2023

London Borough of Barnet Sexual Health Needs Assessment

2023

LONDON BOROUGH OF BARNET PUBLIC HEALTH TEAM

Table of Contents

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The staff and clients of Homeless Action in Barnet

List of Figures

1 Executive Summary

1.1 This section can be read in conjunction with the 'Recommendations' to give an overview of the whole report. Key areas of interest can also be easily found in the main report by selecting the subheading in the left-hand menu.

The Barnet 2023 Sexual Health Needs Assessment looks at data from the last 5 years and uses 2021 census demographic data to help better understand the needs of the Barnet population. The last 5 years have seen unprecedented pressures and changes to sexual health provision and healthcare more broadly both regionally and nationally, due to the COVID-19 pandemic and monkey pox. This needs assessment provides an insight into the use of services over the last 5 years but should also be read with this in mind.

1.2 Overview of sexual health services in the London of Borough of Barnet

There are a number of providers across Barnet providing sexual health services both to Barnet residents and patients from other areas. Patients can access integrated sexual health services through self-referral, and they are not restricted to accessing care at a specific location. patients to choose where they receive care. In Barnet there are currently two active ISH clinics provided by Central and North-West London NHS Foundation Trust (CNWL) in Edgware Community Hospital and in Vale Drive Primary Care Centre.

Long-acting reversible contraception are available in CNWL clinics as well as through 20 CNWL locally commissioned GPs and through ICB commissioned TOP services for those who have had a termination at the service.

Emergency hormonal contraception is available through CNWL clinics as well as through 15 CNWL locally commissioned pharmacies.

General practice and community pharmacy continue to play a role in maintaining good sexual health. Termination of pregnancy and sterilisation services continue to be commissioned in the ICB.

NHS England commissions the treatment and care for individuals diagnosed with HIV. Multiple providers, including the Royal Free NHS Trust, CNWL, and the HIV Psychology service provided by the Barnet, Enfield and Haringey Mental Health NHS Trust, offer HIV services.

Commissioned online services provided through Sexual Health London (SHL) provides STI and HIV self-sampling kits that are delivered and collected through the postal system or collected from CNWL ISH clinics. There has been a steady increase in the number of self-sampling STI kits ordered online since the service started with a sharper increase in use in-line with the start of the pandemic. In 2021/22 73.3% of STI tests completed by Barnet residents were ordered online. SHL also provide some forms of contraception include the emergency pills, the combined and progestogen-only pills, contraceptive patches and vaginal ring contraceptive.

Targeted services for young people include dedicated ISH clinics, the condom distribution scheme (c-card) and commissioned free EHC from 15 community pharmacies for those under 25. The CNWL Bridge Clinic provides a dedicated and comprehensive clinic led by a senior specialist learning disability nurse for people with learning disability and autism who are over 16.

1.3 Integrated Sexual health (ISH) services

ISH services are commissioned through CNWL. There was a significant reduction in the number of interventions in ISH clinics at the start of the pandemic with services reconfigured to support national efforts against COVID-19; both Vale Drive and Edgware Community Hospital clinics closed for 4 months and staff re-deployed. ISH clinic activity remains below previous pre-pandemic activity. Post-pandemic activity in Vale Drive Primary Care Centre has significantly dropped from a 3 year average of 16.6% of interventions over the 3 years preceding the pandemic to 2.9-5%. Following the pandemic, more care to Barnet residents was provided outside of the borough with the most popular ISH clinic for Barnet residents was Mortimer Market in Camden, followed by Edgware Community Hospital and the Archway Centre in Islington.

Females continue to have a greater use of services across all domains and all age groups and use of in-clinic interventions is greatest in the 20-24 years old and 25–29-year-old age group. The use of in-clinic services by different ethnic groups is difficult to determine as there is no recorded ethnicity for over a third of responses. There was no statistical association between the number of interventions and deprivation as measured through IMD.

1.4 Sexual Health Outcomes

The rate of new STI diagnosis have consistently remained below the regional London average but have been above the national average since 2015. However, STI testing rate in Barnet is greater than the national average but below the regional London average. Use of services varies between different ethnic groups, with the Asian or Asian British population being under-represented, this group is also under-represented in the number of positive tests, this may indicate a need for increased testing in this group.

HIV prevalence in Barnet for the reporting period 2021 was 2.1 per 1,000 putting Barnet in the high category (<2 is low, 2-5 is high, ≥5 is extremely high). There has been no significant change in the prevalence of HIV over the last 5 years. The incidence and prevalence of HIV in Barnet is below the London average but above the national average. Reflecting national and local trends in a decrease in STI testing during and since the pandemic there has also been a decrease in HIV testing and over a third of people continue to receive a late diagnosis of HIV in Barnet. [1]

For patients accessing HIV care, coverage for treatment with antiretroviral therapy is good at 99.2% and is above the regional and national average. In the 2021 reporting period, amongst those with PrEP need, based on fingertips data, in Barnet, 76.9% of those in Barnet were initiated on or continued their PrEP compared to 79.4% in the London region and the England average of 69.6%. There has however been an overall increase in the number of appointments for PrEP from 2021 to 2023. [1]

There was a significant drop in the number of school-age HPV vaccinations due to the disruption of the school immunisation programme caused by national lockdowns and school closures. Where vaccinations have been subsequently offered uptake has been below pre-pandemic levels for the borough and lower than the London regional average.

There has been no change in the number of people have terminations of pregnancies over the last 5 years. In Barnet, 41.1% of abortions were repeat abortion, similar to regional and national averages, and 88.1% of abortions were at 3 to 9 weeks.[2] Professionals have

expressed a concern around unmet need around post-termination contraception, with many patients not attending post-termination contraception appointments. At NUPAS, pre-pandemic post-TOP contraception care was provided to 43% of patients' pre-pandemic but only 22.6% post-pandemic.

Knowing the true incidence and prevalence of sexual abuse and FGM is difficult as need is not always expressed. Specialist services and pathways exist for those who have been a victim with a range of services provided by the council, CNWL and the voluntary and community sector.

1.5 Needs arising in the population

Barnet is home to a diverse population with some groups being disproportionately affected by poor sexual health outcomes and different groups benefiting from a range of more targeted approaches to support their sexual health.

In Barnet, as nationally, STIs and HIV disproportionately effect gay, bisexual and other MSM. Targeted health promotion in the community by Brook aims to target this issue.

Analysis has demonstrated that young people suffer from STIs at a higher rate than any other age group. There are specialist services and programmes for young people including the c-card scheme, Brook health promotion programmes, a weekly under-17 walk-in clinic and improved access to clinics through walk-in appointments.

Asylum seekers and refugees are able to access specialist services though the UCLH Respond pilot. Asylum seekers and refugees come from a diverse range of backgrounds and so their needs are similarly diverse. However, common requests for support for sexual health includes access to condoms and contraception and this group can be supported through the co-location of sexual health services with other services.

Discussions with professionals working at Homeless Action in Barnet and its clients revealed multiple practical barriers to accessing sexual health services for those experiencing homelessness. These include cost barriers from transport and difficulties booking and keeping scheduled rather than walk-in appointments.

1.6 Education and Health promotion

Most of PSHE education became statutory for all schools from September 2020 under the Children and Social Work Act 2017. This includes Relationships Education at key stages 1 and 2, Relationships and Sex Education (RSE) at key stages 3 and 4, and Health Education in both primary and secondary phases. The main responsibility for PSHE/RSE delivery firmly sits with each school and support is available from services including Health Education Partnership (HEP), Brook and School Nurses which are commissioned by Barnet Public Health. Barnet schools are also supported through Barnet Education and Learning Service (BELS) who offer support guidance and direct support through their traded service Barnet Partnership School Improvement (BPSI).

Health promotion is also provided in the community with work targeted both for young people and adults. Brook provides a range of offerings including peer education for young people and HIV health promotion activities targeted towards different ethnic minority groups as well as, MSM and LGBTQ+ communities.

1.7 The sexual health needs assessment is a broad document reviewing many areas of sexual health though it is acknowledged that there are areas relating to sexual health that have fallen outside of the scope of the document. It provided an opportunity to create an overview of the sexual health needs of Barnet residents and was closely supported by many partners working in this area. As we move away from the pandemic and adopt to new ways of working as well as changing health-seeking behaviours from our population we will continue to review the needs of our population.

Summary recommendations

1.8 Overview of sexual health services in the London of Borough of Barnet

- Improve eligible resident's knowledge of commissioned EHC and how they can access it, including from community pharmacies.
- Improve residents' knowledge of and uptake of LARC.
- Improve residents' knowledge of sexual health services across the borough through improvements on CNWL and council websites including signposting to services across the system both face-to-face services and online and improved layout and readability scores on the websites.

1.9 Integrated Sexual health (ISH) services

- Staff within CNWL to update the CNWL online booking form questions to improve the recording of attendance to ISH clinic services by different ethnic groups, in order to better understand any inequality in access or use.

1.10 Sexual Health Outcomes

- Increase opportunities for and uptake of STI testing across the population, through increased promotion across the services, social media and signposting from pharmacy services.
- Continue to improve outcomes relating to PrEP by creating clearer pathways for patients and enhancing web pages across the system to help residents understand where and how to access consultations for PrEP.
- Increase testing in hard-to-reach groups such as through co-location of services and provision of point-of-care HIV testing.
- Increase understanding and why uptake of HPV vaccination is low in school children post-pandemic and support the school-age immunisation team to improve uptake.
- Support individuals who have had a termination of pregnancy to get appropriate and timely post-termination contraception.
- A further understanding is needed around FGM prevalence and need.

1.11 Needs arising in the population

- Further research is needed to understand the current RSE offer to students with a learning disability both in mainstream and specialist schools.
- To improve the access to and knowledge of sexual health services in the homeless population in Barnet, through in-reach days, co-location of services, signposting, and the provision of translated materials to the Homeless Action in Barnet Day Centre.

1.12 Education and Health promotion

- Increase contact and support for school link governors to support them in their role and provide opportunities for increased continuity between schools and supporting services.

2 Introduction

Aims and objectives

Aims

- To understand the different sexual health needs of the Barnet population.
- To understand how and if the sexual health needs of Barnet residents are being met.
- To understand unmet needs and gaps in services and make recommendations to inform service improvements.
- To identify potential inequalities in sexual health and make recommendations on how these can be addressed.

Objectives

- To describes the Barnet population.
- To gather from stakeholders and focus groups the different sexual health issues that affect the Barnet population.
- To describe the different sexual health outcomes of the Barnet population and how they relate to different demographics.
- To map the different sexual health services provided in Barnet, considering services provided by both the public sector and third sector services.
- To map accessibility of locally commissioned services considering opening times, availability of information to locate services, geography and barriers to these services for priority groups to address inequalities.
- To describe unmet need and discuss recommendation for service improvement.
- To describe the work of voluntary and community sector in meeting need, especially where this need is unmet by publicly commissioned work.
- To describe the activity of locally commissioned services.
- To compare how expression of need for sexual health services has changed post-pandemic.

Scope

The table below supports the direction of the needs assessment by defining its scope. Sexual health is a broad area which overlaps with other topics such as alcohol and drug use, mental health, harmful cultural practices and it is closely aligned to reproductive health. The scope of this needs assessment ensures that the priority outcomes for the area locally and the country nationally are addressed. The Sexual Health Needs Assessment steering committee guided and supported decisions around the direction of the scope. The scope ensures that areas in-scope are addressed with adequate detail whilst the table below hopes to reassure the reader that there is an acknowledgement of the wide range of topics that effect sexual health and that these may be considered as areas for future work.

In-scope	Out of scope
Condom distribution	Hepatitis C
HIV awareness, testing and prevention	Erectile dysfunction
STI rates and testing	IVF
Hormonal contraception	Infertility
HPV vaccination	Miscarriage
Emergency contraception	Sanitary products
Health promotion in relation to sexual health	Menopause
Psycho-sexual health	
Termination of pregnancy	

Teenage conception Domestic abuse Hepatitis B FGM Mpox	

Nationally-commissioned services around the treatment of HIV remain out of scope of this local needs assessment. The diagnosis of HIV and health awareness and prevention however is firmly within the scope of this needs assessment. [3,4]

3 Policy context

National policy

3.1 The WHO defines sexual health as:

> "…a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled." [5]

3.2 National framework for Sexual Health Improvement in England

3.2.1 The national framework for Sexual Health Improvement in England was set out by the Department of Health and published in 2013. This document sets out key themes and priorities for sexual health. The framework highlighted priority areas for health improvement including: STI testing, HIV, contraception and unwanted pregnancy, abortion counselling and preventing teenage pregnancy. [4]

3.2.2 The framework highlights the importance of prevention and a range of issues across the life course as well as the importance of supporting vulnerable groups including young people, gay and bisexual men, some black and minority ethnic groups and people with learning disabilities. [4]

3.3 Public Health Outcomes Framework

3.3.1 The Public Health Outcomes Framework (PHOF) is produced by the Office for Health Improvement and Disparities (OHID). Outcomes fall into 4 domains of: wider determinants, health improvement, health protection and healthcare and premature mortality.

3.3.2 The framework demonstrates the importance of sexual health by highlighting its inclusion in the PHOF, with key indicators under health protection and health improvement.

3.3.3 Key indictors around sexual health are included in the PHOF:

- Prescribing of long-acting reversible contraception
- Under 18 conceptions
- New STI diagnoses
- People presenting with HIV at a late stage of infection.[6]

3.3.4 There are also other relevant indicators to sexual health:

- Violent crime – sexual offences per 1,000 population
- Population vaccination coverage – HPV vaccination coverage for one dose (12-13 years old) (Female)
- Population vaccination coverage – HPV vaccination coverage for one dose (12-13 years old) (Male)
- Population vaccination coverage – HPV vaccination coverage for two doses (13-14 years old) (Female).[6]

3.4 Sexual and reproductive health profiles

3.4.1 The UK Health Security Agency (UKHSA) and Office for Health Improvement and Disparities have also produced a sexual and reproductive health profile to support monitoring of local population's sexual and reproductive health needs. The data includes data on the following indicators: teenage pregnancy, abortions, contraception, HIV, sexually transmitted infections (STIs) and sexual offences. The profile utilises public health fingertips data. [1]

3.5 E-sexual and reproductive healthcare: national framework

3.5.1 In response to the COVID-19 pandemic Public Health England developed the National Framework for e-Sexual and Reproductive Healthcare. The framework aims to support the commissioning of e-services.

3.5.2 Three providers were appointed as part of the framework:

- Brook / Brook Digital Clinic
- Preventx / SH:UK
- SH:24 / SH:24

3.5.3 E-service provision includes:

- Self-sampling for HIV/ STIs
- Remote prescribing of selected methods of routine contraception
- Remote prescribing of emergency hormonal contraception[7]

3.6 Health promotion for sexual and reproductive health and HIV, Strategic action plan, 2016 to 2019

3.6.1 This strategy ran from 2016 to 2019 and provides background to understanding current sexual health priorities. The strategy identified four priorities from the Department of Health's *A Framework for Sexual Health Improvement in England* as:

- Reduce the burden of HIV infection by decreasing HIV incidence in the populations most at risk of new infection and reducing rates of late and undiagnosed HIV in the most affected communities.
- Reverse the rapid increase in STIs in populations most at risk of infection.
- Minimise the proportion of pregnancies that are unplanned.
- Reduce the rate of under 18 and under 16 conceptions as well as narrow the variation in rates across the country.

3.6.2 The strategic plan identified groups at risk who would benefit from targeted interventions as:

- Young people
    - The strategy highlights the promotion of appropriate contraception and screening for STIs and targeting associated risky behaviours relating to drugs and alcohol.
- MSM
    - Gay, bisexual and other men who have sex with men experience a higher burden of STI and HIV. Targeted intervention should focus on activities relating to prevention such as through condom use and testing. PHE has also created an MSM action plan that takes a whole

system approach including other aspects of health and wellbeing such as mental health.

- Black and minority ethnic populations
    - Black African communities are disproportionately affected by HIV whilst black Caribbean communities are disproportionately affected by STIs. Targeted interventions should focus on the promotion of testing and safer sex practices such as promoting condom use.
- Women of reproductive age
    - This is defined as women aged 15-44 and make up 20% of the English population. They experience the greatest burden of disease. They should have universal access to contraceptive services with targeted support for those with the greatest risk of unplanned pregnancy. [8]

3.7 NICE impact sexual health

3.7.1 The National Institute for Health and Care Excellence (NICE) 2019 impact report reviewed progress since the publication of Department of Health 2013 Framework for Sexual Health Improvement in England to monitor the uptake of relevant NICE guidance. Some of the key findings are listed below.

3.7.2 Teenage conception rates have continued to fall. Rates of under-18 conception vary widely between local authorities, and it is recognised the role socio-economic factors has here.

3.7.3 Since NICE guidance on long-acting reversible contraception (LARC) published in 2005 use of LARC has increased from 23% in 2007/8 to 41% in 2017/18. Additionally, an indicator was added to the Quality and Outcome Framework on the prescribing of LARC.

3.7.4 There have been some concerning trends in relation to STIs with a 150% increase in cases of syphilis between 2008 and 2017, and a tripling of the diagnoses of gonorrhoea over the same time period. This is coupled with the emergence of antimicrobial resistant Neisseria gonorrhoeae. NICE guidance recommends and highlight the importance of partner notification in breaking the chain of transmission. The National Chlamydia Screening Programme audit reported 94% of partners are notified whilst only 31% of all contacts attended a sexual health clinic within 4 weeks.

3.7.5 NICE recommends that everyone who attends a specialist sexual health service be offered a HIV test. 2017 PHE report demonstrated 84% were offered a test with a 63% uptake. This testing identified 2323 HIV diagnoses. [9]

3.8 Towards Zero: the HIV Action Plan for England – 2022 to 2025

3.8.1 The Department for Health and Social Care set out its Action Plan with a commitment to zero new transmission of HIV, AIDS and HIV-related deaths in England by 2030, with an interim commitment to an 80% reduction in transmissions by 2025.

3.8.2 Success to date has been a 35% reduction in new HIV diagnoses in England between 2014 and 2019 and reaching the UNAIDS 90-90-90 target for 3 years in a row.

3.8.3 To achieve this commitment, 4 key objectives have been set out alongside 20 actions:

- Objective 1: ensure equitable access and uptake of HIV prevention programmes.
- Objective 2: scale up HIV testing in line with national guidelines.

- Objective 3: optimise rapid access to treatment and retention in care.
- Objective 4: improving quality of life for people living with HIV and addressing stigma.[10]

3.9 Other national strategies relating to sexual health

3.9.1 Sexual health does not sit siloed and links to other national strategies such as:

- The Home Office's s *Action Plan for Ending Violence Against Women and Girls in the UK* which addresses FGM [8]
- The Department for Education's *Action Plan for Tackling Child Sexual Exploitation* and the role healthcare professionals play in supporting and identifying children who are victims of sexual exploitation [11]
- OHID's *Health matters* work around reducing harmful drinking. Studies have demonstrated that increasing levels of alcohol consumption are associated with intention to engage in unsafe sex. [12]

Commissioning HIV, sexual and reproductive health services

3.10 Commissioning responsibilities

3.10.1 The commissioning responsibility was set out in the 2013 national framework for sexual health improvement in England, last updated in 2018, and the 2013 publication of best practice guidance for commissioning sexual health services and interventions.

3.10.2 Local authorities commissioning responsibilities provision includes:

- Comprehensive sexual health services including most contraceptive services and all prescribing costs but excluding GP additionally-provided contraception. Contraceptive services should be open-access and free.[13]
- sexually transmitted infections (STI) testing and treatment, chlamydia screening and HIV testing. STI testing should be open access and free at the point of use. Provision should also include the notification of sexual partners.[13]
- specialist services, including young people's sexual health, teenage pregnancy services, outreach, HIV prevention (including PrEP), sexual health promotion, services in schools, college and pharmacies. [3,4]

3.10.3 Since publication of this framework in 2018 there has been a restructuring which now places the previous responsibilities of CCGs on ICBs. Their provision responsibilities include:

- most abortion services
- sterilisation
- vasectomy
- non-sexual-health elements of psychosexual health services
- gynaecology including any use of contraception for non-contraceptive purposes.[3]

3.10.4 NHS England commissions:

- contraception provided as an additional service under the GP contract
- HIV treatment and care (including drug costs for PEPSE)
- promotion of opportunistic testing and treatment for STIs and patient-requested testing by GPs

- sexual health elements of prison health services
- sexual assault referral centres
- cervical screening
- specialist foetal medicine service.[3]

Local context

3.11 Barnet's Rough sleeper health needs assessment 2021

3.11.1 Estimating the number of rough sleepers and those a risk of street homelessness is difficult. However, in 2020 Barnet accommodated 200 single people who were currently or at imminent risk of rough sleeping, at the time Homeless Action in Barnet were supporting 113 rough sleepers. In spring 2021 it was estimated that were 15-30 people currently rough sleeping in Barnet. [14]

3.11.2 People who are homeless suffer greater ill health. An audit by Homeless Link found that TB rates were 34 times higher and hepatitis C rates were 50 times higher in the homeless community. [15]

3.11.3 From a sample of homeless individuals in Barnet only 0.2% had undertaken a HIV test in the last 15 months. [14]

3.11.4 Multiple exclusion homelessness can be described as homelessness and one or more of the following other domains of 'deep social exclusion': 'institutional care' 'substance misuse' (drug, alcohol, solvent or gas misuse); or participation in 'street culture activities'. Street culture activities include, amongst other activities, sex work. A study demonstrated 67% had experienced street culture activities. [16]

3.11.5 The health needs assessment identified two local GPs who provide a satellite session in the Homeless Action Barnet Day centre. [14]

3.11.6 In its recommendations the HNA addresses the barriers to accessing suitable healthcare. As part of this, it recommends a thorough review of the locally commissioned homeless health services. The health service as a whole falls outside of the remit of this needs assessment however the report will review the provision of targeted or outreach services for the homeless population in relation to sexual health.

3. 12 Migrant health needs assessment 2022

3.12.1 This needs assessment focused on the health needs of forced migrants. As of September 2022, there were 1,754 asylum seekers and refugees with an unknown number of undocumented migrants in Barnet. Migration has an impact both directly on health and on the wider determinants. This needs assessment found that undocumented migrants have the worse health in seven different areas including sexual and reproductive health, maternal health and mental health.

3.12.2 The needs assessment highlighted the findings of a recent systematic review that identified three themes in relation to preventative sexual and reproductive health. They were: interpersonal and patient encounter factors, health system factors and sociocultural factors. Stigma and lack of knowledge were barriers to accessing care.

3.11.3 Post-traumatic stress disorder and other severe mental illnesses were noted in migrants by healthcare professionals with traumatic related experiences including sexual assault. Issues of special concern in the migrant community as described by healthcare professionals include sexual health needs.

3.11.4 In its recommendations to sexual violence and related healthcare services the health needs assessment included to:

- provide women with the option of seeing female health care providers
- ensure adequate time is given to consultations to allow trust and confidence to build
- strengthen the education of women in preventative care around sexual and reproductive health
- support the training of providers to improve their cultural competency
- review the pathways for reporting sexual violence including historic trauma.

4 Methodology

This needs assessment utilised a mixed methods approach including the epidemiological approach, corporate approach and qualitative approach.

The epidemiological approach was used throughout the needs assessment to understand the population and its current use of services. Outcomes were compared regionally and nationally. Epidemiological data was gathered from a mix of sources including GUMCAD, ONS, Pathway Analytics, Fingertips and data collected directly from services providers. Comparative data was gathered primarily through fingertips. Sexual Health outcomes and utilisation of services are covered in Chapter 6. Chapter 6 considers together both the use of in-clinic service and online services.

Chapter 7 and 8 includes information collected from reports and from the view of professional stakeholders. Chapter 7 describes the current services available across Barnet including publicly funded and voluntary and community sector provision. NHS commissioned services have been included as much as where practical to create an overview of the sexual health service in addition to local authority commissioned services. Chapter 8 focuses on different groups within the population. A focus population of need that has been further explored in this needs assessment is the homeless population. This population was chosen on the basis of recommendations from previous needs assessment completed by the public health team and supported by members of the steering committee. Chapter 8 includes qualitative data collected through interviews from the homeless population in Barnet.

This needs assessment has been written at a time of change and stress within the health services with significant change and disruption brought about by the COVID-19 pandemic and mpox. Chapter 9 considers from the professional's perspective the changes in service use over this time and how services have been re-designed over this time.

5 Demographic profile of London Borough of Barnet-

5.1 Basic demographic profile

5.1.1 The total population of Barnet is estimated at 389, 300 which is an increase by 9.2% compared to 2011.[17] Of this population 51.6% (200, 799) were female and 48.4% (188, 545) were male.[18] This is based on 2021 census data without projection.

5.1.2 The population of Barnet is young with 19.3% (75, 165) of the population in Barnet aged 0-14; this compares to 18% in London and 17.4% in England. 11.2% (43, 859) of the Barnet population are aged 15-24 years old; compared to 12.2% and 11.6% in London and England respectively. 55% (214, 216) of the Barnet population are aged 25-64 years old; compared to 57.7% in London and 52.7% in England. 14.3% (56, 100) of the Barnet population are aged 65 years and older; compared to 11.6% in London and 18.1% in England. [18]

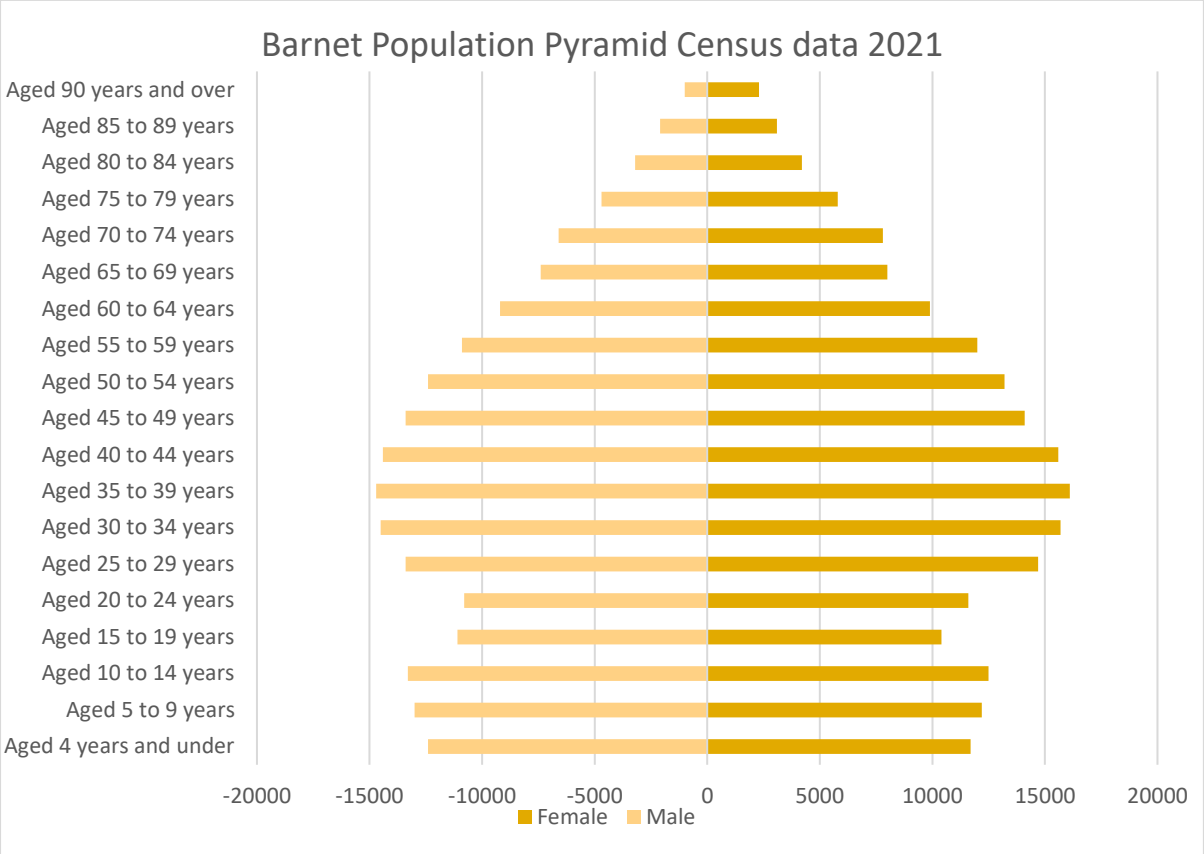


Figure 1: Barnet population pyramid based on the census 2021 [18]

5.2 Ethnic groups and languages

5.2.1 The ethnic profile of Barnet shows a diverse population. Based on 2021 census data 57.7% (224,766) were white compared to 53.8% across London and 81% across England. The largest ethnic minority group in Barnet was Asian, Asian British or Asian Welsh population at 19.3% (74, 970), followed by other ethnic groups at 9.8% (38, 075) and Black, Black British, Black Welsh or African background at 5.8% (22, 405).

5.2.2 Based on 2021 Census data, there are at least 88 languages spoken across Barnet including English. English is the most common main language and is the main language for 77.1% (289,

057) of residents. The 5 next most common main languages spoken are Romanian (3%), Persian or Farsi (2.3%), Polish (1.5%), Gujarati (1.4%) and Portuguese (1%).

5.2.3 Based on 2021 census data, for residents aged 3 and over, 22.9% (86, 045) did not speak English as their main language. 10.4% and 8.4% of residents reported that English was not their main language but spoke it very well or well, respectively. 3.6% reported not speaking English well and 0.5% reported not being able to speak English.[19]

5.3 Sexual orientation and gender identity

5.3.1 The 2021 census was the first census to ask questions about gender identity and sexual orientation.[20]

5.3.2 The sexual orientation question was voluntary and only asked of those aged 16 years and over. The question asked: "Which of the following best describes your sexual orientation?". The different sexual orientations options were:

- straight or heterosexual
- gay or lesbian
- bisexual
- other sexual orientation

If "Other sexual orientation" was selected, the respondent was asked to write, in free text, the sexual orientation with which they identified.

The ONS data notes that sexuality is an umbrella term for sexual identity, attraction and behaviour. Individuals therefore may respond differently and so statistics should be interpreted purely as showing how people responded to the question, rather than being about whom they are attracted to or their actual relationships.

Nationally 92.5% of those aged 16 years and over answered the question. Note that gay or lesbian have been reported together.

In Barnet 87.3% of residents described themselves as straight or heterosexual compared to 86.2% regionally in London and 89.4% nationally. 1.2% of Barnet residents described themselves as gay or lesbian compared to 2.2% regionally and 1.5% nationally. 1.1% of Barnet residents described themselves as bisexual compared to 1.5% regionally and 1.3% nationally. 0.4% of Barnet residents described themselves as pansexual compared to 0.4% regionally and 0.2% nationally. A small percentage of resident described themselves by other orientations including but not limited to asexual and queer. 9.9% of Barnet residents did not answer the question as compared to 9.5% regionally, and 7.5% nationally.[21]

5.3.3 The gender identity question was voluntary and only asked of those aged 16 years and over. The questions asked: "Is the gender you identify with the same as your sex registered at birth?" and had the option of selecting either "Yes" or selecting "No" and writing in their gender identity.

In Barnet 90.0% of residents answered "Yes", indicating that their gender identity was the same as their sex registered at birth, this compares to 91.2% regionally and 93.5% nationally. 0.8% of Barnet residents answered "No", indicating that their gender identity was different from their sex registered at birth, compared to 0.9% regionally and 0.5% nationally. Within this group:

- 0.4% answered “No” but did not provide a write-in response (London: 0.5%, England: 0.2%)
- 0.1% identified as a trans man (London: 0.2%, England: 0.1%)
- 0.1% identified as a trans woman (London: 0.2%, England: 0.1%)
- 0.1% identified as non-binary (London: 0.1%, England: 0.1%)
- A small percentage wrote in a different gender identity.

8.2% of Barnet residents did not answer the question as compared to 7.9% regionally, and 6.0% nationally.[22]

5.4 Deprivation

5.5.1 The Index of Multiple Deprivation (IMD) is a measure of deprivation used on small geographical areas. It considers 7 domains: income deprivation, employment deprivation, education, skills and training deprivation, health deprivation and disability, crime, barriers to housing and services, living environment deprivation. Each domain has a different weighting.

5.5.2 The map shows differences in deprivation across the borough; with the borough broken down by lower super output areas (LSOA). The most deprived areas are shown in the darkest shade of blue whilst the least deprived areas are shown in a light green.

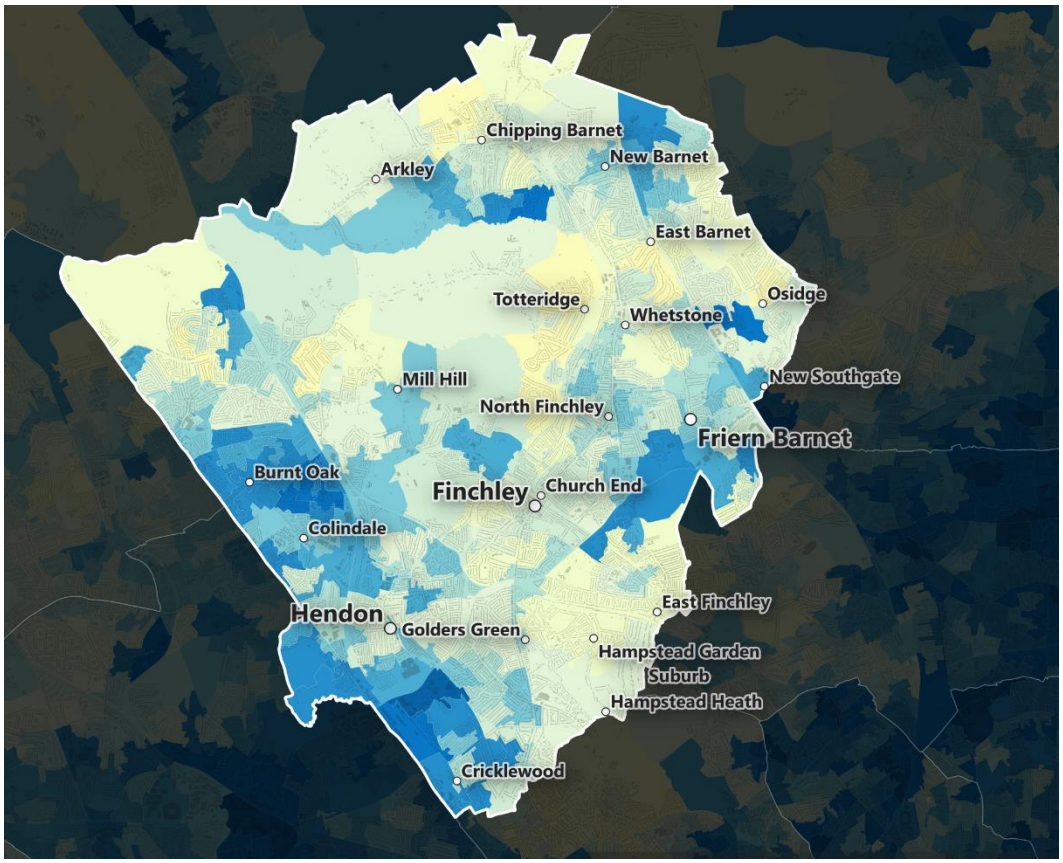


Figure 2: Index of multiple deprivation (2019) Rank by LSOA, London Borough of Barnet[23]

5.5.3 The London Borough of Barnet has an IMD score of 16.1, which is lower the than the London region IMD score of 21.8 and the national average IMD score of 21.7. This indicates that overall Barnet is less deprived than the regional or national average. Figure 2 demonstrates however that there are pockets of higher deprivation in the borough. Most areas of

deprivation based on the IMD are in the west of the borough including Burnt Oak and towards the east of the borough in Woodhouse, East Barnet and Brunswick Park.

6 Sexual Health Outcomes

6.1 CNWL clinic interventions

6.1.1 Data on interventions is derived from ISH service data from CNWL clinics, reported via the Pathway Analytics platform or directly from the Central and North West London NHS Foundation Trust. The reporting period starts in Quarter 2, 2017-18 and ends in Quarter 2, 2022-23. In this context, an intervention is an element of sexual health care received by a patient, for which the commissioning local authority is charged. Patients may have multiple interventions as part of one appointment. Data for patients whose gender is not recorded as female or male has been excluded from this analysis due to small counts, as there have been fewer than 20 interventions recorded for this group each year. Throughout the report the words gender and sex have been used in line with the language used by reporting systems from which the data was derived.

6.1.2 There are dips in service use corresponding to the pandemic with significant dips corresponding to 'waves' in the pandemic where there were national lockdowns and widespread disruption to services and day-to-day life. Service use within CNWL clinics has not returned to pre-pandemic levels. The effects of the pandemic on in-clinic provision, the use of e-services relating to sexual health and the changing health-seeking behaviour of patients are explored to understand the changes seen in figure 3.

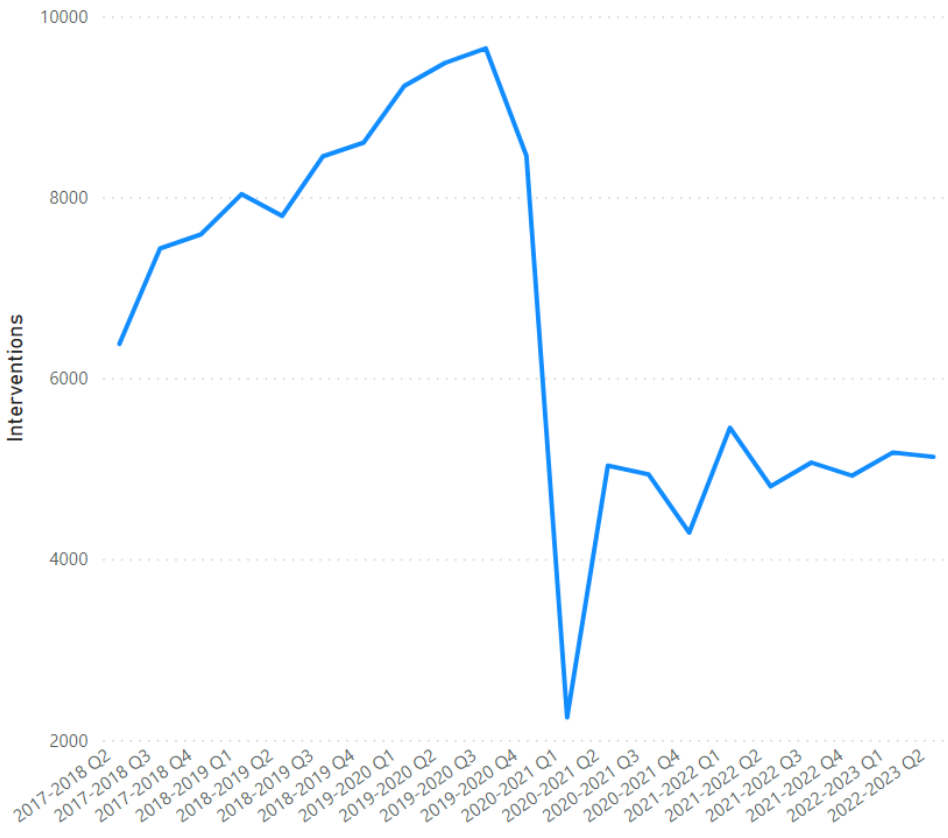


Figure 3: Number of clinic interventions for Barnet residents in CNWL clinics

6.1.3 The main interventions provided are STI testing, Sexual and Reproductive Health and STI interventions.

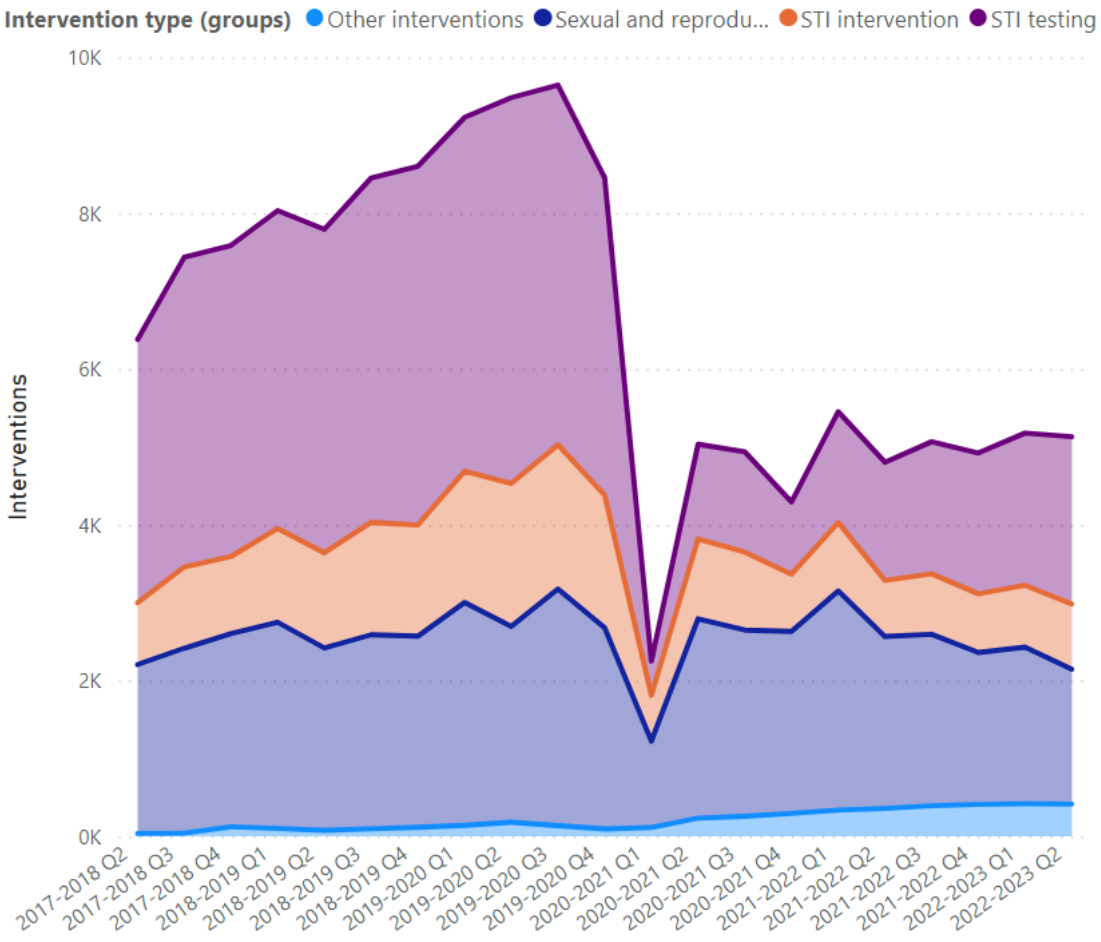


Figure 4: CNWL clinic interventions by type for Barnet residents receiving care in a CNWL clinic.

6.1.4 The data demonstrates that females are more likely to attend Integrated Sexual Health (ISH) services than men across all categories of interventions, but there has been a steady increase in interventions for male patients from Quarter 3, 2021-22 onwards as seen in figure 5.

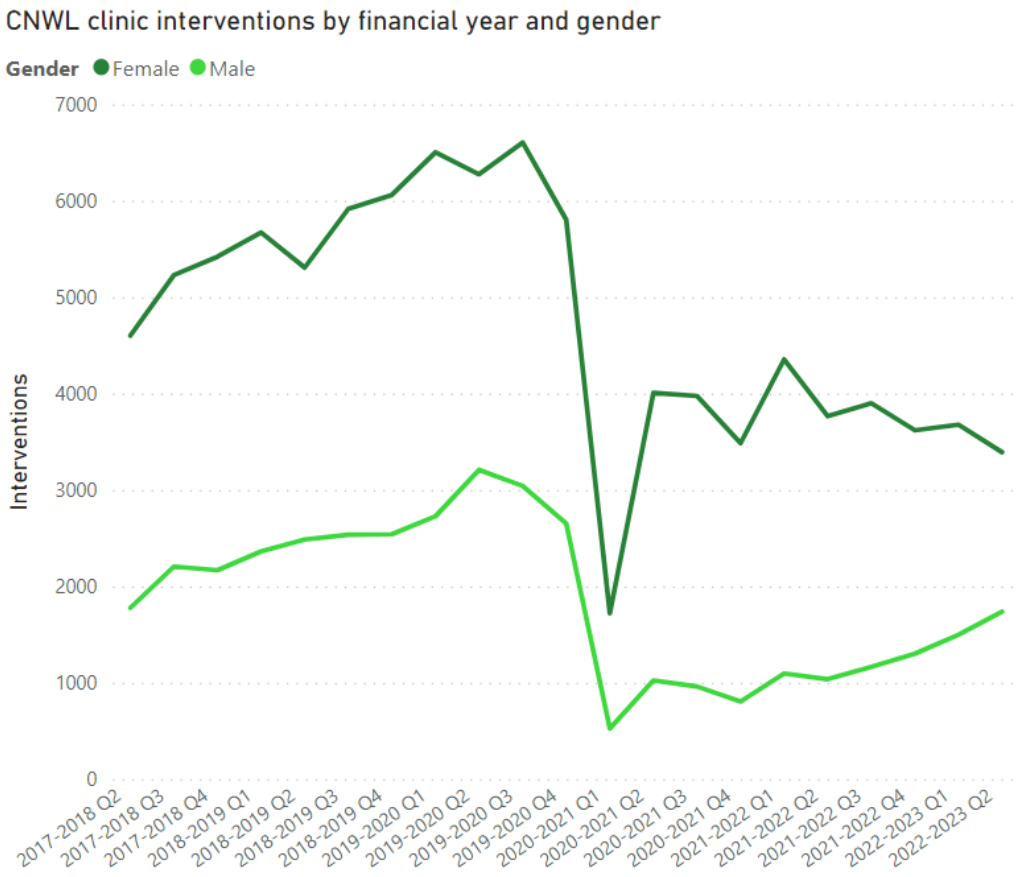


Figure 5: Number of clinic interventions by male and female gender for Barnet residents attending CNWL clinics.

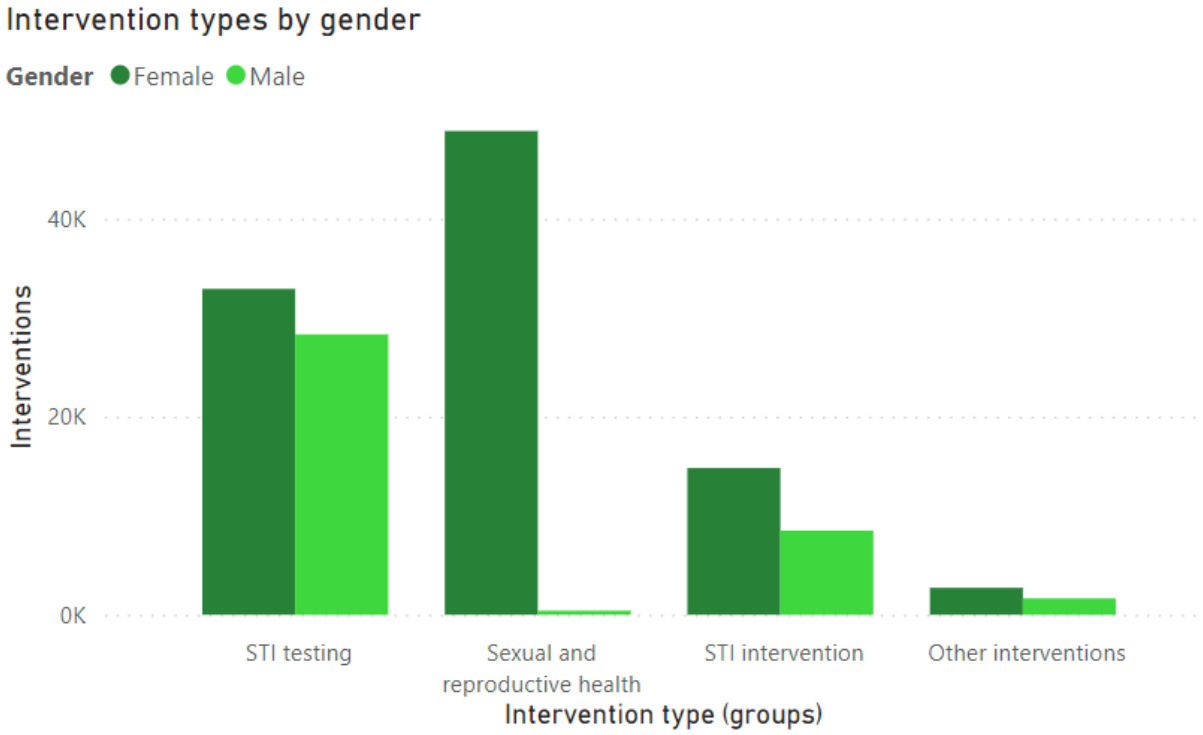


Figure 6: Intervention type for Barnet residents by male and female gender

6.1.5 The proportion of interventions delivered by different CNWL clinics has changed significantly since the start of the pandemic. Between 2017-18 and 2019-20, the largest percentage of interventions for Barnet residents were delivered at Edgware Community Hospital in Barnet, followed by the Archway Centre in Islington, Vale Drive Primary Care Centre in Barnet and Mortimer Market Centre in Camden. The Barnet clinic in Grahame Park Health Centre also saw a small proportion of patients. Mortimer Market Centre, Edgware Clinic and Archway Centre are specialist units providing complex interventions whereas Vale Drive Primary Care Centre is a lower level two service. Since 2020-21, Mortimer Market Centre has provided the most interventions for Barnet residents, followed by Edgware Community Hospital and the Archway Centre.

CNWL sexual health clinics at Graham Park, Edgware and Vale Drive all closed in March 2020 due to the pandemic and Grahame Park sexual health clinic has remained temporarily closed in consultation and agreement with commissioners. There has been a fall in activity reported through Pathway Analytics from Vale Drive following the pandemic. It should be noted that in addition to regular face-to-face services clinicians at Vale Drive are providing phone clinics to patients across London, which is not reported through Pathway Analytics and so does not feature in the figure below. Barnet resident specific data was not separately reported. This means that most interventions for Barnet residents are provided outside Barnet.

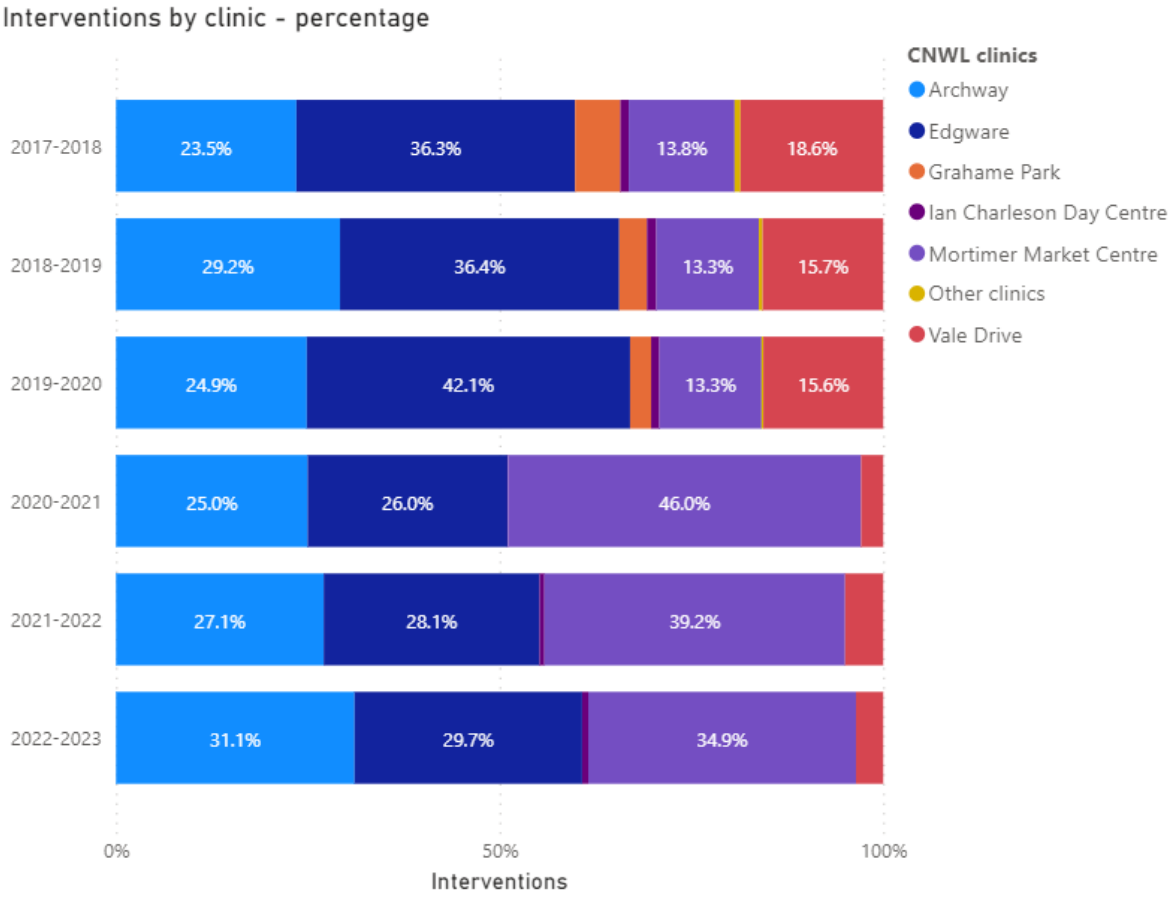


Figure 7: Proportion of interventions completed at different CNWL clinics for Barnet residents.

6.1.6 Looking at all patients from January 2018 to September 2022 who were seen in Barnet ISH clinics, 36.2% of appointments in Edgware community hospital and 26% at Vale Drive Primary Care Centre were from patients from another local authority. Patients who did not

report their local authority have been excluded from the analysis. The most common reported boroughs patients were from Brent (23%), Harrow (19.6%), Hertsmere (13.4%) and Enfield (11.7%). Patients from Camden, Islington and Haringey cumulatively represented 14.6% of patients.

6.1.7 In addition to accessing CNWL NCL clinics, Barnet residents can attend sexual health clinics commissioned by other boroughs. The pattern for Barnet residents accessing clinic services within and outside Barnet is similar, with dips in activity due to the pandemic and lockdowns. Approximately 2 out of 3 clinic interventions for Barnet residents recorded on Pathway Analytics are provided by CNWL, with a slight increase during 2019-20 which is likely to be due to pandemic lockdowns. Between 2017-18 and September 2022, the out of borough services with the most clinic interventions for Barnet residents were: Chelsea and Westminster Hospital NHS Foundation Trust (15.8%), Imperial College Healthcare NHS Trust (6.5%) and London North West University Healthcare NHS Trust (5.3%); during the same time period 65% of clinic interventions were within CNWL clinics.

In the graph, CNWL represents all interventions that occurred in a CNWL clinic including CNWL clinics located in other boroughs. It is of note that this data only records interventions from Pathway Analytics which is not used by all sexual health services and so is likely an underestimation of out-of-borough use. In the last reported quarter Q2, 2022-23, 37.3% of clinic interventions were not provided by CNWL clinics.

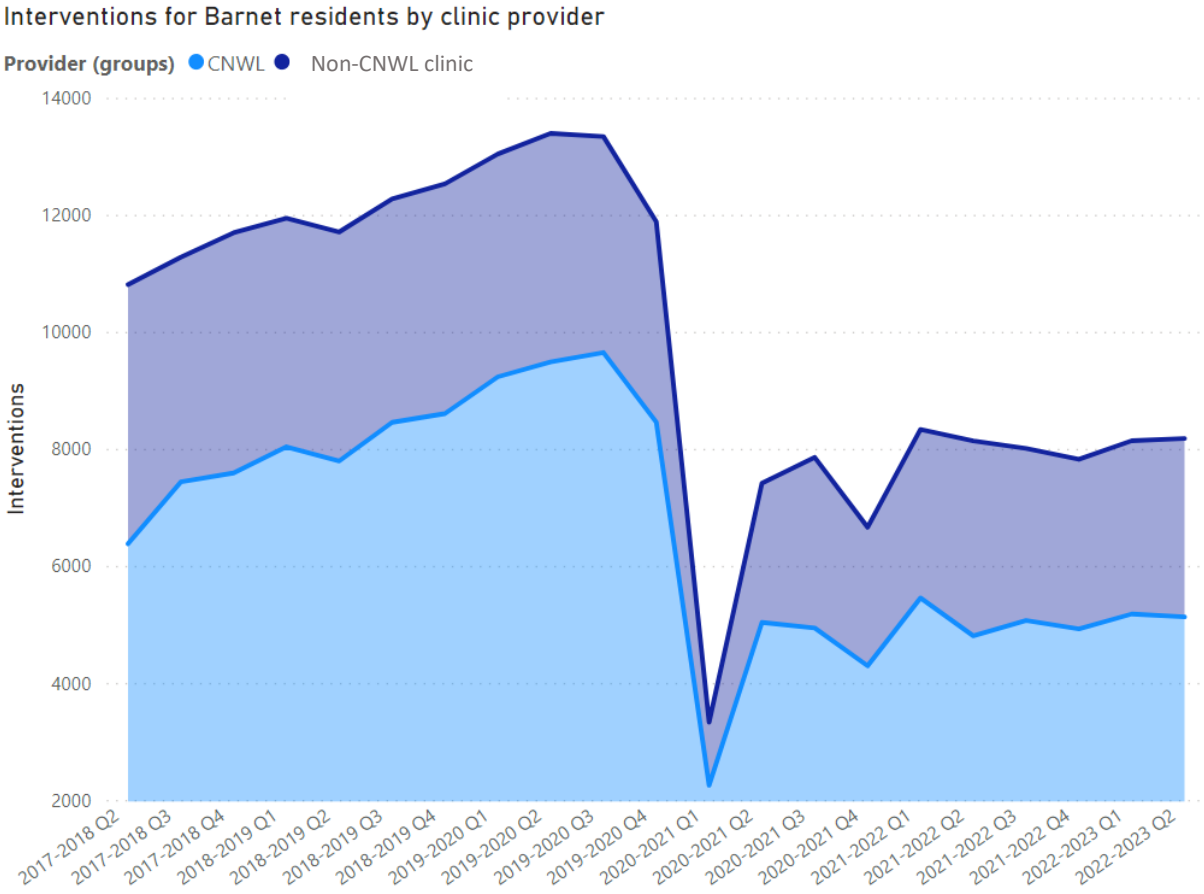


Figure 8: Interventions for Barnet residents recorded on Pathway Analytics

6.1.8 Across the reporting period Barnet patients seen in ISH services ranged from age 12 to 83. There were a greater number of interventions for those recorded as female until the age of

55, after which those recorded as male had a greater number of appointments at ISH services.

The age group with the largest proportion of interventions was 20-24 years old (22.2%) and 25-29 years old (22.1%). Men were most likely to have an appointment when aged 25-29 years old, whilst women were most likely to have an appointment when aged 20-24 years old.

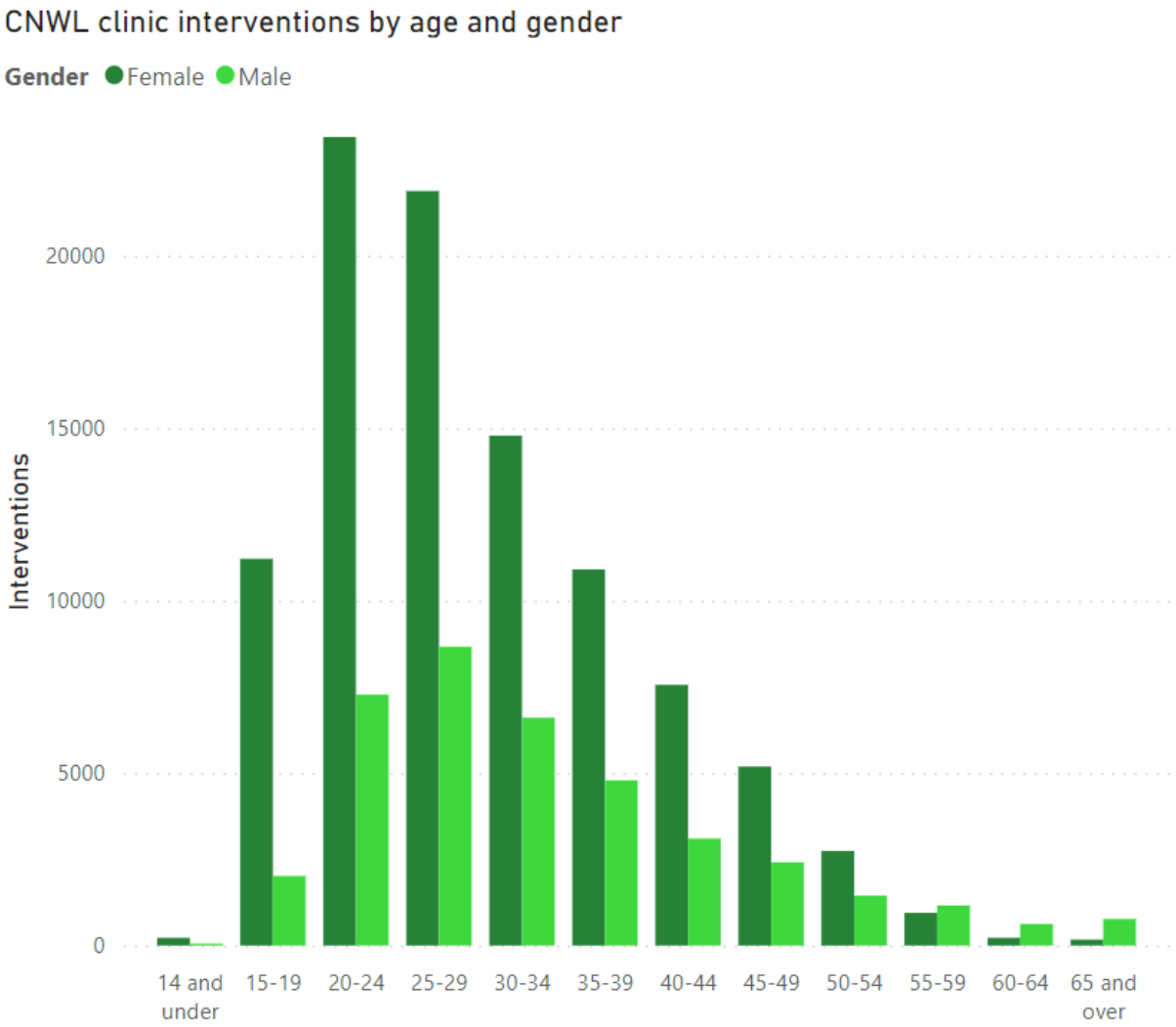


Figure 9: Barnet residents, number of interventions by age and gender in CNWL clinics

The percentage of interventions for 20–24-year-olds has declined from 24.5% in 2019-20 to 17.6% in 2021-22, and this trend continues in the first half of 2022-23. Over this same time period this age group has also become the most likely to complete STI testing online. See Chapter 6.3 for further details. There has been a decline in the percentage of interventions for those aged 15–19-year-olds attending CNWL clinics.

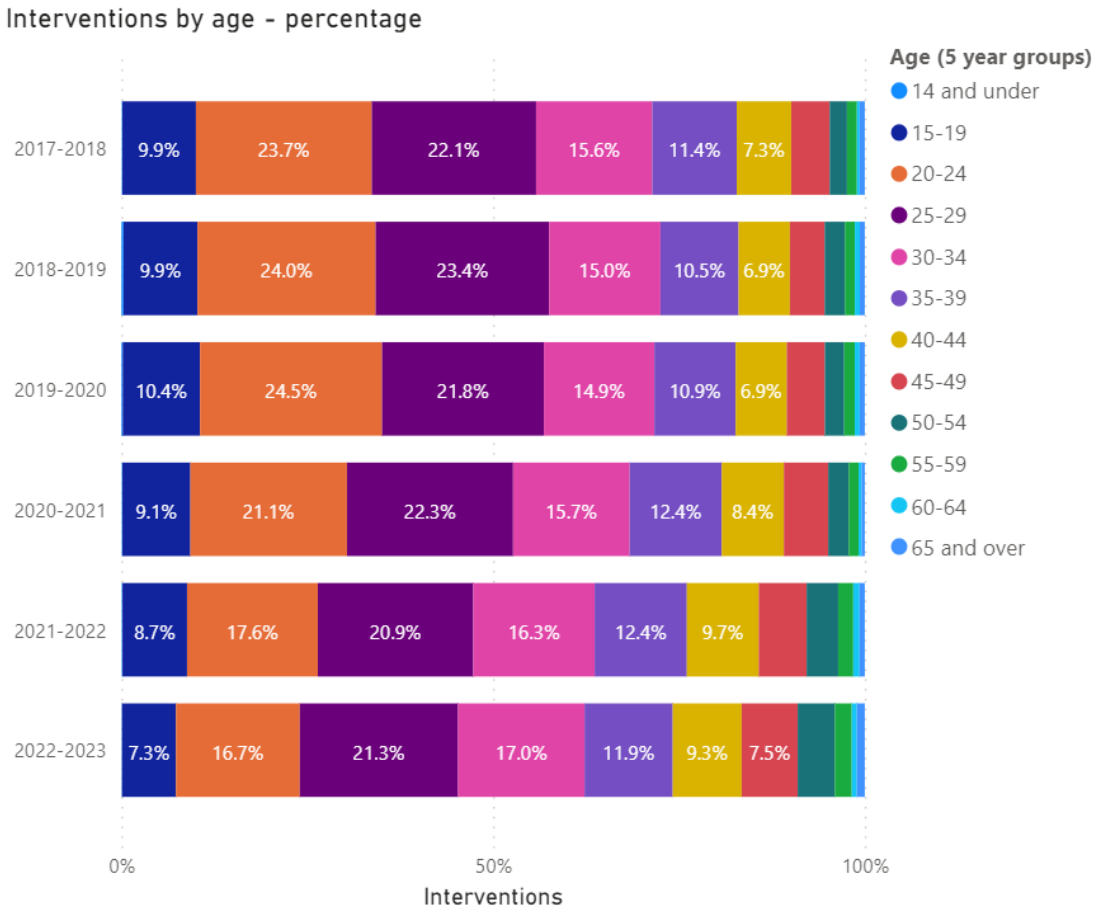


Figure 10: Proportion of intervention by age group, by year for Barnet residents in CNWL clinics

6.1.9 In the reporting period from quarter 4, 2017/18 to quarter 3, 2019/20, 92.6% of Barnet resident seen in CNWL clinics had a walk-in appointment, where appointment type was recorded. This reporting period was chosen to represent pre-pandemic reporting within the last 5 years. Walk-ins were popular across all age groups and represented 78.2% - 95.9% of appointments across the age groups.

The number of Barnet residents attending walk-ins and appointments more generally dramatically dropped during the pandemic as expected from changes made to service delivery models and access arrangements to appointments for infection prevention control/social distancing and more generally in relation to national restrictions such as lockdowns. In the last 4 completed reporting quarters, at the time of writing from quarter 3 of 2020/21 to quarter 2 2022/23, 68.9% of appointments were walk-ins.

A similar picture was seen across all age groups attending ISH Clinics in Barnet with a dramatic drop in walk-in appointments in the second quarter in 2020, mirroring a fall in all appointments. In the latest completed quarter of 2022 (July-September) walk-ins accounted for 41.8% of appointments compared to 93.9% in the same quarter in 2019.

6.1.10 Data, for Barnet residents attending ISH services or patients receiving ISH care in Barnet, around ethnicity and country of origin is quite incomplete mirroring gaps in knowledge around this data point generally. In 2021-22, 37.2% of appointments had no reported patient ethnicity. Most appointments with an ethnicity were for White or White British patients. It is difficult to draw conclusions about the relative proportions of ethnic groups

due to the large amount of missing ethnicity data, as it is unknown whether data is more or less likely to be absent for different ethnic groups.

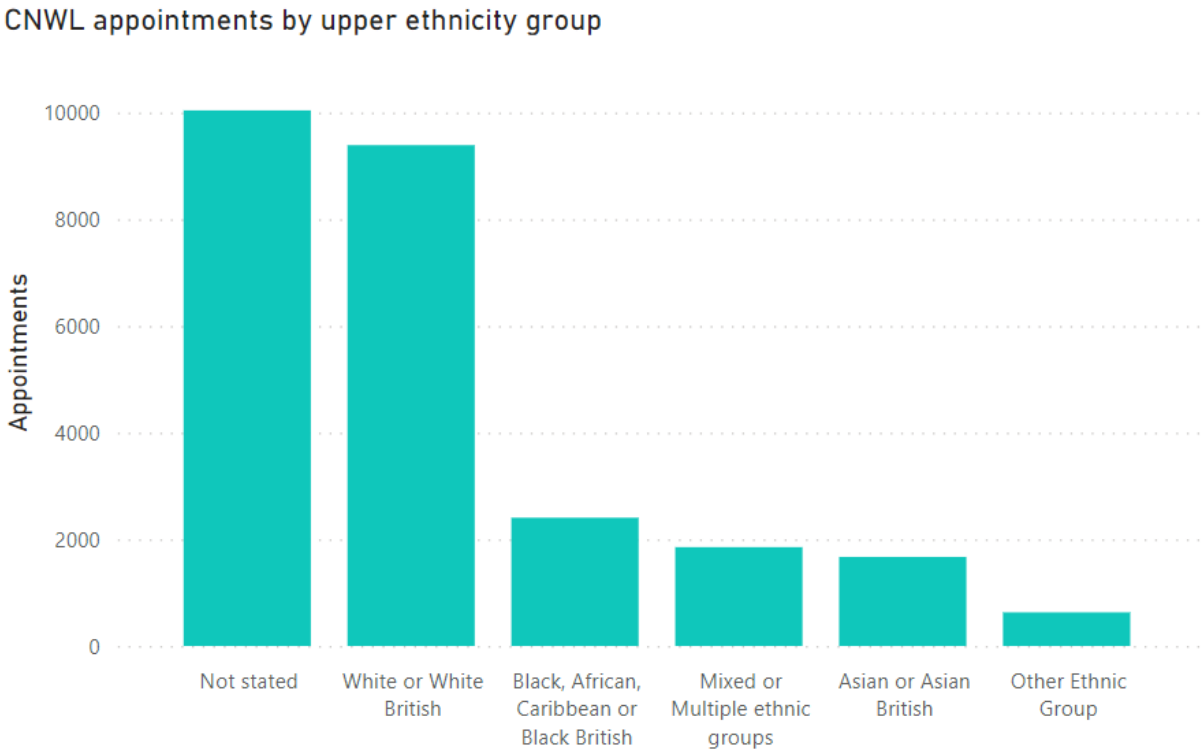


Figure 11: Number of appointments by ethnicity for Barnet residents attending a CNWL clinic.

6.1.11 Figure 12 demonstrates the use of in-clinic interventions by Barnet residents based on lower super output area (LSOA) between 2017 and 2022. Demand is varied across the borough, with areas of both higher and lower use in areas directly geographically surrounding the two Barnet ISH clinics.

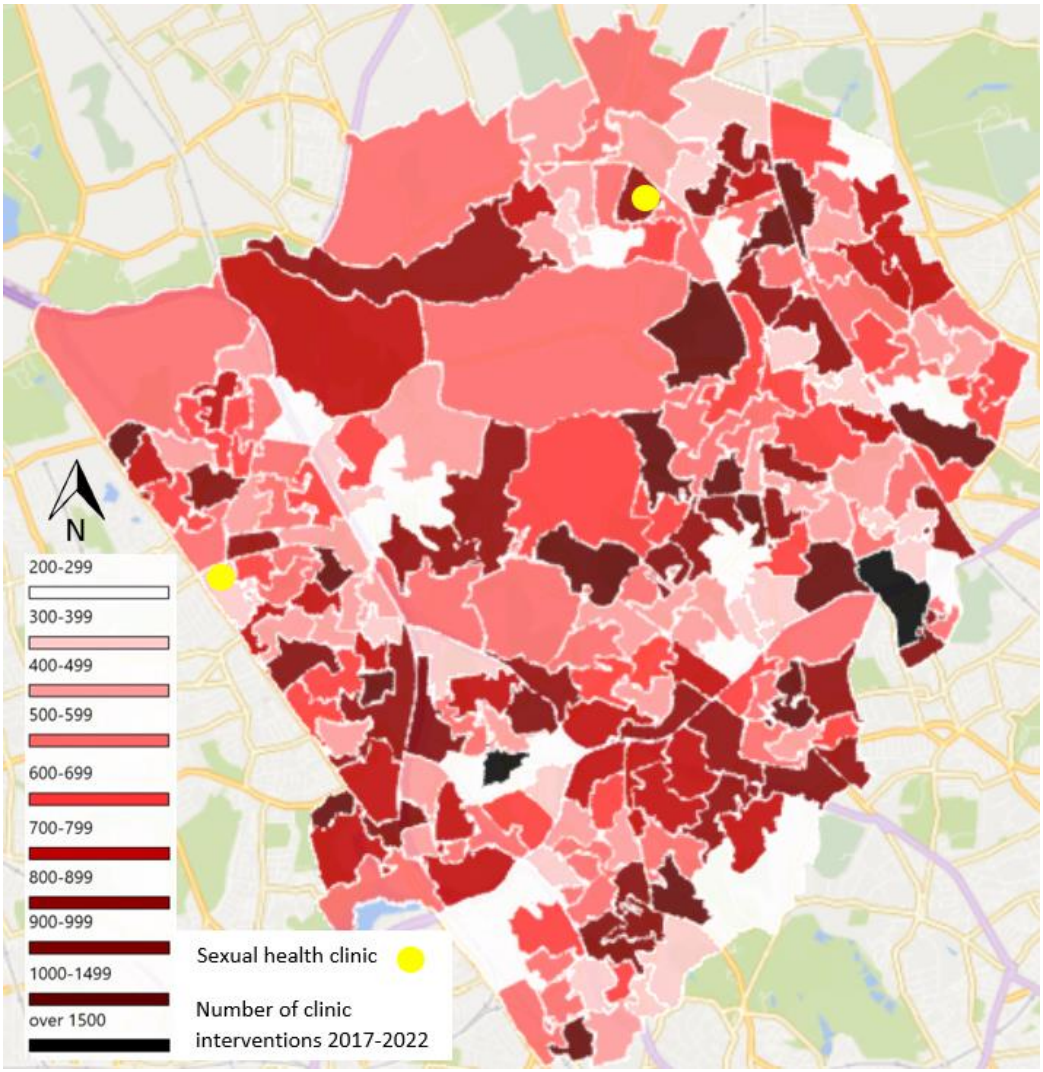
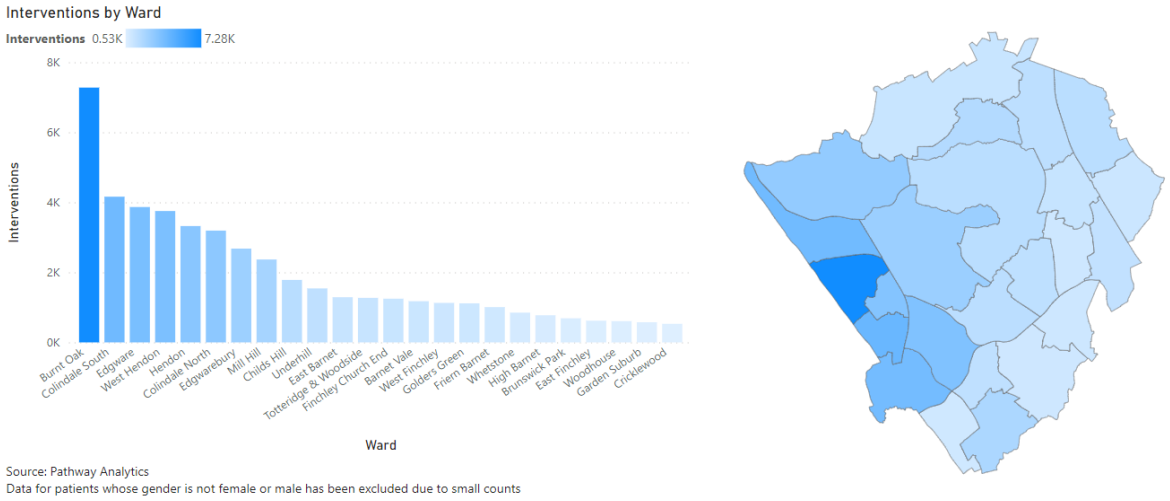


Figure 12: Choropleth map of number of clinic interventions by LSOA for Barnet residents

Looking at individual clinics, most commonly used by Barnet residents, at a ward level we can see that there is a geographical association between clinic use and patient home location. This holds true for clinics in Barnet as well as in bordering boroughs. For example, of all the interventions at Edgware Community Hospital the greatest proportion were to patients who lives in neighbouring Burnt Oak ward.

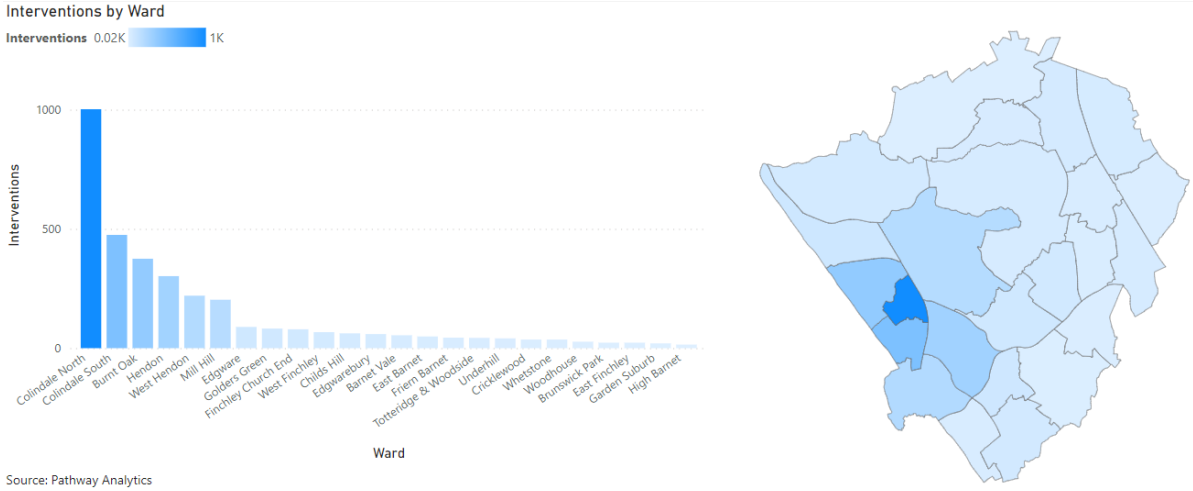
Edgware Community Hospital:



Source: Pathway Analytics
Data for patients whose gender is not female or male has been excluded due to small counts

Figure 13: Number of interventions by ward for Edgware Community Hospital

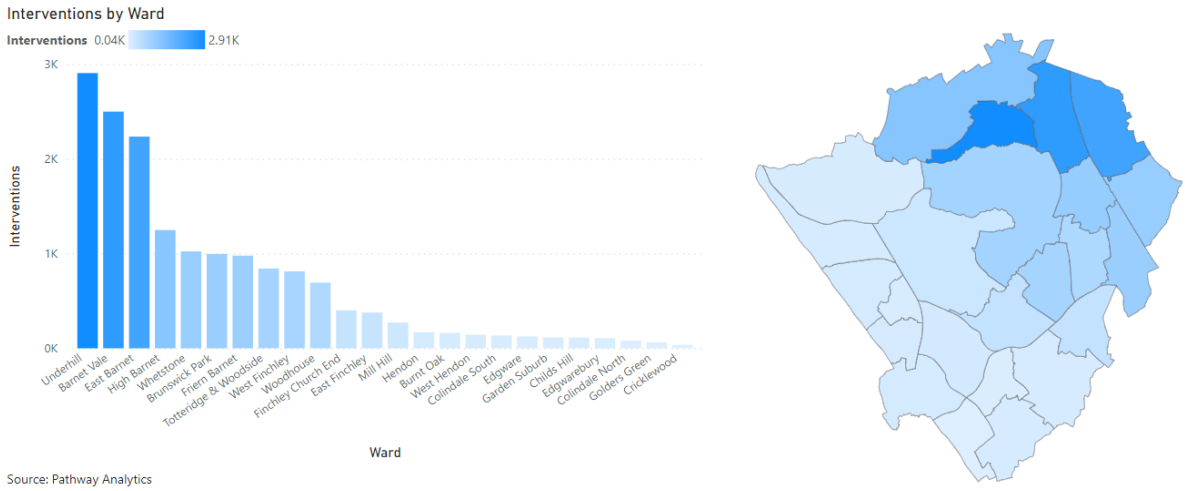
Grahame Park Health Centre (currently closed):



Source: Pathway Analytics
Data for patients whose gender is not female or male has been excluded due to small counts

Figure 14: Number of interventions by ward for Grahame Park ISH clinic

Vale Drive Primary Care Centre:



Source: Pathway Analytics
Data for patients whose gender is not female or male has been excluded due to small counts

Figure 15: Number of interventions by ward for Vale Drive Primary Care Centre

Archway Centre:

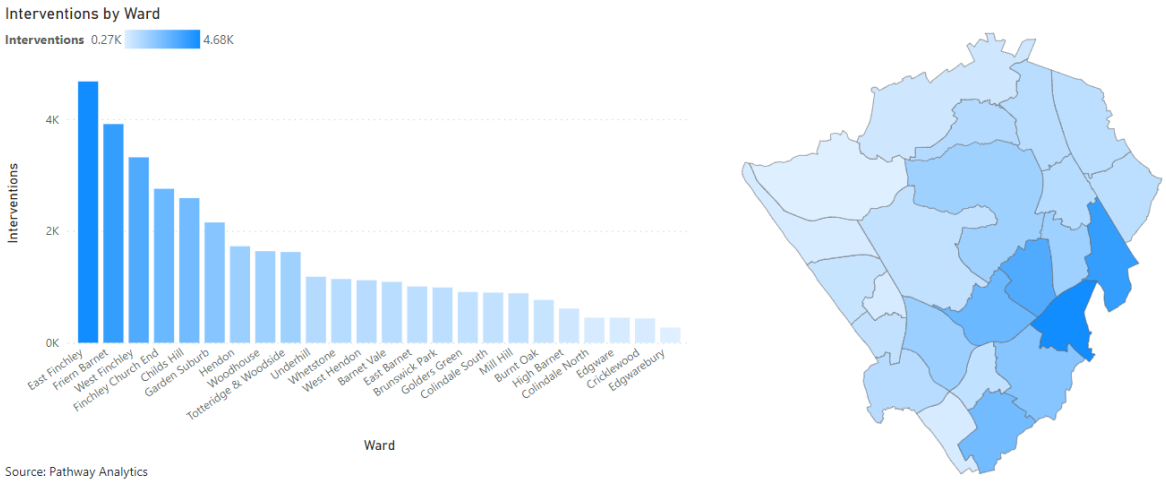


Figure 16: Number of interventions by ward for Archway ISH clinic

Mortimer Market Centre:

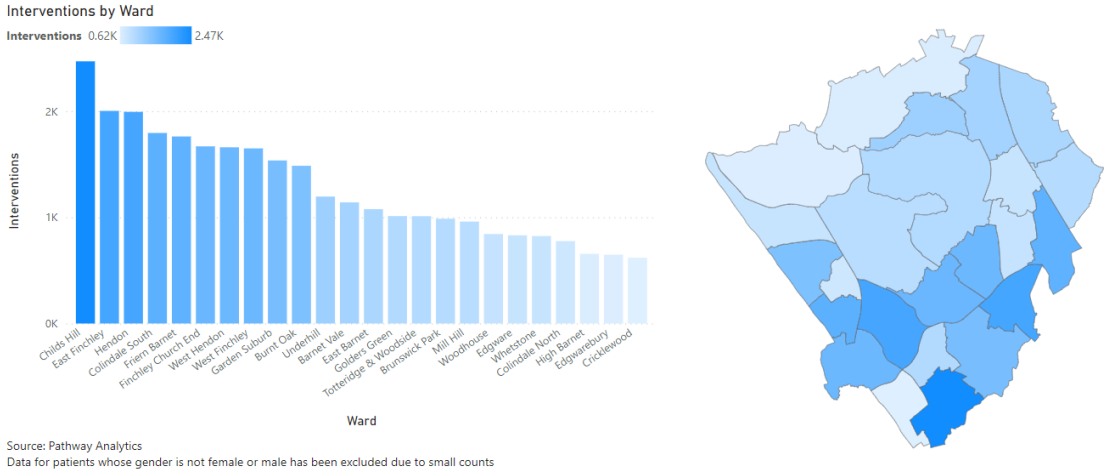


Figure 17: Number of interventions by ward for Mortimer Market Centre

6.1.12 Looking at data at an LSOA level, for Barnet residents, there was no association between Index of Multiple Deprivation (IMD) and the number of in-clinic interventions. Figure 18 allows a side-by-side direct visualisation of IMD and number of in-clinic interventions.

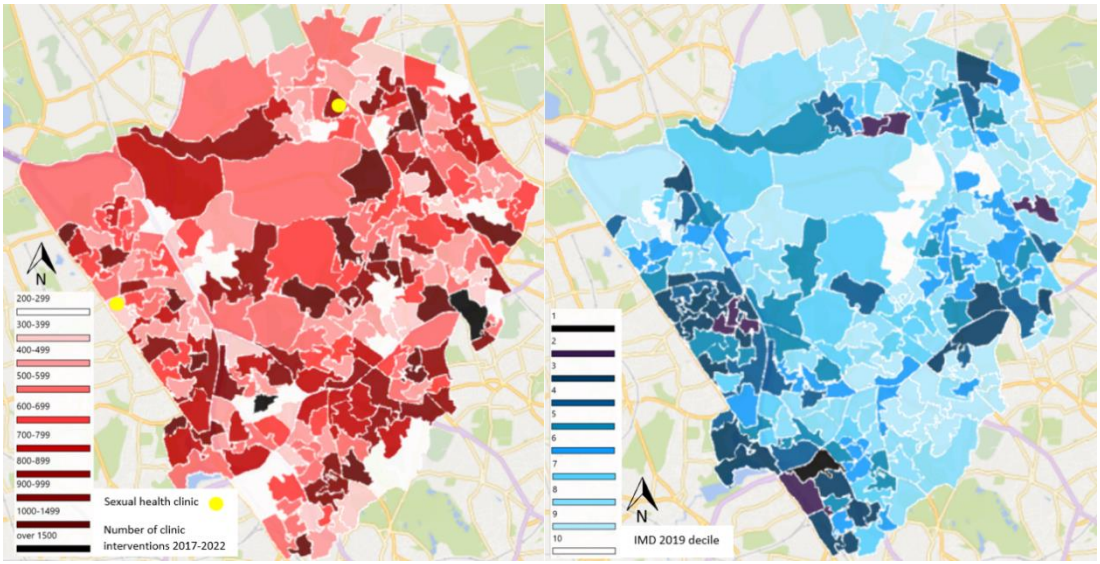


Figure 18: Side-by-side choropleth maps, number of interventions by LSOA (right), IMD by LSOA (left)

Figure 19 is a scatter plot of IMD 2019 by percentile against number of in-clinic interventions at an LSOA level. The r^2 relating to the regression line is close to 0 demonstrating there is no association between number of clinic interventions and IMD by LSOA.

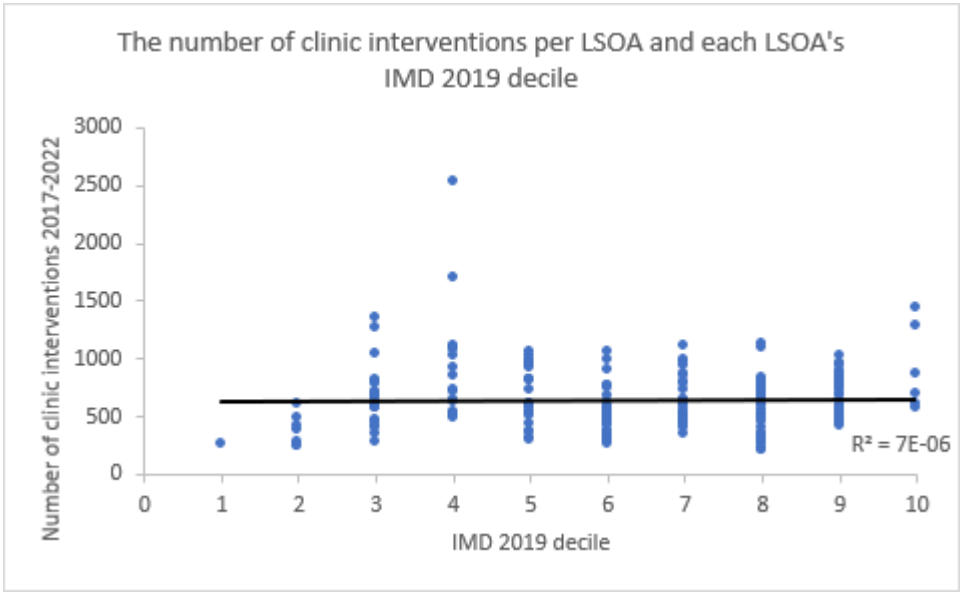


Figure 19: number of clinic interventions by LSOA IMD, with regression line

6.1.13 Online sexual health testing became available in February 2018 is also available from Sexual Health London, which is separately commissioned, and was an important part of supporting ongoing access to sexual health services during the pandemic and continues to play an important role for choice and access moving forward. Use of the online service also saw a drop during national lockdowns which is further detailed in Chapter 6.2.

6.2 Sexually transmitted infections

Data from OHID's sexual and reproductive health profiles demonstrate that STI rates across Barnet have consistently been below London regional rates, however rates have remained above the England average since 2015. The pattern of new STI diagnoses have been similar locally, regionally and nationally with a notable increase between 2017 and 2019 followed by a decreasing rate of STIs.[24] STI diagnosis rates continued to fall during the pandemic. The cause for the fall in the rates is therefore likely to be multifactorial. Rates of new STI diagnosis should continue to be carefully monitored as sexual health behaviours and use of services continue to change following the pandemic.

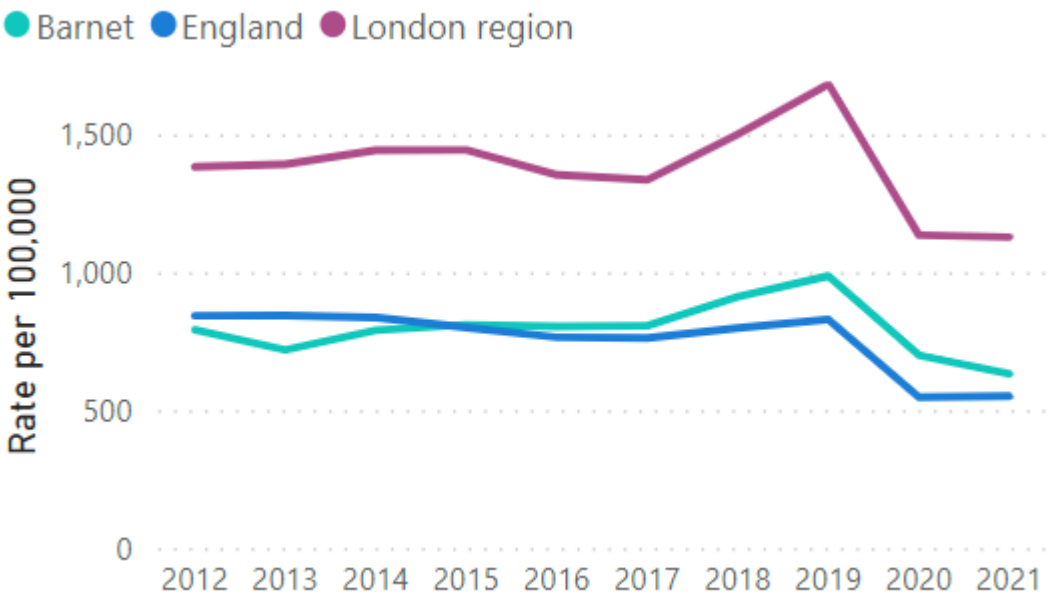


Figure 20: Rate of new STI diagnosis per 100, 000 of the total Barnet population from 2012 to 2021, comparing Barnet, London regional and England rates[24]*

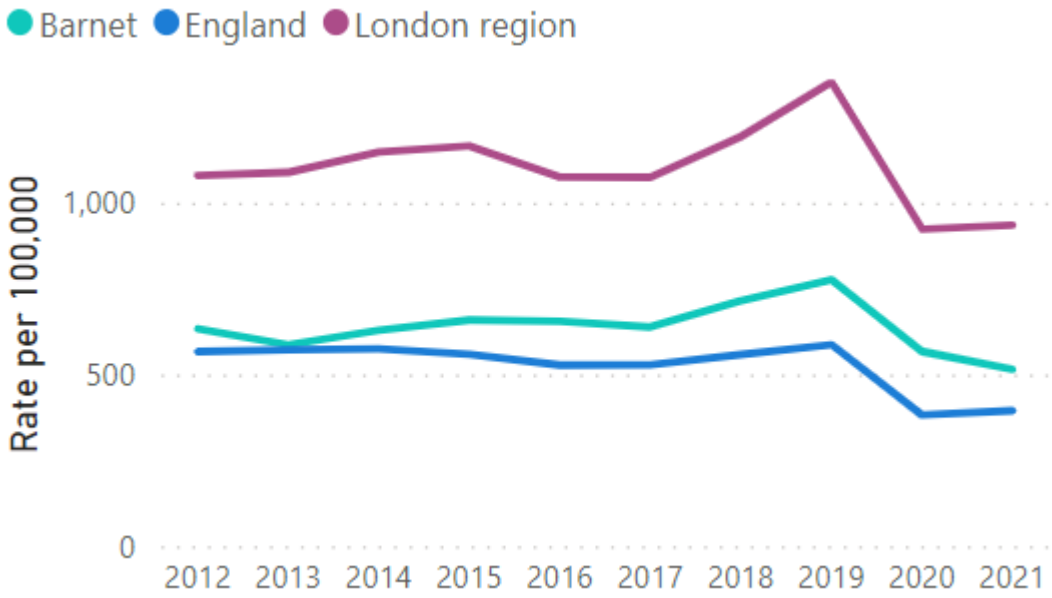


Figure 21: Graph demonstrating the rate of new STI diagnosis excluding chlamydia in under 25's per 100, 000 from 2012 to 2021, comparing Barnet, London regional and England rates[24]*

*STI diagnosis with Figures 20 and 21 above include data relating to diagnosis of: chancroid, *Lymphogranuloma venereum* (LGV), donovanosis, chlamydia, gonorrhoea, first episode anogenital herpes, new HIV diagnosis, molluscum contagiosum, non-specific genital infection (NSGI), pelvic inflammatory disease (PID) and epididymitis: non-specific, scabies and pediculosis pubis, syphilis (primary, secondary and early latent), trichomoniasis, first episode genital warts. Data from 2015 also includes codes for: *Mycoplasma genitalium* (C16); *Shigella: flexneri*, *sonnei* and unspecified.

6.2.1 Chlamydia

Chlamydia is a sexually transmitted bacterial infection. It can affect the urogenital tract, conjunctiva, rectum and nasopharynx. At least 70% of women and 50% of men infected are asymptomatic. Complicated chlamydia, where the infection ascends up the genital tract, can cause pelvic inflammatory disease (PID) in women and epididymo-orchitis in men.[25] PID can lead to pain and discomfort and complications can increase the risk of ectopic pregnancy and infertility.[26]

Chlamydia detection rate

The UKHSA recommends that local authorities should work towards the revised female-only PHOF benchmark detection rate indicator of 3,250 per 100, 000 aged 15 to 24 (female)[27]. [27]Chlamydia detection rates among females under 25 reflect measures of chlamydia control; with the denominator reflecting a population that has targeted opportunistic screening intervention through the National Chlamydia Screening Programme (NCSP). The national chlamydia screening programme though not compulsory is cited in the best practice guidance. The aim of the programme is to reduce the harms of undiagnosed and untreated chlamydia by increasing screening. It highlights the importance of opportunistic testing in people with wombs or ovaries such as in GP consultations or in pharmacies. [28] In June 2021 changes were made to the NCSP with the focus on reducing reproductive harm in young women aged under 25 years, it was previously targeted to all young people under 25.[27]

In the reporting period 2021 chlamydia detection rates in females aged 15 to 24 are below the national recommendation, at 1502 per 100, 000. Chlamydia detection rates are higher in females in this age group than males with almost double as many females having a positive test as compared to males. This likely reflects the NCSP's focus on reducing reproductive harm of untreated infection in young women. [24]

In the reporting year 2021 14.9% of people aged 15-24 were screened for chlamydia, compared with 20.8% for the London region and 14.8% nationally. There was a modest but steady increase in screening between 2012 and 2019. As with the national average, and likely reflecting changes caused by the COVID-19 pandemic, there was a notable decline in screening between 2019 and 2020 from 21.6% to 14.9%.[24]

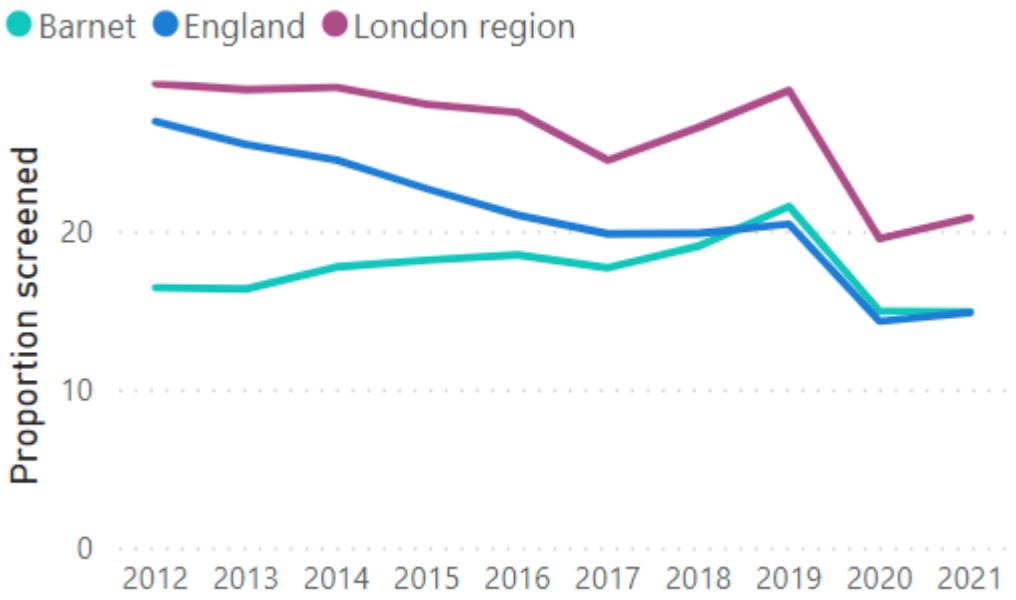


Figure 22: Proportion of young people aged 15 to 24 years old screened for Chlamydia, comparing Barnet, London regional and England screening [24]

Chlamydia diagnostic rate

In 2021 the chlamydia diagnostic rate across all age groups was 276 per 100, 000 which is lower than regional rate at 480 and the England rate of 282 per 100,000. There was an increase in the diagnostic rate between 2012 and 2019 however 2020 saw a return to 2013 rates. [24]

The diagnostic rate was 229 per 100, 000 for those over 25 years old in 2021, above the England average of 178 but below the London average of 416 per 100, 000. This reflects the STI testing rate which is similarly higher in Barnet as compared to England but lower than London. [24]

The diagnostic rate differs from the detection rate; both numerators are of those testing positive for chlamydia however the populations differ. The detection rate is completed on the under 25 population who have a targeted screening programme whereas the diagnostic rate looks at those who have accessed sexual health services. This is an important distinction in understanding the efficacy of control measures because of the large proportion of individuals who are asymptomatic when infected. [24] Data on the number of cases of Chlamydia come from GUMCAD with all commissioned specialist (level 3) and non-specialist (level 2) sexual health services required to complete and return data.

Trend in detection and diagnostic rate

Over the last 5 years the diagnostic rate for chlamydia (rate per 100,000 of the population) of Barnet residents has decreased. The detection rate amongst 15 to 24-year-olds has also decreased whilst there has been no significant change in the diagnostic rate in those 25 years and over.

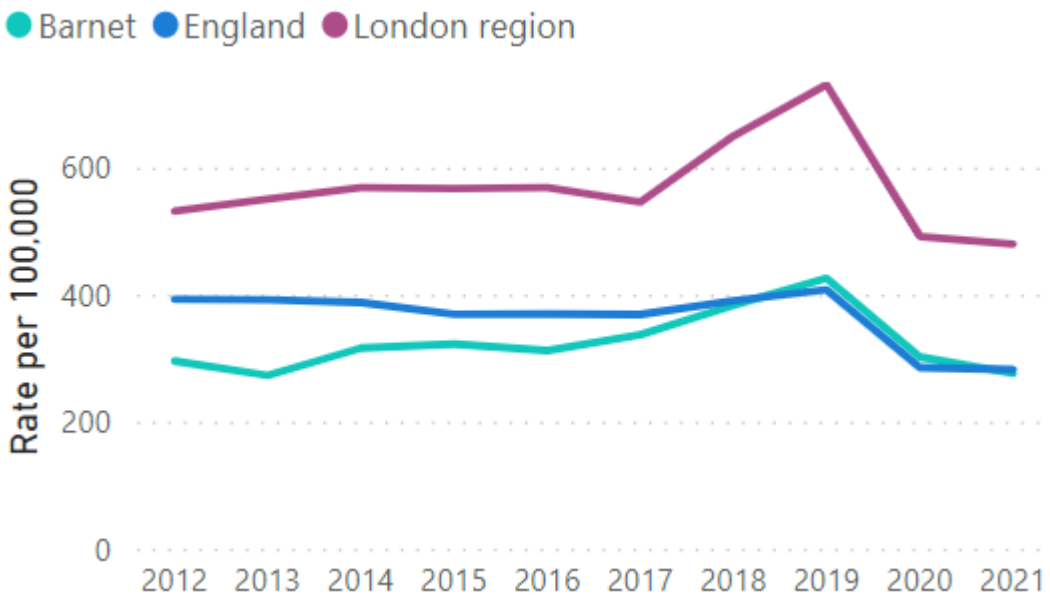


Figure 23: Chlamydia diagnostic rate er 100, 000 of the total Barnet population comparing Barnet, London regional and England screening[24]

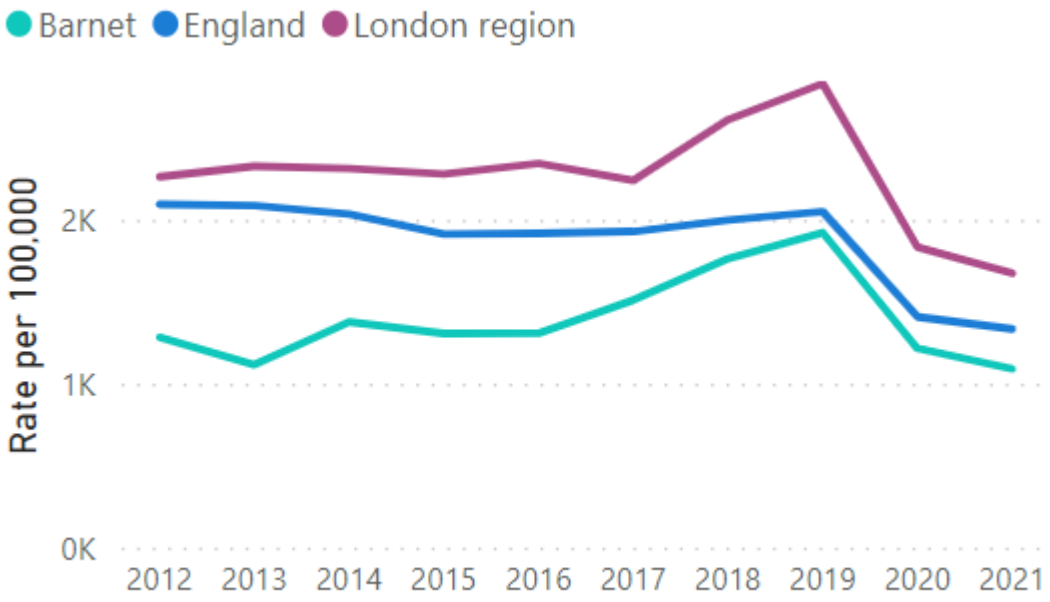


Figure 24: Chlamydia detection rate comparing Barnet, London regional and England screening[24]

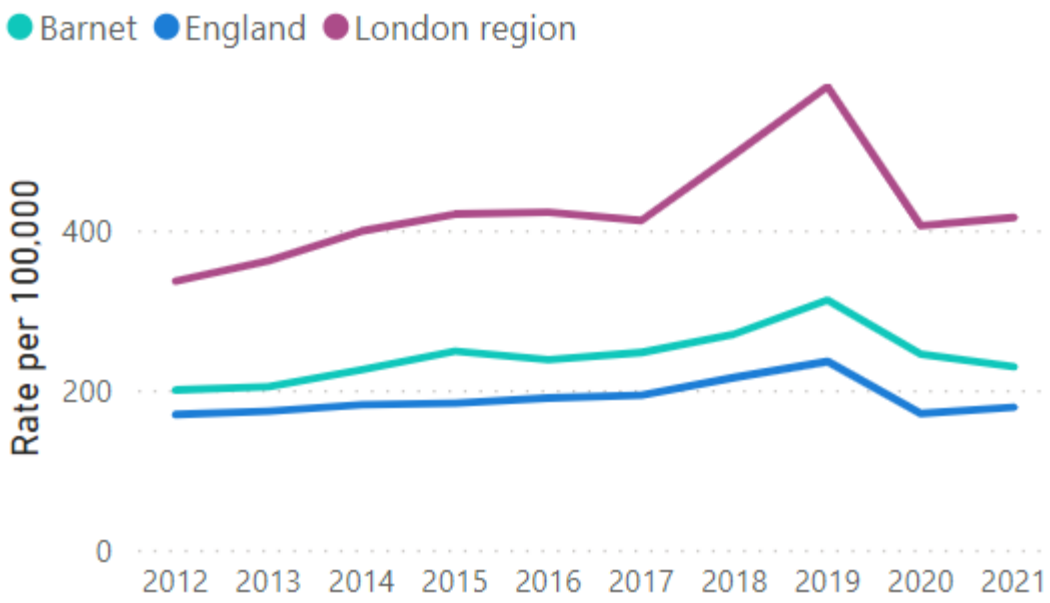


Figure 25: Chlamydia over 25s diagnostic rate comparing Barnet, London regional and England screening.

Demographic groups

Between July 2017 and June 2022, most chlamydia diagnoses among Barnet residents were for people aged 25-34 (36% of diagnoses among Barnet residents) and people aged 20-24 (32% of diagnoses).

Most diagnoses were for heterosexual patients (44% for heterosexual women, 28% for heterosexual men), but gay men also had a significant proportion of diagnoses at 20%.

The proportion of diagnoses for Black/Black British and mixed ethnicity patients was over-representative as compared to the proportion of the Barnet population they make-up, based on the 2021 census (15% of diagnoses, 8% of population for Black/Black British; 9% of diagnoses, 5% of population for mixed ethnicities), while Asian/Asian British and other ethnic groups made up a lower percentage than expected (7% of diagnoses, 19% of population for Asian/Asian British; 3% of diagnoses, 10% of population for other ethnicities). 21% of chlamydia diagnoses did not have a recorded ethnicity, so it is possible that these differences could be even larger.

There has been an increasing amount of STI testing occurring through online test kits provided through SHL. Between 2018 and 2021, 30,949 online chlamydia tests were returned, of which 1,465 (4.7%) were positive.

Ethnicity data for in-clinic consultations is relatively incomplete with 37.2% of appointments in 2021-22 having no recorded ethnicity. However, during the same period, ethnicity was not recorded for only 0.5% of test kits ordered.

Of those who had a positive test for chlamydia via the online testing service between 2018 and 2021, 58% were White, 18% were Black/Black British, and 11% were of mixed ethnicities. These ethnicities make up 58%, 8%, 5% of Barnet residents respectively.

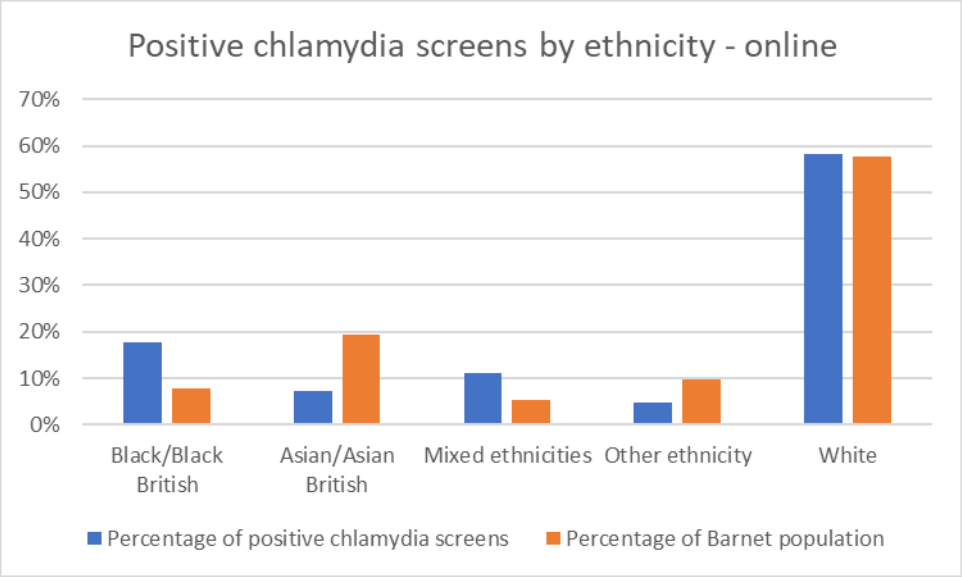


Figure 26: Percentage of positive chlamydia tests by ethnicity as compared to Barnet population make-up.

6.2.2 Gonorrhoea

Gonorrhoea is sexually transmitted disease caused by the bacterium *Neisseria gonorrhoea*. 90% of infections are uncomplicated, affecting the mucous membranes of the urethra, endocervix, rectum, pharynx and conjunctiva. Over 90% of men and 50% of women are symptomatic of the infection. Symptoms can include dysuria in men and women and purulent urethral discharge in men and altered vaginal discharge in women. Complicated untreated gonorrhoea infections can lead to epididymitis, infertility and prostatitis in men and PID and complications of pregnancy in women.[29]

In 2021, the gonorrhoea diagnostic rate was 128 per 100,000 in Barnet, with a total count of 511 positive tests in Barnet. This is higher than the national average and but lower than the London region. [24]

There has been no significant change in the diagnostic rate of gonorrhoea over the last 5 years. [24]

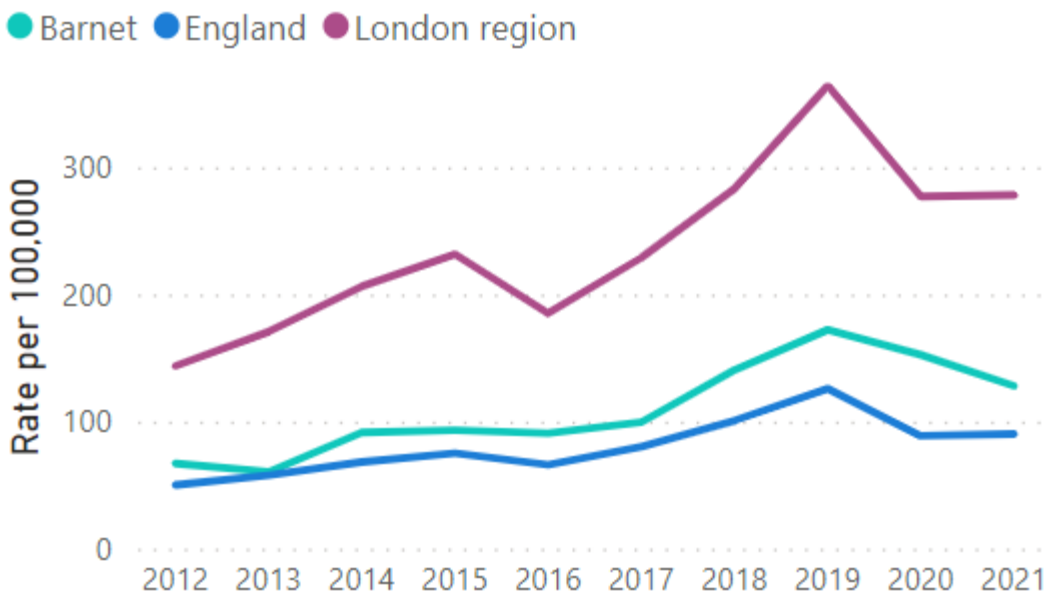


Figure 27: Gonorrhoea diagnostic rate, comparing Barnet, London regional and England rates.

Demographic groups

Between July 2017 and June 2022, 42% of gonorrhoea diagnoses among Barnet residents were for people aged 25-34, 21% were for people aged 20-24 and 18% were for people aged 35-44.

50% of diagnoses were for gay men, 17% for heterosexual men and 19% for heterosexual women. Noting here that men are more likely to have symptoms of infection.

Diagnoses for Black/Black British and mixed ethnicity patients made up a higher percentage of diagnoses than would be expected from Barnet's 2021 Census population (12% of diagnoses, 8% of population for Black/Black British; 9% of diagnoses, 5% of population for mixed ethnicities), while Asian/Asian British and other ethnic groups made up a lower percentage than expected (4% of diagnoses, 19% of population for Asian/Asian British; 3% of diagnoses, 10% of population for other ethnicities). 16% of gonorrhoea diagnoses did not have a recorded ethnicity, so it is possible that these differences could be even larger.

Between 2018 and 2021, 30,951 online gonorrhoea tests were returned, of which 508 (1.6%) were positive. Of those who had a positive test for Gonorrhoea online 62% were White, 12% were Black/Black British and 12% were of mixed ethnicities. These ethnicities make up 58%, 8%, 5% of Barnet residents respectively.

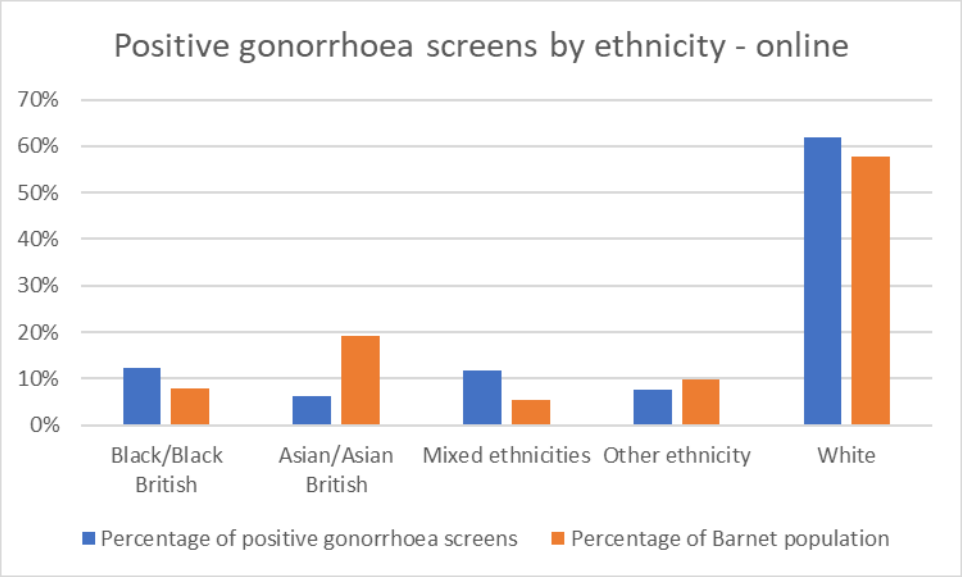


Figure 28: Gonorrhoea diagnosis by ethnicity as a percent versus percentage in the Barnet population

6.2.3 Syphilis

Syphilis is a bacterial infection caused by *Treponema pallidum*. Most cases are transmitted sexually however transmission can also be from contact with infected lesions. Syphilis can be cured with antibiotics, but untreated syphilis can lead to severe and sometimes irreversible complications such as neurosyphilis, aortic aneurysms, heart failure and adverse pregnancy outcomes amongst other complications.[30]

In the reporting period 2021 the syphilis diagnostic rate was 17.8 per 100, 000 giving a total of 71 cases. The Barnet rate was lower than the London rate (40.4 per 100, 000) but greater than the England rate (13.3 per 100, 000). Syphilis rates in Barnet have steadily increased since 2012, with an increase in diagnostic rate also seen across London.[24]

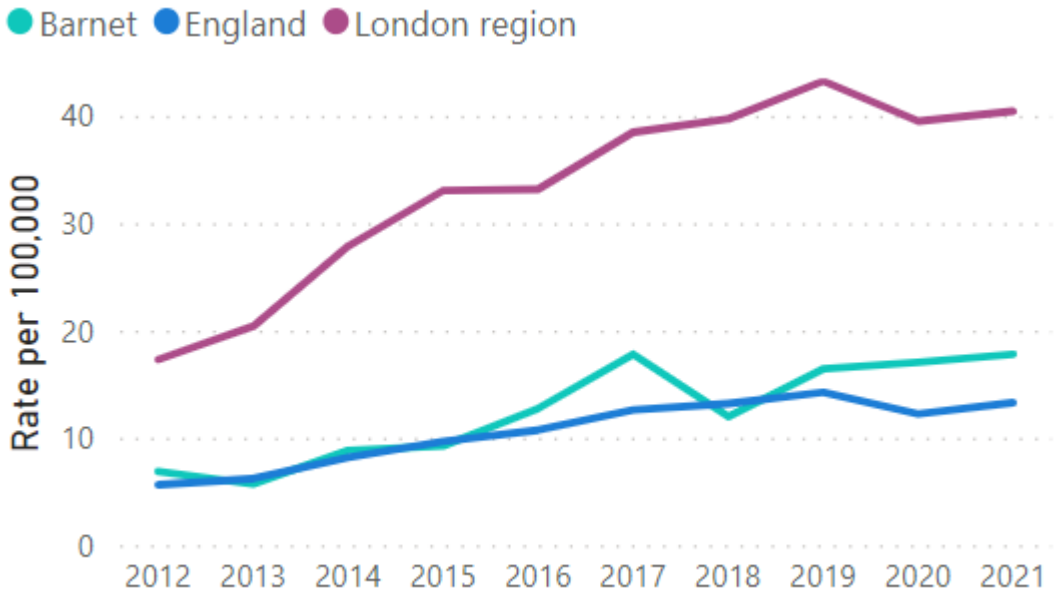


Figure 29: Syphilis rates comparing Barnet, London regional and England rates.

Demographic groups

Between July 2017 and June 2022, 38% of syphilis diagnoses among Barnet residents were for people aged 25-34, 25% were for people aged 35-44 and 20% were for people aged 45-64.

Most syphilis diagnoses were for males (94%). 67% of diagnoses were for gay men, 12% were for bisexual men and 10% were for heterosexual men.

Diagnoses for Asian/Asian British patients and those from other ethnic groups made up a lower percentage than would be expected from Barnet's 2021 Census population (7% of diagnoses, 19% of population for Asian/Asian British; 3% of diagnoses, 10% of population for other ethnicities). Diagnoses for Black/Black British and mixed ethnicity patients were similar to or the same as the Census percentages (6% of diagnoses, 8% of population for Black/Black British; 5% of diagnoses, 5% of population for mixed ethnicities). However, 21% of syphilis diagnoses did not have a recorded ethnicity, so it is possible that the true picture is different.

Between 2018 and 2021, 22,909 online syphilis tests were returned, of which 788 (3.4%) were reactive. Of those who had a reactive test for syphilis online 74% were White, 7% were Black/Black British, 7% were Asian/Asian British and 7% were other ethnicities. These ethnicities make up 58%, 8%, 19% and 5% of Barnet residents respectively.

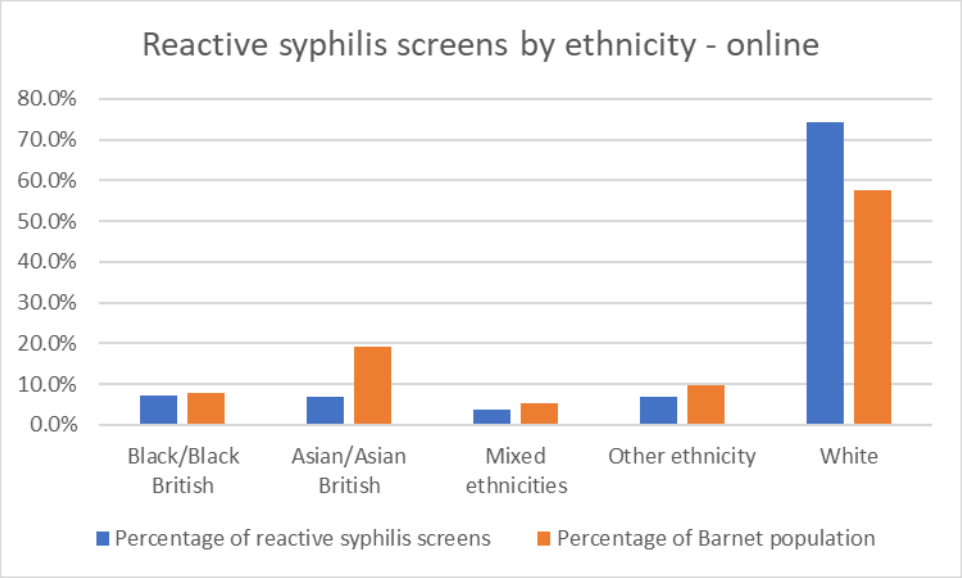


Figure 30: Reactive syphilis screens from online testing by ethnicity

6.2.4 Genital Herpes

x.1 Genital herpes is caused by the genital herpes simplex virus, HSV-1 or HSV-2. It is sexually transmitted and can lead to oral, genital and ocular ulcers. The first episode of genital herpes presents with multiple painful blisters, this is the primary infection. After the initial infection the virus becomes latent, remaining in the nervous system without causing symptoms. The virus can become reactivated causing recurrent symptomatic genital herpes.

In the 2021 reporting period the diagnosis rate of genital herpes was 35.8 per 100, 000 – with 143 diagnoses cases in Barnet. This rate was lower than the London rate (60.7 per 100, 000) and similar to the England average (38.3 per 100, 000).

There has been a decrease in the rate of cases of genital herpes in the last 5 years.[24]

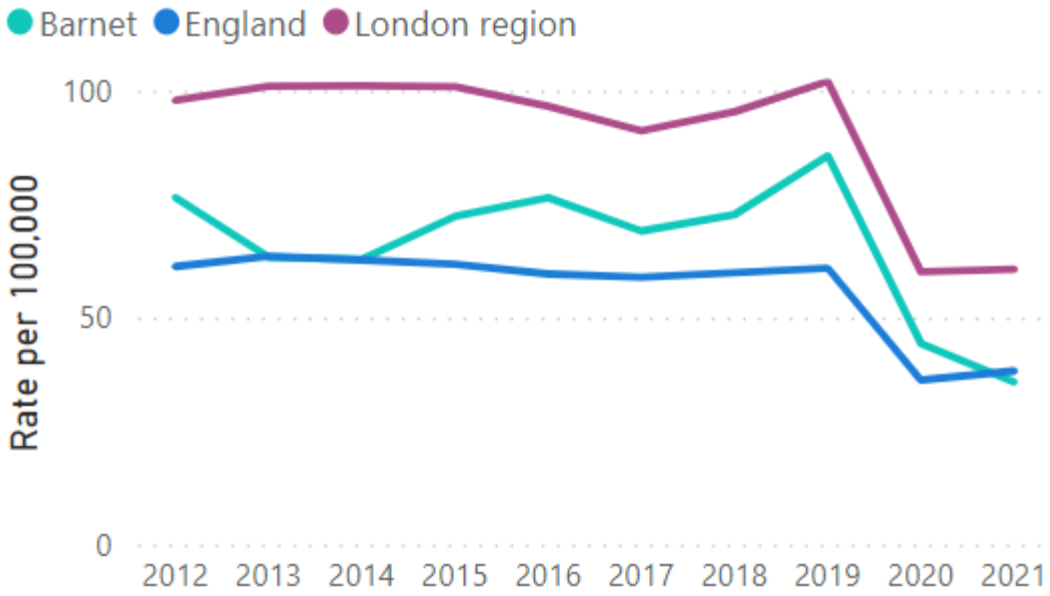


Figure 31: Genital herpes diagnostic rate since 2012 comparing Barnet, London and England[24]

Demographic groups

Between July 2017 and June 2022, 40% of genital herpes diagnoses (first episode) among Barnet residents were for people aged 25-34, 24% were for people aged 20-24 and 14% were for people aged 35-44.

57% diagnoses were for heterosexual women and 27% for heterosexual men.

Diagnoses for Black/Black British made up a slightly higher percentage of diagnoses than would be expected from Barnet's 2021 Census population (10% of diagnoses, 8% of population), while mixed ethnicity patients had a similar percentage (6% of diagnoses, 5% of population). Asian/Asian British and other ethnic groups made up a lower percentage than expected (6% of diagnoses, 19% of population for Asian/Asian British; 3% of diagnoses, 10% of population for other ethnicities). 35% of herpes diagnoses did not have a recorded ethnicity, so it is possible that these differences could be even larger.

Genital herpes is not tested for as part of the SHL online self-sampling kit.

6.2.5 Genital Warts

Anogenital warts are caused by the human papillomavirus (HPV). It is transmitted most commonly through sexual contact but can be also transmitted perinatally. It can cause proliferative benign growths in the genital, perineal, anal, perianal areas and the hands.[31]

In the 2021 reporting period that diagnostic rate of genital warts was 60.4 per 100, 000 giving 241 cases in Barnet. This was lower than the London region average rate but greater than the England average rate. Since 2012 there has been an overall decrease in the rate of the genital warts, even before the 2020 rates. [24]

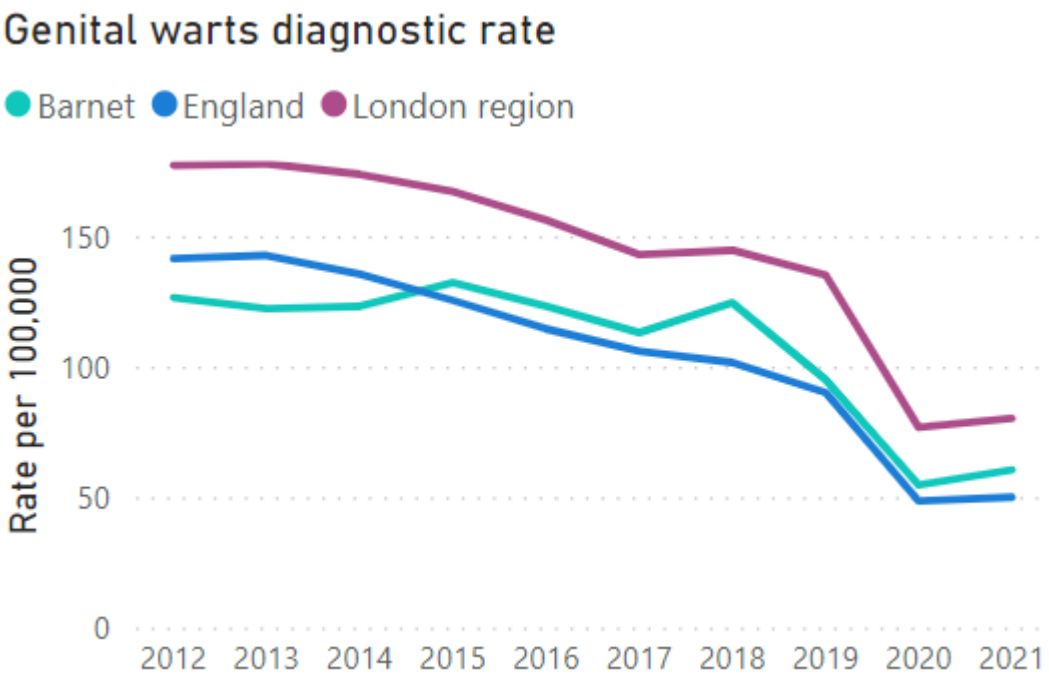


Figure 32: Genital warts diagnostic rate since 2012 comparing Barnet, London and England[24]

Demographic groups

Between July 2017 and June 2022, 41% of genital warts diagnoses (first episode episode) among Barnet residents were for people aged 25-34, 28% were for people aged 20-24 and 18% were for people aged 35-44.

48% of diagnoses were for heterosexual men and 36% of diagnoses were for heterosexual women.

Diagnoses for Asian/Asian British patients and those from other ethnic groups made up a lower percentage than would be expected from Barnet's 2021 Census population (8% of diagnoses, 19% of population for Asian/Asian British; 5% of diagnoses, 10% of population for other ethnicities). Diagnoses for Black/Black British and mixed ethnicity patients were similar to or the same as the Census percentages (6% of diagnoses, 8% of population for Black/Black British; 6% of diagnoses, 5% of population for mixed ethnicities). However, 33% of genital warts diagnoses did not have a recorded ethnicity, so it is possible that the true picture is different.

Genital warts are not tested for as part of the SHL online self-sampling kit.

6.2.6 STI testing

STI testing rates below include tests for syphilis, HIV, gonorrhoea and chlamydia (aged over 25) among people accessing sexual health services in England. The STI testing figure includes an individual who has been tested for one or more of the above tests. Tests include data from specialist sexual and reproductive health services as well as other care services and community sources including GP, internet services, pharmacies and outreach.

In the 2021 reporting period, STI testing rate in Barnet is 4569.8 per 100, 000, with a total of 18, 234 tests in the reporting period. This rate is greater than the England average however

below the London average. STI testing rates have increased between 2012 and 2019 however decreased in 2020.[24]

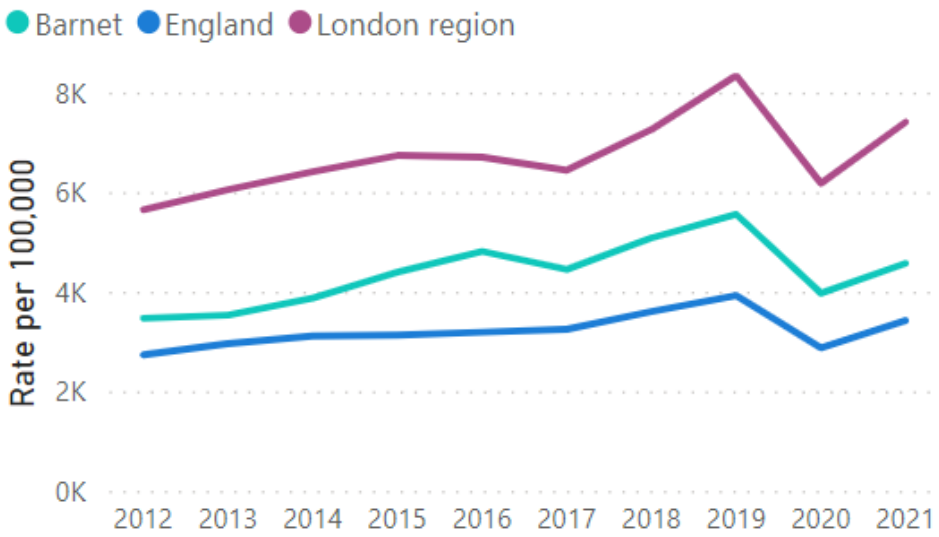


Figure 33: STI testing rate (excluding chlamydia aged under 25) since 2012 comparing Barnet, London and England[24]

STI testing is available both online through SHL and at ISH clinic services. STI testing is not currently provided in Barnet through community pharmacists. Data for Barnet residents online service use was supplied by Preventx, the service provider. Patients may order a maximum of 4 tests across as 12-month period. Data for patients whose gender is not recorded as female or male has been excluded from this analysis due to small counts, as there were very small numbers in this group during the early years of the service. From the start of the service to the end of Quarter 2, 2022-23, 470 patients entered a gender other than female or male; over half described themselves as non-binary. As patients enter their own gender information online, this information is likely to be more accurate than the clinic data.

Since the start of the SHL online service, there has been a steady increase in the number of test kits ordered. There was a sharper increase in the use of online services during Quarter 1 and 2 of 2019/20 and 2020/21. Test kits ordered continue to increase each quarter, demonstrating ongoing and sustained behaviour change.

In 2018/19, 24.6% of SHL tests for Barnet residents had CNWL recorded as the referring service compared to 3.0% in 2021/22. In 2018/19 Edgware Community Hospital was recorded as the referral site for 2.0% of these test kits and 0.1% in 2021/22; none were coded from Vale Drive.

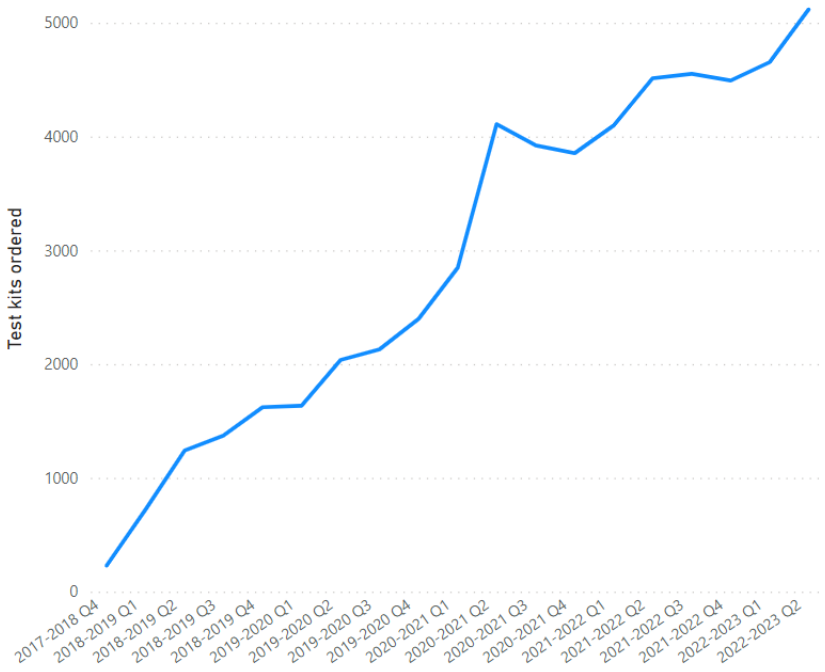


Figure 34: Number of online tests ordered by Barnet residents.

In 2018-2019 Barnet residents had 22,215 STI tests from commissioned services, of which 22.3% were ordered online. By 2021/22 Barnet residents continue to actively engage in STI testing with 24,096 tests, of which 73.3% were ordered online.

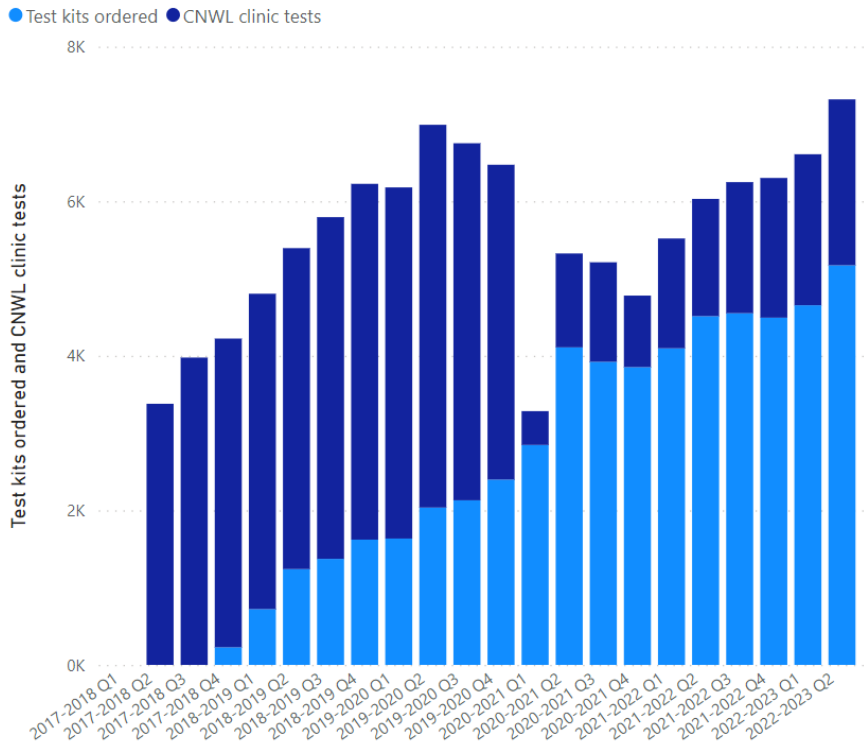


Figure 35: Total number of tests over time by quarters including STI tests completed online and in-clinic.

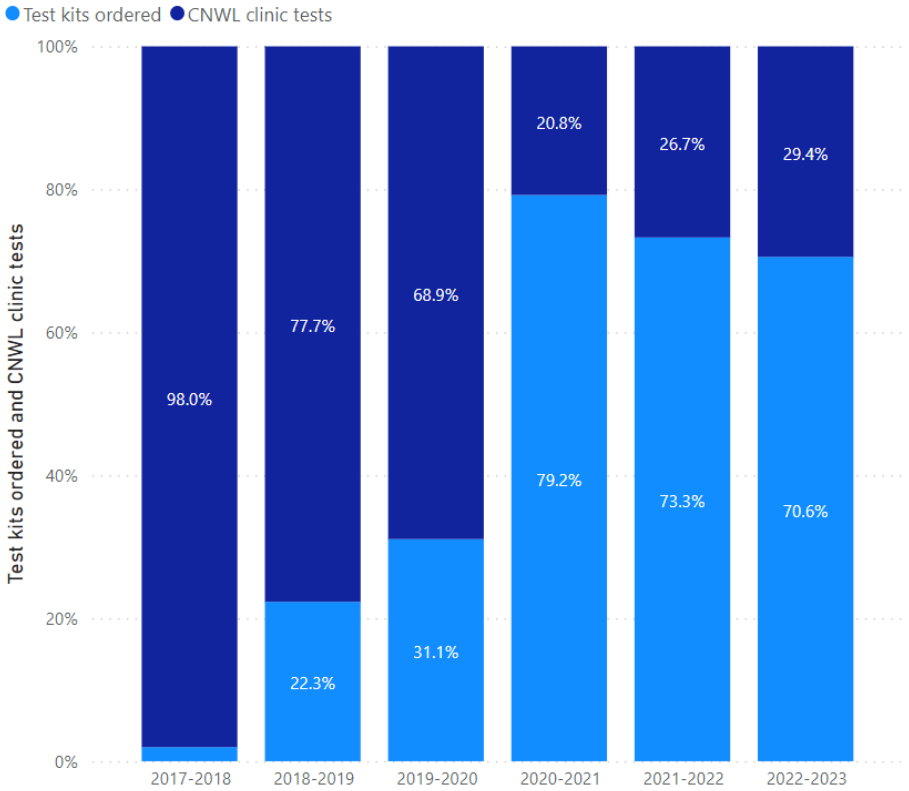


Figure 36: Proportion of tests by financial year including STI tests completed online and in-clinic.

Over time there has been an increasing number of users returning to SHL for further online STI testing kits, with an increasing trend. SHL is becoming a choice both for new and returning users.

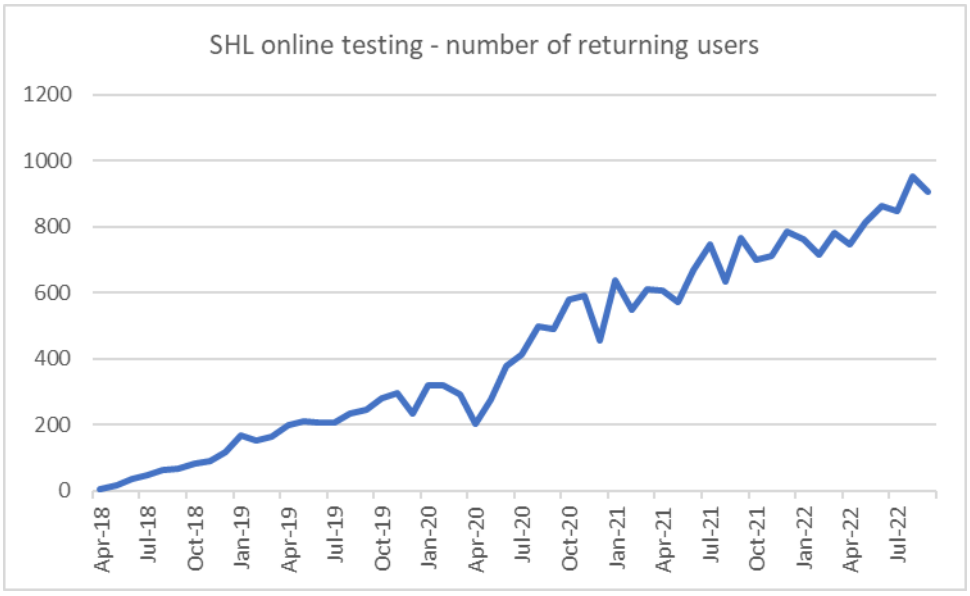


Figure 37: number of returning user to SHL for online testing, for Barnet residents.

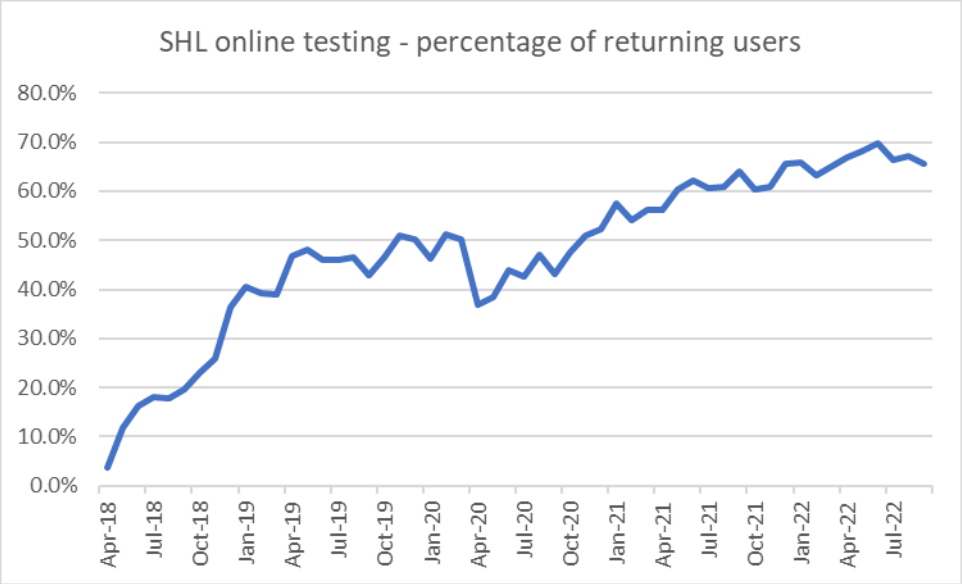


Figure 38: number of returning user to SHL for online testing, for Barnet residents.

Online testing has proved popular across all eligible age groups with increased and sustained behaviour change over the pandemic. There was a substantial change in the percentage of tests ordered online between 2019-20 and 2020-21 due to the pandemic. Most notably use in the over 65-year-olds increased from 6.5% in 2019-20 to 45.5% in 2020-21, although this had fallen to 20.7% in Q1-2 2022-23.

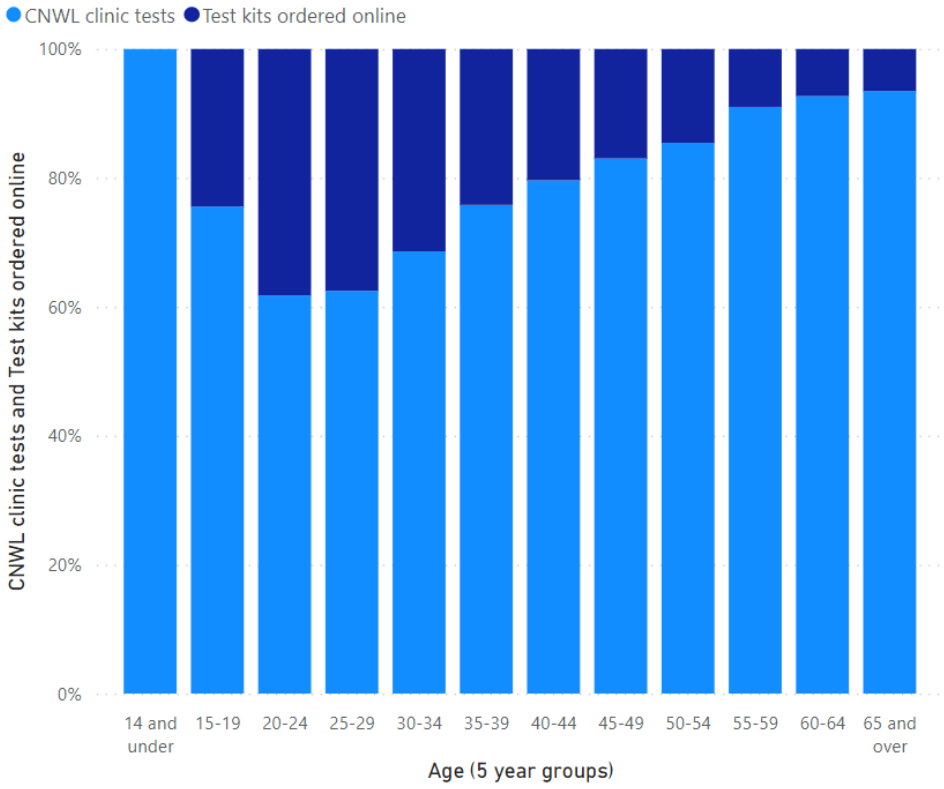


Figure 39: Proportion of STI tests completed online or in-clinic by age group, for 2019/20

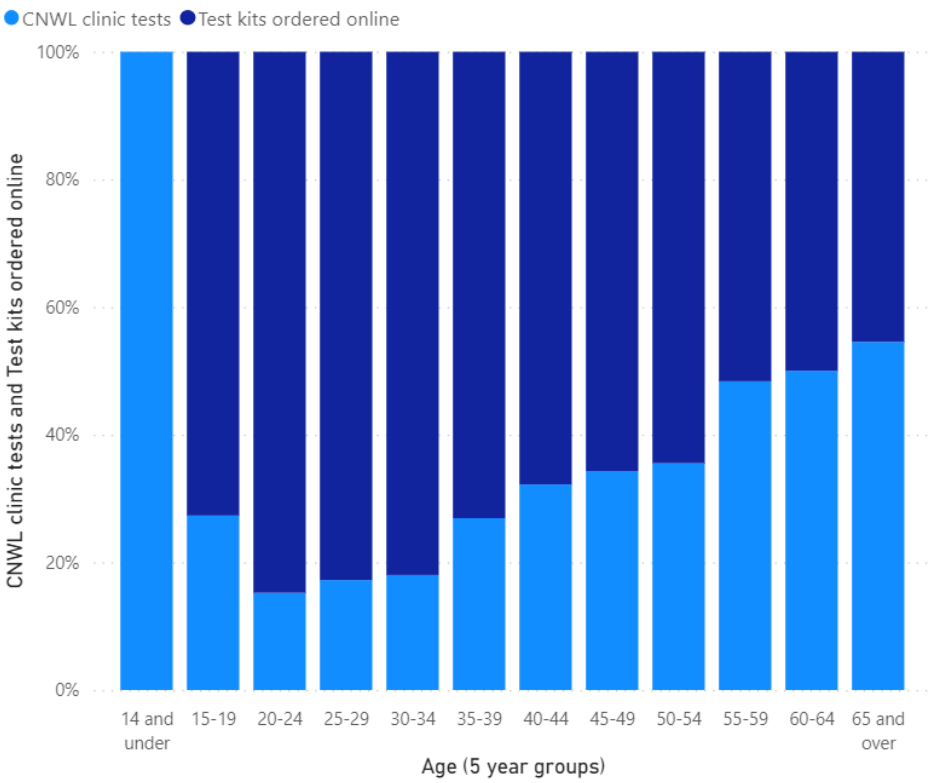


Figure 40: Proportion of STI tests completed online or in-clinic by age group, for 2020-21

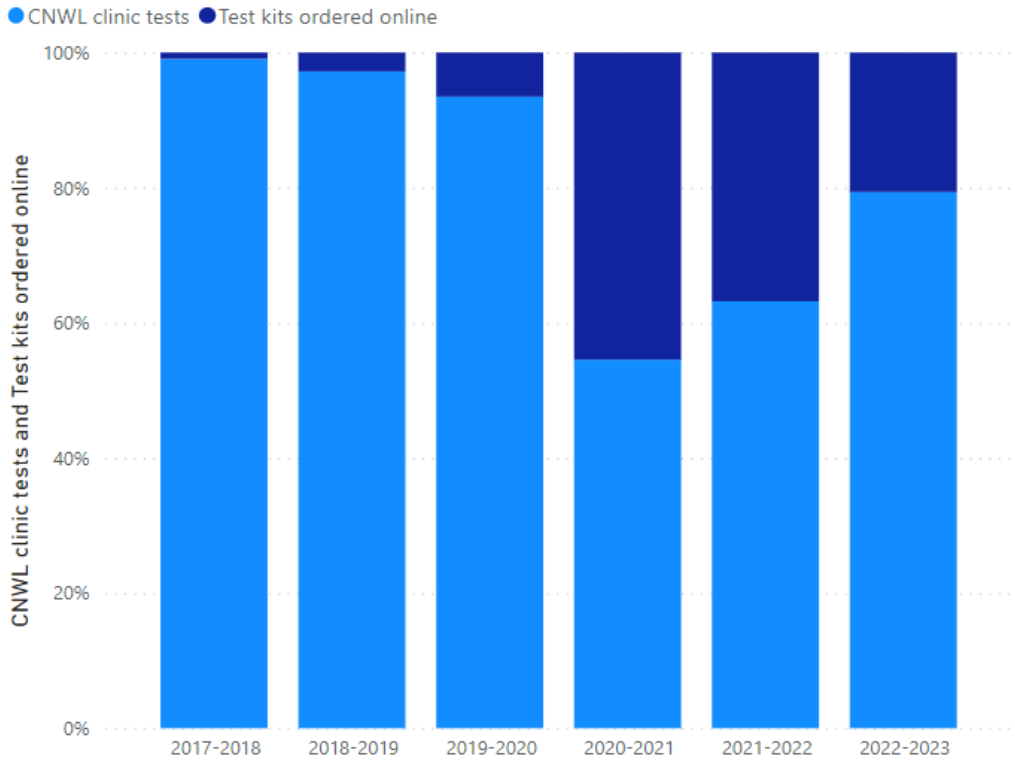


Figure 41: Proportion of STI test completed online or in-clinic by year for those over 65 years old.

Reflecting existing trends generally seen in ISH services including face-to-face appointments, females were more likely to utilise the online service than males, representing 61% of the online service use for STI testing.

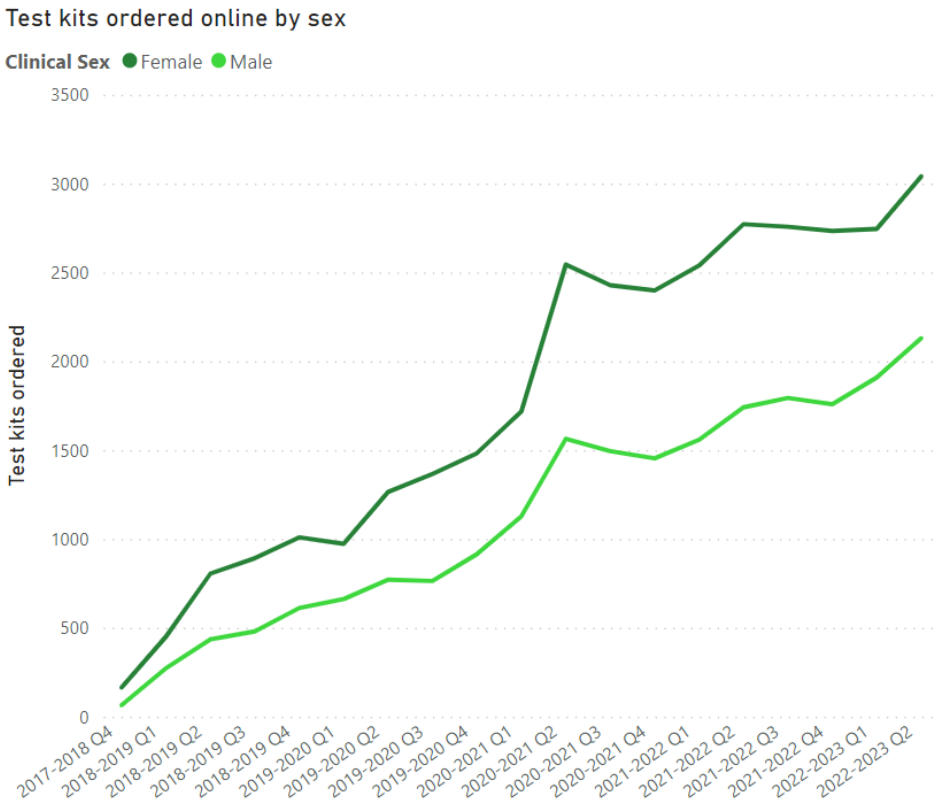


Figure 42: Number of online test kits ordered by sex, female and male.

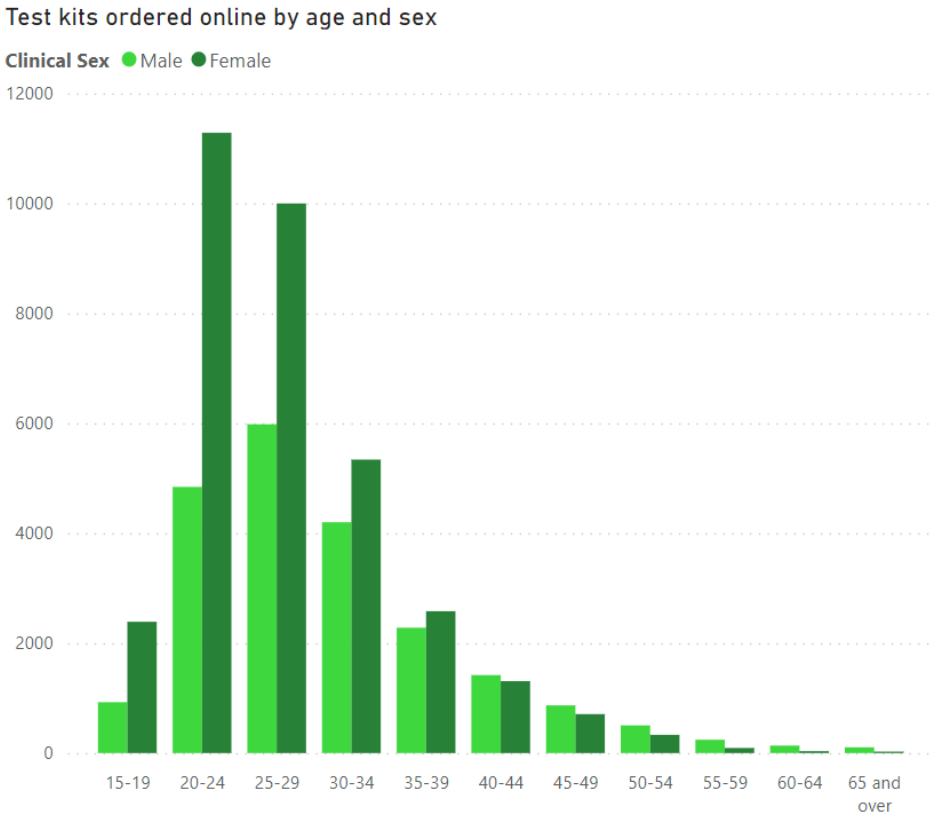


Figure 43: number of test kits ordered by age and sex, male and female.

Unlike clinic-based data where ethnicity data is often incomplete, for online STI testing data is complete for over 99% of patients.

Figure 44 demonstrates the ethnicity breakdown of patients over the reporting period from Quarter 4, 2017-18 to Quarter 2, 2022-23. Comparing access of online services to the ethnicity of the borough more widely we see that whilst the White population accounts for 58% of Barnet they accounted for 60.4% of overall online activity. For those identifying as Black/ Black British they accounted for 15.9% of the patients accessing online STI testing as compared to 8% of the borough and similarly for Asian groups who make up 7.7%% of online STI testing patients they account for 19% of the borough's population.

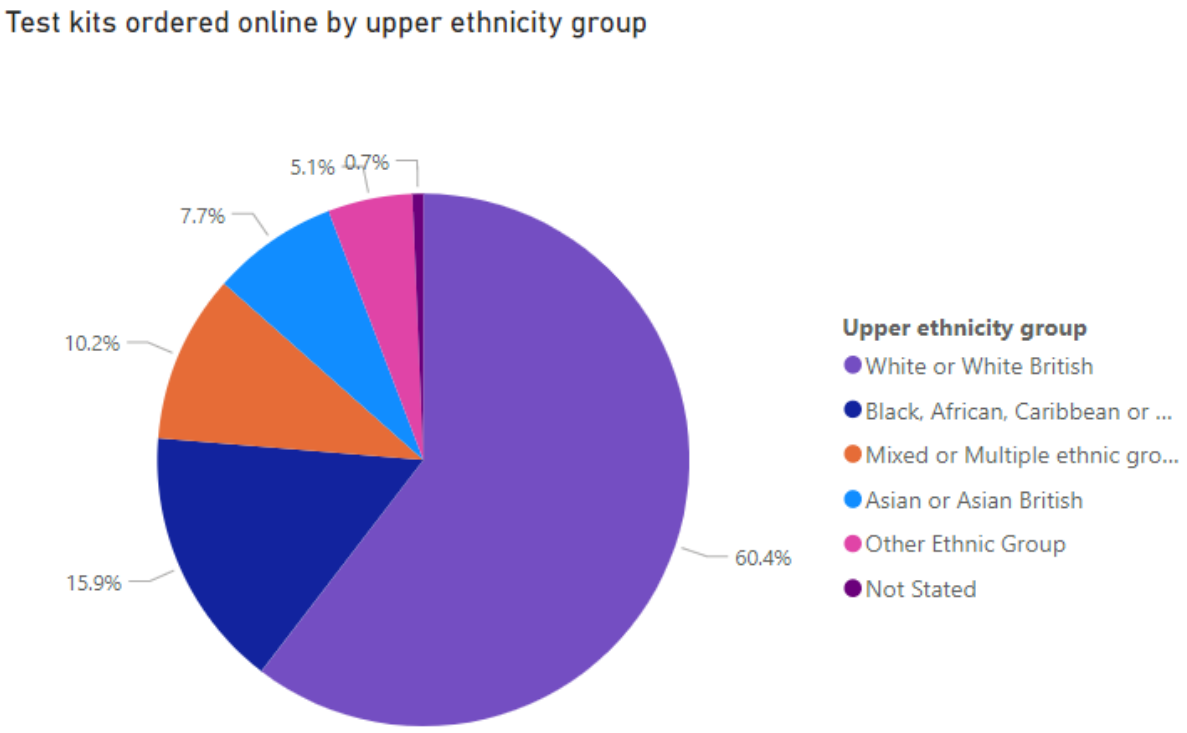


Figure 44: online tests kits ordered by ethnicity for Barnet residents.

Looking at use, taking into account both age and ethnicity, we see that the Asian/Asian British ethnicity group is under-represented on online STI testing. The Black/ Black British population use of STI testing services is double what would be expected for their proportion of the Barnet population; however, they are more likely to test positive for certain STIs and HIV and so the disproportional use is aligned with need.

6.3 HIV

6.3.1 Human immunodeficiency virus (HIV) is a retrovirus that infects and destroys cells that make up the immune system. Over time individuals become immunodeficient and are vulnerable to opportunistic infections such as pneumocystis pneumonia and developing malignancies such as Kaposi sarcomas.[32]

6.3.2 Treatment of HIV is with antiretroviral therapy and initiated in specialist secondary services and patients can be managed in primary care.[32] The Joint United Programme on HIV/AIDS (UNAIDS) is a joint venture between the United Nations family to unite against AIDS.[33] UNAIDS has set targets including 90% of all people with diagnosed HIV to receive treatment;

Barnet exceeds this with a 98.7% coverage.[24] HIV treatment and care is commissioned by NHS England and so will not be further detailed in this report. [3]

6.3.3 Prevention, screening and diagnosis

HIV and other STI testing is available in-clinic. HIV testing can also be accessed through the online kits provided through SHL through a finger-prick test.

Prevention work includes health promotion activities undertaken in the community by Brook's HIV specialist, which is further detailed in the health promotion section. Patients can also be prescribed pre-exposure and post-exposure prophylaxis (PrEP and PEP) in Barnet sexual health service clinics and CNWL Sexual Health Clinics in other boroughs.

Pre-exposure prophylaxis

PrEP is a drug given to those who are HIV-negative to stop them acquiring HIV. It reduces the risk of contracting the HIV virus. It is prescribed to those who are at high risk of HIV infection and is taken as a tablet before exposure.[34,35]

In Barnet PrEP can be accessed through CNWL services. Residents are able to book appointment online to consider starting or to continue PrEP or otherwise book through the central booking office. PrEP is also offered opportunistically based on risk assessment during face-to-face consultations. NCL commissioners currently fund CNWL to deliver a programme to promote uptake of PrEP in the community. The Programme covers the 4 London boroughs of Barnet, Camden, Islington and Haringey.

In the reporting period 2021, for Barnet, 9.1% of those attending sexual health services were determined to have a need for PrEP; need was defined as being at substantial risk according to a combination of GUMCAD codes or other clinical or behavioural markers and therefore could benefit from PrEP. This is the first year this statistic has been reported as part of the OHID sexual and reproductive health profile. PrEP need in Barnet is lower than the regional average need in London, but higher than the national need.[24]

In the 2021 reporting period, amongst those with PrEP need (as described above) in Barnet, 76.9% of those in Barnet were initiated on or continued their PrEP. This is below the London region average of 79.4% but above the England average of 69.6%. The reasons for people not having PrEP are not examined and can include clinical indications. There has however been an overall increase in the number of appointments for PrEP from 2021 to 2023 as seen in Figure 45.

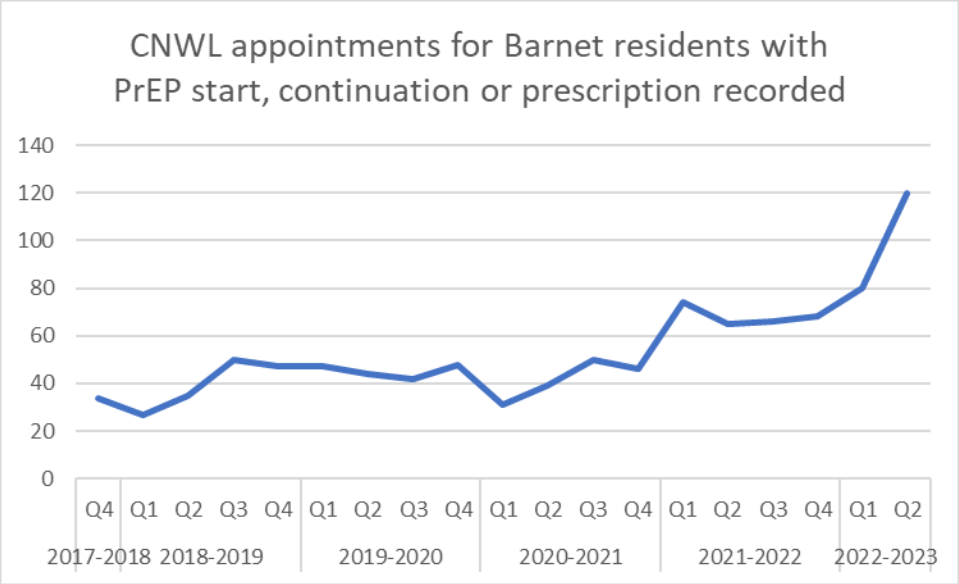


Figure 45: number of appointments for Barnet residents in CNWL clinics with PrEP

Between Quarter 3, 2020-21 and Q2, 2022-23, 97.5% of PrEP interventions provided by CNWL have been for male patients. The main age groups are 25-29 years (22.8%), 30-34 years (18.7%) and 35-39 years (14.3%).

PrEP was most commonly prescribed to White (51.2%), mixed ethnicities (10.3%) and Black/ Black British (6.0%), who make up 58%, 5% and 8% respectively. Asian/ Asian British are under-represented as with other outcomes accounting for only 3.7% of appointments but 19% of the Barnet population. However, ethnicity was not stated for 23.7% of those who had appointments to start, continue or have a prescription of PrEP.

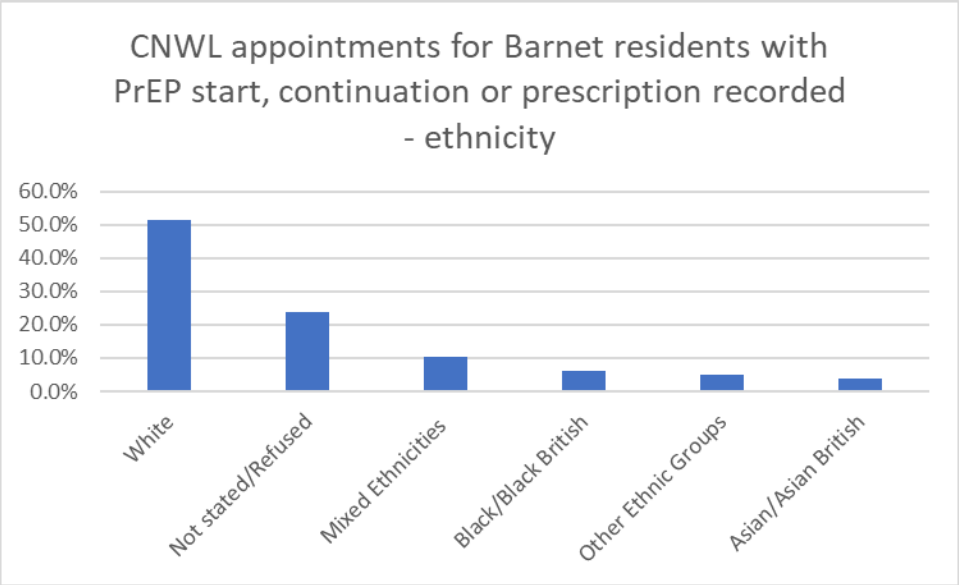


Figure 46: Proportion of appointments relating to PrEP by ethnicity for Barnet residents.

Post-exposure prophylaxis

Post-exposure prophylaxis (PEP) is an antiretroviral treatment that is given to those who are HIV-negative who have been exposed to HIV. PEP reduces the chance of seroconversion by around 80%. Exposure may be through sexual contact but other exposures such as

occupational exposure will be within the statistic. PEP should be given as soon as possible after exposure, preferably within the first 24 hours and treatment course is for 28 days.[36]

Uptake of PEP has fallen since 2018 even before the pandemic. This may be due to improving and increasing number of people who are taking PrEP but a decrease in uptake due to not accessing PEP or preference to access PrEP at other services must also be considered.

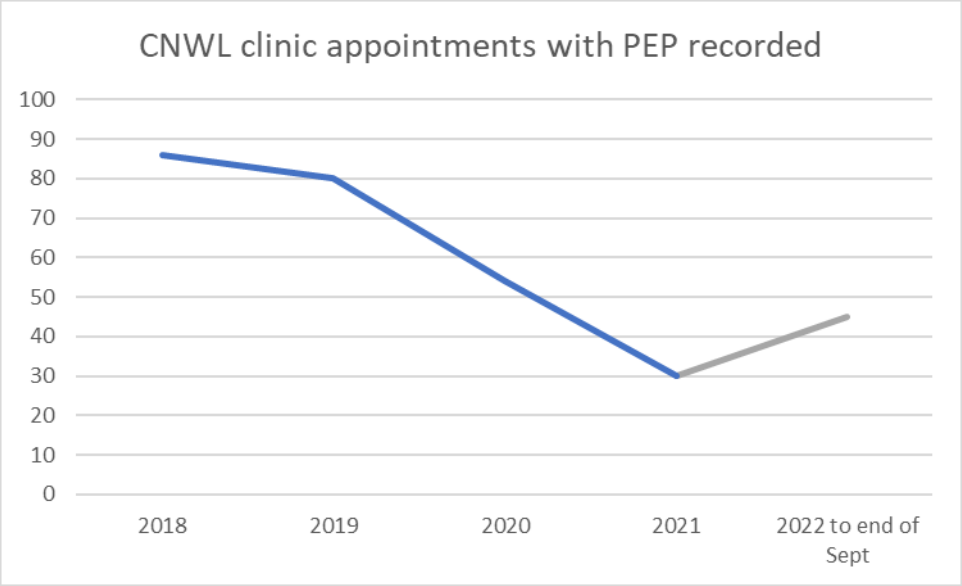


Figure 47: CNWL clinic appointments with PEP for Barnet residents

83.1% of Barnet residents who attended PEP appointments were male. A large proportion of those receiving PEP do not have a recorded ethnicity. The trend in the use of PEP matches by age matches overall activity in-clinic activity, with the greatest use in those aged 25-29 years old.

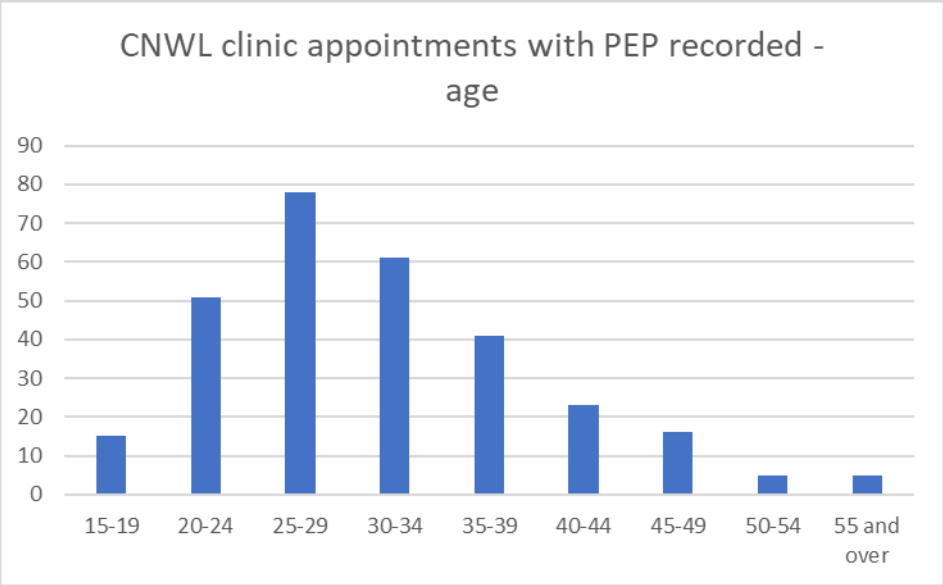


Figure 48: Clinic appointments for PEP by age, for Barnet residents

In the reporting period PEP was given to 305 individuals with a clinical indication relating to sexual exposure. Of these 305 individuals, 14 individuals (4.6%) were started on or continued taking PrEP either from the clinic or through another source. Of these 14 patients, 3 had PrEP prescribed to them in the same consultation where they were also prescribed PrEP.

6.3.4 Treatment and care

Treatment and care for those with a diagnosis of HIV is commissioned by NHS England. A range of services are provided by the Royal Free NHS Trust, CNWL and HIV Psychology service provided by the Barnet, Enfield and Haringey Mental Health NHS Trust. Data from the HIV and AIDS Reporting System from UKHSA show that most Barnet residents who were seen for HIV care attended Royal Free Hospital; Mortimer Market Centre was the next most common treatment site.

In the 2021 reporting period Barnet had a 99.2% antiretroviral therapy coverage in people accessing HIV care. This is above both the regional and national average. Prompt antiretroviral therapy initiation in newly diagnosed HIV patients was 81.2% in Barnet, similar to the London region (81.0%) but below the national average (83.5%). Prompt initiation is defined as starting antiretrovirals within 91 days of diagnosis. Virological success in adults accessing HIV care was 97.4% in the same period, similar to regional (97.8%) and national (97.8%) averages.[24] Virological success is defined as those with an undetectable viral load. This is an important measure because U=U (undetectable = untransmissible); HIV transmission does not occur when a patient's viral load is undetectable on antiretroviral therapy.

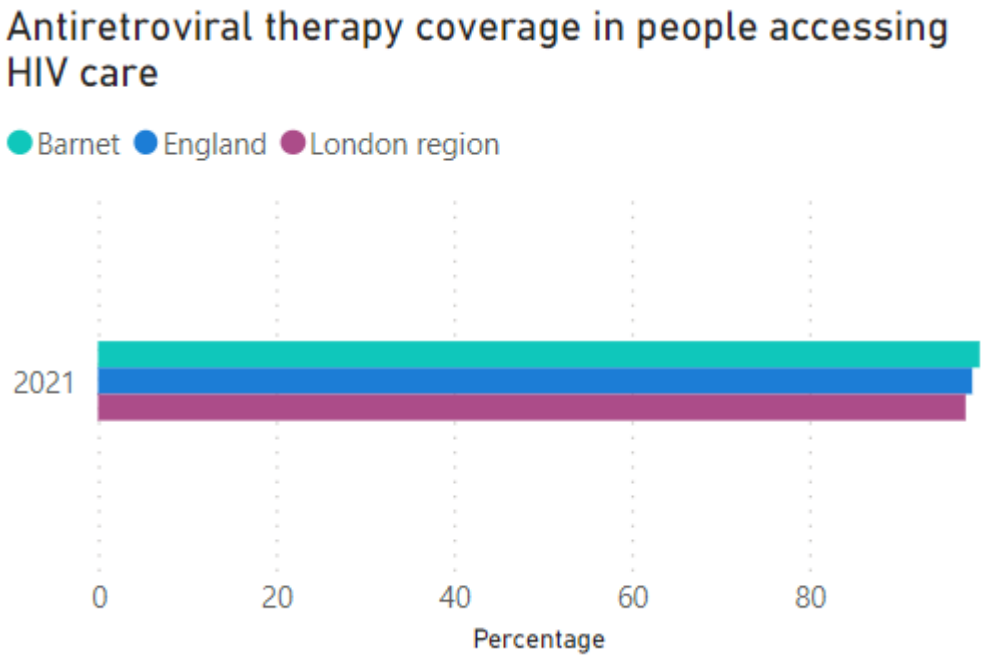


Figure 49: Antiretroviral therapy coverage in people accessing HIV care, comparing coverage between Barnet, London region and England[24]

Figure 50: Prompt antiretroviral therapy initiation in people accessing HIV care, comparing between Barnet, London region and England[24]

6.3.5 HIV data for Barnet

HIV prevalence can be compared against benchmarking thresholds set using the 2020 testing guidelines developed by British HIV Association (BHIVA), British Association for Sexual Health and HIV (BASHH), and British Infection Association (BIA). The thresholds are benchmarked as: <2 is low, 2 to 5 is high and ≥5 is extremely high. HIV prevalence for the reporting year 2021 in Barnet residents is 2.11 per 1,000. When benchmarked against set thresholds this puts Barnet in the high category. In relation to HIV prevalence, Barnet is above the national average but below the regional London average, with no significant change in the prevalence of HIV over the last 5 years. A similar picture is seen when HIV prevalence is examined only for residents aged 15 to 59. [24]

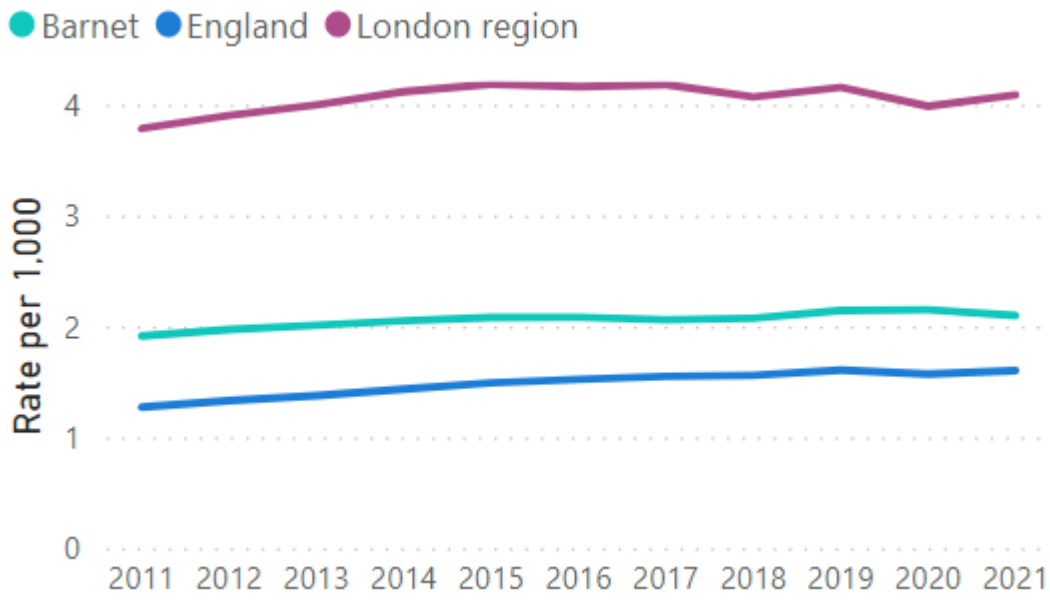


*Figure 51: **Prevalence of HIV diagnosis** comparing Barnet, London regional and England rates*[24]

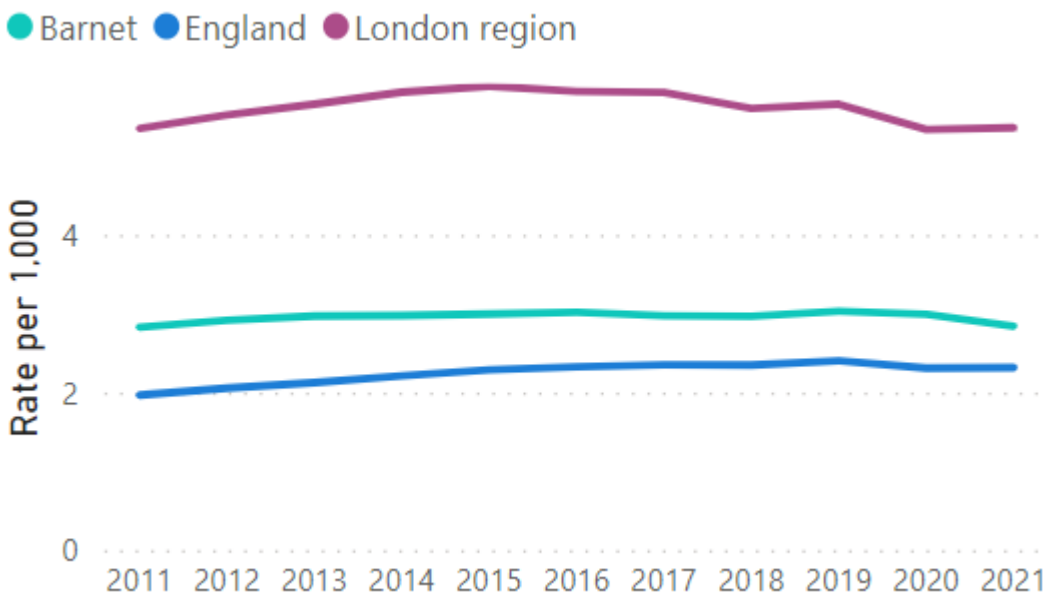


*Figure 52: **Prevalence of HIV diagnosis for residents aged 15-59** comparing Barnet, London regional and England rates* [24]

New HIV diagnosis in the reporting year 2021 in Barnet had a rate of 6.8 per 100, 000 which includes diagnosis first made in the UK and where first positive test was outside the UK; new UK first diagnosis was 4.8 per 100, 000. As per prevalence, incidence remains above the England average and below the London average rate.[24]

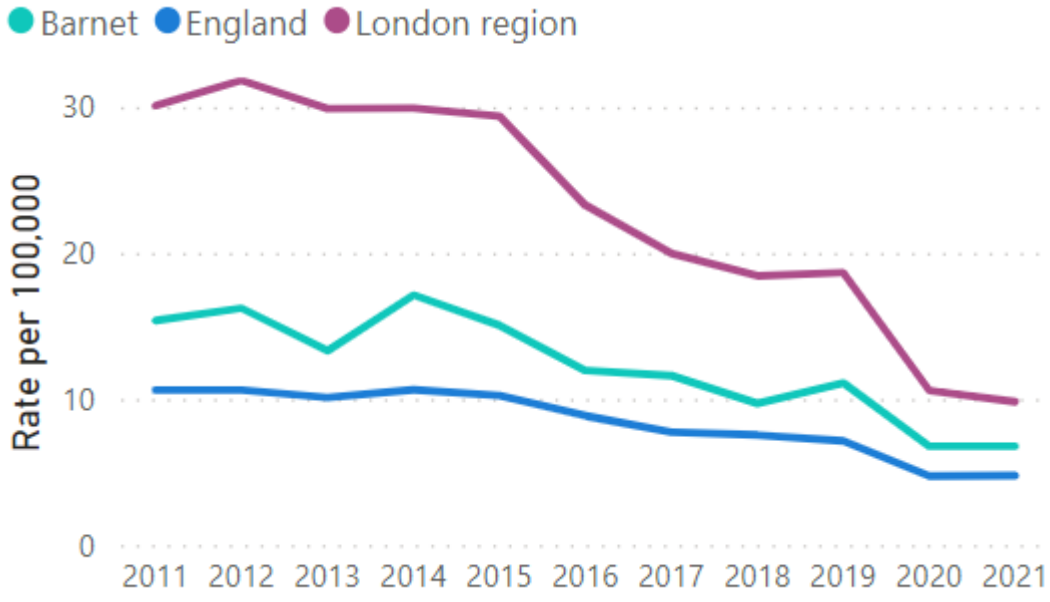


*Figure 53: **Incidence of new HIV diagnosis** comparing Barnet, London regional and England rates*[24]

Reflecting the trend nationally in 2020 and 2021 and the trend in STI testing there was a decrease in HIV testing amongst eligible individuals in specialist sexual health services (SHS) as compared to 2019 across all groups. The decline was greatest amongst women, conversely repeat testing amongst gay, bisexual and other men who have sex with men

(MSM) increased as a proportion between 2019 to 2020 by 16.8% however the total number of individuals actually decreased by 29%.[24]

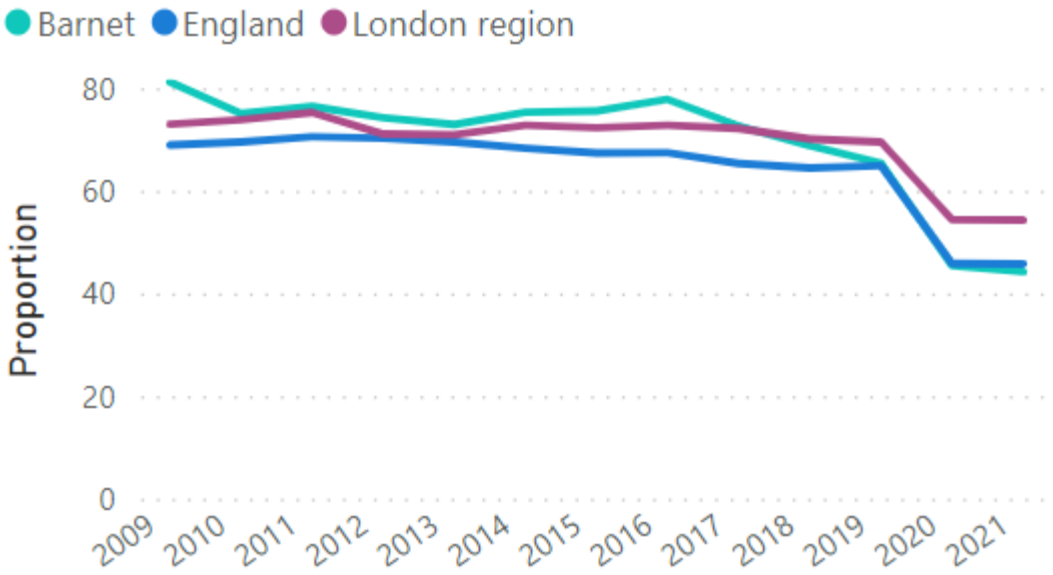


Figure 54: Overall HIV coverage, for Barnet residents, comparing Barnet, London regional and England rates [24]

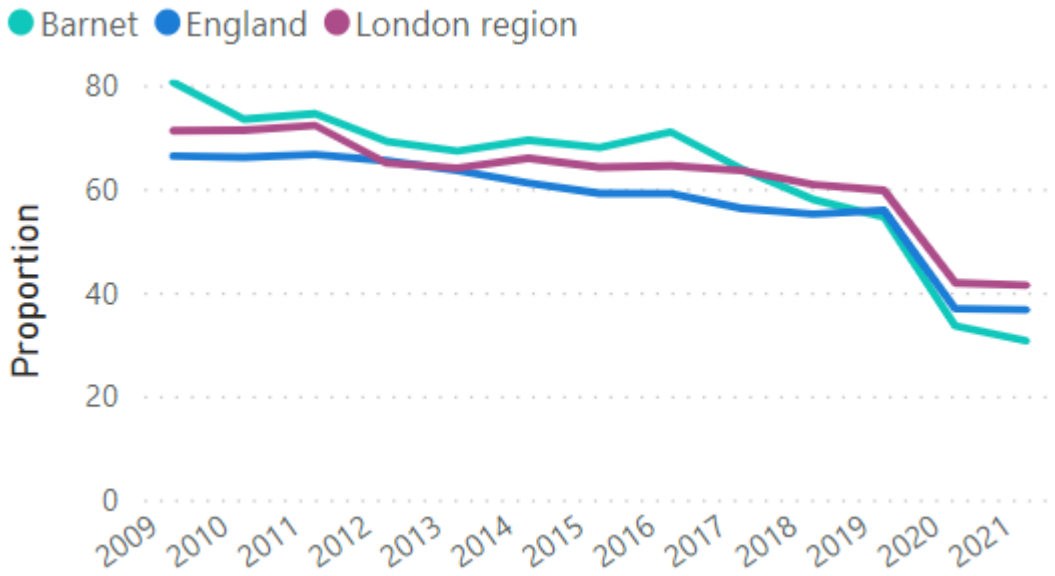


Figure 55: HIV coverage for women, for Barnet residents, comparing Barnet, London regional and England rates [24]

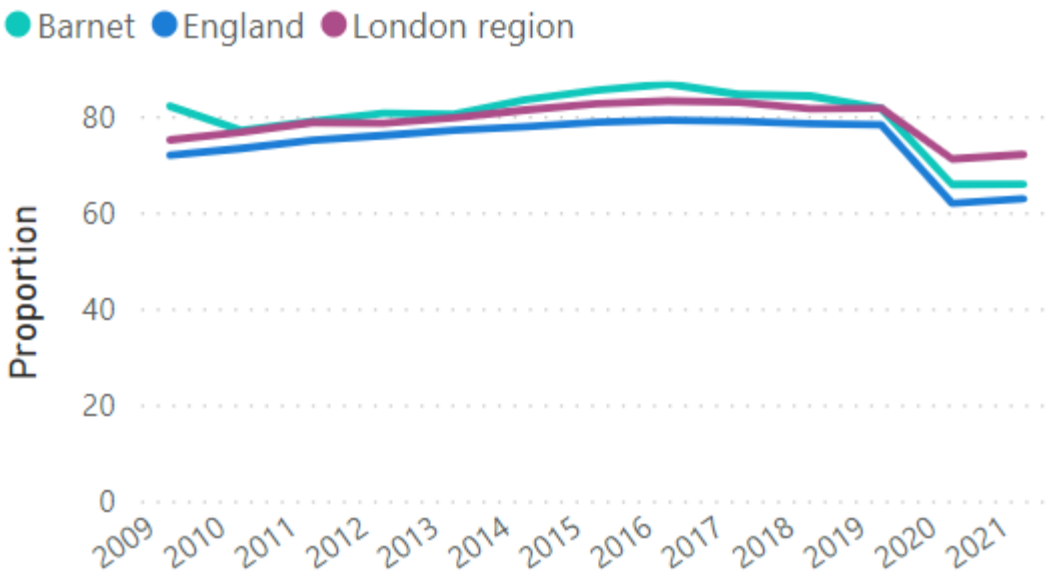


Figure 56: HIV coverage for men, for Barnet residents, comparing Barnet, London regional and England rates [24]

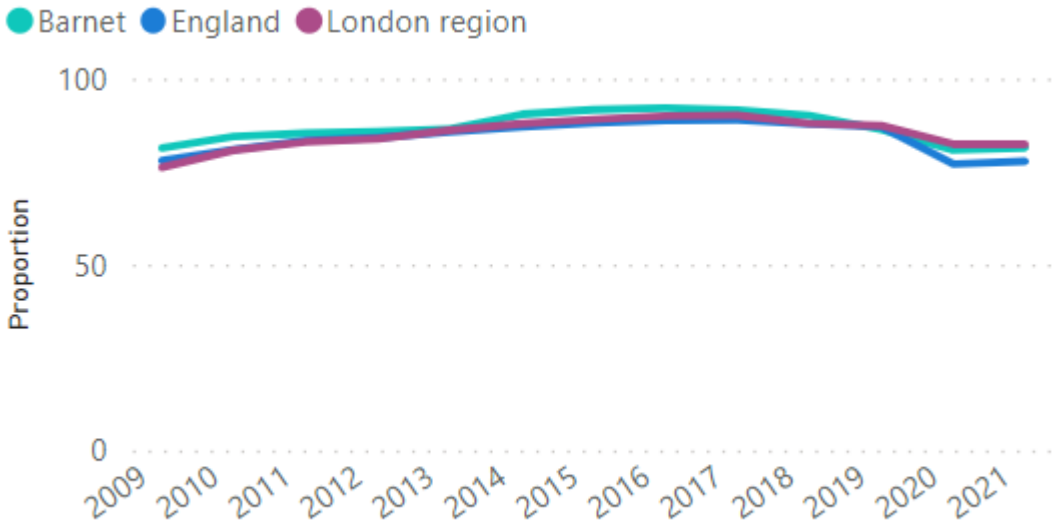


Figure 57: HIV coverage for gay, bisexual and other MSM, for Barnet residents, comparing Barnet, London regional and England rates [24]

Data from online testing provider SHL showed that between 2018 and 2021, 22,920 online HIV tests were returned and screened, of which 152 (0.7%) were reactive.

Of those who had a reactive test for HIV online: 60% were White, 19% were Black/Black British and 9% were of mixed ethnicities. These ethnicities make up 58%, 8%, and 5% of Barnet residents respectively.

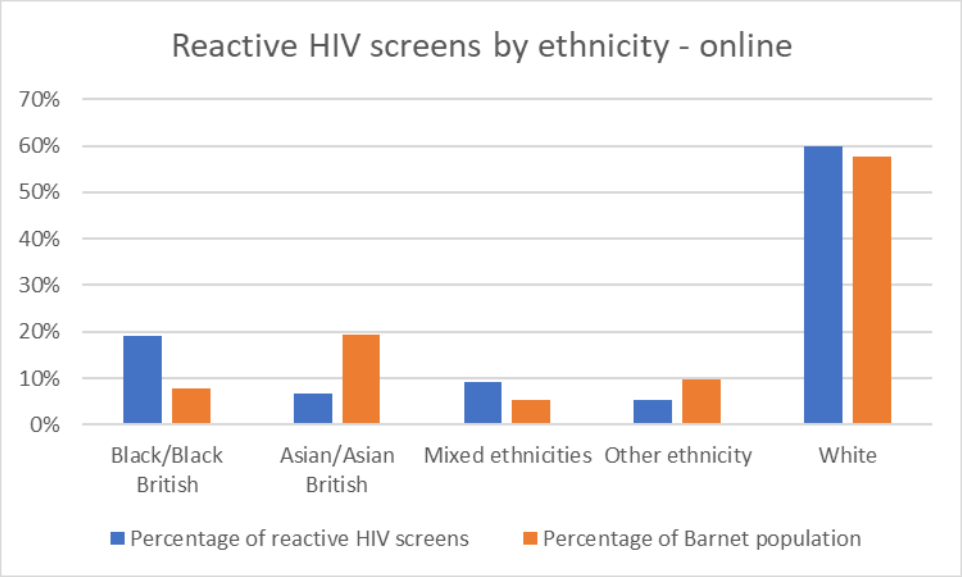


Figure 58: Reactive HIV screens from SHL self-sampling kit by ethnicity

People presenting with HIV at a late stage of infection continues to be an important indicator. Late diagnosis of HIV is defined as individuals with a CD4 count of less than 350 cells per mm^3 without evidence of recent seroconversion. Late diagnosis of HIV impacts both on the patient and in relation to the spread of HIV to potential sexual partners. Groups at particular risk or where prevalence is highest includes MSM and the black African population. [13]

In Barnet in the 3-year reporting period 2018-2020 36.8% on individuals had a late diagnosis of HIV, with the greatest proportion of late diagnosis being in heterosexual men (50%) and the smallest proportion of late diagnosis being amongst MSM (33.3%), similar to the national picture. [24,37] Late HIV diagnosis in Barnet as compared to national and regional averages have been fluctuant but have remained below the national average for the last 4 reporting years.

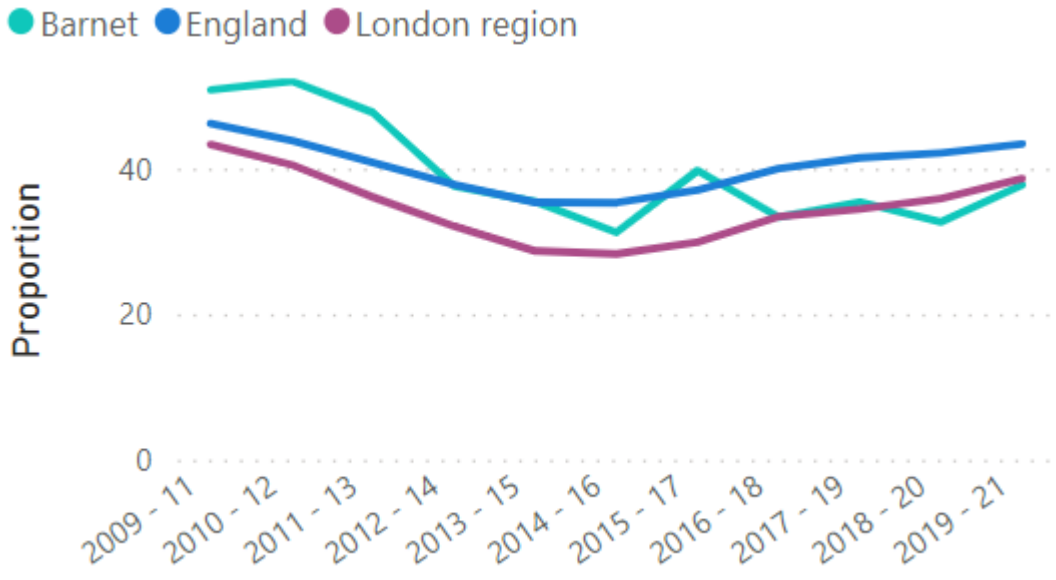


*Figure 59: **Proportion of late HIV diagnosis,** comparing Barnet, London regional and England rates*[24]

6.4 Hepatitis B

6.4.1 Hepatitis B is a viral infection that affects the liver. It can be acute, meaning it is a short-term illness that occurs within the first 6 months after someone is exposed to the hepatitis B virus, or it can be chronic, meaning it lasts longer than 6 months. Chronic hepatitis B can lead to serious complications, such as liver cirrhosis (scarring of the liver) and liver cancer.

The main forms of transmission of hepatitis B are through:

- Unprotected sexual contact with an infected person
- Sharing needles or other injecting equipment to use drugs
- Mother to baby transmission during childbirth
- Occupational exposure (for healthcare workers and others who may come into contact with blood or body fluids as part of their work).

In the UK, the mains forms of transmission are though needle sharing or sex.

Vaccination is the most effective way to prevent hepatitis B infection. The hepatitis B vaccine has been part of the routine childhood immunisation schedule for babies in the UK since 2017, and it is also recommended for certain groups of people who are at increased risk of infection, such as people who have multiple sexual partners, people who inject drugs and MSM.[38,39]

6.4.2 Nationally, men aged 25-44 have a higher burden of Hepatitis B compared to other age groups and women. Those who identify as mixed or other ethnicity are 5 times more likely than those identifying with white ethnicity to test positive and those of black ethnicity are almost 5 times more likely to test positive and Asians more than twice as likely to test positive.[38]

6.4.3 In the reporting period 2018, in Barnet, the rate of acute hepatitis B incidence was 0.77 per 100, 000. The rate was below the London regional rate of 1.25 but above the England national rate of 0.69.[40]

6.4.4 GUMCAD data reported from the 5-year period 01/07/2017 to 30/06/2022 records Hepatitis B vaccination in GUM and non-GUM settings for Barnet residents given both in and out-of-borough. In this period 509 1st dose of the Hepatitis B vaccination was given. Of these 86.1% were given to males, of which 69.2% were recorded as gay or bisexual. Over the same time period, 347 2nd doses were given, 254 3rd doses and 22 4th doses were given. There were 128 boosters administered.

6.5 HPV Vaccination

6.5.1 The human papillomavirus (HPV) can be spread through sexual contact and through non-sexual contact such as vertical transmission from mother to new-born baby. HPV infection can lead to genital warts and anogenital cancers in both women and men.[41] HPV is thought to be the cause of more than 90% of cervical cancers. [42]

6.5.2 The human papillomavirus vaccine was included into the childhood immunisation schedule in 2008. Initially to adolescent females and then extended to include adolescent males in 2019. Currently a 2-dose schedule is used, given in year 8 and year 9.[43,44]

6.5.3 The HPV vaccination programme is a universal offer delivered through the school-based immunisation programme. National lockdowns occurring during the academic years of

2019/2020 and 2020/2021 alongside the need for students to stay at home if they tested positive for COVID led to disruptions in the school-based immunisation programmes across the country. Nationally, HPV vaccination levels fell and though improving have not reached pre-pandemic levels.[45]

Data provided looks at students enrolled in Barnet schools, this therefore includes Barnet residents and non-residents. Over the last 5 completed academic years starting with the academic year 2016/17 we can see that there has been significant fluctuation in girls first and second dose in Year 8 and Year 9 respectively due to the pandemic. There is a significant drop in the academic year 2019/20, in-line with London wide trends. However, the drop in coverage in Barnet was greater than London overall. As with before the pandemic HPV vaccination coverage as a percentage in Barnet school students remains below London.

In the three years prior to the pandemic the percentage coverage was between 77% - 80% for girls first dose in Year 8 and 75% for girls second dose by Year 9, this fell to 2.1% and 15.6% respectively in the academic year 2019/20. Latest coverage in the academic year 2020/21 showed an improving coverage to 67% for the first dose in Year 8 however the second dose in Year 9 had a 0% coverage. 0% coverage in Year 9 was due to that cohort missing their first dose in summer 2020 with that cohort having an only 2.1% vaccination coverage in the year before, so they received their first dose in summer 2021. In Summer 2021 this cohort returned 68% of their permission forms, with active refusals from 4.1% achieving a coverage of 59%. [45] Work is currently underway within the council public health team to better understand the fall in immunisation rates.

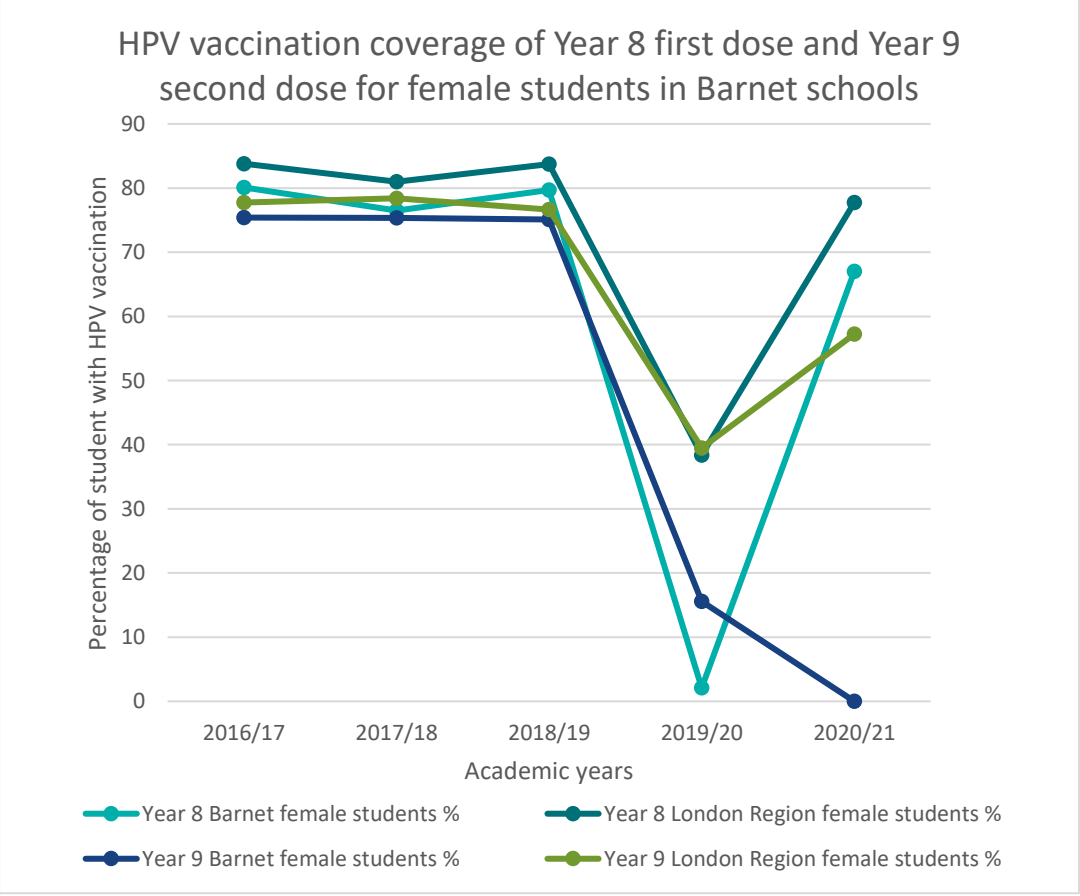


Figure 60: coverage of first and second dose for girls by academic year from academic year 2016/17, with comparative London regional and Barnet local trend

The academic year 2019 was the first year of a universal offer of the HPV vaccination for both males and females. Of students educated in Barnet in the academic year 2019/20 2% of males received their first dose (London coverage: 36.7%) and in the academic year 2020/21 0% received their second dose (London coverage: 53.2%) and 59.7% (London coverage: 72%) received their first dose.[45]

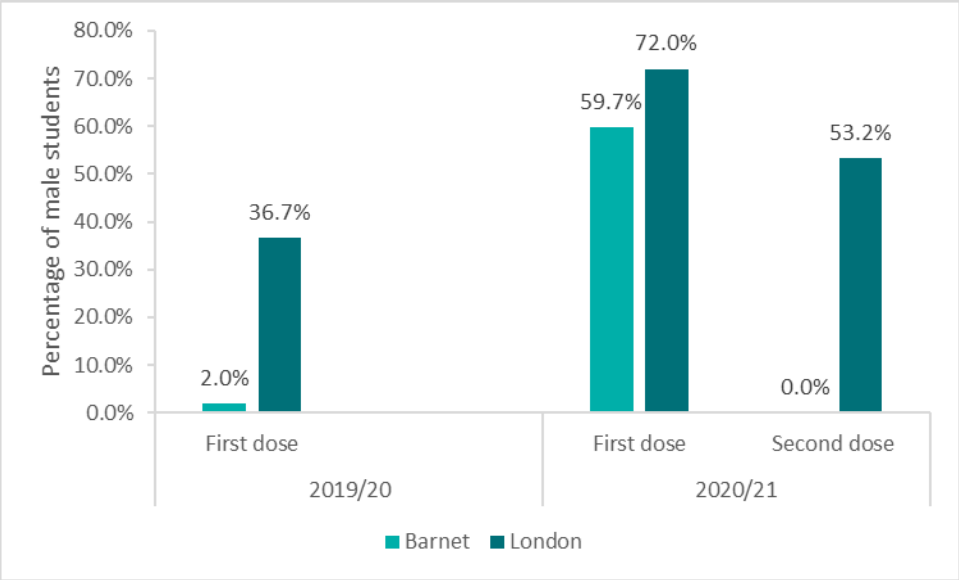


Figure 61: coverage of first and second dose for girls by academic year from academic year 2016/17, with comparative London regional and Barnet local trend

Comparing Barnet students regionally HPV vaccination coverage was lower in Barnet for both males and females. In response to national lockdowns and expected effects on vaccination coverage programmes were put in place to ensure routine delivery where possible and a catch-up programme.[44]

6.5.4 HPV vaccination is also available on the NHS for women up until their 25th birthday and MSM up to and including the age of 45 years old. There is no national database or register that records percentage of uptake in these groups.

MSM are able to get the HPV vaccination from sexual health clinics or HIV clinics. The current schedule is for 2 doses or 3 if known to have a weakened immune system.[46]

GUMCAD data reported from the 5-year period 01/07/2017 to 30/06/2022 records HPV vaccination in GUM and non-GUM settings for Barnet residents given both in and out-of-borough. In this period 586 1st dose of the HPV vaccination was given. Of these 97% were given to males, of which 81% were recorded as gay or bisexual. 442 2nd doses were given over the same period of which 97% were given to males of which 87% were recorded as gay or bisexual. HPV vaccination was offered and declined 110 times and 377 times was recorded that vaccination had been previously received in full.

6.6 Contraception

6.6.1 Effective contraception is the best way to avoid unplanned pregnancy and good contraceptive services are correlated with lowering teenage pregnancy. The full range of contraception should be available to all age groups. [13]

Long-acting reversible contraception (LARC) includes implants, the intra-uterine system (IUS) and the intrauterine device (IUD). They are highly effective as they do not rely on daily compliance and are more cost effective than condoms and the pill. LARC does not include contraceptive injections as they rely on relatively frequent and timely repeat injection every 8 to 13 weeks.[24,47]

6.6.2 LARC is used by 2120 women in Barnet (26.5 per 1,000) at a similar rate to the London average. 32% of LARC is prescribed by GP whilst 68% is prescribed by sexual and reproductive health services. [24]

In Barnet and reflecting the national picture, LARC continues to be a more popular choice in over 25s than under 25s (24.8% versus 44.3%). There is an increasing trend in popularity in LARC for under 25s over the last 5 years increasing from 19.7% (95% CI 18.1%, 21.4%) in 2017 to 34.9% (95% CI 32.3%, 37.6%) in 2021.

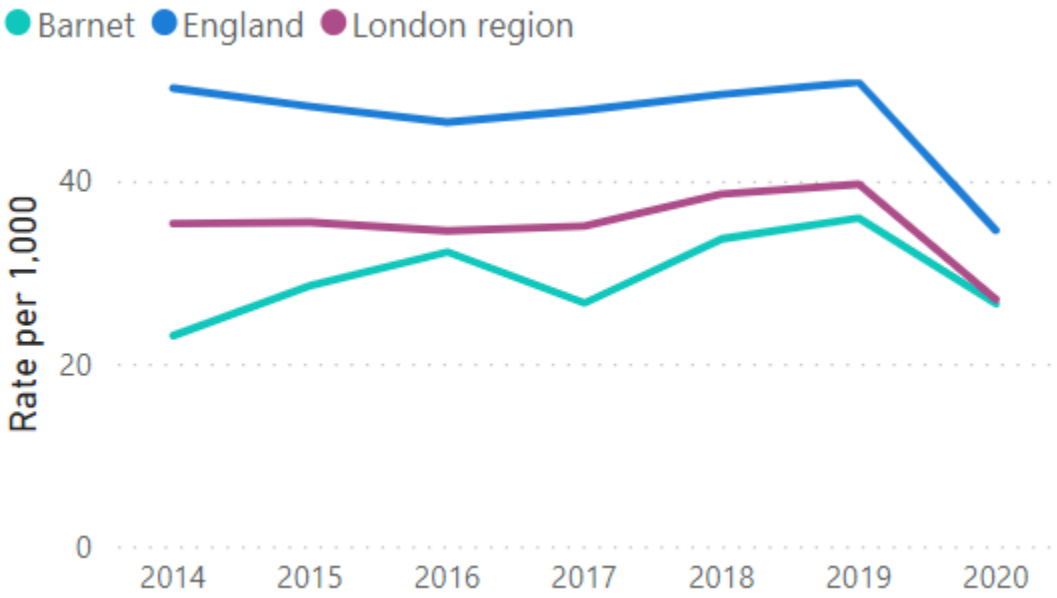


Figure 62: Total prescribed LARC excluding injections, per 100, 000, comparing Barnet, London and England

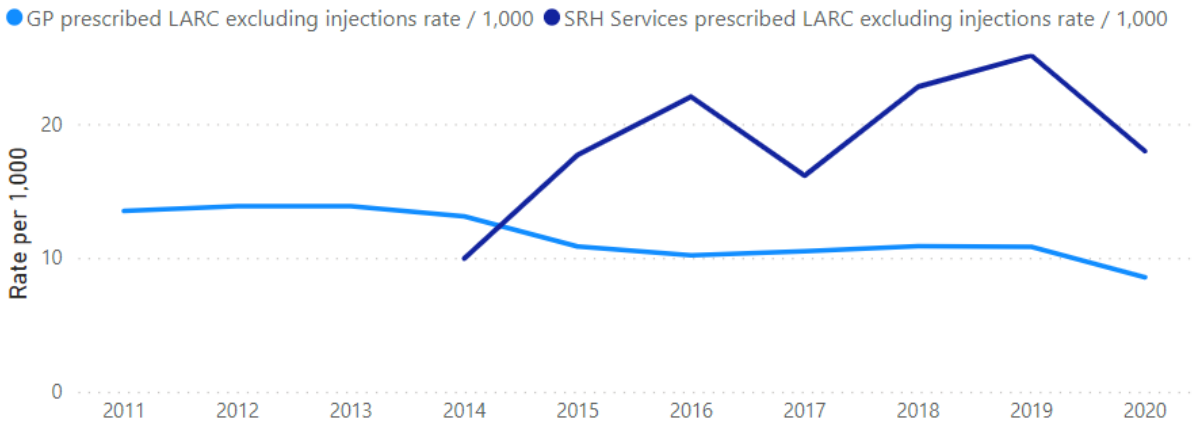


Figure 63: Comparing rates of LARC prescribed in GP and sexual health services (excluding injections)

6.6.3 The hormonal based intrauterine system (IUS) remains more popular than the IUD (copper based). Activity for insertion varied as expected with national lockdowns or waves. Current levels are within the activity levels pre-pandemic.

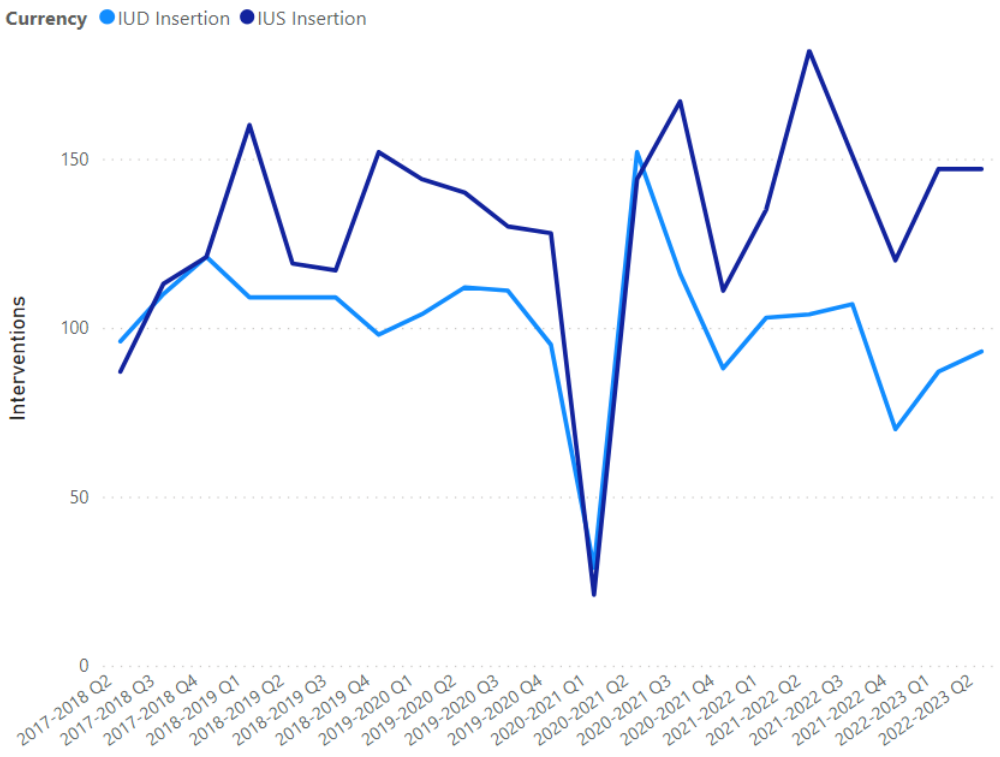


Figure 64: number of IUD and IUS insertion for Barnet residents completed in a CNWL clinics.

6.6.4 Patterns in dips of activity for implant insertion mirror that in other services and IUS/IUD insertion. Current activity remains within the parameters of pre-pandemic activity, although the average is lower than in the 4-quarters preceding the pandemic.

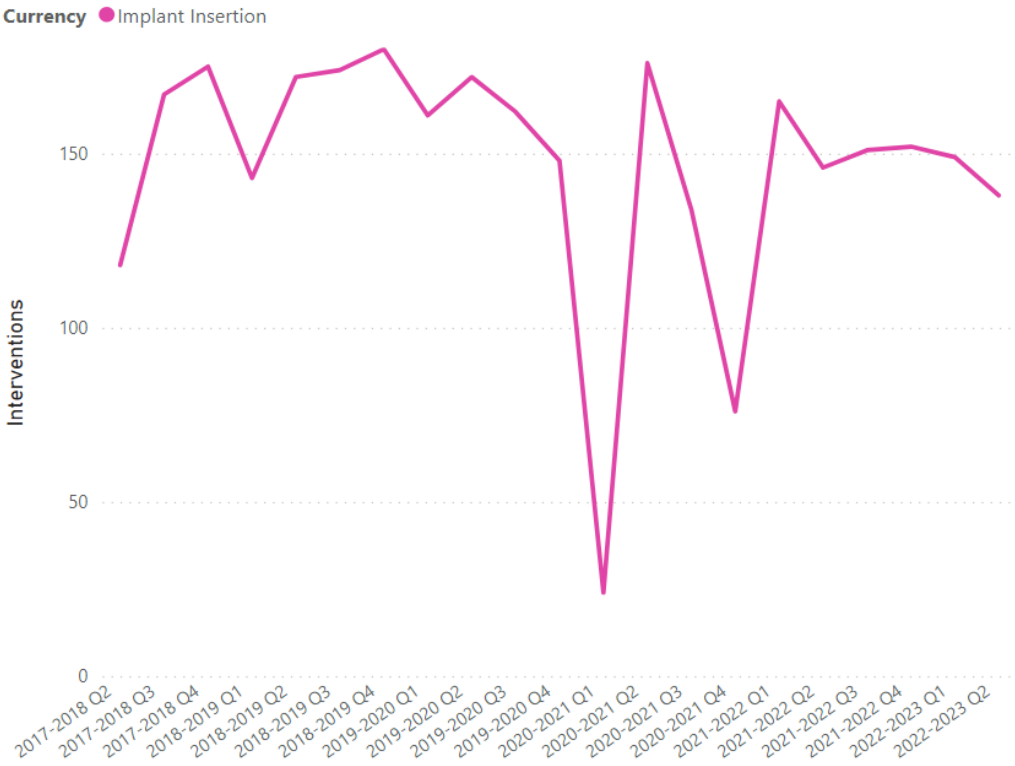


Figure 65: number of implant insertions for Barnet residents completed in a CNWL clinics.

6.6.5 Injections as a method of contraception remains the least popular choice for women with 4% of women with a recorded main method of contraception receiving injections at sexual and reproductive health services.

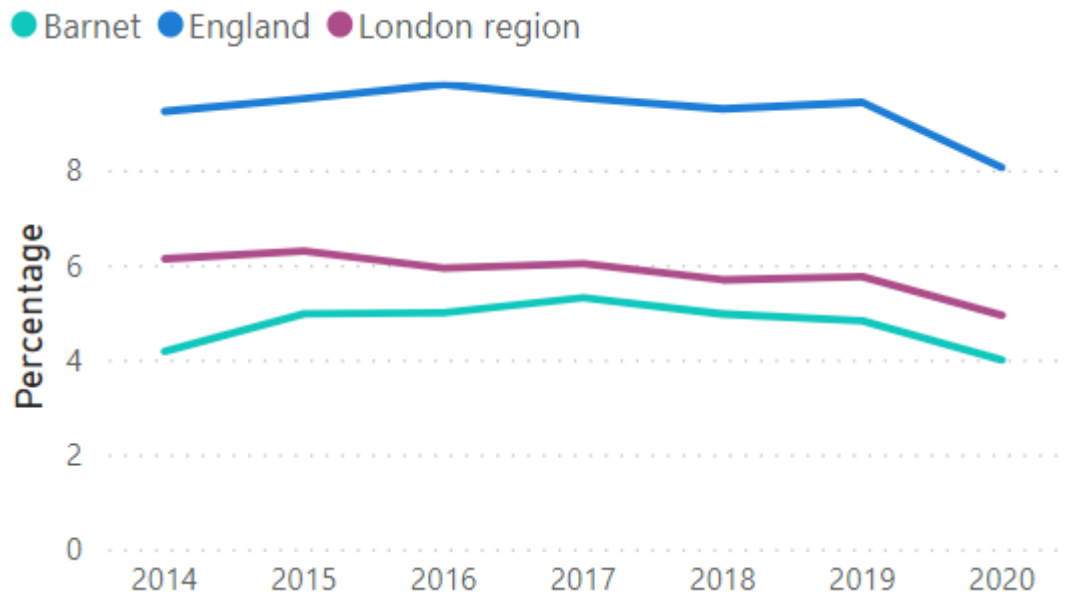


Figure 66: women receiving injection at SRH services, comparing Barnet, London and England

6.6.6 User dependent contraception includes all forms of contraception that relies on daily compliance such as the hormonal contraceptive pill and condoms, and so excludes LARC, it includes the 'natural family planning' method.

User dependent contraception remains the most popular choice for women in Barnet, with 57.8% of women attending SRH services choosing it in 2020. In the last 5-years there has been a significant decrease in the number of women choosing user-dependent methods.

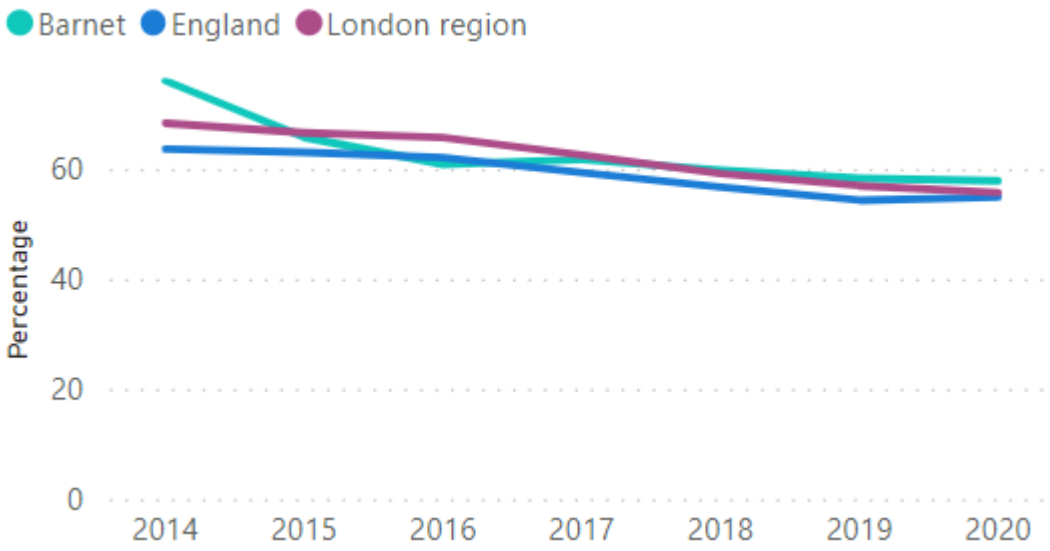


Figure 67: Percentage of women attending SRH services with a main recorded contraceptive method, who are using a user-dependent method, comparing Barnet, London and England

Hormonal short-acting contraception includes the contraceptive pill, patch or vaginal ring. In the 2020 reporting period, this was the contraception of choice for 42.6% of women attending SRH services. There has been no significant change in the number of women choosing this method over the last 5 years.

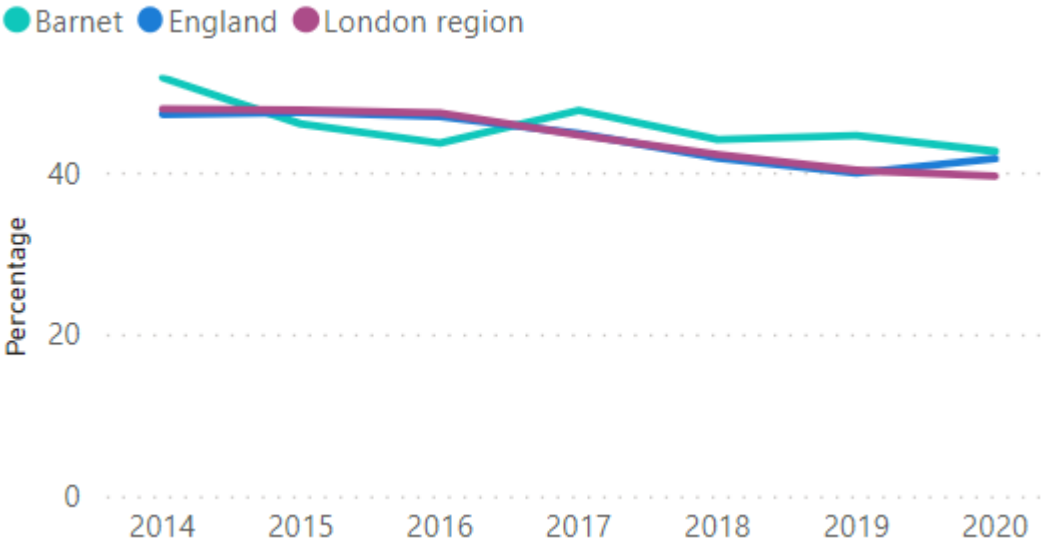


Figure 68: percentage of women choosing hormonal short-acting contraceptive services, comparing Barnet, London and England

6.6.7 For attendances that were coded through GUMCAD, attendances to ISH services over the last 5-years for contraception as compared attendances for other reasons can be seen below for Barnet residents. In the year 2018/19 an average of 34.4% of appointments included contraception, in the last full reported 2 quarters at the time of writing 38.8% of

appointments included contraception. The actual number of consultations has reduced overall from 5195 to 2851 in Quarter 2 of 2018/19 and the number of appointments for contraception has reduced from 1742 to 1083.

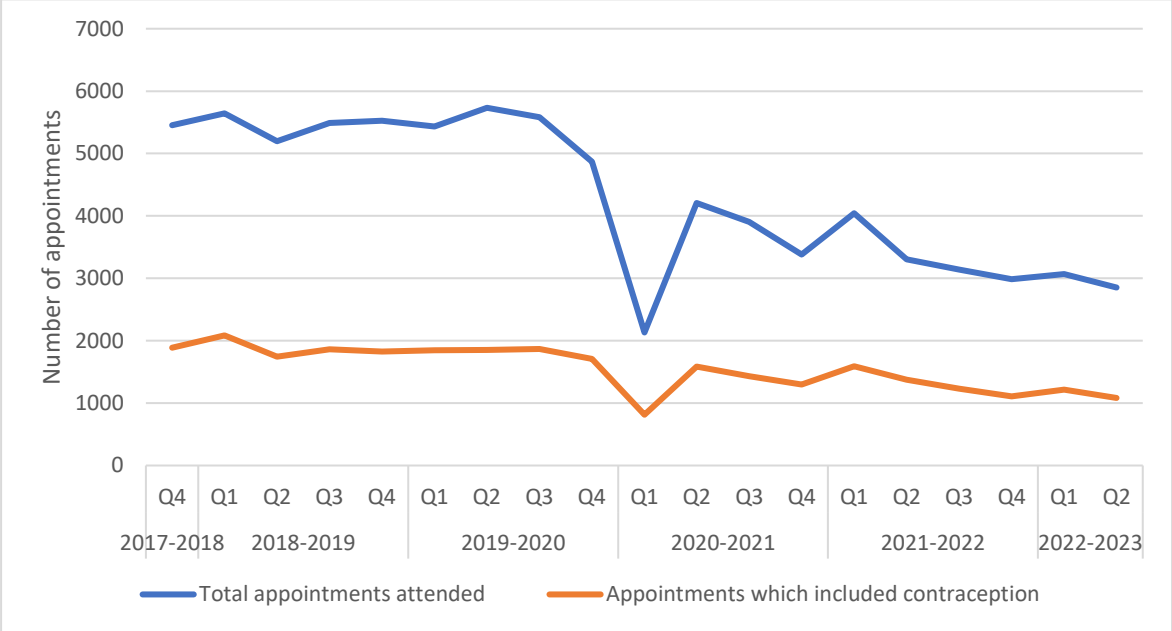


Figure 69: Barnet residents' attendance to ISH services, total appointments and appointments including contraception.

6.6.8 GP LARC activity commissioned by CNWL includes IUC insertions, PC IUD insertions, SDI (sub-dermal implant) insertions and SDI removals. CNWL has sub-contracts for LARC delivery with 20 Barnet GP practices, although not all of them have reported activity in each financial year all practices have shown some activity over the last 5 years. There was an upward trend in GP LARC activity with a fall in 2020-21, in-line with the pandemic. In 2021-22 activity level has shown recovery with 51.8% more activity than in the preceding year.

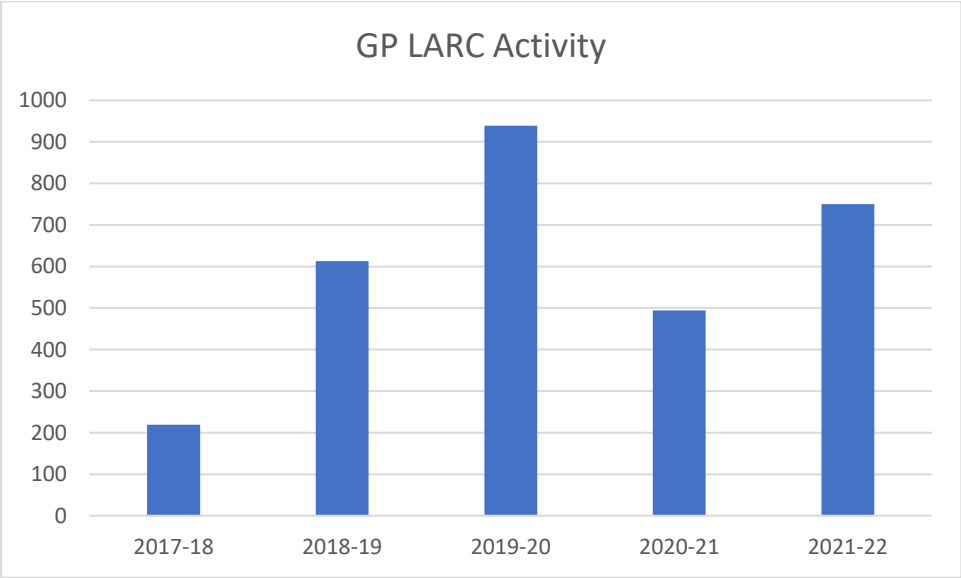


Figure 70: LARC activity and GP practices including insertions and removals.

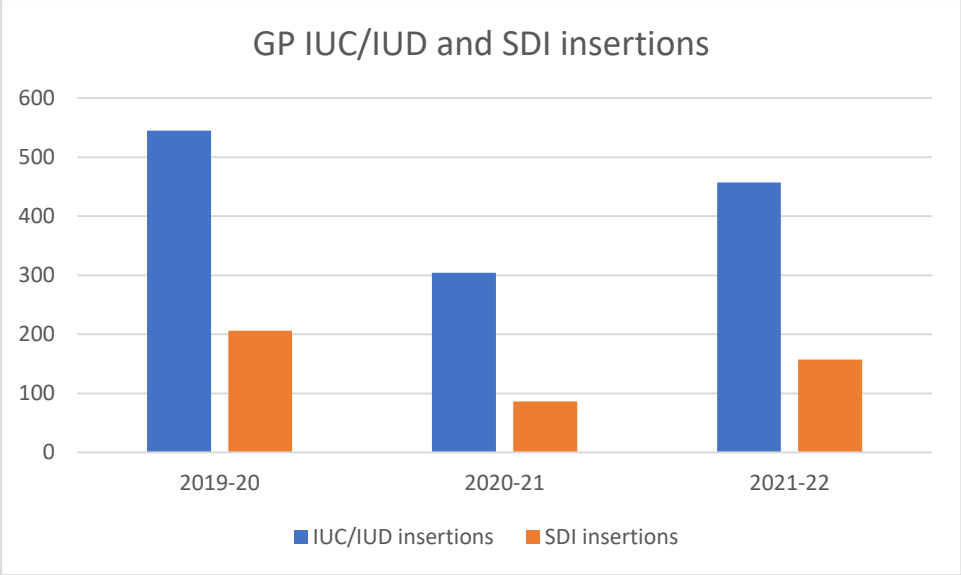


Figure 71: number of insertion of IUC/IUD and SDI in GP

6.6.9 In Quarter 3, 2022, 28% of contraception consultations carried out by Sexual Health London were for emergency hormonal contraception, while 72% of consultations were for routine contraception (such as pills, patches, rings). At the time of writing SHL data for contraception is too small to allow meaningful breakdown by demographics or allows use of absolute numbers for this sensitive data.

6.6.10 Emergency hormonal contraception (EHC) delivered through CNWL clinics decreased during the pandemic and currently remains below pre-pandemic levels.

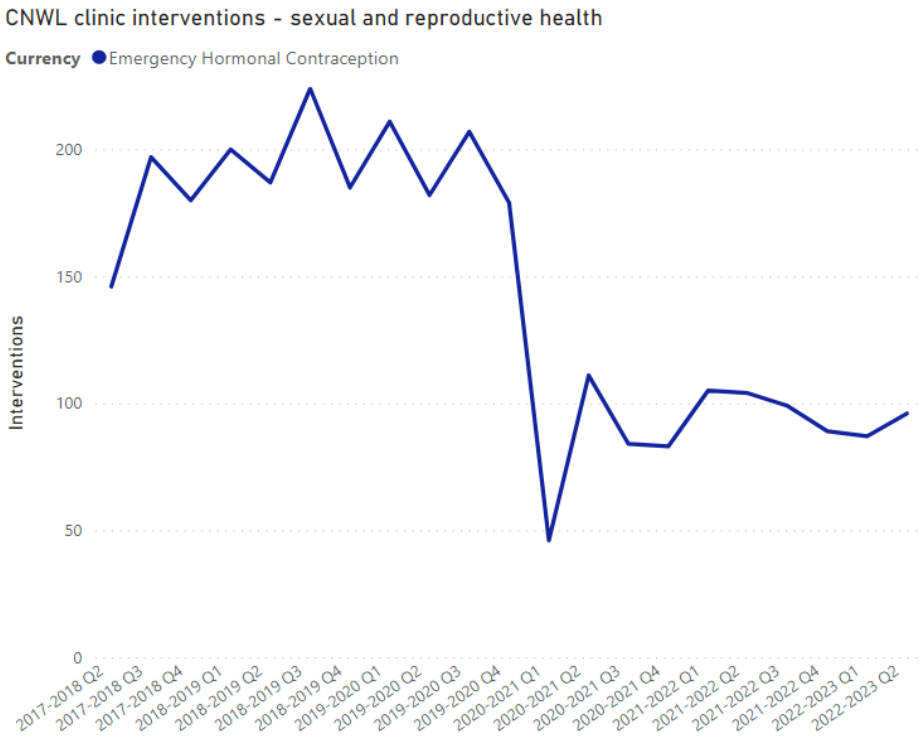


Figure 72: number of EHC interventions for Barnet residents in CNWL clinics

6.6.11 CNWL's commissioned pharmacy EHC service commenced in August 2020. 15 pharmacies have signed up to deliver the service; activity varied between pharmacies with some activities having no activity at all since August 2020, 8 of the providers have seen no patients for EHC within this commissioned contract. EHC is also available from community pharmacies through private sale however the data for this is not available but is an important caveat to the presented data.

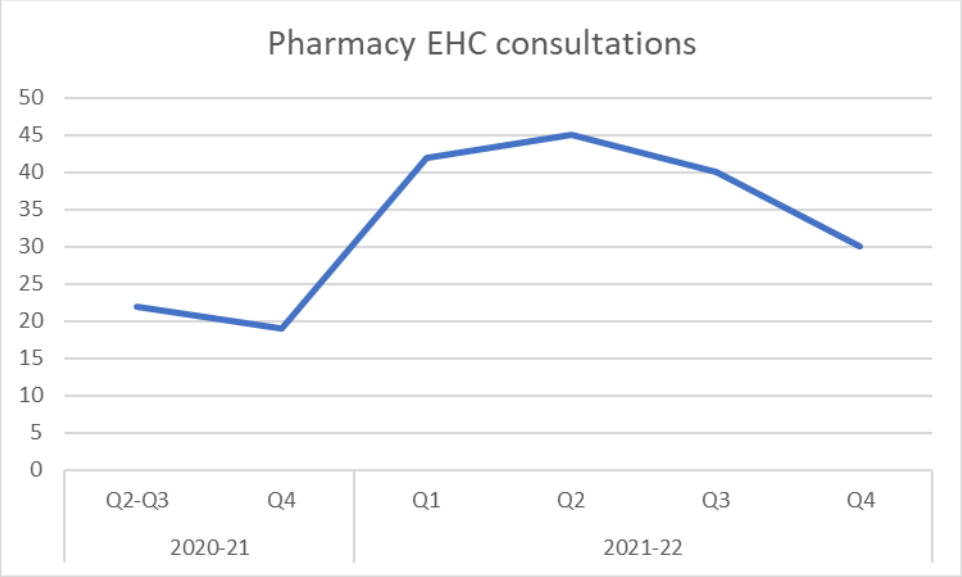


Figure 73: Number of consultations in pharmacy for commissioned EHC

6.6.12 The majority of encounters for commissioned EHC (from pharmacy and clinic) were with those aged 20-24 years old (30.9%) and 15–19-year-olds (27.3%).

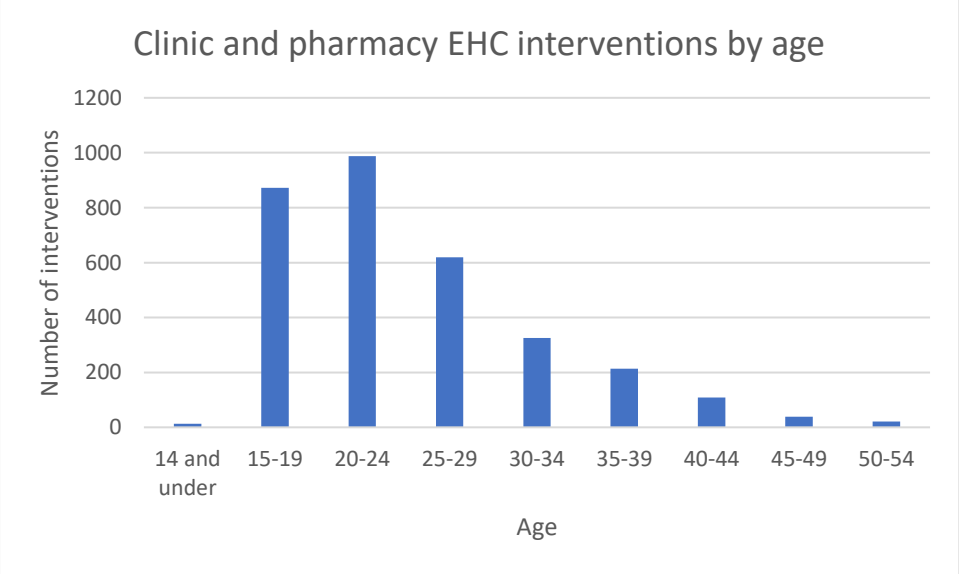


Figure 74: Number of commissioned EHC interventions in-clinic and pharmacy by age

EHC is now available to Barnet residents through commissioned pharmacies, at sexual health clinics, through GP and through SHL. In 2021-22, there were 157 pharmacy EHC consultations and 397 clinic appointments. EHC from SHL is a relatively new service so there is limited data here to make a comparison.

6.7 Teenage conception

6.7.1 Teenage pregnancy is linked to poor health and social outcomes for both mother and child. Teenage mothers are less likely to finish their education and infant mortality rates are 60% higher for babies of teenage mothers. Child and mother and more likely to live in poverty which have repercussive effects on mental health and children are more likely to have accidents and behavioural problems.

6.7.2 Initiatives to decrease teenage conception have been effective with the under-18 conception rate in England and Wales decreasing by 63% between 1993 and 2019. This was achieved through a whole-system approach in addition to effective contraception. Ongoing work however is needed as teenage pregnancy rates in England remain higher than in European counterparts.

6.7.3 The under-18 conception rate in Barnet in the reporting year 2020 was 9.8 per 1000, lower than the England and London average. 75% of under-18 conceptions led to abortion and there were 8 babies born to mother under-18. [24]There has been no significant change in the rate or percentage of under-18 conception, abortion or birth in the last 5 years.

6.8 Termination of Pregnancy

6.8.1 ONS data shows that in 2021 there were 1441 (95% CI 1368 – 1517) terminations of pregnancy for Barnet residents. The greatest number of abortions were amongst the 35+ year old age group and the 25-29 years old group. The highest rate was amongst the 20–24-year-olds at a crude rate of 33.4 per 1,000. The rate of terminations per 1,000 women in the population was lower across all age groups in Barnet as compared to the London region as a whole.[2]

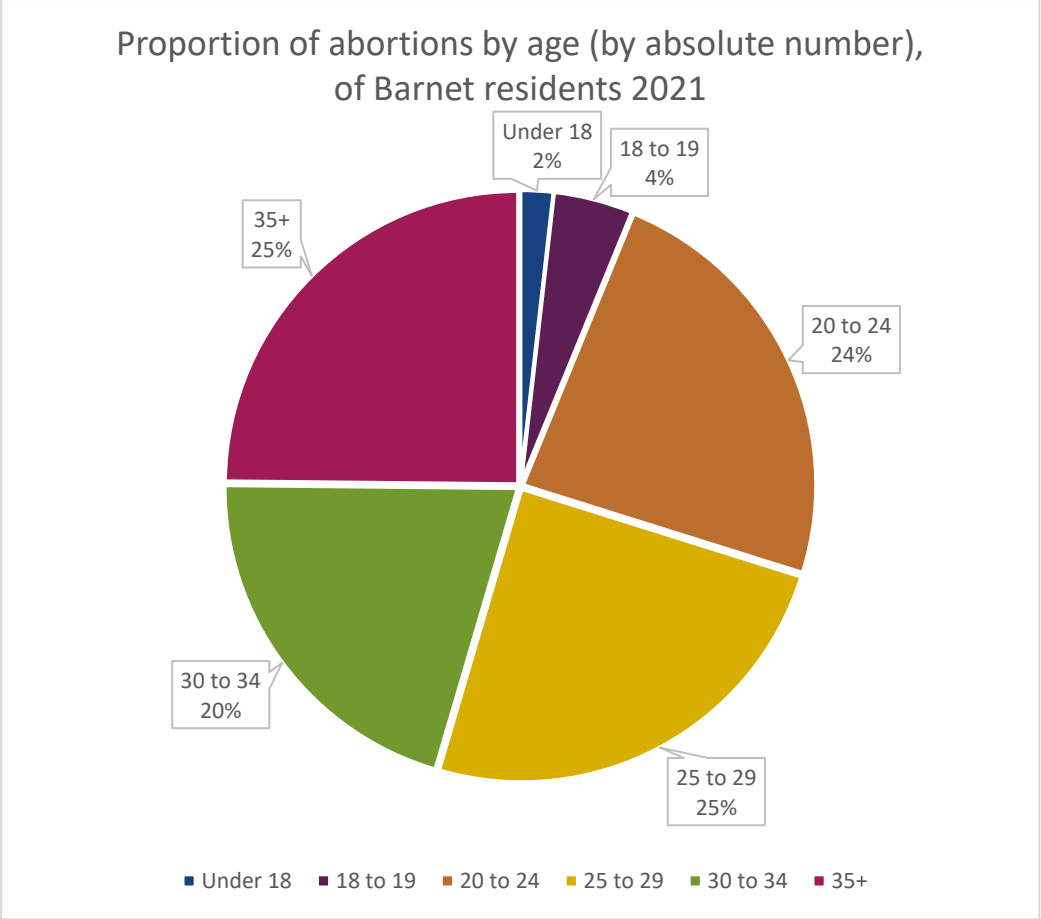


Figure 75: Proportion of terminations of pregnancy by age

6.8.2 In the 2021 reporting period in Barnet, 41.1% of abortions were repeat abortions this compares to 43.4% regionally across London and 42.6% across England. 35.6% of abortions for those under 25 were repeat abortions in Barnet, this compares to 33.3% regionally and 29.7% nationally. Repeat abortions are higher in the over 25-year-old group accounting for 43.4% locally. [2]

6.8.3 In the 2021 reporting period, in Barnet, 88.1% of terminations were at 3 to 9 weeks, 5.0% at 10 to 12 and 6.9% were at 13+ weeks. It is of note when reviewing these figures that standard obstetric care includes the 12-week scan focussed on dating which can also include checking for spina bifida, Down's syndrome and other developmental findings which may be completed alongside a blood test and a further 20-week anomaly scan. These percentages

are very close to national findings with a trend in time nationally shown in the chart below.[2]

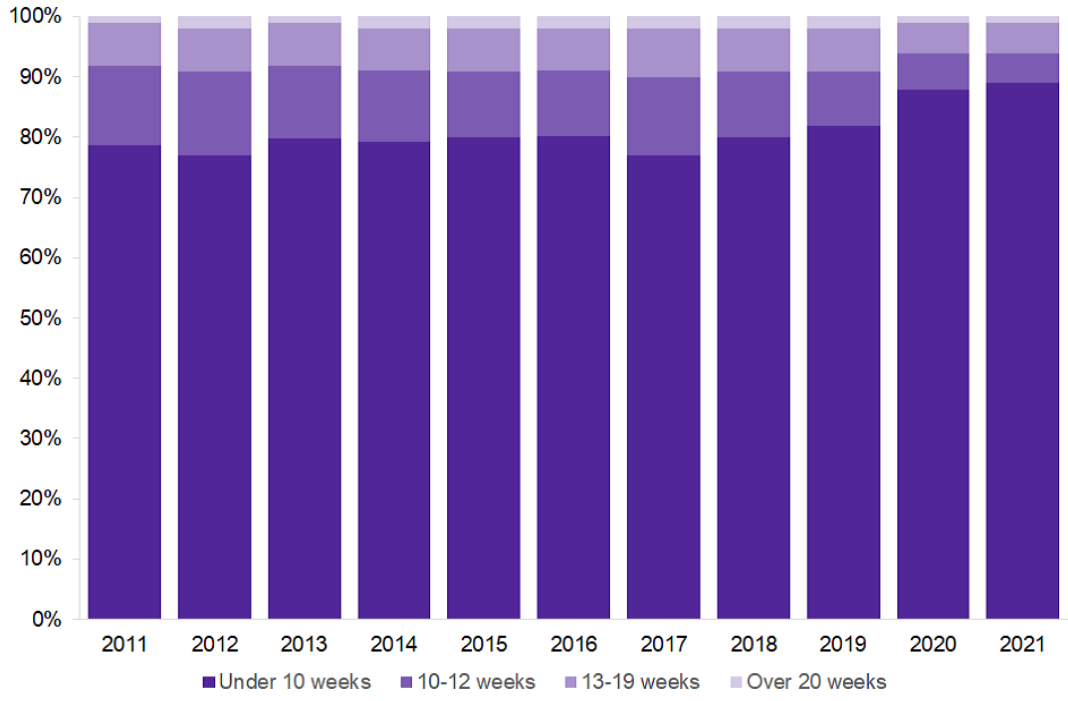


Figure 76: Percentage of abortions by gestation, England and Wales, 2011 to 2021

6.8.4 For Barnet residents, the majority of terminations (89.5%) were completed in the private sector but were NHS funded.[2]

6.8.5 There has been no statistically significant difference in the number of terminations in the last 5 years. [2]

6.9 Sexual abuse

6.9.1 Sexual abuse can be physical but also include manipulative, deceitful or coercive behaviour to make victims do things against their wish. Sexual abuse may also occur as part of wider domestic abuse. [48]

In the year ending March 2022, 5.9% of adults aged 16 to 59 years experienced domestic abuse.[49] Disabled people were more than twice as likely to have been victims of domestic abuse, stalking or rape than people without a disability. Gay, lesbian and bisexual people were more likely to be victims of domestic abuse than heterosexual people. Trans and non-binary people were less likely to access support for domestic abuse.[50] The number of crimes reported however is not a reliable indicator of total underlying need and demonstrates expressed need only.

6.9.2 Across the reporting period January 2018 to September 2022 239 Barnet residents were seen in CNWL ISH services for sexual abuse. Of these appointments 38% were acute being seen within 7 days of the abuse, with the remaining patients categorised as been seen later than 7 days. 87% of those seen for sexual abuse were women. 46% of these Barnet residents chose to be seen in Edgware Community Hospital or Vale Drive Primary Care Centre.

6.9.3 To support the commitment to tackling domestic abuse and violence against women and girls, Barnet council has commissioned 4 specialist domestic abuse services namely the

Advocacy and Support Service, 2 women's refuges, the perpetrator programme and the Identification and Referral to Improve Safety (IRIS) programme.[50]

One of the specialist services is the Identification and Referral to Improve Safety (IRIS), which is based in general practice and provides training, support and a referral programme for primary care staff for patients experiencing domestic abuse. The aim is to provide support at an early stage.[50]

6.9.4 Sexual abuse and bullying is also a concern for our children and young people. 88% of girls and 83% of boys experience sexual bullying. Almost a third of girls experience unwanted sexual touching in UK schools. Over half of LGBTQ young people have experienced homophobic bullying at school and 40% of pupils who have experienced homophobic bullying have skipped school because of it.[51]

RSE as part of the PSHE curriculum, has an important role in informing and empowering young people to contribute to positive sexual health outcomes and to build healthy relationships. Research has demonstrated that RSE can support addressing the root causes and cultures of sexual and gender-based violence.[52]

To support early intervention, and importantly prevention, the Department of Education has introduced a Relationships, Sex and Health education curriculum. They have also updated the Keeping Children Safe in Education statutory guidance to ensure staff in schools and colleges know how to deal with reports of sexual violence and harassment both in and outside of school. [50]

In Barnet there is multi-service approach to support prevention, recognising the multifaceted and layered nature sexual violence and abuse can take. Schools and youth groups are at the central to taking a whole systems approach to sexual violence and abuse within their setting. They are supported through a range of services offered through:

- Brook, who provide 1:1 support for young people who need additional help and workforce training and RSE support for secondary schools. This includes extensive training for staff and sessions in schools addressing sexual violence and healthy relationships as part of the London Sexual Violence Education and Training Programme.
- BELS who provide a child-on-child abuse audit tool to guide schools in managing this type of abuse.
- HEP who supports PSHE leads in developing effective PSHE, including RSE delivery and are updating a Healthy Schools London template that will also support schools achieve a whole settings approach.
- The Resilient Schools Programme through Generation Verified – as part of work to increase awareness and support managing online abuse.
- In Barnet, the Barnet Prevent Education Officer provides online safety sessions for parents/ guardians and children. This helps to protect young people against tech-enabled abuse such as grooming. [50]
- A range of VCS organisations are also able to provide support such as through the Young Barnet Foundation and Barnet Together.

6.9.5 As presented in the Barnet VAWG strategy and detailed in interviews with professionals working with the Barnet Council VAWG team, feedback from victims of sexual abuse is that they feel mental health services are not sufficiently tailored to their needs and as with other

groups there are long wait times to access services. In response, the new post of Domestic Abuse and Sexual Safety Co-ordinator was created within Barnet, Enfield and Haringey Mental Health NHS Trust.

Patients seen in-clinic in Barnet are routinely asked screening questions about domestic and sexual abuse. Those who have been victims can be referred, with consent, to the Independent Domestic and Sexual Violence Advisor (IDSVA) from Solace. The service provides support to people regardless of their gender and whether the abuse is current, recent or historic. The service provides support for victims regardless of the character of the abuse and includes abuse that may not meet the eligibility criteria of some other services such as date rape and abuse from friends.

The support is holistic and individualised to each patient. It can involve emotional and mental health support with signposting to other services such as counselling services and buddy support. It can also include support around social elements such as housing.

6.9.6 CNWL sexual health services also has a Safeguarding Team with a dedicated Safeguarding Lead for Barnet services who work closely with safeguarding agencies and the IDSVA.

In Quarter 2, 2022 53 safeguarding referrals were made for Barnet residents from CNWL clinics. Across the CNWL safeguarding service the greatest proportion of referrals were for domestic abuse (40%), referrals for female genital mutilation accounted for 20% of referrals.

The CNWL safeguarding team also provide a single point of contact on-call safeguarding advice line. Between July and August there was an average of 35 referrals per month.

6.9.7 Sexual Health London (SHL) provide online sexual health services to Barnet residents, and many other London boroughs. As part of its service, it includes domestic abuse screening questions to help identify patients who need further support. The support includes online support, telephone calls and onward referral as appropriate. 1.7% of users were identified by the domestic abuse and/or violence questions, with 66% being female. 26% of those triggering the questions had never visited a clinic and 80% accepted a discussion around domestic abuse and further support. [53]

6.10 Female Genital Mutilation (FGM)

6.10.1 As defined by the World Health Organisation:

"Female genital mutilation (FGM) involves the partial or total removal of external female genitalia or other injury to the female genital organs for non-medical reasons. The practice has no health benefits for girls and women. FGM can cause severe bleeding and problems urinating, and later cysts, infections, as well as complications in childbirth and increased risk of newborn deaths."[54]

6.10.2 FGM is illegal in the UK and in England civil and criminal legislation on FGM is contained in the Female Genital Mutilation Act 2003.[55]

6.10.3 It is difficult to know the prevalence and incidence of FGM and so estimation is needed. NHS Digital produces the Female Genital Mutilation Enhanced Dataset. This dataset is compiled from data within the NHS system including acute trusts, mental health trusts and GP practices.[56]

In the recording period April 2021 to March 2022 105 individuals in Barnet were seen in reporting NHS organisations who had FGM. Forty of these were newly recorded within the FGM dataset. Newly recorded does not indicate when the FGM occurred but that this is the first recording within the dataset for the individual.[56] Of the 105 recorded as attendees with FGM at least 5 were born in the UK.[56]

The majority of attendances within the reporting period where FGM was identified were within the midwifery service, accounting for 72% of attendances.[56]

The number of individual women and girls attending NHS services in Barnet with previously recorded FGM between 2017/18 and 2021/22 was between 85 and 105 per year and over the same period the number of newly recorded FGM cases have varied between 40 and 65.

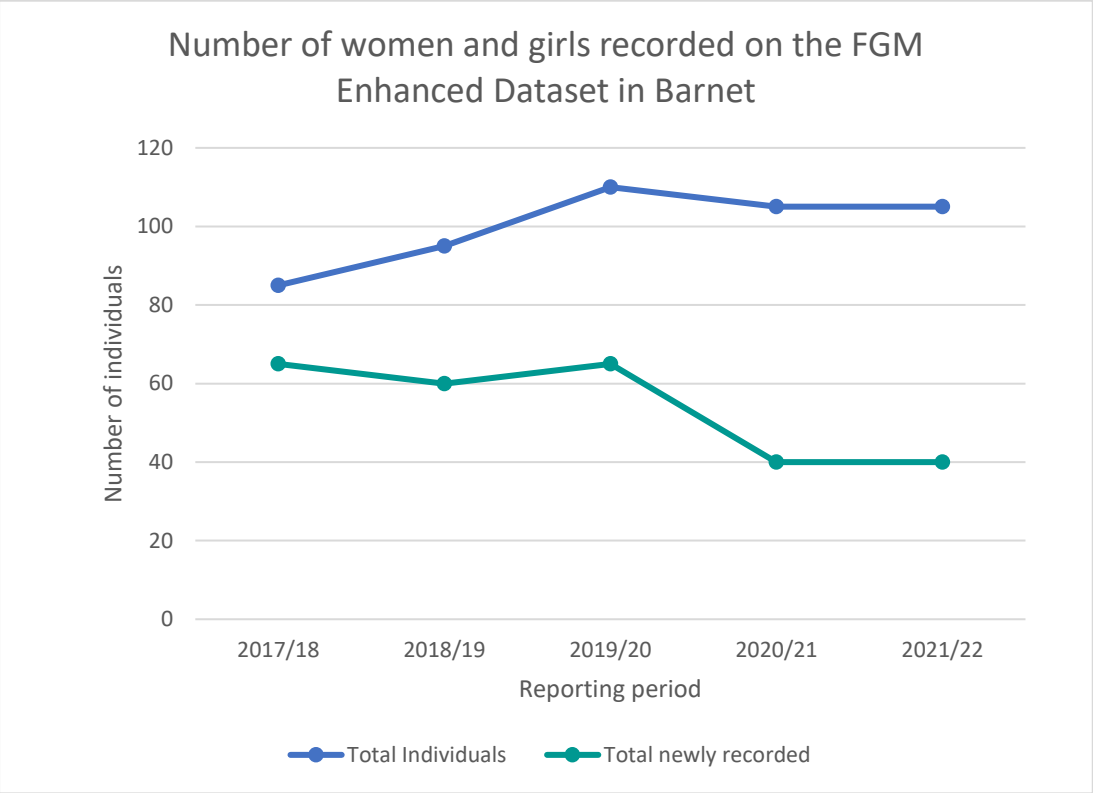


Figure 77: Number of women and girls recorded on the FGM Enhanced Data set in Barnet. [57]

6.10.4 Support for women and girls who have been victims of FGM are multifaceted and include local third sector support, National FGM Support Clinics of which 5 are available across London as well as individualised support in other health settings.[55] In Barnet, it is currently unclear how many women and girls are receiving support from third sector support and so the level of need remains unclear and if third sector organisations are struggling to meet this need or if expressed need from victims is low due to lack of knowledge of services or reticence to come forward.

In-clinic sexual health services in Barnet, routinely ask patients screening question for FGM. Where FGM is identified a Datix report is completed and local safeguarding policies are followed which includes informing their GP, referring the patient to the FGM clinic and risk to other children and siblings are also assessed.

Additional support needs for women who have been victims of FGM include support in maternity services and mental health. Discussions with professionals in Barnet VAWG team revealed that those who have been victims of FGM feel that mental health services offerings are not tailored enough to their needs and as with many other groups also have long waiting times to access services.

7 Needs arising in the population

7.1 MSM

7.1.1 Gay, bisexual and other men who have sex with men experience a higher burden of STIs and HIV. [8] The PHE action plan 2015-2016: 'Promoting the health and wellbeing of gay bisexual and other men who have sex with men', includes in its action to improve sexual health. Including improving the management of HIV and STIs from surveillance and testing to treatment. It also discusses the opportunities around PrEP and HPV vaccination. [58]

7.1.2 Data collection around MSM can be complex with some systems coding only heterosexual, gay or bisexual male which may not always be identities that MSM identify with. Further, understanding rates and the burden of disease has been difficult as previously there has been only estimations to the size of this group. The 2021 census has for the first-time recorded sexuality. It found that in Barnet, of those who put a sexuality, 1.2% of Barnet residents described themselves as gay or lesbian, 1.1% of Barnet residents described themselves as bisexual and 0.4% of Barnet residents described themselves as pansexual. A small percentage of resident described themselves by other orientations. (A breakdown of the above by sex has not been released by the ONS at the time of the report.)

7.1.3 STIs and HIV are known to disproportionately effect gay, bisexual and other MSM. GUMCAD data for Barnet demonstrates that gay men represented 20% and 50% of positive tests for chlamydia and gonorrhoea respectively. Gay and bisexual men accounted for 67% and 12% respectively of syphilis cases.

7.1.4 In response to this, specific health promotion programmes and preventative care are in place.

Gay, bisexual and other MSM are able to receive the HPV vaccination up to the age of 45. Although there is some uptake in the borough, as there is no register and no clear denominator it is hard to determine the success of uptake. HPV vaccinations can be accessed in sexual health services for these patients. MSM are also able to access Hepatitis B vaccinations.

HIV testing coverage and repeat testing coverage in gay, bisexual and MSM are specifically recorded within the sexual and reproductive health profile. Like the trend seen in STI testing in Barnet there has been a fall in the number of HIV tests completed. PrEP and PEP care are available in borough and there is also targeted health promotion through Brook through the HIV specialist work.

Services and tests provided are tailored to the individual both in clinic and online.

7.2 Young people

7.2.1 Young people typically refers to those aged up to 25 years old and the Faculty for Sexual and Reproductive Health (FSRH) also calls for ensuring adequate and appropriate services for

those aged under-16 years old.[59] Areas of sexual health effecting young people include STIs, contraception, stigma and relationship and sex education (RSE

7.2.2 Young people suffer from STIs at a higher rate than any other age group. Young people are at a higher risk as they typically have more sexual partners and are less likely to use protection. They are also at an increased risk of re-infection.[60] Steps taken towards this include health education programmes and support such as the c-card scheme (condom distribution).

7.2.3 OHID's sexual and reproductive health profile indicators relating to young people include:

- Chlamydia detection rate per 100,000 aged 15 to 24
- Chlamydia proportion aged 15 to 24 screened
- Under 18s conception rate/ 1,000
- Under 18s conceptions leading to abortion
- Under 18s birth rate/ 1,000
- Under 25s choose LARC excluding injections at SRH services (%)
- Under 25s individuals attend specialist contraceptive services rate/ 1,000.

The sexual and reproductive health profiles also include wider determinants relating to under 18s admission relating to alcohol, number of under 16s living in low-income families, school attainment and attendance.

Chlamydia screening proportion and detection rate in Barnet has fallen and is below the national average. Under-18 conception rate and birth rate remains below the national and regional average. There is an increasing trend for under 25s to choose LARC.

7.2.4 Young people are able to attend any clinic and those under-18 are able to attend as a walk-in. There is also a weekly specialist walk-in clinic for those under 17 at Edgware Community Hospital. Services are all accessible via public transport and there are services outside of school hours, twice a week at Edgware Community Hospital and once a week at Vale Drive Primary Care Centre.

Young people have the greatest use of ISH services, with 20–24-year-olds accounting for 22.2% of interventions, young women are more likely to receive care than young men. There was a decrease in the number of interventions in the pandemic, which has not returned yet to pre-pandemic levels. The fall in in-clinic interventions was accompanied by an increase in online e-services.

7.2.5 SHL e-services are available to those over the age of 16 and includes contraceptive care and STI self-sampling testing. As with all age groups there was a significant increase in the number of STI test kits ordered online during the pandemic. In 2019-20 online test kits accounted for 58.2% of test kits of those aged 20-24 and 44.0% for those aged 15-19; comparatively in 2020-21 online test-kits accounted for 84.8% of STI tests for 20–24-year-olds and 72.7% for 15- 19-year-olds.

7.2.6 Young people are able to get free EHC in-clinic as well as from 15 commissioned pharmacies across Barnet. EHC up-take from community pharmacies has been limited.

7.2.7 HPV vaccination are part of the school immunisation programme and as a result of the pandemic and resultant school closures large numbers of students missed either a first or

second dose. A catch-up programme is in place to bring students up to date with their vaccinations. A similar picture is seen across London.

7.2.8 Health promotion, education and preventative care is a cornerstone of sexual health, especially for young people.

RSE remains a statutory requirement for schools to deliver to their students. Schools in the borough can get support in RSE delivery from Brook and Health Education Partnership (HEP) who are commissioned by the local authority public health team. Brook is able to support in delivering a limited commissioned number of sessions and assemblies as well as a more holistic 1:1 programme for referred students; and both Brook and HEP support school faculties to build their resource bank and skills set to deliver the RSE curriculum.

Brook also works with young people in the community such as through community sessions, developing peer health champions and through the delivery of the c-card scheme.

There are a diverse range of treatment, preventative and health promotion services especially designed for young people across Barnet. Take-up of some services, such as the c-card scheme and commissioned EHC by young people is low, reflecting London regional trends and the impact of the COVID-19 pandemic and so work is needed to promote and increase awareness of these services. Similarly, there is opportunity to build and strengthen current work with teachers and teaching staff to support them in their delivery of the RSE curriculum both in mainstream schools and specialist schools where engagement to date with council commissioned services have been lower.

7.3 People with learning disabilities

7.3.1 Sexual health is often an area that is ignored or over overlooked for individuals with disabilities.[61] Knowledge of and an opportunity for a healthy relationships and sexual health is a human right and so it is important that our services enable this.[62]

Being in a loving relationship is an enriching experience, however only 3% of people with a learning disability lives as a couple as compared to 70% of the general population.[63] People with learning disabilities are also at increased risk of sexual assault and abuse both as adults and as children.[61] These increased risks as well as disparity in outcomes highlights the needs for specialist and enhanced services and provisions.

7.3.2 Discussions with a professional from the CNWL sexual health learning disability services in Barnet (The Bridge) highlighted the unique needs of those with learning disabilities in relation to sexual health. These centred around: access, structure of appointments and additional health promotion and educational needs centring around RSE.

Patients with learning disabilities benefit from additional support around access. The Bridge service at CNWL' is a service for those with learning disabilities addresses these needs by:

- Increasing flexibility around booking appointments, by providing a separate mobile number for patients with a learning disability which can be called at any time
- Providing the option to contact the service by text or WhatsApp via the mobile
- Providing walk-in appointments to all patients with learning disabilities.

Individuals are therefore able to access services in a way that is familiar and convenient to them.

Access to online services may also be more difficult for some members of this group due to the complexity and number of questions needed to be asked in the process. Further, use of kit may be difficult for some groups, particularly steps including the fingerpick test. This may be a barrier for both those with a learning and physical disability. This further highlights the benefits of a face-to-face dedicated clinic for those with a learning disability as provided by The Bridge.

7.3.3 The needs of children with learning disabilities in their RSE sessions were further highlighted during conversations with the specialist nurse from The Bridge. It was expressed that students may benefit from additional support around RSE, especially when attending a mainstream school. There is opportunity for further collaboration between existing services who would also like to work with schools and colleges, including specialist schools to enhance the current offer to these young people.

Barnet Public Health are working closely with Brook who are developing resources nationally for neurodiverse young people; as well as collaborating within the council with the BELS specialist autistic and neurodiversity team to create resources for young people.

7.4 Ethnicity

7.4.1 There are ethnic inequalities in the distribution in STIs across different ethnic groups. Since the mid-1990s the burden of STIs has been higher in black African and Caribbean men and women, even when adjusted for other factors such as area-level deprivation, marital status and individual-level sexual behaviours. Findings from Natsal-3 found that other factors such as socioeconomic status, substance use, depressive symptoms and sexual behaviours only partially explained inequalities in the attendance to sexual health clinics, diagnosis of STIs, and EHC use among some ethnic groups relative to white British ethnicity but did not eliminate differences between these ethnic groups.[64]

7.4.2 The ethnic breakdown of Barnet comes from the most recent 2021 census and are presented in more detail in section 5.2. Data relating to sexual health service use and ethnicity is difficult to interpret because ethnicity is a field that is commonly left unfilled or unreported in data returns.

In the reporting period 2021-22, 37.2% of in-clinic ISH appointments had no reported patient ethnicity, 35.9% were recorded as White or White British, 9.7% were recorded as Black, African, Caribbean or Black British, 7.4% were described as mixed or multiple ethnics groups and 7.2% were Asian or Asian British, this compares to 58%, 8%, 5% and 19% respectively within the Barnet population. The White or White British and Asian or Asian British ethnic groups are underrepresented in their use of appointments. These proportions however are not standardised by age.

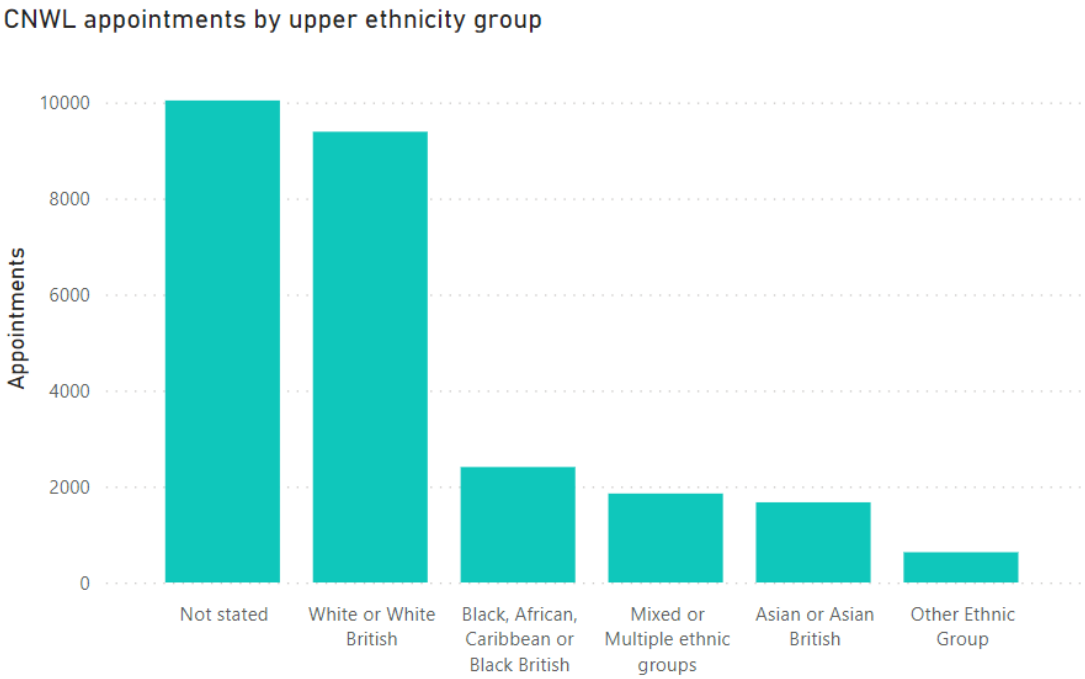


Figure 78: Number of CNWL appointments by upper ethnicity

7.4.3 Ethnicity data is relatively complete for online STI testing though SHL, with response by over 99% of patients. 60.4% were recorded as White or White British, 15.9% were recorded as Black, African, Caribbean or Black British, 10.2% were described as mixed or multiple ethnics groups and 7.7% were Asian or Asian British, this compares to 58%, 8%, 11% and 19% respectively within the Barnet population.

Exploring ethnicity data from online testing given its completeness, the White or White British ethnicity were over-represented for both gonorrhoea and syphilis positive tests. The Black/Black British and Mixed or multiple ethnic groups were over-represented for chlamydia and gonorrhoea positive tests. The Asian or Asian British ethnic group were under-represented in positive tests for STIs however they were also under-represented in the number of online tests they completed.

Looking at use of online testing, Black/Black British ethnic groups were over-represented accounting for 19% of reactive tests compared to representing 8% of the population. The White ethnic groups represented 60% of the reactive tests and 58% of the Barnet population.

7.4.4 Black African populations were the ethnic group experience the greatest prevalence of a late diagnosis of HIV.[37]

7.5 Deprivation

7.5.1 Deprivation within this report is categorised using IMD which is explored in more detail in the Chapter 5.

7.5.2 In relation to STIs it is seen nationally that rates tend to be higher in the most deprived areas and lowest in the least deprived area, regardless of the STI.[65] The same trend is seen in the rate of new STI diagnoses in Barnet.[66]

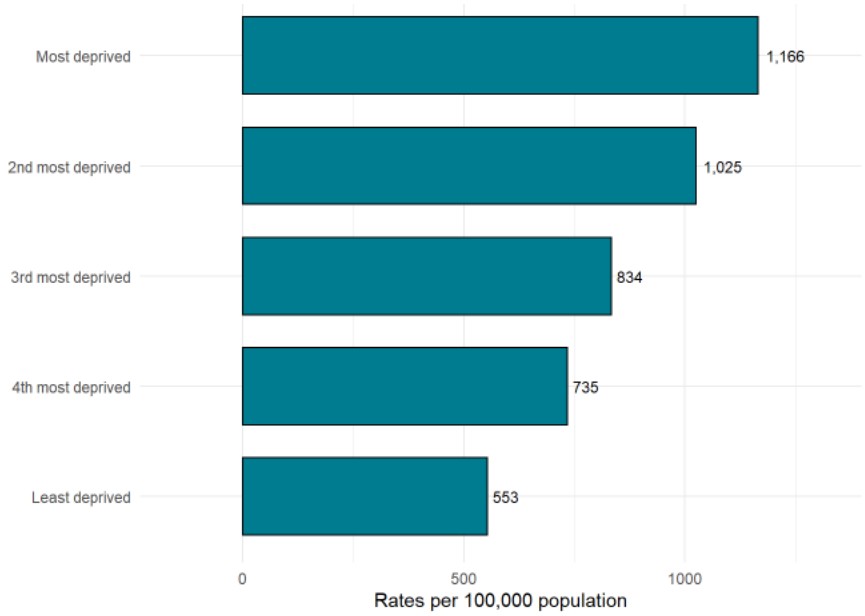


Figure 79: Rates per 100, 000 population of new STIs by deprivation category in Barnet (SHS diagnoses only): 2020[66]

7.5.3 Nationally, there is an association between deprivation and under-18 conception with the most deprived areas having the highest rate of under-18 conception.[65] Under-18 conception is low in the borough at 6.3 per 1,000 in the reporting period 2020, the absolute number is too low to make further inference in relation to IMD.[24]

7.5.4 When exploring use of in-clinic services and interventions overall by IMD we can see there is no statistical association between IMD and number of in-clinic interventions.

7.6 Asylum seekers and refugees

7.6.1 The asylum seeker and refugee health service pilot is commissioned by NCL CCG and provides services across North Central London. The service is run by 3 clinical nurse specialists and runs from a range of locations, in Barnet this has included GP practices and asylum seeker contingency hotels. The asylum seeker and refugee service provides a holistic offering. The service provides a one appointment style service where patients are seen and reviewed in relation to their physical health, including sexual health and their mental health. At these appointments patients also have investigations including tests for BBV and STI testing. Where there are positive test results appropriate referrals are made. From the appointment an integrated migrant healthcare plan is created.

To maximise accessibility of services they are located close to or in contingency hotels. Appointments are at least 45 minutes in length and Language Line, an interpreting provider, is available for translation. The service is also able to signpost to relevant partners such as family support workers, health visitors, IAPT and third sector organisations to provide a holistic service, addressing the wider determinants of health.

7.6.2 Discussion with a healthcare professional working with asylum seekers and refugees from RESPOND revealed that barriers to good sexual health and use of services included: a language barrier, literacy in English and in their first language; health literacy and previous RSE exposure and cultural attitudes and stigma surrounding sexual health.

The majority of information is provided in English making it difficult to access for many asylum seekers and refugees. Even where translated information is available, disruption to or lack of access to education for many may mean that they don't have the literacy levels, in their first language, to read this information independently.

Asylum seekers and refugees come from a diverse range of backgrounds and cultures, and some may not have had school lessons about relationships and sexual health or previously discussed the topic with a healthcare professional. There may also be shame or stigma associated with the topic. This can make it difficult for some patients to express their needs in relation to sexual health.

Other barriers which effect health more generally also include a lack of knowledge about the NHS and how care and different types of care are accessed and concerns about how accessing care may affect their claim for asylum.

7.6.3 Common requests for support relating to sexual health includes condoms and contraception. The asylum seeker and refugee pilot has strong ties across the local healthcare system to ensure appropriate treatment if needed. For example, for those wishing to have LARC or requiring other services at the sexual health centre, they are able to directly support in booking an appointment to help patients overcome language and access barriers, with direct access to the Barnet nurse co-ordinator at the clinics to simplify the process.

7.6.4 Refugees and asylum seekers can be supported to access services through the co-location of multiple services to improve ease of access and tailored support where needed, to attend healthcare appointments.

7.7 People experiencing homelessness

7.7.1 Interviews with professionals working with homeless populations in Barnet revealed barriers to healthcare services for this population as well as successful interventions or ways of working that enables access.

7.7.2 In relation to sexual health services, barriers were those in common with healthcare services in general. The location of sexual services presented a barrier to the homeless population due to access. The clinics are inaccessible to many people experiencing homelessness dependent on where in the borough they are due to the amount of time it would take to walk there. The location of the clinics near tube or bus stops does not always confer accessibility for this population.

The ability for those experiencing homelessness to communicate with services highlights the digital divide. Whilst digital services reduce inequality and improves access for some groups it can also exacerbate existing inequalities in access for others. Conversations with professionals working with the homeless population revealed that some of those experiencing homelessness do not have access to the internet to make use of online services or book face-to-face appointments. Others may not have a phone, or otherwise inadequate credit on their phones to make calls. Further, this group may not have a safe, appropriate and private place in which to have a remote appointment.

The need to book an appointment in advance, especially as a growing theme across healthcare services following the pandemic, provides an additional challenge to access as this population may struggle to make timed appointments. Walk-in appointments therefore provided greater opportunity and access to services.

Further there is thought to be a lack of knowledge around services, including online services and the option to have self-test kits posted to the Homeless Action Barnet PO box.

As with other groups stigma and embarrassment are barriers to accessing service and expressing needs.

7.7.3 Professionals from Homeless Action Barnet (HAB) in partnership with Change, Grow, Live (CGL) already demonstrate successful ways of working with the homeless population in relation to health. A common theme is the importance of meeting people experiencing homelessness where they are and combining opportunities for health in the same spaces where other needs are being met. At the HAB day centre there is an existing clinic room. In this space CGL commissions a GP, nurse and keyworker who work within a clinical space in the HAB day centre once a week and are able to provide services relation to general health and testing for blood-borne viruses including Hepatitis C, Hepatitis B and HIV. There is no current facility for smears or LARC.

Further, successful health fairs have been run at the day centre that combined a range of health services from vaccination to healthy hearts and there is an opportunity for sexual health services to join this. The day centre can also support the population to better understand what services are available to them and written information around sexual health services can be distributed there, though these need to be in a range of languages to maximise access. CGL also note an opportunity to share information about sexual health services with their clients.

7.7.4 One-to-one interviews were conducted with 5 clients of Homeless Action in Barnet, with a focus on access to sexual health services.

Interviewees described a range of barriers to access including being able to attend the two current ISH clinics in Edgware Community Hospital and Vale Drive Primary Care Centre due to the cost of transport to get there. English language was also a barrier for those speaking English as a second language when looking up information online or trying to book appointments online. Interviewees viewed the HAB day centre as a safe and reliable place for support and information relating to their sexual health. Further analysis of the interviews can be found in Appendix 1.

8 Sexual Health Services in London Borough of Barnet

8.1 Integrated sexual and reproductive health in-clinic services

8.1.1 The London Borough of Barnet co-commissions an integrated sexual health service across North Central London with Camden, Islington and Haringey. Services are provided across a range of sites with three level 3 (specialist) clinics (one in Barnet, one in Islington and one in Camden) providing additional specialist services in order to provide a comprehensive service across the network. Services are commissioned through Central and North-West London NHS Foundation Trust who, within Barnet, provide clinics at:

- Edgware Community Hospital (Level 3 Clinic)
- Vale Drive Primary Care Centre
- Graham Park Health Centre (currently closed in agreement with commissioners)

Across the network Barnet residents have provision of the following services:

Core offer and services at non-specialist clinics:

- Information and advice
- Offer and supply of condoms and lubricant
- Act as a registration site for c-card scheme
- Risk assessment and onward referral as appropriate
- Routine and emergency contraception and reproductive health services
- Diagnoses and treatment of simple genital dermatoses
- Screening, testing, results notification, diagnosis and treatment for STIs and HIV
- Testing for viral hepatitis B and C for high-risk groups
- Partner notification
- Promotion and delivery of vaccination
- Referral to other services as appropriate
- Promotion of self-managed care where appropriate such as through registration with the c-card scheme.

Specialist sexual and reproductive health services:

- Complex contraceptive care
- Complex care of patients with sexually transmitted infections
- Provision of PEP
- Provision of PrEP
- Psychosexual dysfunction.

The service is commissioned to work collaboratively with the online service provided through Sexual Health London (SHL), with active signposting of appropriate asymptomatic patients. Barnet joins the majority of other London boroughs in providing e-services through this provider giving parity of access and clear routes to online sexual health services.

8.2 Psychosexual services

Barnet residents can access psychosexual services as part of CNWL's collaboratively commissioned specialist services. Clinics are in Camden (at the Mortimer Market Centre) and Islington (at the Archway Centre). This is a specialist service requiring referral following a general sexual health appointment. Patients cannot self-refer to these services.

The service provides psychosexual therapy for a range of sexual issues including:

- Sexual difficulties related to having a sexually transmitted infection (STI), for example, sexual difficulties related to HSV or HPV.
- Sexual difficulties related to an increased risk of contracting an STI, for example, erectile difficulties that are preventing condom use with sexual partners.
- Psychosexual aspects of dyspareunia after organic causes have been excluded or management optimised in a medical assessment within specialised sexual medicine consultant referral clinic.
- Sexual difficulties related to sexual assault, fertility concerns or gender-based violence.

8.3 Contraceptive services

8.3.1 The integrated service provides the following contraceptive services:

- Condoms and lubricant distribution in clinic

- C-card scheme registration
- Emergency contraception (including IUD and oral)
- Diaphragms
- Implants
- IUDs/IUSs
- First prescription and supply of user-dependent contraceptive methods
- LARC
- In Barnet, CNWL subcontracts primary care-based enhanced services for LARC in GP practices.
- In Barnet, CNWL subcontracts EHC for under-25s in community pharmacies.

8.3.2 Contraceptive services are also available through SHL. Products include:

- Continuation of an existing method (Pills, Patches and Rings)
- Initiating a new method (Progesterone-Only Pills; or Combined Hormonal Contraceptive, subject to medical eligibility/risk assessment)
- Providing Emergency Hormonal Contraception pills

8.3.3 Emergency hormonal contraception is available through the emergency contraceptive pill and the IUD.

Emergency contraception is available as a walk-in at Edgware Community Hospital and Vale Drive Primary Care Centre. In addition to this, CNWL has sub-contracted emergency hormonal contraception to be provided to under-25s on behalf of Barnet council by 15 community pharmacists. EHC is also available through private sale at many pharmacies across Barnet.

Oral emergency contraception is also available through SHL.

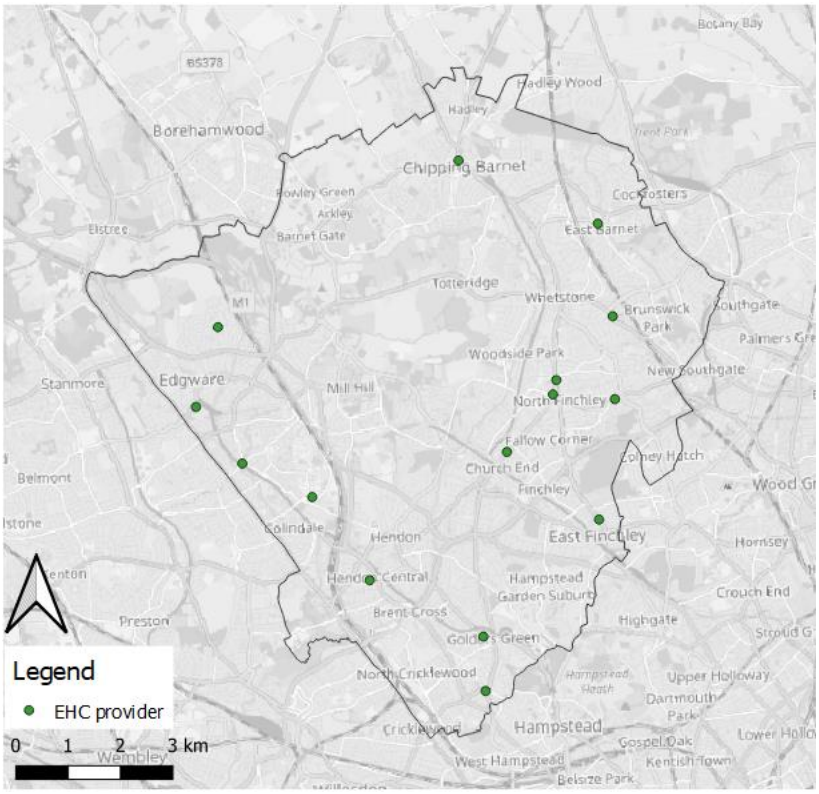


Figure 80: Map of locations where community pharmacy EHC is commissioned by CNWL.

8.4 Online Services

8.4.1. Online services are by provided by Sexual Health London. This is commissioned on behalf of London boroughs by the City of London.

8.4.2 The online services provide the opportunity to order self-sampling kits for STIs personal devices. STIs include chlamydia, gonorrhoea, syphilis and blood-borne viruses, HIV and Hepatitis B and C. The service is for asymptomatic users over the age of 16.

Alongside testing patients will have access to professional health advice and online information.

8.4.3 The SHL page is only available in the English language. SHL requires users to have a good command of English so that they are able to accurately and independently complete online questions and understand the advice given. SHL advise through their website that users should seek support in their local sexual health clinic if they feel they need language support. They do not provide interpreting services.[67]

8.4.4 CNWL clinic sites also provide on-site access to and use of SHL self-sampling kits and the ability to use the on-line service through free Wi-Fi to users and access to devices if needed. On-site facilities facilitate e-service self-sampling by acting as a pick-up point and as a space for on-site self-sampling where needed. it is commissioned to provide a drop-off point however does not currently provide this.

8.4.5 Treatment and partner notification for uncomplicated genital chlamydia can be completed through the e-service. Where there are positive results for other tests referrals will be made to a clinic who will take on clinical responsibility.

8.4.6 Access to in-clinic and GP provided contraception significantly changed during the time of the pandemic due to staff re-deployment and infection control requirements. SHL were instructed to explore how they could fill this gap in need, building on the success of online STI testing. In response the service is now able to offer:

- Continuation of an existing method (Pills, Patches, Rings and Injectables)
- Initiating a new method (Progesterone-Only Pills; or Combined Hormonal Contraceptive, subject to medical eligibility/risk assessment)
- Provision of Emergency Hormonal Contraception pills

8.5 Community Pharmacy

8.5.1 Pharmacies in Barnet are part of the Middlesex Pharmaceutical Group of LPCs. Pharmacies across the Middlesex Pharmaceutical Group contribute to maintaining good sexual health through:

- Dispensing of prescriptions relating to user-dependent contraception.
- EHC (both private sale and free-to user commissioned EHC).
- Private sale of condoms.
- C-card scheme (for young people aged 13-24).
- STI testing including point-of-care HIV testing and hepatitis screening.
- National Chlamydia screening programme.
- Pharmacists as healthcare professionals are able to provide health promotion, advice and safeguarding to patients.

8.5.2 There are 75 pharmacies across Barnet. Barnet pharmacies currently provide:

- EHC is available as Levonelle or ellaOne which are both pharmacy-only medicines and may be prescribed and supplied by pharmacists.
    - 15 pharmacies are commissioned on behalf of the London Borough of Barnet by CNWL to provide EHC free of charge to under-25s.
    - EHC is also available through private sale.
- Dispensing of prescriptions relating to user-dependent contraception.
- Private sale of condoms.
- C-card scheme is available at 10 pharmacies within Barnet.

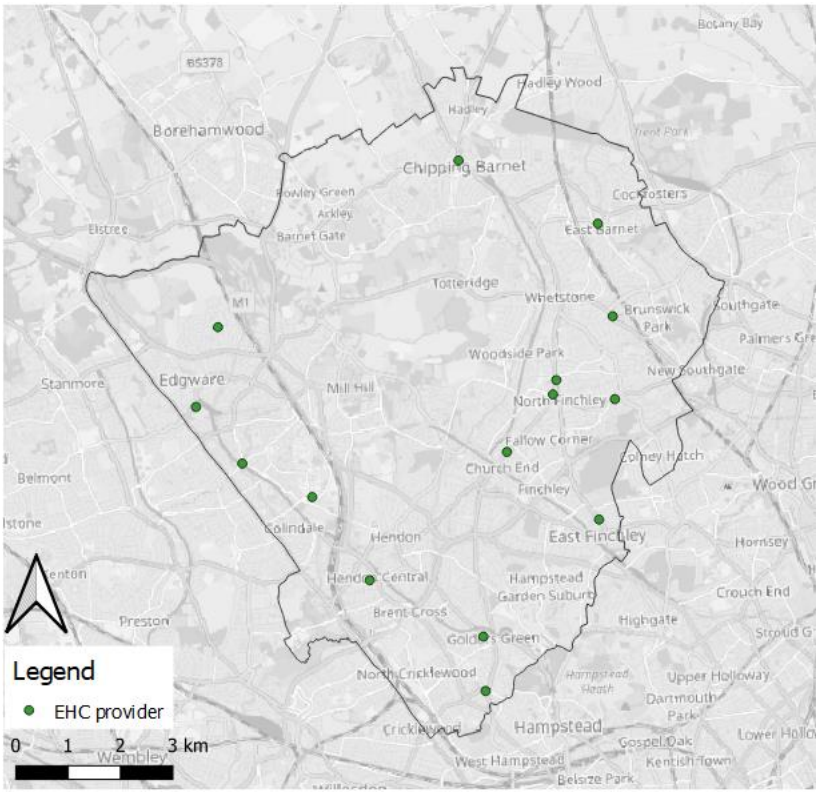


Figure 81: Pharmacies commissioned to supply EHC free-of-charge to user for under-25s.

8.6 General Practice

8.6.7 GPs across Barnet are able to provide a wide provision of sexual health care as part of their work as well as being able to refer to more specialist services. Provision such as for LARC varies between practices dependent on skills mix and as well what is commissioned. Provision from GP includes:

- Placement or removal of LARC
- Prescription of routine and emergency contraception
- Repeat prescriptions of contraception
- STI testing
- Other infections: PID, Urethritis, candida, BV, balanitis
- Erectile dysfunction
- Sexual health advice and promotion
- Safeguarding
- Vaccinations (including Hepatitis B and HPV)
- Referral to specialist services.[68]

8.7 Termination of pregnancy (TOP)

8.7.1 In the London Borough of Barnet, self-referrals services for termination of pregnancy are available at Finchley Memorial Hospital and Woodcroft Medical Centre. Services provided within Finchley Memorial Hospital are provided by the National Unplanned Pregnancy Advisory Service (NUPAS). Termination of pregnancy services are provided by MSI Reproductive services in the Woodcroft Medical Centre in Edgware. These services are commissioned by the ICB.

Both services are open to self-referral as well as from professionals. A holistic approach is taken towards care, alongside termination of pregnancy treatment patients are may also be able to access STI testing, LARC and pre- and post- counselling services.

The majority of terminations are medical abortions. Both services are able to provide, where clinically appropriate, abortion pills that can be sent in the post and taken at home. Services are able to provide care both face-to-face or on the phone, based on patient preference and clinical appropriateness.

8.7.2 To better understand need and the landscape of abortion care in Barnet professionals from NUPAS were consulted. NUPAS have taken steps to maximise access for patients at the Finchley Memorial Service. This includes opening 6 days a week and in the evenings, providing information in multiple languages and braille, ensuring services are discretely placed and providing a leaflet specifically for those with learning disabilities.

In the reporting year April 2021-22 NUPAS had 480 consultations. There were 380 terminations of which 97% were early medical abortions. There were 27 instances of long-term contraception given including IUD, Depot, Mirena IUS and the implant. Oral contraception was given 59 times. This represents only 22.6% of patients receiving contraception care post-TOP from the TOP provider. There were only 19 tests of gonorrhoea and chlamydia and 17 HIV tests.

Looking at the last reporting year unaffected by COVID in 2018-19, NUPAS in Barnet had 590 consultations and there were 400 terminations, only one of which was a surgical termination. 38 women were given a long-acting contraception and 134 chose oral contraception. This represents 43% of termination encounters receiving contraception care post-TOP from the TOP provider. STI testing uptake was much higher with 439 HIV tests and 438 Gonorrhoea and Chlamydia tests, representing 74% of those consulted.

NUPAS use an 'Every Contact Counts' model to promote long-term contraception with the patient. Discussions with professionals from NUPAS, backed by evidence from the activity data, revealed concerns around patients getting long-term contraception after termination. Whilst many patients expressed a wish for contraception after termination many did not attend their follow-up appointments for contraception. It is also of note that in Barnet, 41.1% of abortions are repeat abortions. Whilst there may be multiple reasons for this, professionals felt some patients may prefer to have their contraception somewhere else, rather than with a service associated with the termination. In this case healthcare professionals are only able to signpost patients.

8.8 Sterilisation

8.8.1 Sterilisation services are commissioned by the ICB. NCL ICB has commissioned a community service from MSI Reproductive Choices for the provision of vasectomies. Referral for this can be made through GP.[69]

Sterilisation services for females are accessed through gynaecology services and referral to this can be made through the GP.

8.9 Targeted services

8.9.1 Young people

In-clinic

There is a dedicated clinic for young people aged 17 and under at Edgware Community Hospital every Tuesday. This service is a walk-in and open between 3:30pm and 6:30pm. Young people can access generalist services if aged 17 or under by walking in during opening times Monday-Friday. If over 16 with a learning disability they can also attend The Bridge Sexual Health Service. The services are also provided outside of school hours 2 days a week at Edgware Community Hospital and once a week at Vale Drive Primary Care Centre. Both services are accessible by public transport.

C-card scheme

A C-Card scheme is one type of condom distribution scheme, which provides registered young people with a C-Card – a paper or credit card-style card – which entitles them to free condoms. Young people can also join at an outlet or online if aged over 16 and then receive products online or at an outlet.

Since November 2019 Brook have implemented a local condom distribution (Come Correct) service for young people in Barnet. Come Correct is the name of the free, confidential condom scheme for young people aged 13-24 across London. Barnet young people can access condoms for free up until they turn 25 using the Come Correct condom distribution scheme. As well providing young people with free condoms and lube, the staff delivering the scheme across the borough are trained by Brook to have honest, non-judgemental conversations with young people about their sexual health. This approach ensures young people not only have the skills to use the condoms they are receiving but also to advocate for their own sexual health in their relationships. Being able to access condoms in places where young people go every day such as colleges, youth clubs and pharmacies, normalises condom use and helps to break down some of the shame and stigma associated with sexual health. Once registered on the scheme, young people can access condoms from approved outlets across London.

Currently outlets include clinics, pharmacies, schools, colleges and youth organisations. The Barnet scheme has currently (2022) 27 outlets listed online 10 of which are community pharmacies. In addition, Brook set up “drop ins” at colleges and other locations to promote sexual health and condom use. Prior to COVID -19 there were 61 outlets across the Borough however some of these have been slow to return to use and were based in schools. These are expected to come back in use once the school nursing service is fully mobilised. In many cases contacts originally trained have moved on and Brook are implementing a programme of refresher training.

Barnet Public Health is currently undertaking a review of the C-Card scheme to inform future direction.

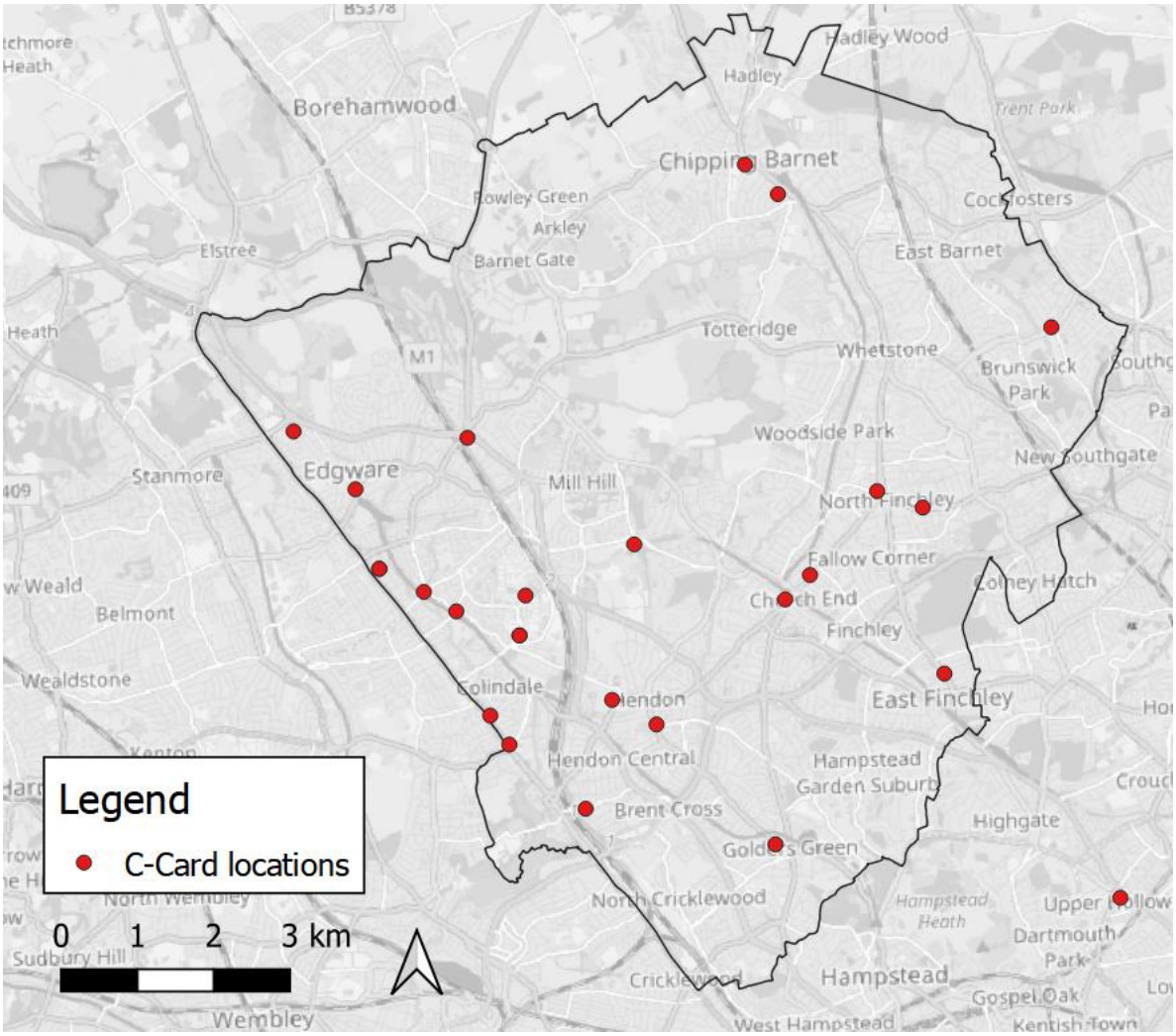


Figure 82: Map of outlets providing c-card.

In the reporting year November 2021/22, 278 young people in Barnet signed-up to the c-card scheme of which two thirds were Barnet residents. There were 81 repeat encounters, from young people who were already registered in the scheme. Non-white groups represented 53% of registrations and young people identifying as heterosexual represented 56% of registrations. The majority of registrations were by 16 and 17 years old. Age groups have been combined in order to protect the anonymity of these groups where the numbers are smaller. 54% of those registering were female and 46% were male. Those recorded as identifying with other gender identities have been supressed to protect their anonymity.

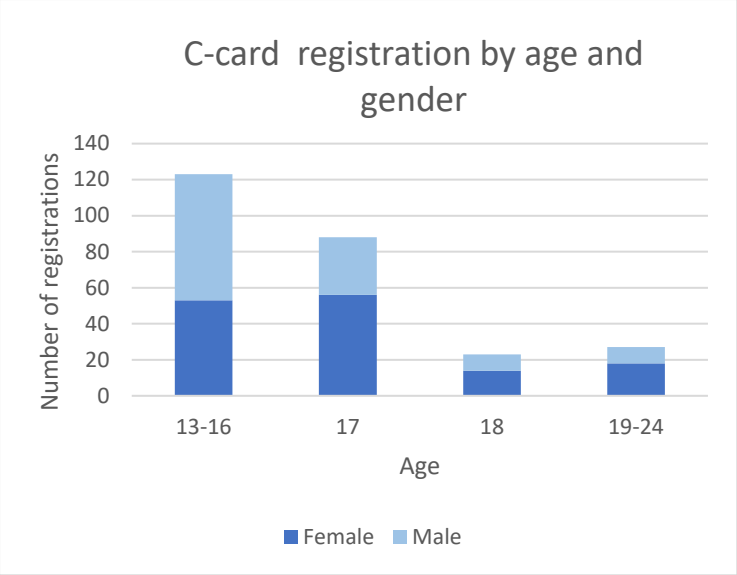


Figure 83: number of registrations for c-card by age

Discussions with Brook who manage this service on behalf of Barnet have noted that opportunities to improve the service locally include:

- Increasing the number of outlets
- Retention of outlets to minimise changes in provision.

Discussions with professionals representing local pharmacies identified opportunities to improve uptake through further promotion and knowledge of the c-card scheme amongst eligible groups.

8.9.2 Learning disabilities

The Barnet Sexual Health service for people with Learning Disabilities and their carers commenced in September 2021 and is led by a senior Specialist Learning Disabilities Nurse. A dedicated clinic is provided - The Bridge - for people with a learning disability and autism who are over the age of 16. The aim of the service is to provide advice and support on sex and relationships, provide contraception including LARC and free condoms, STI tests, prevention and treatment for STIs and HIV in a setting for those who might find it more difficult to attend a regular appointment.

The service is commissioned by CNWL in both clinic locations in Barnet, Edgware Community Hospital and Vale Drive Primary Care Centre. Clinics are available Monday to Friday with opening times varying between 8am and 7pm.

Between September 2021 and April 2022 there were 21 attendances. Demographic data is not described here to protect anonymity. The majority of attendances were self-referrals or repeat appointments. The most common service provided was relationship and sex education. RSE sessions cover subjects such as relationships, female and male anatomy, sexual health, contraception, pregnancy, consent, online safety, public versus private etc.

Appointment times within the Bridge Clinic are a minimum of an hour. This allows the practitioner to provide a comprehensive and holistic offer and gives enough time and space for the patient to build trust with the practitioner.

The specialist nurse running the clinic is very experienced and a prescriber and so is able to provide a range of services from STI care to contraception and health promotion advice, as well as act as a chaperone if a patient needs a coil. In this way the practitioner is able to build a strong relationship with the patient and they do not need to see multiple practitioners to meet their sexual health needs.

Extended appointment times is additionally helpful as it gives the practitioner adequate time to incorporate elements of relationship and sex education where needed. Discussions with professionals both from CNWL and Health Education Partners highlight unmet need in relation to RSE especially for those with a learning disability. This need is seen both in young people in education as well as adults who attended school when RSE was not statutory for all schools.

Further work is planned to increase knowledge of and use of the services at The Bridge Clinic. The service has been going out into the community to raise awareness and provide support in the community. This has included attending face-to-face events to promote the work of the clinic to providing asymptomatic screening services in the community. Moving forward options for this outreach and health promotion work are various and include 1:1 sessions, group sessions and clinic in a box. The service aims to reach out to existing services that work with people with a learning disability such as day centres to meet residents in familiar environments they already attend. The service works with local partners to provide a more holistic approach to their care such as the GP liaison nurse, Barnet Mencap and Barnet Learning Disability Service: Nursing, Social Work and Psychology teams.

8.10 Accessibility of services

8.10.1 Edgware Community hospital:

CNWL provides sexual health services from a clinic at Edgware Community Hospital during weekdays Monday to Friday. The clinic has a range of opening hours from Monday to Friday as follows:

- Monday: 8:30am to 3pm
- Tuesday: 12:30pm to 7pm
- Wednesday: 8:30am to 3pm (the clinic is closed between 1pm and 4.30pm for training on the 1st and 3rd Wednesdays of the month)
- Thursday: 12:30pm to 7pm
- Friday: 8:30am to 3pm

There are no services provided on a Bank Holiday including no walk-ins.

Edgware community Hospital is accessible via public transport. It is located a 9-minute walk from Burnt Oak Tube station and is served by 8 bus lines.

Services can be accessed through a mix of online and telephone booking as well as walk-ins for emergency contraception, PEP, sexual assault and under 18s.

In relation to access of the website landing page to signpost patients to the correct service: the landing page is clearly laid out, with Google translate enable on the top of the webpage to allow for translation. However, there is no in-built translated pages on the website. The website is easily identifiable through the Google search engine.

The landing page has a Flesch-Kincaid readability score of 52.3 which is describes as fairly difficult to read. Acronyms within the page are not explained.

8.10.2 Vale Drive Primary Care Centre

Vale Drive Primary Care Centre provides appointments on Mondays, Wednesdays and Thursdays. The opening hours for the service are:

- Monday: 8.30am to 3pm
- Wednesday: 12.30pm to 7pm (the clinic is closed between 1pm and 4.30pm for training on the 1st and 3rd Wednesdays of the month)

There is no service on Bank Holidays.

The location is accessible via public transport and is a 4-minute walk from High Barnet station and is served by 11 different bus routes.

Services can be accessed through a mix of online and telephone booking as well as walk-ins for oral emergency contraception and under 18's.

In relation to access of website landing page to signpost patients to the correct service: the landing page is clearly laid out, with Google translate enable on the top of the webpage to allow for translation. However, there is no in-built translation services by the website. The website is easily identifiable through the Google search engine.

The landing page has a Flesch-Kincaid readability score of 51.3 which is describes as fairly difficult to read.

8.10.3 Contraception

Commissioned EHC is available at 15 of the 75 community pharmacies in Barnet. Feedback from professionals working in pharmacies is that patients are not aware of where they can get free EHC. They feel that improved advertising by the commissioner and awareness of the service which pharmacies provide may improve uptake. They feel that greater accessibility to the commissioned service would be of value to the public.

The expected wait time for LARC within the CNWL ISH service is a challenge to estimate due to the way in which the booking service is provided. New appointments are released daily for the following 7 days, as a result recorded data cannot measure a wait any greater than 7 days and would not reflect a true wait time.

9 Education and Health promotion

9.1 Relationship and Sex Education as part of Personal, Social, Health and Economic Education (PSHE)

9.1.1 Relationship and sex education are a compulsory subject within Personal, Social, Health and Economic (PSHE) for secondary schools. The relationship and sex education curriculum is broad and includes families, respectful relationships, online and media, safety, intimate relationships and sexual health and the law.

Most of PSHE education became statutory for all schools from September 2020 under the Children and Social Work Act 2017. This includes Relationships Education at key stages 1 and 2, Relationships and Sex Education (RSE) at key stages 3 and 4, and Health Education in both primary and secondary phases. The main responsibility for PSHE/RSE delivery firmly sits with

each school with support available from services including Health Education Partnership (HEP), Brook and School Nurses which are commissioned by Barnet Public Health. Barnet schools are also supported through Barnet Education and Learning Service (BELS) who offer support guidance and direct support through their traded service Barnet Partnership School Improvement (BPSI).

The delivery of PSHE varies between schools, with some secondary schools delivering PSHE in form time by form tutors whilst other schools have teachers who are dedicated to providing the PSHE curriculum. Some RSE topics are also covered as part of the national science curriculum such as sexually transmitted infections. In primary schools, lessons are often delivered by class teachers, with most primary schools now choosing to comply with the DfE recommendation to deliver Sex Education beyond statutory relationships, science and health education requirements. Additional support is provided by family services for provision for children with autism. Schools can also utilise support from national and regional agencies and organisations such as the PSHE Association.

A gap in knowledge is around the needs and provisions of RSE for electively home educated children.

9.1.2 Health Education Partnership

Barnet Public Health commission HEP to support schools to translate the guidance published by the Department of Education into a practical curriculum that can be delivered to students in a way that is relatable and engaging. HEP supports teachers to plan and deliver the curriculum and engages with teachers from the early years up to sixth form. The service is available to all educational institutions in Barnet and to all teachers and teaching staff including subject teachers as well as PSHE leads. Support is provided through training workshops; 1:1 sessions and local network meetings, which enable learning and sharing experiences and signposting to support materials. Newsletters are shared with all schools where a contact has been provided. Support is available to all state schools with HEP also able to provide some of this offer to private sector schools.

HEP supports schools to prioritise which parts of the PSHE curriculum to emphasise with students. Schools achieve this in part by consulting with parents and students about the content of the curriculum. HEP can set up these surveys and collate the data. HEP also provides tools for schools to audit and evaluate their PSHE offer and to review how it links to OFSTED's judgement of a school's personal development programme. Guidance is also available to school governors including the link governor for RSE where school have appointed one.

Educational institutions are responsible for how they deliver PSHE and can choose if and how much they engage and gain support from HEP. Over the last 3 years HEP has had engagement from the majority of secondary schools in the borough.

The Young People's RSE Poll 2021 run by the Sex Education Forum found that young people would like to learn more about: sexual pleasure, FGM, gender identity and power imbalances in relationships amongst other topics.[70] In delivering a comprehensive life skills programme, a range of themes are covered to support the personal, social, emotional and health development of all pupils, some of which are related to dangers, risks and negative behaviours. Rather than creating an atmosphere of fear or anxiety, these are best taught

through a positive approach, acknowledging that when we are faced with various risks and negative events, we can learn to make informed decisions and responses based on knowledge, attitudes, skills and strategies to recognise and manage these situations as effectively as possible. Resources should be chosen carefully to avoid retraumatizing or victim blaming.[71] There is also an increasing focus of equipping teachers with the skills and information they need to discuss relationships that occur both online and face-to-face.

It remains a challenge to maintain continuity of provision and engagement with HEP when teaching staff change roles within schools. However regular contact with schools is offered through the school circular, Head Teachers briefings and newsletters that are circulated throughout the school's community.

Ongoing barriers to access for students to the RSE curriculum are especially notable for non-attenders, infrequent attenders and those who move school. Further work is needed to understand if any additional support is needed from specialist schools who focus on provision for children with complex or additional needs. The needs of these students may already be being met by the school themselves or through their specialist school nurse.

9.1.3 School Nurses

School Nurses in Barnet are commissioned to complete a School Partnership Agreement with each school which forms the basis of discussions about what the school requires in support from school nurses. In relation to RSE provision as part of PSHE topic options include:

- At primary school level
    - supporting puberty and reducing stigma of periods
- At secondary level:
    - Relationships and Sexual health education
    - Mental health
    - FGM
    - Smoking drugs and alcohol
    - Awareness raising of period poverty and reducing period stigma.

Topic choice and provision are locally negotiated between the school nurse and school.

9.1.4 Brook

Brook are commissioned by Barnet Public Health to provide support to schools across Barnet to deliver the RSE curriculum to students. Their service includes:

- A range of training opportunities for the education workforce and other professionals working with young people and covers sexual health, gender identity, consent and relationships. The sessions also cover teaching sensitive subjects and teaching sexual health to pupils with SEND.
- Brook provides a range of resources that can be used within schools.
- RSE sessions to young people in small groups session and through assemblies. Group RSE sessions can be delivered online or face-to-face and cover a range of topics including consent, contraception, STIs and more. Assemblies cover a range of RSE topics and have a focus on signposting students. They are currently commissioned to deliver 30 sessions and 8 assemblies.
- My Life 1:1 programme for young people where referrals can be made through school.

9.2 Sexual health promotion for young people in the community

Barnet Public Health commission Brook to work with young people through targeted community sessions. They provide community sessions in a range of settings include youth groups, libraries and special schools.

Brook provides *MyLife* a 1:1 programme for young people with a specialist. It is a supportive goal-based programme with goals set by the young person and worked towards over 6 sessions. Goals are wide-reaching, holistic and supportive of wellbeing. Young people can access the service through referral such as through schools, social care and CAMHS.

Peer education is available through a public health level 2 accredited programme for peer educators. This is led by Brook and delivered through the Young Health Champions programme.

Provision to upskill a wide range of professionals is provided through Brook's professional training. Professionals may range from teachers and those leading youth groups to council workers and those who work with looked-after-children. Professional are trained to discuss topics including condom distribution, teaching young people with SEND, and various RSE topics such as Sexual Health, Consent and Healthy relationships. They provide free and open-access online training that Barnet professionals through Eventbrite. Open-access training is also available for c-card training and organisations can also arrange training for their staff. Through professional training Brook have engaged with 58 professionals and over 530 people were engaged while out conducting outreach in year 1.

College and university students are supported through Brook's health promotion activities. This has included events such as at freshers' fairs, drop-ins, outreach sessions such as for National HIV week and a student group at Middlesex university. This events also allows Brook to support students to sign-up to the c-card scheme and hand out SHL STI kits.

Brook also lead the c-card scheme in Barnet which is further detailed in section 8.9.1.

9.3 HIV and STI health promotion activities

Barnet Public Health commission Brook to provide HIV health promotion activities. These activities are targeted towards minority groups in adult population, including Black African, Caribbean, Eastern European communities, MSM and LGBTQ+ communities. The aim is to engage minority groups and those who may have additional barriers to accessing services such as language or cultural barriers.

The promotion is delivered through publicity, awareness-raising events and face-to-face/virtual professional training. Brook engages with communities, to have healthy culturally appropriate conversations around HIV and STI testing and signposting towards testing services. In 2022 Brook engaged with 25 stakeholders, had 265 views on YouTube Livestream and 175 people engaged through NetReach.

10 Impact of the pandemic and mpox on sexual health services

10.1 SARS-COV-2 Pandemic

During the pandemic CNWL services needed to be rapidly re-configured to support the National NHS Emergency response to Covid-19 and to ensure care could be provided safely. To minimise face-to-face contact and so the potential threat of the spread of COVID, needs were met through online and telephone consultations where possible and clinically

appropriate. Patients were offered a telephone appointment as standard and then clinicians could decide on further management steps including having face-to-face consultations, online testing or remote dispensing of medications.

Patients could still walk in for emergency contraception (oral or copper coils) and PEP and for support following sexual assault. Vulnerable adults, those under 18 and those with specific clinical needs (such as first line intramuscular treatments for sexually transmitted infections) were automatically seen through face-to-face consultations.

Staff resources needed to be managed differently during this time both to minimise the number of healthcare workers that were seeing each patient in order to minimise the potential spread of COVID and due to redeployment. Redeployment of staff from Barnet clinics to other NHS services such as on the wards of St. Pancras hospital meant that Grahame Park, Vale Drive and Edgware Community Hospital sexual health clinics were closed, and remaining staff consolidated sexual health service at the Archway Centre from 15th March 2019 to June 2019.

Changes made during the pandemic offered an opportunity to trial new ways of working with some being successful for the circumstance of the pandemic, others not working as well as face-to-face appointments and some providing a new model of patient care for specific conditions that could be used moving forward.

Barriers to remote ways of working included patients not having a safe or private place to speak about the sexual health in their home, such as those patients at risk of domestic violence and young people living with their families. Further, telephone consultations or online enabled appointments created a barrier for those with a language barrier and those who are digitally excluded.

Trials of remote ways of working included a genital photography virtual clinic for dermatological conditions and a telephone contraception clinic.

Telephone consultation was found to be convenient for patients especially where medication could be posted or picked up at the clinic front door; however, if a face-to-face appointment was subsequently needed then this method conferred an additional time burden for both patient and clinician as two appointments were then needed. The genital photography virtual clinic was found not to be successful in part due to poor photograph quality.

Coming out of the pandemic the clinic continued to provide telephone consultations for positive STI results and treatment can be posted or collected by the patient where applicable and partner notification completed remotely to avoid additional face-to-face appointments. However, moving forward the majority of the care provided by the CNWL clinics in Barnet has reverted back to face-to-face delivery. Patients wanting an asymptomatic screen for STIs continue to be signposted to the online platform provided by SHL as appropriate. Asymptomatic screening continues to be offered ad-hoc in clinic for those not wanting to use SHL or for those not meeting the criteria.

10.2 Mpox

In response to the mpox outbreak emerging in May 2022, CNWL set-up two specialist assessment clinics; one in Camden at the Mortimer Market Centre and one in Islington at the Archway Centre to assess patients with possible mpox. One full-time nurse and one

admin assistant were deployed from Barnet to support these mpox clinics. There were no clinics in Barnet that were set-up as specialist mpox clinics however all clinics had appropriate procedures and PPE to deal with any case that came in unexpectedly as a walk-in.

A telephone mpox welfare clinic was also set up for patients who had been diagnosed. These patients were checked on every 72 hours by phone during the 21 days of isolation. Specific pathways were also set-up for cases requiring hospitalisation or those unable to isolate at home due to living with others who were clinically vulnerable. This telephone clinic was staffed by 2 members of the Barnet nursing team until it was stood down when mpox cases diminished.

Vaccination clinics for mpox were challenging due to availability of vaccines, the need for staff training and having enough people who had the necessary prescribing licenses. At the time of writing this report a nurse-led weekend clinic outside of standard clinic operating hours has been set-up to meet demand. Patients are also being opportunistically vaccinated in clinic during standard consultations when clinically appropriate. At the time of the report writing the number of positive cases of mpox was falling.

11 Recommendations

Recommendations have been presented under thematic headings bringing together understanding of the current use of services, sexual health outcomes and normative need as expressed by professionals working in the area and patients. Recommendations range from those looking at enhancing current working to considering new ways of working.

Discussions with professionals working within the field have been the cornerstone to the creation of these recommendations ensuring they respond to clinical need and are practical to implement.

CNWL interventions Recommendations		
Identified needs	**Recommended actions**	**Partners**
• It is unclear if any ethnic groups are less likely to attend ISH clinics due to incomplete data and therefore to understand if there is need or inequality in access.	• To update the CNWL online booking form to include a question on ethnicity. There is precedent and high uptake of this in the SHL online form. *(Under action at the time of publication with training provided to clinic staff and changes to online forms)*	• CNWL
STIs Recommendations		
Identified needs	**Recommended actions**	**Partners**
• Increase testing as part of the National Chlamydia screening programme to reach national targets. • Increase STI testing across the population. • Get the population back into the habit of testing post-pandemic. • To understand why some ethnic groups test less than other groups.	• Increase the opportunity to screen for Chlamydia such as through pharmacies and health promotion events. • Increase the opportunity to screen for STIs when receiving EHC in community pharmacies. • Better promotion of all local services available on all partner websites and social media. • Review uptake of STI testing at least annually over the next 3-5 years as behaviours are likely to change as we move away from the pandemic and target health promotion activities around testing accordingly.	• CNWL • SHL • Barnet Public Health team • Local pharmacies • GP
HIV Recommendations		
Identified needs	**Recommended actions**	**Partners**
• The government's Towards Zero Action plan details England's action plan to reduce new HIV transmissions for 80% by 2025 and to have zero new transmissions by 2030. As part of the action plan	• Create a local plan including increasing uptake of PrEP, increased testing, and support for prompt treatment. *(Under action at the time of publication through the NCL PrEP Awareness Programme)* • Update patient facing websites to help patients understand	• Barnet Public Health Team • The Royal Free NHS Trust • CNWL • SHL • Brook

local authorities have been asked to develop their own local plan on how they will contribute to this plan. • Improve access to PrEP by creating a clearer pathway for patients to enquire about PrEP. • HIV testing in hard-to-reach groups.	where and how consultations for PrEP can be accessed. • Co-location of HIV testing with drug and alcohol services, homeless day centres and domestic violence serviced. • Point-of-care HIV testing for health promotion activities by the Brook HIV specialist • SHL to support and direct patients accessing online service into CNWL PrEP clinics as clinically appropriate.	• Community Pharmacies • CGL • HAB
Hepatitis B Recommendations		
Identified needs	**Recommended actions**	**Partners**
• Hepatitis B has a shared transmission route with HIV of which we know that there are more opportunities for testing.	• Opportunities for co-testing for Hepatitis B when blood samples are taken to test for HIV.	• Outreach teams such as in drug and alcohol services where HIV testing is already being done. • CNWL • SHL
HPV Recommendations		
Identified needs	**Recommended actions**	**Partners**
• Increase awareness of the option of HPV vaccination amongst MSM. • Increase uptake in school aged HPV immunisation.	• To continue to couple the offer and promotion for HPV vaccination at MSM targeting health promotion activities or healthcare such as mpox vaccination clinics. • Add adult HPV vaccination as a service to Barnet and CNWL website pages around sexual health. • Support the work of the Barnet Public Health, Health protection team to understand why uptake of HPV immunisation is low in school children post-pandemic. • Supporting the school age immunisation teams to improve the promotion of school age immunisations in schools including HPV vaccination.	• CNWL • SHL • Barnet Public Health Team
Termination of Pregnancy Recommendations		
Identified needs	**Recommended actions**	**Partners**
• Need for support with contraception post-termination given the high	• Support shared working and patient transfer between sexual health services/GPs and termination services for	• GP • CNWL • Pharmacies

number of repeat terminations. • Further work is needed to support regular and EHC contraception access given the majority of terminations occur in the first 9 weeks of pregnancy.	patients who do not want to receive post-termination contraception care from the termination service. • Improve access to EHC through clearer advertising of where commissioned EHC can be obtained.	• Abortion services
Contraception Recommendations		
Identified needs	**Recommended actions**	**Partners**
• Increase LARC prescription as services recover from the pandemic. • Increase take-up of post-TOP contraception care. • EHC uptake from pharmacies is low. • Further work needs to be done to understand the accessibility of LARC appointments. • Improve resident knowledge of how to access EHC without payment, particularly in light of the cost-of-living crisis. • Improve visibility of referral pathways for female sterilisations amongst healthcare professionals and patients.	• Opportunity for LARC to be offered to the general public by abortion services to increase supply. • Improve pathway for patients from TOP services to ISH clinics. • Improve advertising of pharmacy commissioned EHC for those under 25 and their locations. • Improved advertising of LARC and where patients can access it. • Increase the number of pharmacies offering EHC in the borough. • Further work with CNWL and general practice to understand how long on average patients wait to get LARC. • Improve the online information for sterilisation.	• CNWL • Abortion services • Barnet Public Health • General Practice • Community pharmacies
Health Promotion Recommendations		
Identified needs	**Recommended actions**	**Partners**
• Increasing work with RSE school link governors.	• Increase contact and support for school link governors to support them in their role and provide opportunities for increased continuity between schools and supporting services.	• Health Education Partners • Barnet Education and Learning Service
C-cards Recommendations		
Identified needs	**Recommended actions**	**Partners**

• Increase awareness of the c-card scheme and where outlets are located. • Increase the number of c-card outlets in the borough. • Complete C card review and use to inform further recommended actions.	• Promote the c-card scheme on sexual health services websites using a hyperlink. • Work with community pharmacies and youth centres to increase the number of outlets offering c-cards. • Re-establish the c-card outlet at Middlesex University Campus • Link contracts for c-card and EHC to incentivise uptake of the c-card scheme by community pharmacy partners.	• Barnet Public health team • CNWL • SHL • Brook • Community pharmacies
Female Genital Mutilation Recommendations		
Identified needs	**Recommended actions**	**Partners**
• A further understanding is needed around FGM prevalence and need.	• To consider whether further needs assessment is needed around FGM.	• Barnet Public Health team • Barnet VAWG team
Access to services Recommendations		
Identified needs	**Recommended actions**	**Partners**
• Improved knowledge of all services available across the borough. • Improved accessibility of CNWL and council website. • Limited clinic times in the evening and no weekend options. • Out of hours service particularly for PEP and EHC.	• Improved information on CNWL website about all the services provided including PrEP. • Improved signposting across CNWL webpages to other provision including SHL, pharmacy commissioned EHC and c-card. • Improved readability of CNWL landing pages. • Improved layout, accessibility, and update of council website in relation to sexual health including translated versions. • Consider increasing flexibility of clinic opening times and provide more out of school hour clinics. • Clear signposting on the CNWL website on where emergency care including EHC can be accessed out of hours and eligibility.	• CNWL • Barnet Public Health
Learning Disabilities Recommendations		
Identified needs	**Recommended actions**	**Partners**
• Further research is needed to understand the current RSE offer to students with a learning disability both in mainstream and specialist schools.	• Undertake a review and apply the findings to ensure a comprehensive education provision for RSE to SEND pupils and children electively home educated.	• Bridge Clinic, CNWL • HEP • Brook • Barnet Public Health Team • BELS

• Improve RSE knowledge for adults with learning disability, especially as they went through the schooling system where RSE was not part of the statutory guidance.	• To ensure that the Bridge clinic specialist nurse can deliver sessions to students with learning disabilities. • Bridge nurse specialist nurse to deliver adult outreach health promotion sessions in community sessions.	• Barnet schools
Homeless Recommendations		
Identified needs	**Recommended actions**	**Partners**
• Improved geographical access. • Improved access to services caused by language barrier. • Promotion of the service and option to the population	• Co-location of sexual health services with other services already accessed by those experiencing homelessness. • In-reach from ISH clinics into Homeless Action Barnet Day Centre e.g. at the health fair • Collaboration and signposting between HAB and HAB based services to SHL and in-clinic CNWL services to promote testing, treatment and prevention including PrEP and PEP. • Provision of translated leaflets for the HAB day centre	• Homeless Action Barnet • SHL • CNWL • Change, Grow, Live • Barnet Public Health Team

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Appendix

1 Interviews at Homeless Action in Barnet

Introduction

In Barnet, Homeless Action in Barnet (HAB) provides support and services to people who are homeless or at risk of becoming homeless. In February 2022, five one-to-one interviews were conducted with HAB clients to explore their experiences and perceptions of accessing sexual health services. Below is a description of the methodology and the key findings from the analysis.

Methodology

In February 2022 5 one-to-one interviews were conducted with clients of Homeless Action in Barnet. The interviewees included male and female identifying participants. All interviews were conducted in English, but not all participants spoke English as their first language. Participants were recruited opportunistically by staff at Homeless Action in Barnet. Interviews were conducted in a private room at the Homeless Action in Barnet day centre, a place where the interviewees attend most days and is a convenient and familiar setting for them. The interviewer has a medical background having worked clinically but with no specialism in sexual health and no previous specific experience working with the homeless population. All interviews were recorded and transcribed. Data was coded by the interviewer and analysed using the framework method, as outlined in Gale et al., 2013.[72]

Findings

The categories arising for the framework analysis were:

- Sources of information
- Accessing clinic services
- Using SHL self-test kits
- STI and HIV testing
- Improving access
- Sexual health literacy
- Access to contraception
- GP
- Tech exclusion
- Self-care
- Other

Sources of information

"First of all, in the modern world, I would look on the internet. So any issue I had I would type it up on the google search."

The internet was cited as an important source of information and may be accessed before speaking to any professionals as a source of information. Interviewees described using a general search rather than looking for information on a specific website, although some did cite that they would look for local information such as provided by the NHS or the council. Healthcare professionals and professionals working at HAB were also cited as important and trustworthy sources of information. It was noted that public promotion campaigns such as through social media or on TV may not reach those who are homeless because they do not have as ready access to these media outlets.

"So basically if I have some questions, or what I want to do a test or something, I'm gonna come to the HAB."

Accessing clinic services

Interviewees reported a sentiment that walk-in services were mainly for or directed at young people however, identified that walk-ins would support access for them. Walk-in would help to overcome the barriers presented by booking through phone or online and also would help in keeping to appointments due to concerns about competing priorities and appointment clashes.

"I think a walk-in one is better than a set appointment but either one will work."

Booking appointments through the phone presented a barrier for some interviewees for a number of reasons. Reasons cited included: the amount of time on hold, opening hours of the phone lines having sufficient phone credit and have a private and quiet place to take the call. Interviewees felt more flexible phone hours including afternoon hours would support access.

"You have to call people, yo. Can you transfer money? … But that's another debt on top of, another stress on top."

Interviewees widely agreed that the location of the clinics in Barnet were geographically accessible from HAB but that the cost of transport presented a barrier to accessing in-clinic services as it was too far to walk. Some participants explained that they would have to borrow money in order to meet the costs of transport to get to a clinic if needed.

Using SHL self-test kits

A clean, safe and private place to complete SHL tests kits were the key barriers to using SHL self-test kits. Not all participants were aware of the option to self-test for sexual health and that these could be ordered online or picked up in a clinic.

Participants described whether they were in a night shelter or a hostel, the needs to use shared bathrooms meant that interviewees did not have a private place to complete the test and there were also concerns about cleanliness and safety particularly with the finger-prick element of the test.

STI and HIV testing

Interviewees identified the internet as their first source of information to figure out how to get an STI or HIV test.

"I would not know how to access it, I would just look on the internet."

Improving access

HAB day centre was seen as an important location from which accessible health services are already delivered and interviewees also see it as an appropriate place to deliver healthcare relating to sexual health including prevention through the distribution of condoms. One interviewee also suggested the use of a mobile clinic, further highlighting the need for outreach services reaching people in places they regularly visit for other needs.

Sexual health literacy

Generally, participants felt that they were lacking knowledge in sexual health and most participants asked the interviewer factual medical questions about diseases or treatments during the interviews as topics arose, demonstrating a need and want for more knowledge regarding sexual health. Perception of risk of STIs and risks from different types of sexual activity are also areas that should be addressed as part of sexual health messaging. Participants felt that good RSE in schools was important to prevent this in the future and also felt that health promotion campaigns such as through social media were important to help improve the knowledge of adults.

More broadly, English language was a barrier for those speaking English as a second language, particularly around the use of medical terms and confusion created by the phrases positive and negative in diagnostics. General health literacy also was a barrier such as not knowing what consent was. Interviewees described the utility of pictures and videos in helping them to understand online content.

"I try to read about it first. If I can't then I go to the pictures videos through."

Access to contraception

Contraception was generally seen as accessible, either through the internet, through walk-ins and for condoms through GP clinics, ISH clinics or to buy. Interviewees were generally confident about how to access contraception. Some but not all saw price as a barrier to using condoms.

GP

The GP is still seen as a key source of information and care, including for sexual health with one participant also seeing the GP as a gatekeeper to sexual health services as with other specialist services.

Technological exclusion

The internet as accessed through a smartphone was viewed as an important source of information. However, it was noted that some of those experiencing homelessness would experience barriers to accessing care due to technology. For some booking appointments online was difficult due to a mix of digital literacy and being able to use the forms as well as the difficulty in the number of questions that are asked and how this links generally to literacy and sexual health literacy levels. For those without a phone, HAB provides Nokia phones, however these are not smartphones. Credit and access to Wi-Fi are also important considerations. For those without a smartphone they would then be forced to use a public computer if they wanted to look up information, which may be hard to maintain the desired privacy, another issue highlighted, when reading about this topic.

Self-care

Interviewees described that self-care can be challenging; as there is no place to store medication, they may lose it, but it is also an additional item that must be carried around. Further, medication that needs to be applied to the genital area can be difficult to administer due to a lack of private space to do this. Finally, some interviewees described a general lack of self-efficacy relating to health and varying perceptions of risk relating to untreated sexual health conditions.

Summary

This analysis as a qualitative piece of data summarises the thoughts of the 5 interviewees from HAB on their experiences and perceptions of accessing sexual health services. The interviews revealed that the internet, healthcare professionals and staff at HAB were seen as important and trustworthy sources of information. Walk-in services were identified as a helpful way to overcome the barriers of booking appointments online or through the phone. The cost of transport presented a barrier to accessing in-clinic services. The interviews found that self-test kits were not widely known about, and their use was obstructed by a lack of a clean, safe, and private place to complete the test. Sexual health literacy was found to be generally lacking, with participants asking factual medical questions during the interviews and English language was also found to be a barrier, particularly around the use of medical terms. Contraception was generally seen as accessible, either through the internet, walk-ins, pharmacy and stores. The interviewees noted that health promotion campaigns through social media may not reach those experiencing homelessness.

2 Glossary of terms

AIDS	Acquired Immune Deficiency Syndrome
BBV	Blood borne viruses
BELS	Barnet Education and Learning Service
BPSI	Barnet Partnership School Improvement
C-card	Also known as come correct is a scheme that provides free condoms across London
CCG	Clinical commissioning group
CGL	Change, Grow, Live
CNWL	Central and North West London NHS Foundation Trust
EHC	Emergency Hormonal Contraception
FGM	Female Genital Mutilation
FSRH	Faculty of Sexual and Reproductive Healthcare
GUMCAD	Genitourinary Medicine Clinic Activity Dataset
HAB	Homeless Action In Barnet
HEP	Health Education Partnership
HIV	Human Immunodeficiency Virus
HPV	Human papillomavirus
ICB	Integrated Care Board
IDSVA	Independent Domestic and Sexual Violence Advisor
IMD	Index of Multiple Deprivation
IRIS	Identification and Referral to Improve Safety
ISH	Integrated Sexual Health
IUD	Intrauterine device (copper)
IUS	Intrauterine system (hormone based)
IVF	In vitro fertilisation
LARC	Long-acting reversible contraception
LSOA	Lower Super Output Area
MSM	Men who have Sex with Men
NCL	North Central London
NCSP	National Chlamydia Screening Programme
NICE	National Institute for Health and Care Excellence
NUPAS	National Unplanned Pregnancy Advisory Service
OHID	Office for Health Improvement and Disparities
ONS	Office for National Statistics
PEP	Post-exposure prophylaxis, an antiretroviral treatment for HIV-negative individuals who have been exposed to HIV
PEPSE	Post-exposure prophylaxis after sexual exposure to HIV
PHE	Public Health England
PHOF	Public Health Outcomes Framework
PID	Pelvic Inflammatory Disease
PrEP	Pre-exposure prophylaxis
PSHE	Personal, Social, Health and Economic education
RSE	Relationship and sex education
SDI	Sub-dermal implant
SEND	Special Educational Needs and Disabilities
SHL	Sexual Health London

SHS	Sexual Health Services
SRH	Sexual and reproductive health
STI	Sexually Transmitted Infection
TOP	Termination of Pregnancy
UCLH	University College London Hospital
UKHSA	UK Health Security Agency
UNAIDS	A joint venture between the United Nations family to unite against AIDS
VAWG	Violence Against Women and Girls
WHO	World Health Organisation