- **The abortion rate across the tri-boroughs is 22.3 per 1,000 women aged 15-44 – this is higher than the national rate, but lower than the rate in London during 2011, with highest rates in Hammersmith and Fulham, which was higher than England.**
- **Abortion rates are highest in women among women aged 18-24, however, the abortion rate across the tri-borough in women aged <18 and 30 and above is also high compared to England as a whole;**
- **Westminster has one of the highest proportions of privately funded abortions in England;**
- **A high proportion of abortions are conducted under 10 weeks gestation – a higher proportion than in London and England, suggesting that the tri-borough women have good access to abortion services;**

Table 14: Abortions in women aged under 25 years by ethnic group and Strategic Health Authority of residence, 2006-08 (3 combined years): Rate per 1,000 women aged 15-24 years (Data source: APHO Sexual health profiles)

Ethnicity	London	England
All groups	19.7	25.2
White	18.2	23.3
Mixed	54.6	35.6
Asian	16.2	20.0
Black	54.3	73.8
Chinese or other	17.5	26.6

We do not have ethnicity data available for those abortions for tri-borough area. However, as shown in table 14, high rates of abortions were observed among mixed ethnic groups and black community groups in London.

Figure 35: Total Abortions, 2011, Age-standardised rate per 1,000 female population aged 15-44 years (Data source: APHO Sexual health profiles)



The abortion rate across the tri-borough is 22.3 per 1,000 women aged 15-44 – this is higher than the national rate, but lower than the rate in London during 2011, with highest rates in Hammersmith and Fulham, which was higher than England.

Figure 36: Number of abortions in 2011, by age of mother
Source: NCHOD 2011

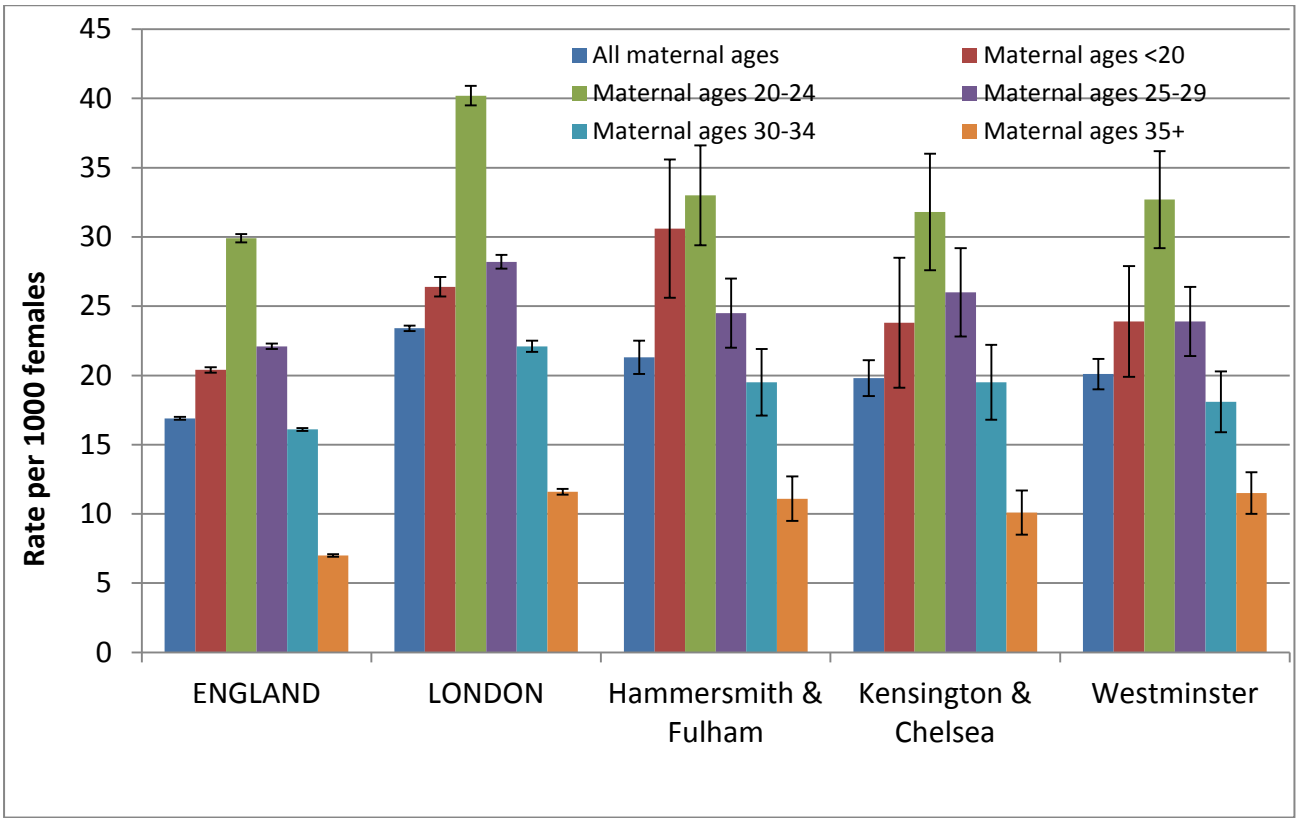
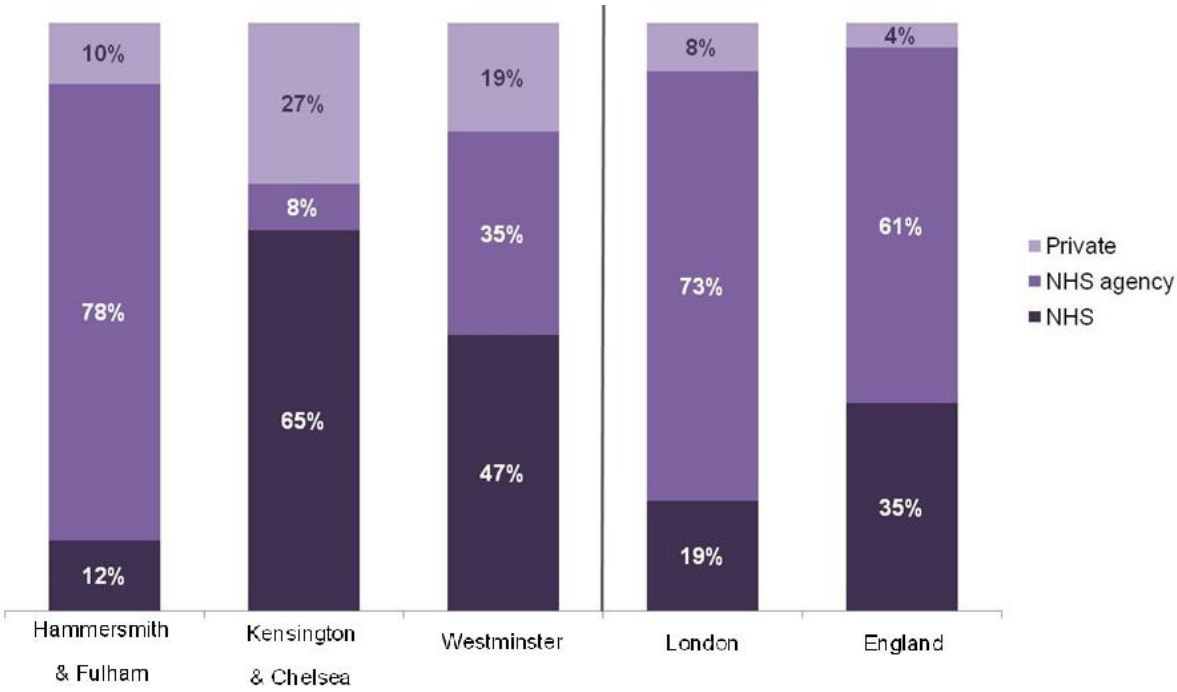


Table 15: Abortions by gestational age less than 10 weeks, 2011 (Data source: APHO Sexual health profiles)

	Total abortions 2011	Abortions less than 10 weeks	% less than 10 weeks
Hammersmith & Fulham	1,115	910	82%
Kensington & Chelsea	775	665	86%
Westminster	1,140	954	84%
London	46,800	37,729	81%
England	181,438	141,741	78%

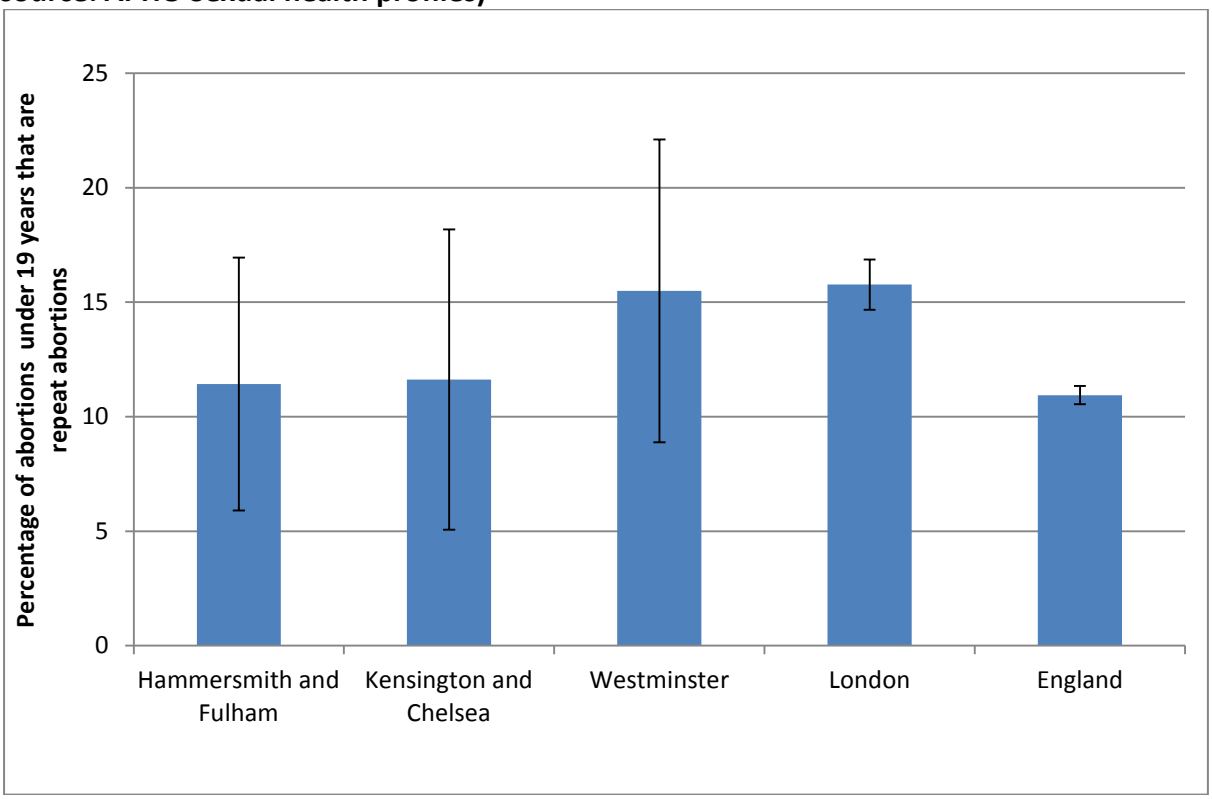
Most of the abortions were carried out when the gestational age was less than 10 weeks in 2011 in the tri-borough. Each of the three boroughs had higher proportion of such abortions were carried out when gestational age was less than 10 weeks compared with London and England.

Figure 37: Abortions by provider- NHS or private, 2011 (Data source: NCHOD 2011)



As shown in figure 37, high proportion of abortions were carried out in private clinics in Kensington and Chelsea and Westminster, which was higher than average London and England proportions.

Figure 38: Percentage of abortions in age under 19 years that are repeat abortions, 2011 (Data source: APHO Sexual health profiles)



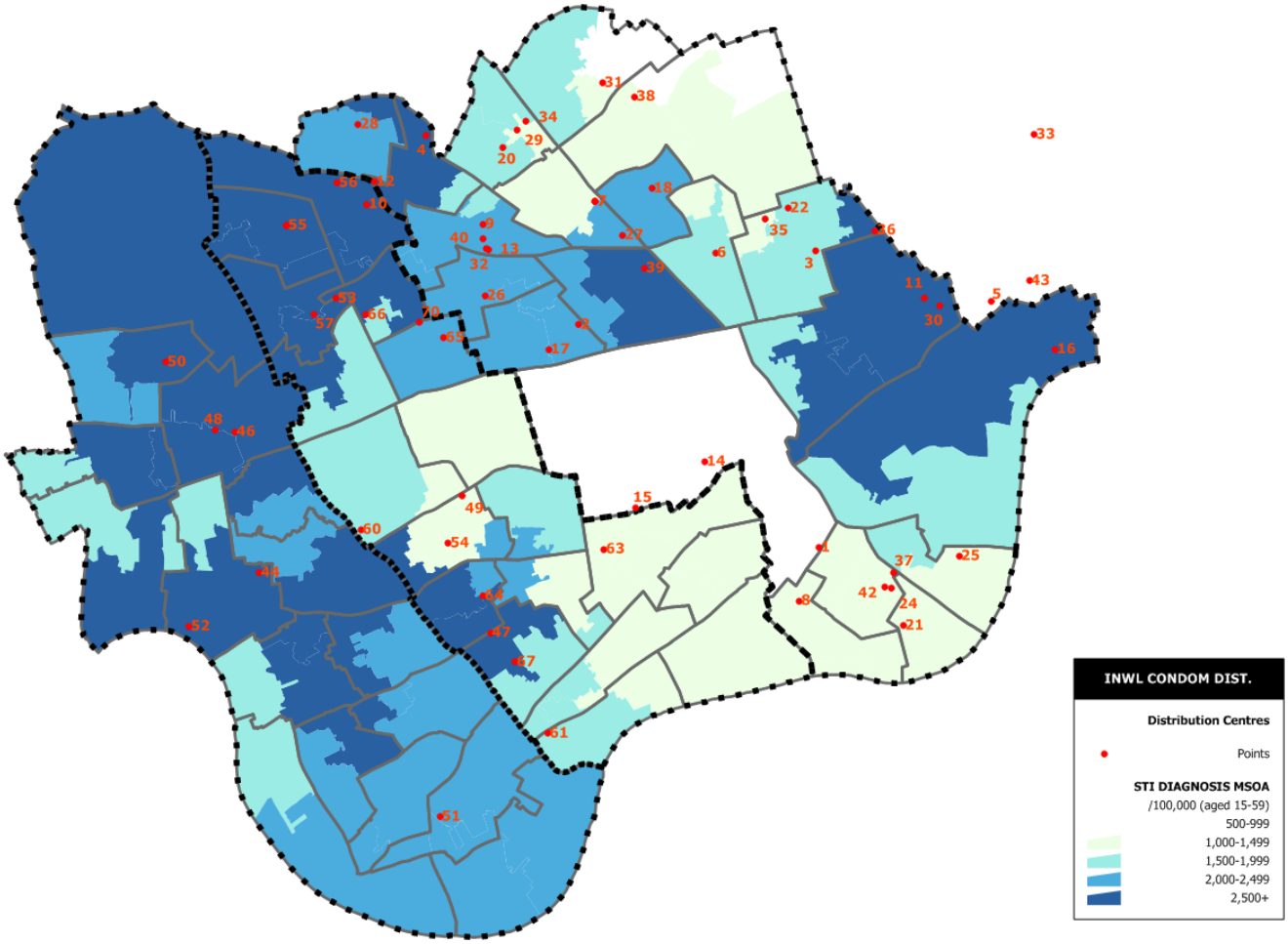
Under 19 repeat abortions were generally high in Westminster compared with England during 2011.

Provision of Sexual Health Services across the tri-borough

Table 16: Tri-borough residents attending to GUM clinics by service: 2011 (Top 5 services), (Data source: HPA STI report 2012)

Service centre	Westminster (%)	Kensington & Chelsea (%)	Hammersmith & Fulham (%)
St Mary's Hospital London	49.5	30.9	11.6
Dean Street Clinic	18.5	8.9	6.9
Mortimer Market Centre	12.3	4.7	3
John Hunter Clinic	6.3	41	21.8
Charing Cross Hospital	2	7.4	47

Figure 39: STI diagnosis rate per 100,000 aged 15-59, 2010 and condom distribution centres in the tri-borough (Data source: GUMCAD) (Table 3 shows the name of the condom distribution centre)



This map excludes distribution points for the Pan London HIV prevention Programme Gay Men's Condom Distribution Scheme.

There is a paucity of evidence available as to the beneficiaries of the tri-borough condom distribution scheme.

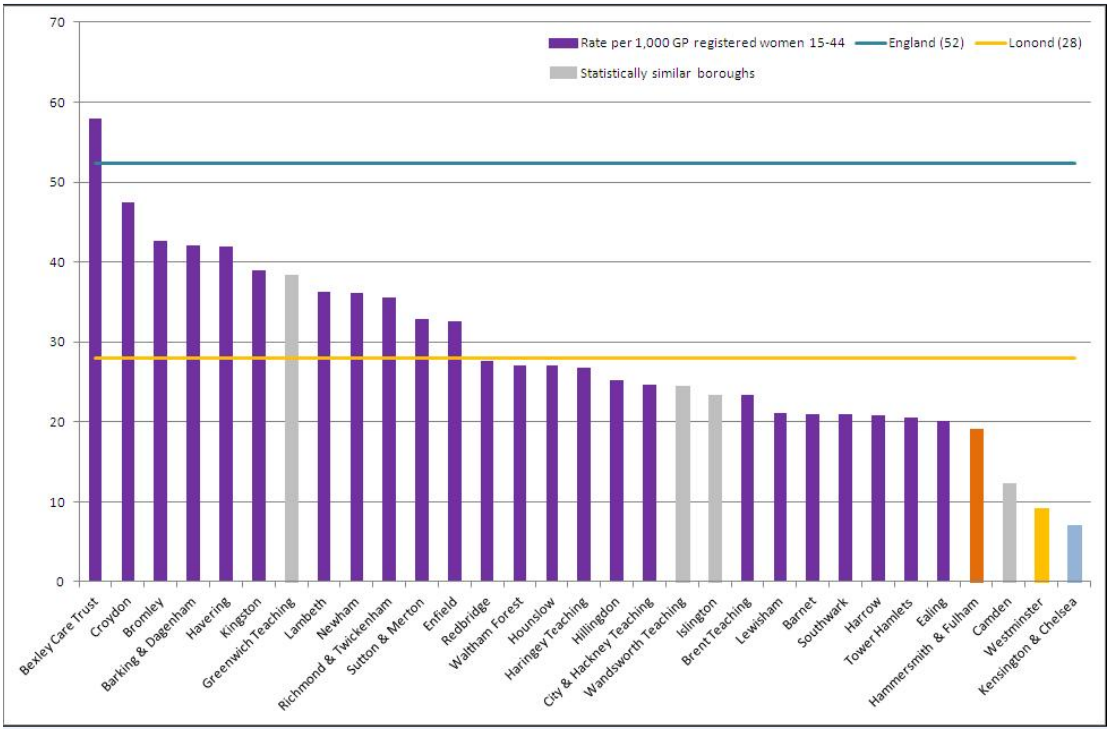
Some parts of the 'tri-borough' area including Soho, Earl's Court, Paddington and Shepherd's Bush areas have among the highest rates of STIs in London.

Long Acting Reversible Contraception (LARC)

Long-acting reversible contraception (LARC) are methods of birth control that provide effective contraception for an extended period of time without requiring user action. They include intrauterine devices (IUDs) and subdermal implants. They are the most effective reversible methods of contraception because they do not depend on patient compliance. Their 'typical use' failure rate is less than 1% per year. LARC methods are some of the most cost-effective in the long term. The NICE clinical guideline on long-acting reversible contraception (LARC) offers the best-practice advice for all women of reproductive age who may wish to regulate their fertility by using LARC methods. It covers specific issues for the use of these methods during the menarche and before the menopause, and by particular groups, including women who have HIV, learning disabilities or physical disabilities, or are younger than 16 years.

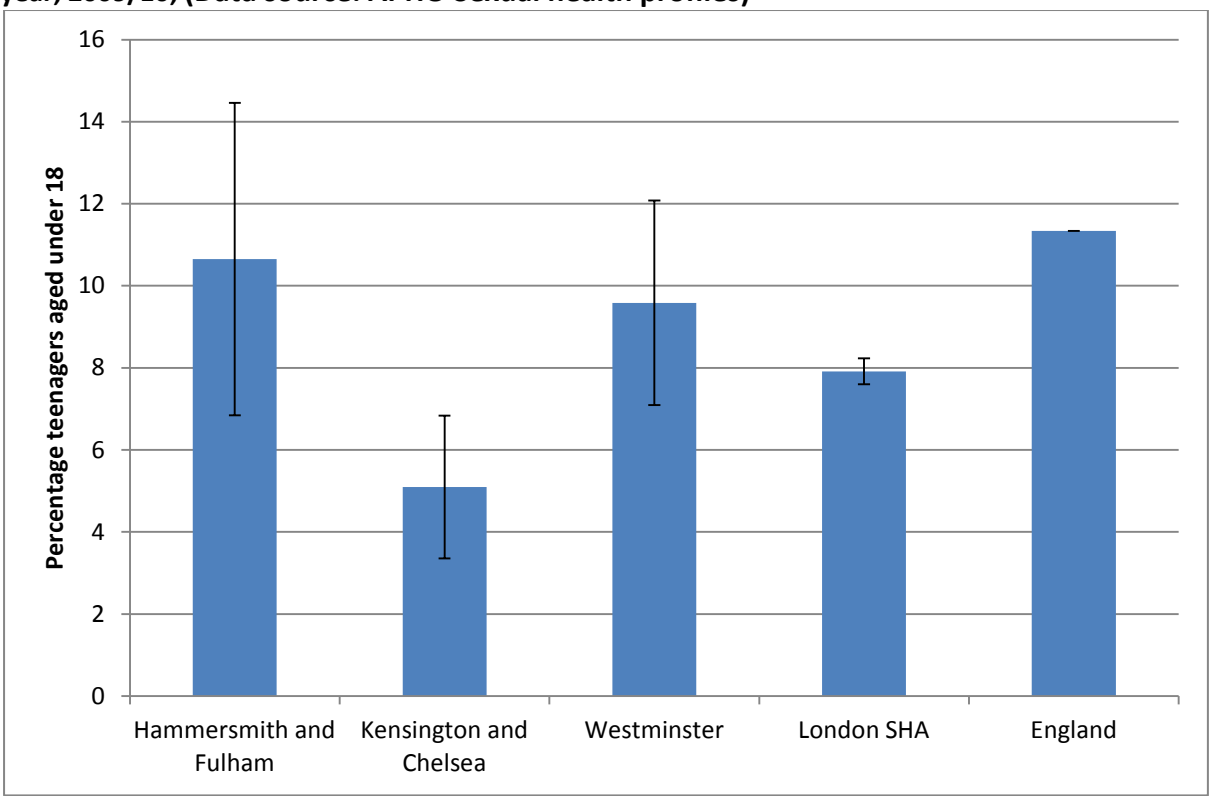
The three boroughs generally have low rates of GP-prescribed LARC than the rest of London with Kensington & Chelsea and Westminster have the lowest rates in London.

Figure 40: Rate of GP-prescribed LARC in London, 2011/12: Long acting reversible contraception (LARC) per 1,000 GP-registered women 15-44.
(Data source: APHO Sexual Health Balanced Scorecard)



Furthermore, those under 18 teenagers attending Community sexual & reproductive health services have better rates of LARC at the first contact in the tri-borough compared with London, except Kensington and Chelsea.

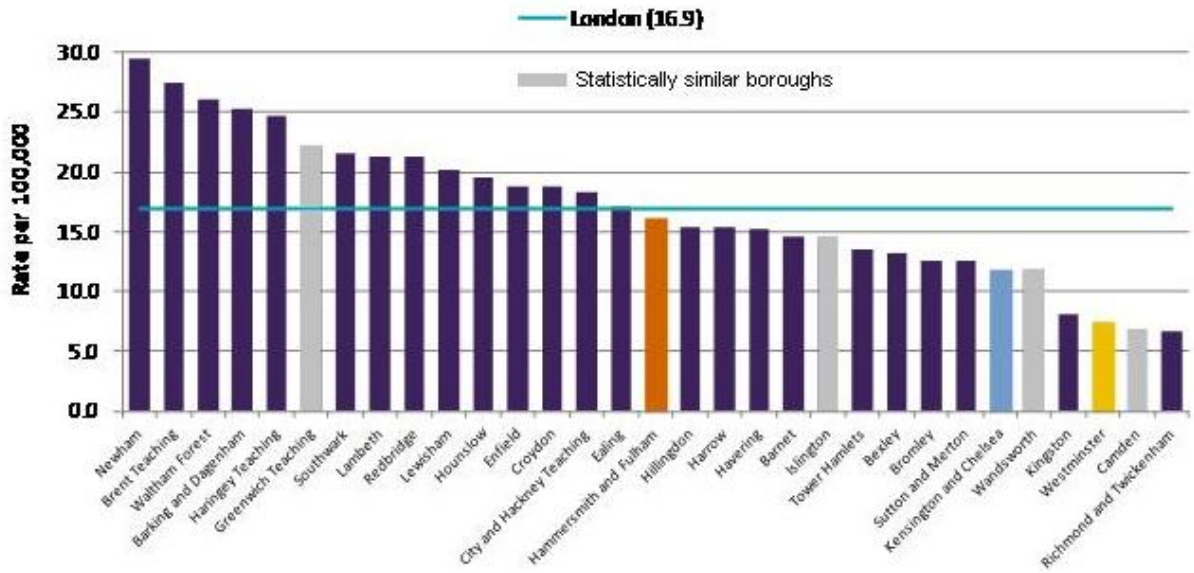
Figure 41: Percentage teenager girls aged under 18 at Community Sexual & Reproductive Health (CSRH) services who choose long acting reversible contraception (LARC) at the first contact in the year, 2009/10, (Data source: APHO Sexual health profiles)



Sexual assaults

Westminster had the highest number of serious sexual assaults reported to the Police. Referral rates of residents to Haven's for medical assessment is lower than the London average (figure below 2011/12)

Figure 42: Rate of Referrals of residents to Haven's for medical assessment during 2011/12 (Data source: HPA 2012)



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