Wiltshire Council
Where everybody matters

AGENDA

Meeting:	Health Select Committee
Place:	Kennet Committee Room, County Hall, Bythesea Road, Trowbridge, BA14 8JN
Date:	Tuesday 6 March 2018
Time:	**10.30 am**

Please direct any enquiries on this Agenda to Will Oulton, of Democratic Services, County Hall, Bythesea Road, Trowbridge, direct line (01225) 713935 or email william.oulton@wiltshire.gov.uk

Press enquiries to Communications on direct lines (01225) 713114/713115.

This Agenda and all the documents referred to within it are available on the Council's website at www.wiltshire.gov.uk

Membership:

Cllr Christine Crisp (Chairman)
Cllr Gordon King (Vice-Chairman)
Cllr Clare Cape
Cllr Mary Champion
Cllr Gavin Grant
Cllr Howard Greenman
Cllr Mollie Groom
Cllr Deborah Halik
Cllr Andy Phillips
Cllr Pip Ridout
Cllr Fred Westmoreland
Cllr Graham Wright
Cllr Chuck Berry

Substitutes:

Cllr Pat Aves
Cllr Trevor Carbin
Cllr Ernie Clark
Cllr Anna Cuthbert
Cllr Peter Fuller
Cllr Russell Hawker
Cllr George Jeans
Cllr David Jenkins
Cllr Nick Murry
Cllr Steve Oldrieve
Cllr Robert Yuill

Stakeholders:

David Walker — Healthwatch Wiltshire
Diane Gooch — Wiltshire & Swindon Users Network (WSUN)
Irene Kohler — SWAN Advocacy

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If you have any queries please contact Democratic Services using the contact details above.

Pre-meeting briefing

The meeting will be preceded by a presentation – topic to be confirmed (9.30-10.30 am in the Kennet meeting room).

PART I

Items to be considered whilst the meeting is open to the public

1 **Apologies**

2 **Minutes of the Previous Meeting** *(Pages 7 - 14)*

To approve and sign the minutes of the meeting held on 9 January 2018.

3 **Declarations of Interest**

To receive any declarations of disclosable interests or dispensations granted by the Standards Committee.

4 **Chairman's Announcements**

To note any announcements through the Chairman, including:

4a **Women's Health Week**

This week is Women's Health Week with opportunities to learn more about some common health issues the council's female employees have said they'd like more information about. There is a programme of events and details are accessible on the Wire.

4b **User engagement with Adult Care - tender process update**

4c **CCG Strategic Outline Case**

In September 2017, The Governing Body of the CCG requested that a Wiltshire-wide strategic outline programme be developed, which is underway and weaves into the development of the CCG'S primary care strategy, the Joint Strategic Needs strategy from Public Health and the CCG's Care Operating Model. It is anticipated that the committee will receive a report on the overall programme in the late summer of 2018.

4d **NHS Funded Patient Transport Survey**

At its last meeting, the Committee requested further information regarding the breakdown of the consultation responses between users and non-users of Patient Transport. The attached document provides this information.

The Committee will receive a further overall update on Patient Transport, possibly in July, including further details of the contract.

5 **Public Participation**

The Council welcomes contributions from members of the public.

Statements
If you would like to make a statement at this meeting on any item on this agenda, please register to do so at least 10 minutes prior to the meeting. Up to 3 speakers are permitted to speak for up to 3 minutes each on any agenda item. Please contact the officer named on the front of the agenda for any further clarification.

Questions
To receive any questions from members of the public or members of the Council received in accordance with the constitution.

Those wishing to ask questions are required to give notice of any such questions in writing to the officer named on the front of this agenda no later than 5pm on **Wednesday 28 February 2018** in order to be guaranteed of a written response**.** In order to receive a verbal response questions must be submitted no later than 5pm on **Friday 2 March 2018**. Please contact the officer named on the front of this agenda for further advice. Questions may be asked without notice if the Chairman decides that the matter is urgent.

Details of any questions received will be circulated to Committee members prior to the meeting and made available at the meeting and on the Council's website.

6 **Avon and Wiltshire Mental Health Partnership - Transformation Programme**

The Committee will be informed of the Transformation Programme for the Avon and Wiltshire Mental Health Partnership.

7 **Age UK Contracts - 2016 and Beyond**

When the committee considered the Age UK contracts on 19 April 2016, it was agreed that an update on implementation would be provided on the implementation of the contracts and on the implementation of the long-term investment grant in partnership with the CCG with Age UK (for a total maximum term of four years based on a two-year agreement with the option to extend the agreement for an additional two years based on the agreement of the parties).

The committee will receive a verbal update.

8 **NHS Health Checks - update** *(Pages 35 - 42)*

At its meeting on 27 June 2017 the committee considered the retrospective evaluation of the NHS Health Checks programme in Wiltshire.

It was agreed that the committee would receive an update showing how

outcomes for those on the programme compared with those not participating in it.

9 **Sexual Health and Blood Borne Virus Strategy 2017-2020** *(Pages 43 - 118)*

The committee will consider the final Sexual Health and Blood Borne Virus Strategy ahead of Cabinet's decision, currently planned for April 2018.

10 **Places of safety - update** *(Pages 119 - 124)*

To receive an update from the CCG regarding the temporary closure of the Places of Safety in Salisbury and Swindon following the announcement at the meeting of this Committee on 9 January 2018.

11 **Integrated Urgent Care mobilisation programme - update**

To receive an update on the Integrated Urgent Care mobilisation programme.

12 **Task Group and Programme Boards Representatives Updates** *(Pages 125 - 130)*

To receive any updates on recent activity for active task groups and from members of the Health Select Committee who have been appointed as overview and scrutiny representatives on programme boards.

13 **Forward Work Programme** *(Pages 131 - 138)*

The Committee is asked to consider the work programme.

14 **Urgent Items**

To consider any other items of business that the Chairman agrees to consider as a matter of urgency.

15 **Date of Next Meeting**

To confirm the date of the next meeting as 24 April 2018 at 2.00pm.

PART II

Items during whose consideration it is recommended that the public should be excluded because of the likelihood that exempt information would be disclosed

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Wiltshire Council
Where everybody matters

HEALTH SELECT COMMITTEE

DRAFT MINUTES OF THE HEALTH SELECT COMMITTEE MEETING HELD ON 9 JANUARY 2018 AT KENNET COMMITTEE ROOM, COUNTY HALL, BYTHESEA ROAD, TROWBRIDGE, BA14 8JN.

Present:

Cllr Christine Crisp (Chairman), Cllr Clare Cape, Cllr Gavin Grant, Cllr Howard Greenman, Cllr Andy Phillips, Cllr Pip Ridout, Cllr Tony Trotman, Cllr Fred Westmoreland, Cllr Graham Wright, Diane Gooch, Irene Kohler, Cllr Anna Cuthbert (Substitute), Cllr Robert Yuill (Substitute) and David Walker

Also Present:

Cllr Jerry Wickham

1 **Apologies**

Apologies were received from: Councillor Deborah Halik (substituted by Councillor Anna Cuthbert) Councillor Mollie Groom (substituted by Councillor Robert Yuill) and Councillor Mary Champion.

2 **Minutes of the Previous Meeting**

The minutes of the meeting held on the 7 November 2017 were considered.

Resolved

That the minutes of the meeting held on the 7 November 2017 were agreed as a correct record.

3 **Declarations of Interest**

David Walker declared an interest in items 4a and 4b, that Health Watch Wiltshire has been involved in engagement work on these issues.

Diane Gooch declared an interest in item 4a.

Cllr Pip Ridout declared an interest in the update from AWP and stated that she would listen to the debate but not participate.

4 **Chairman's Announcements**

The following announcements were noted as follows:

- User engagement with Adult Care

At its meeting on 7 November 2017, with regards to User Engagement with Adult Care, Cabinet resolved to agree to adopt Option 2 in the report it considered (to commission two separate services: one to deliver the statutory HealthWatch function and the other to deliver the non-statutory functions which would ensure a co-ordinated user engagement service and provide opportunities for efficiencies). This was on the condition that the delivery of this provision should be achieved by either two or one organisations, and that, if in the latter case, there would be a requirement for the contacted organisation to commission user led services from a number of providers and for them to ensure that the widest range of users are included.

Cabinet also resolved to secure delegated authority for the Corporate Director for Adult Care and Health, in consultation with the Cabinet Member for Adult Social Care, Public Health and Public Protection and the Associate Director for Finance to award a contract to the preferred provider/s when identified, as a result of the tender process.

At its March meeting the Health Select Committee would received an update on the outcome of the tender process.

The evaluation of submissions would conclude on 16 January and the committee will receive an update at the March meeting.

- CCG Strategic Outline Case

The Governing Body of the CCG requested that a Wiltshire-wide strategic outline programme be developed. It was noted that this was underway and linked into the development of the CCG's primary care strategy, the Joint Strategic Needs strategy from Public Health and the CCG's Care Operating Model. There would be a report on the overall programme in the summer of 2018.

- NHS England South procurement of orthodontic services

Committee members were invited to respond to NHS England on its proposals in relation to orthodontic services by 20 December 2017.

A number of contracts to provide orthodontic services in the south of England would be coming to an end on 31 March 2019. NHS England would be holding a procurement process in the New Year to award new contracts to provide orthodontic services from 01 April 2019.

Further information can be found on:
https://www.england.nhs.uk/south/info-professional/dental/

It was noted that members were sent an email, and that the consultation had now concluded.

- Consultation on a new model for radiotherapy services in England

NHS England is consulting on a new model for radiotherapy services in England.

The consultation is seeking feedback on a new specification for adult radiotherapy services and has recently been extended to 24 January 2018 and can be accessed on:

https://www.engage.england.nhs.uk/consultation/radiotherapy-service-specification-consultation

It was noted that members were sent an email, and that members could engage with consultation until 24 January.

5 **Public Participation**

There were no public questions or statements.

6 **Adult Care Charging Policy - Update**

Following previous considerations of the matter by the Committee, the meeting received a further progress report on the Adult Care Charging Policy since it was initially introduced in August 2016, including how lessons had been learnt, as agreed at 5 September 2017 meeting of Health Select Committee.

Matters highlighted in the course of the discussion included: whether there was a need for further overview or scrutiny; the additional resources required to meeting the additional processing needs; a recognition that staff had worked hard to meet this need; and the recommendations arising from the Healthwatch report.

Resolved

That confirmation be given to the meeting, possibly via an announcement after 31 March 2018, to confirm all re-assessments undertaken.

7 **Maternity Care Strategy - Update**

The meeting received a verbal update regarding the progress from the NHS Wiltshire Clinical Commissioning Group.

Matters highlighted in the course of the debate included: that service reconfiguration was a key focus; that the meeting would welcome another opportunity to discuss options, given to mothers, after May 2018; that options for meeting the midwifery team be discussed.

The Chair thanked the officer for the update.

8 **Non-Emergency Patient Transport Service - Update**

The meeting received an update on progress from the NHS Wiltshire Clinical Commissioning Group regarding non-emergency patient transport.

Matter highlighted in the course of the debate included: the results of the recent consultation; the engagement via stakeholder events; the plans to promote the Healthcare Travel Cost Scheme more widely; that the draft contact should be reading in February with a view to go out market over the next 6 months; that the expectation was for the new provider to be in place in June 2019.

At the conclusion of the debate, the meeting;

Resolved

1. **To receive a further update, possibly in July, including further details of the contract;**

2. **To receive, in the interim, further information regarding the breakdown of the consultation responses.**

9 **Wiltshire Health & Care (Adult Community Health Care Service) - CQC report**

Following a presentation, at the September meeting, on the delivery of the service since its commencement in July 2016, the Committee had resolved to consider the CQC report once published following the inspection of the Wiltshire Health & Care.

The Committee considered the CQC report, published on 09 November 2017, which can be accessed here.

Douglas Blair, Managing Director, Wiltshire Health and Care and Sarah Jane Peffers, Head of Quality, provide an update which informed the committee of the actions planned by Wiltshire Health and Care following the CQC report. The slides to accompany their presentation are attached here for reference.

The Committee also consider the need for further overview or scrutiny.

Matters highlighted in the course of the debate included the review of delivery structure; the further review of Board governance structure; the review of clinical leadership structure; the impact on funding on the security of the posts; the further integration with urgent care system; and Homefirst and care pathways.

Following the conclusion of the debate, the meeting;

Resolved

To receive a further update, possibly in July 2018, providing further information regarding the implementation of actions, and the development of the trust.

10 **Avon & Wiltshire Mental Health Partnership Trust - CQC report**

Having previously received an update on improvement from the Avon & Wiltshire Mental Health Partnership Trust on 21 June 2016, the meeting considered a further update including the CQC report, published on 3 November 2017, which can be accessed here.

A representative of the Avon & Wiltshire Mental Health Partnership Trust attended the meeting to inform the Committee of the Trust's planned actions following the CQC report.

The Committee was asked to consider the appropriateness of further overview or scrutiny, jointly with other local authorities, of the Avon & Wiltshire Mental Health Partnership Trust.

During the debate, particular attention was given to issue of provision of 'places of safety'. Newlands Anning, AWP's representative at the meeting, informed the meeting of the temporary closure of the places of safety in Salisbury and Swindon. This was identified as an area that would require further involvement by the committee.

It was agreed that the way in which this future work would be undertaken would be confirmed by the Chair and Vice-Chair following information gathering by contacting the Chair of Swindon's Health Select Committee and liaising with Wiltshire's Cabinet Member for Adult Social Care, Public Health and Public Protection, as well as relevant partners

Resolved

That a further update be provided.

11 **Task Group and Programme Boards Representatives Updates**

The meeting received the updates on recent activity for active task groups. The meeting was also asked to confirm the creation of the CAMHS (Children and Adolescents Mental Health Services) Task Group.

The meeting noted that both chair and vice-chair had been appointed as representatives on the Adult Social Care Transformation Programme Board; and that would attend the Joint Strategic Needs Assessment meeting prior to the Health and Wellbeing board on 25 January 2018.

Resolved

1. **To note the update; and**

2. **To confirm the establishment of the CAMHS (Children and Adolescents Mental Health Services) Task Group as set out in the report.**

12 **Forward Work Programme**

The Committee considerrf the work programme included in the agenda pack.

It was noted that following the annual meetings between the Chair and Vice-Chair of the Committee and Executive Members:

1. That the feasibility of the following areas of work for overview and scrutiny was being scoped:

    - SEND employment support;
    - Transition from children services to adult care;
    - Sustainability and Transformation Plans;
    - Community Area Health and Wellbeing Groups;
    - Embedding public health across the council's services.

2. That the following items were added to the committee's forward work programme:

- Pre-meeting briefing on the Adult and Social Care transformation programme;
- Public Health annual report to the Health Secretary;
- Update on Domestic Abuse Service;
- Update on Substance Abuse.

It was also decided that officers would discuss with chair the inclusion following additional matters:

- CCG forward work programme after the end of January.
- Recruitment and retention of staff at 999.
- Winter performance 24 April meeting

13 **Date of Next Meeting**

It was noted that the next meeting would be on 6 March 2018 at 10.30am.

14 **Urgent Items**

There were no urgent items.

(Duration of meeting: 10.30 am - 12.38 pm)

The Officer who has produced these minutes is Will Oulton, of Democratic Services, direct line (01225) 713935, e-mail william.oulton@wiltshire.gov.uk

Press enquiries to Communications, direct line (01225) 713114/713115

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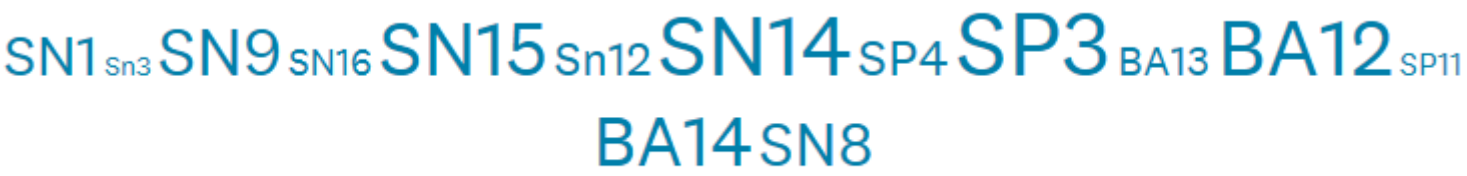
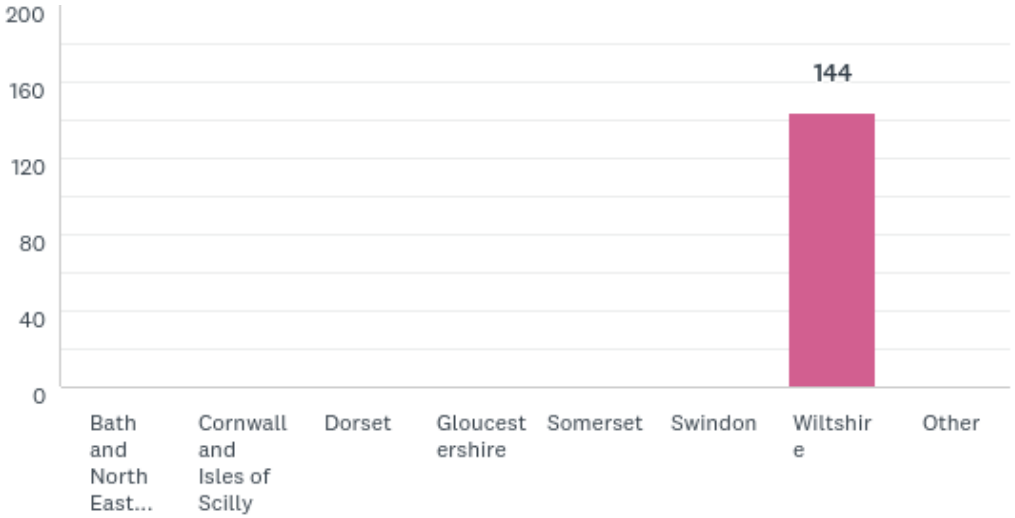
NHS Funded Patient Transport Survey

Wiltshire Non NEPTS Users

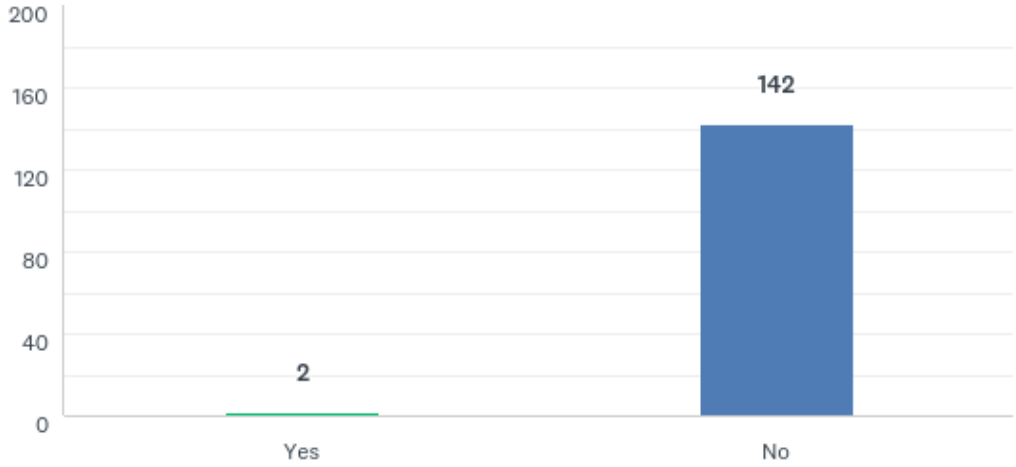
Q1: If you are a patient or responding on behalf of a patient please provide us with the first part of your postcode e.g. GL3 or TA9.



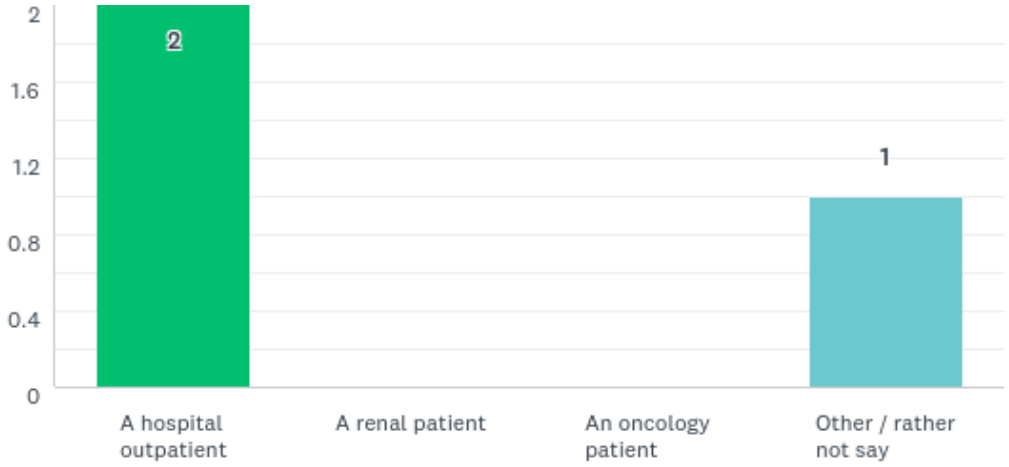
Q2: In which area is your GP practice based?



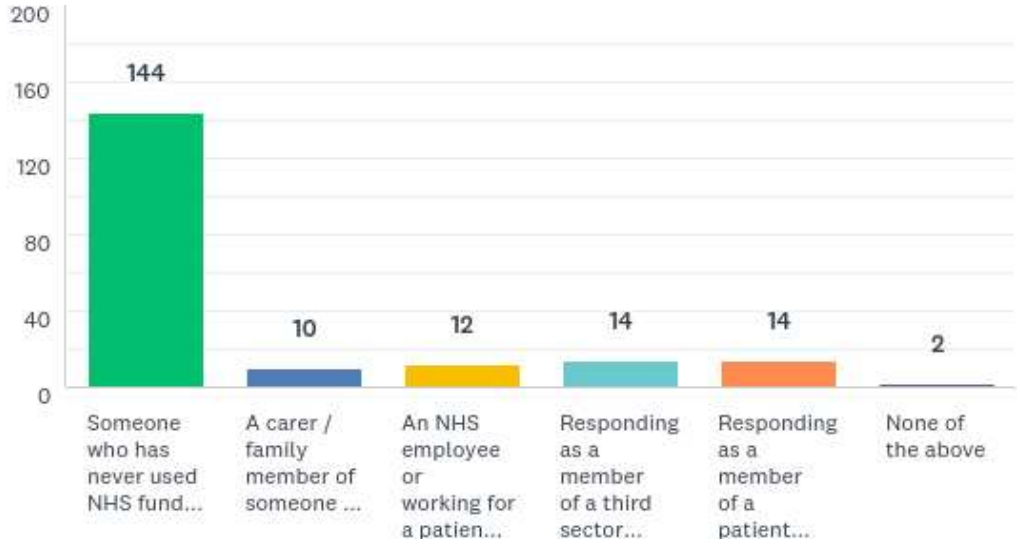
Q3: Are you someone who has used NHS funded non-emergency patient transport in the last year



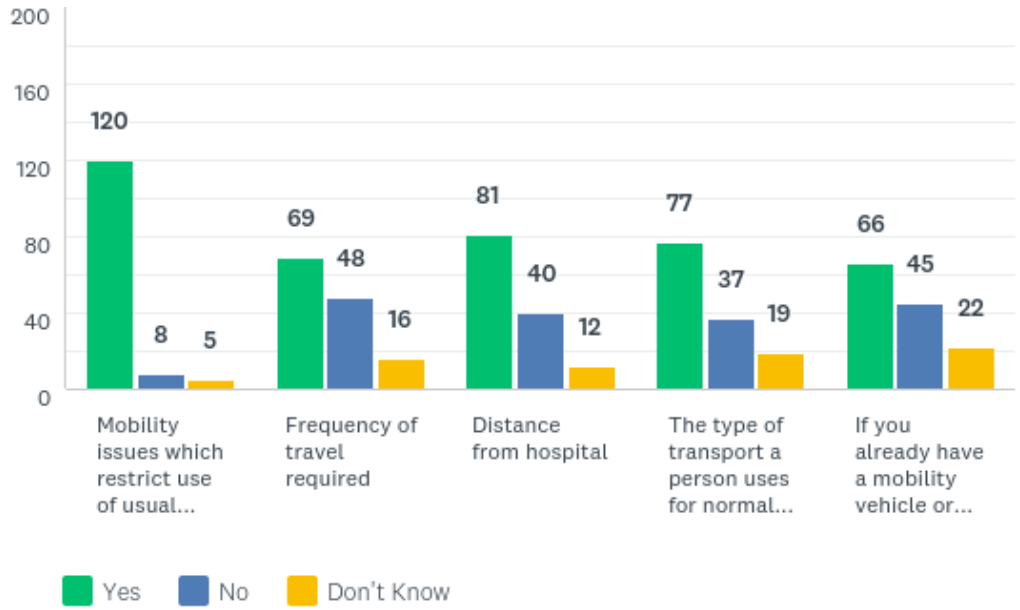
Q3a: If you have said yes to Q3 are you:



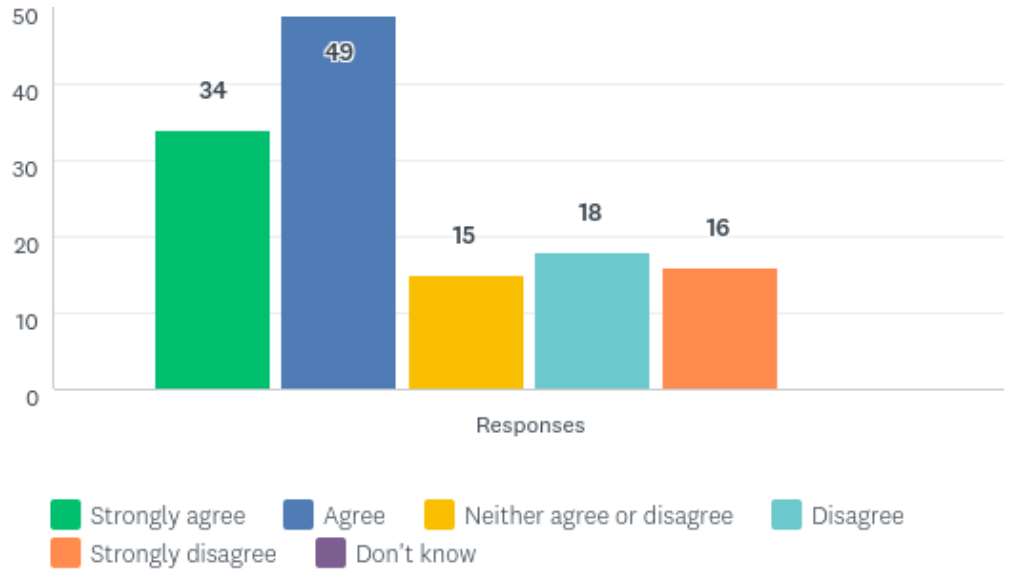
Q4: Are you? (you may tick more than one box)



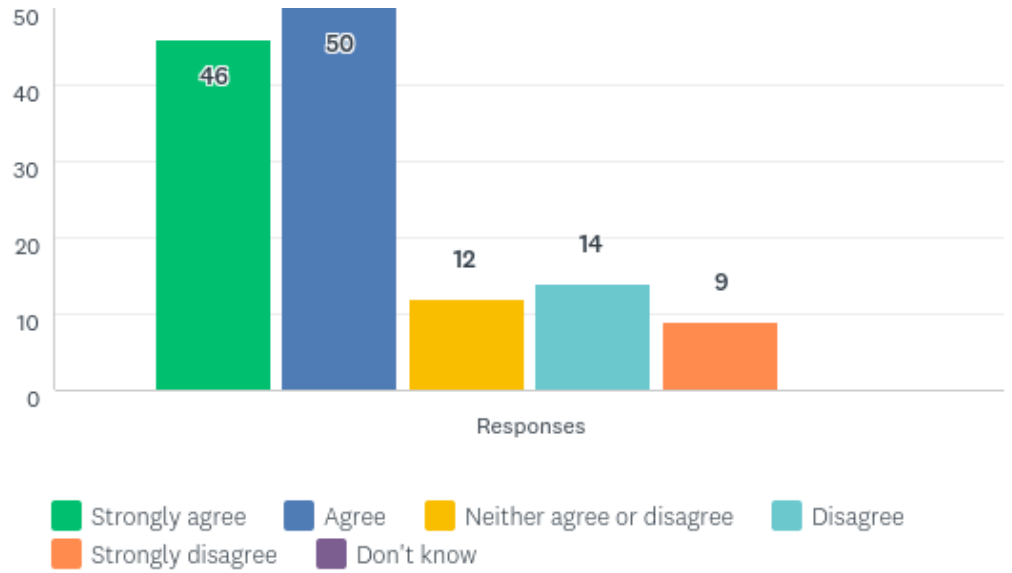
Q5: Eligibility is currently based on medical condition, what other factors do you think need to be taken into consideration? (for each factor please select yes, no or don't know)



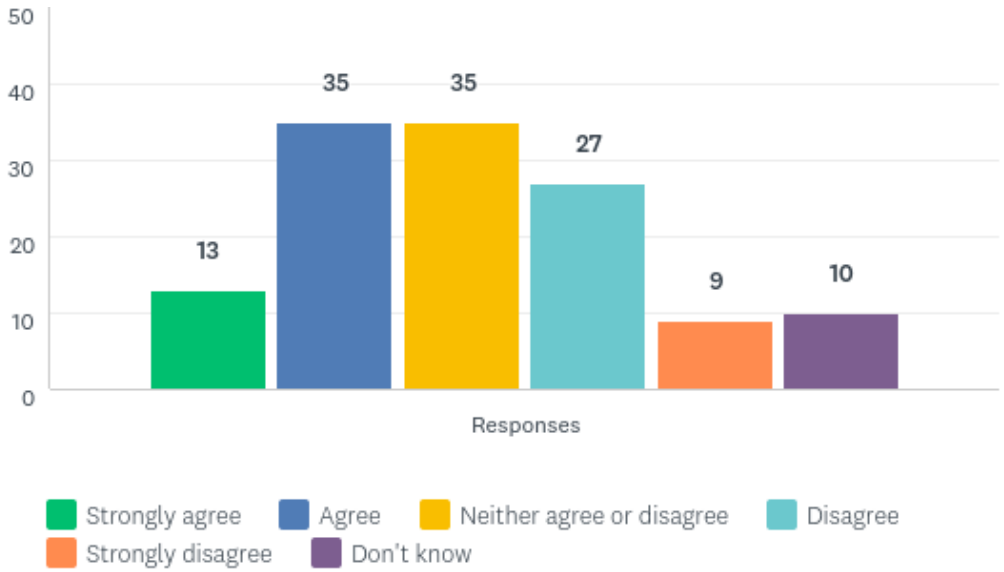
Q6: People who are able to make their own way to or from other appointments including hospital (e.g. driving themselves, being driven by friends, neighbours, family or voluntary services, or able to use public transport) should normally be assessed as NOT eligible for NHS funded non-emergency patient transport (tick one)



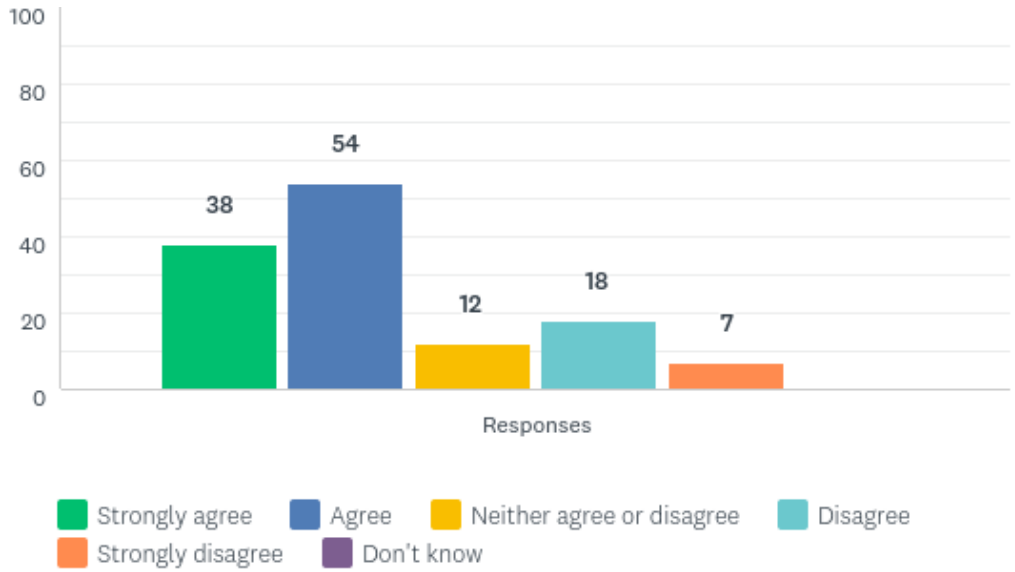
Q7: NHS funded non-emergency patient transport should be available only to people who need it for a medical reason, that is, they cannot travel safely by any other means (tick one)



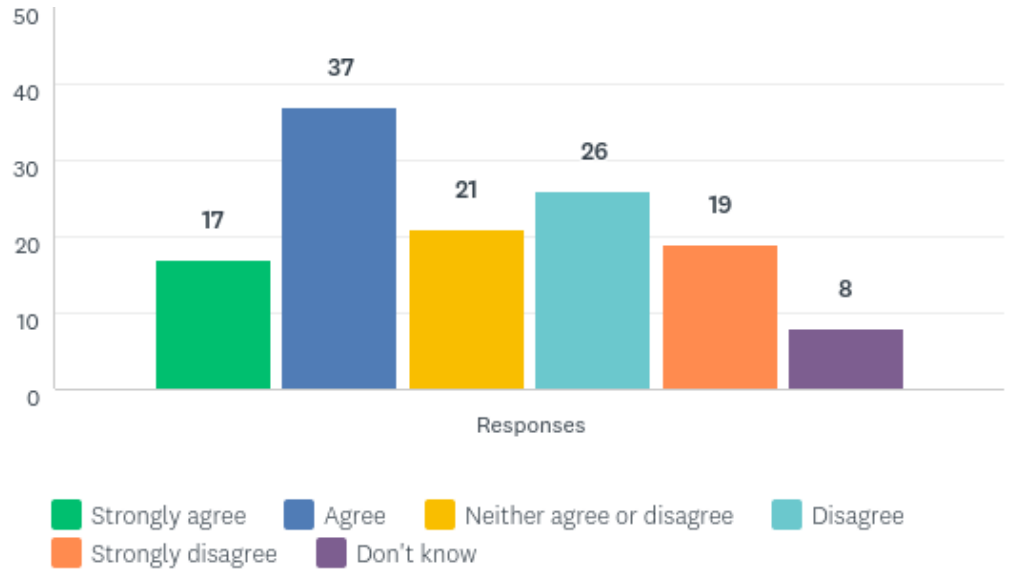
Q8: People should be entitled to NHS funded non-emergency patient transport if they need help getting to and from the vehicle, that is, they have no particular medical or mobility need for the transport journey itself (tick one)



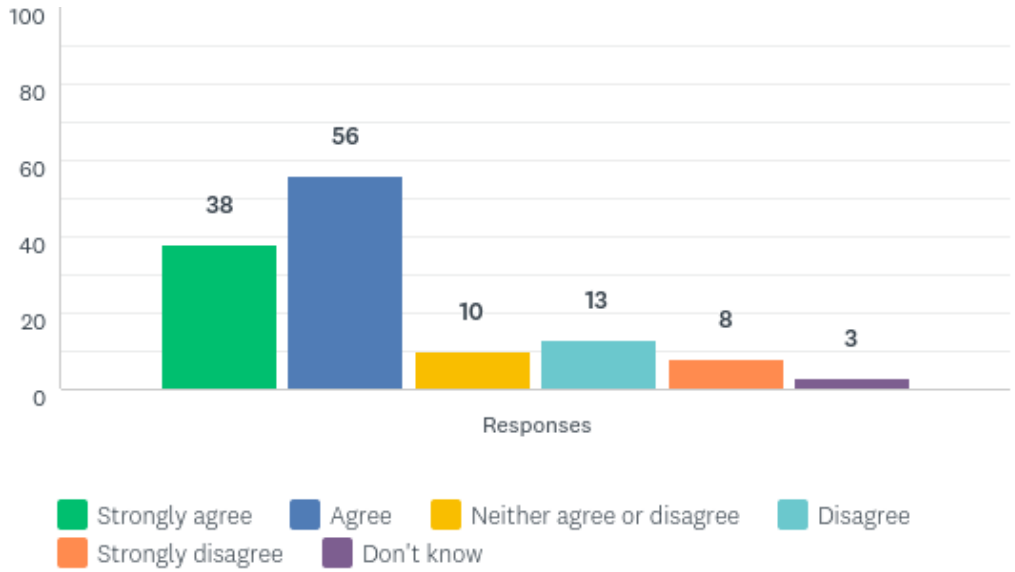
Q9: NHS funded non-emergency patient transport should not be available to people if they are able to travel safely by private car or public transport (tick one)



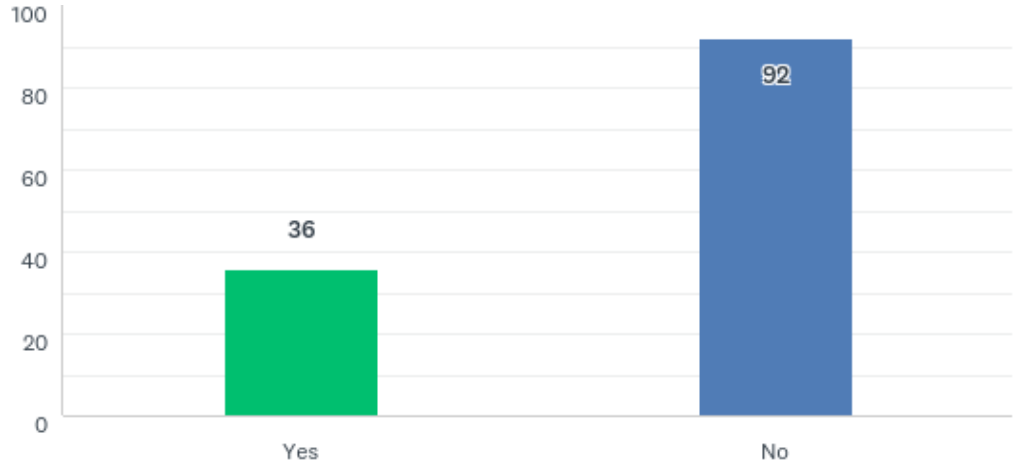
Q10: People who have a mobility vehicle, or similar, or who are in receipt of a higher level mobility payment should also be eligible to receive NHS funded non-emergency patient transport (tick one)



Q11: The same eligibility assessment for NHS funded non-emergency patient transport should be applied equally to all (tick one)

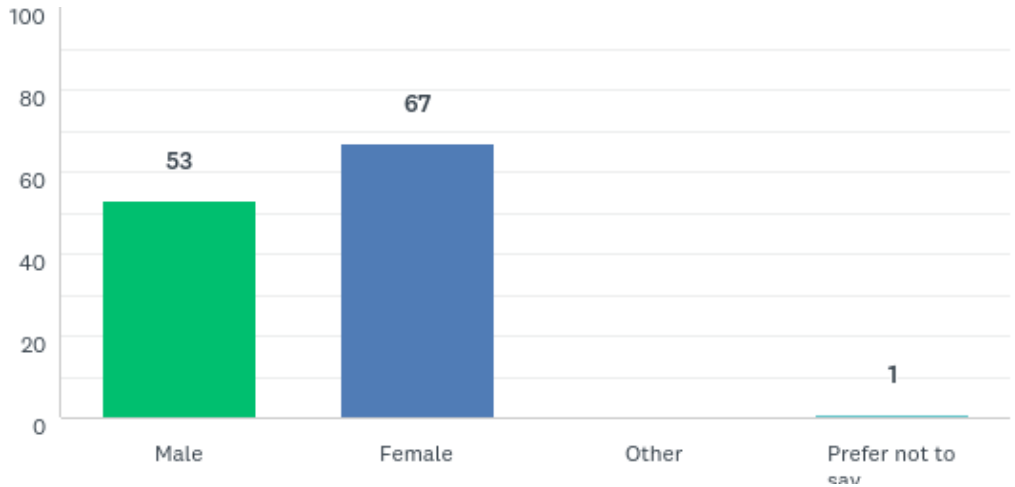


Q12: Some people who are not eligible for NHS funded non-emergency patient transport but who are either on a low income or in receipt of specific benefits may be eligible to claim travel costs under the Healthcare Travel Cost Scheme (HTCS). Are you aware of this scheme?

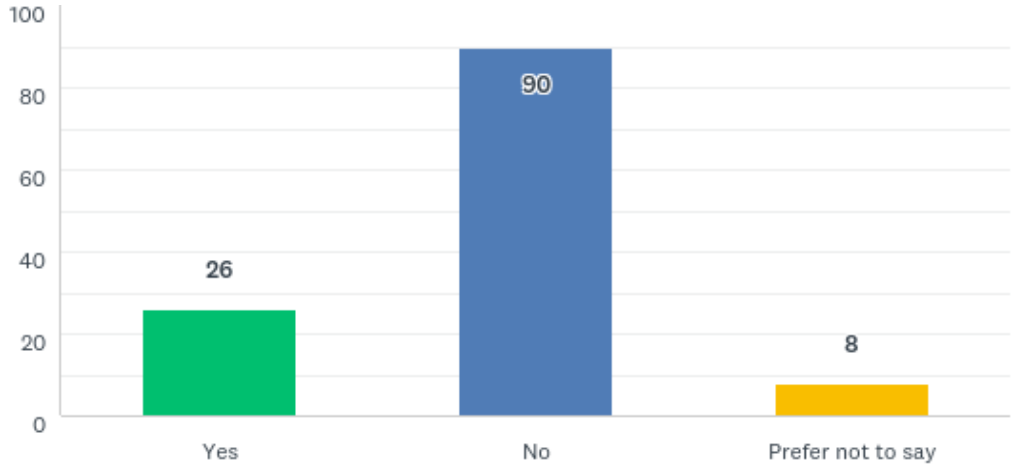


Q13: If you have any suggestions or comments, including how we can support people to make alternative plans to get to their hospital appointment rather than rely on NHS funded non-emergency patient transport, please note them here.

Q14: What is your Gender?

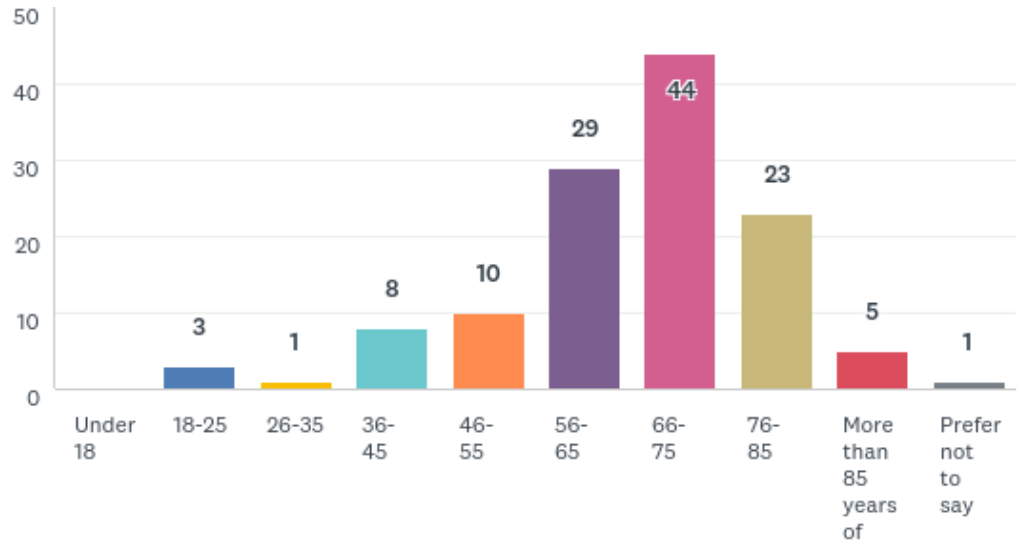


Q15: Do you have a disability? (This means a physical or mental impairment which has a substantial and long term adverse effect on your ability to carry out normal day to day activities.)

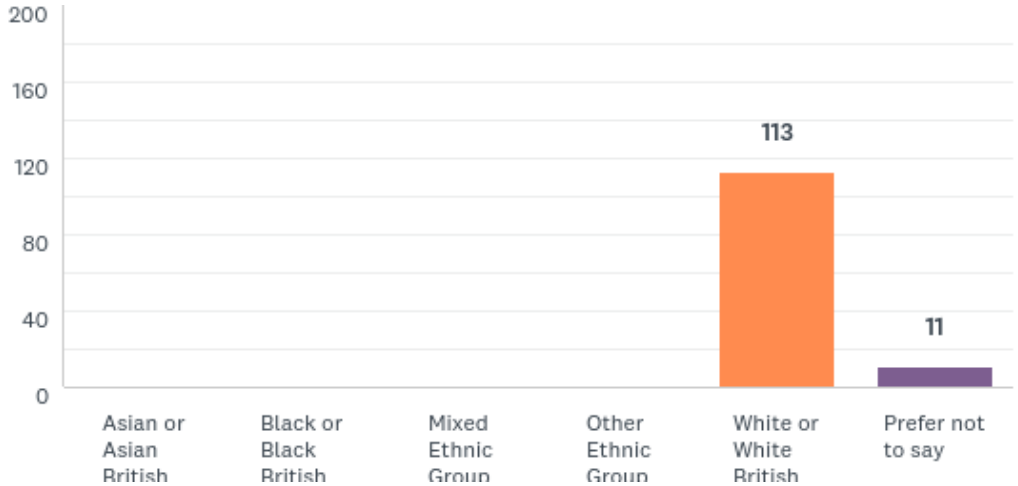


Q16: If you ticked yes and are happy to, please very briefly describe the nature of the disability

Q17: What is your age?



Q18: How would you define your ethnic origin?



Wiltshire Council

Health Select Committee

6 March 2018

5-Year Evaluation of Wiltshire's NHS Health Check Programme

Purpose

1. To provide an evaluation update on the NHS Health Checks programme to the Health Select Committee.

Background

2. NHS Health Checks are intended to identify early signs of cardiovascular disease. They are delivered by primary care providers (general practice) to adults in England aged between 40 and 74 years without any pre-existing cardiovascular disease every five years. The NHS Health Checks programme is commissioned by Wiltshire Council as a mandated service required by the Health and Social Care Act (2012).

3. The NHS Health Check programme began in Wiltshire in 2011. This programme was evaluated by the public health team in May 2017. The evaluation showed an increase in the percentage of the eligible population invited to attend an NHS Health Check: from 21.7% in 2012 – 2013 to 32.2% in 2015 - 2016.

4. From 2012 to 2016 an average of 45.5% of patients who were invited for an NHS Health Check attended and the percentage uptake increased from 2012 to 2016. On average from 2012 to 2016, 55.5% of patients who were invited for an NHS Health Check did not attend.

5. In 2017 the results of the evaluation were presented to the Health Select Committee at Wiltshire Council. The committee requested more information regarding the outcomes of patients who had been invited to attend an NHS Health Check but did not attend.

Aim of the evaluation

6. The aim of this evaluation was to review anonymised case notes of patients who were invited for an NHS Health Check but did not attend the programme, to determine if they subsequently developed cardiovascular disease or other medical condition.

Methodology

7. Cluster sampling was used to identify three general practices in Wiltshire. A clinical computer system, known as SystemOne was used to perform searches and generate reports of patients who had been invited for an NHS Health Check, had not attended it and had subsequently developed cardiovascular disease. The timescale was between 2012 and 2018, and the search used in this evaluation was run in January 2018.

8. Cardiovascular disease is defined as diseases of the heart and blood vessels. The following clinical search terms (known as read codes), were used in searches: atrial fibrillation, chronic kidney disease, coronary heart disease, diabetes, heart failure, hypertension, peripheral vascular disease, stroke.

9. Eight case studies were selected based on their demonstration of significant adverse clinical outcomes. These case studies were anonymised and detailed in this report.

Results

10. In the three general practices that participated in the evaluation, 6,989 patients were clinically coded as having been invited for an NHS Health Check between 2012 to 2017. 55.8% of these patients were coded as having had their NHS health check completed.

11. 44.2% of patients invited for an NHS Health Check did not have a completed NHS Health Check clinically coded in their medical records. 6.3% of these patients were subsequently clinically coded as having later developed a cardiovascular disease.

12. The case studies (see appendix) demonstrated a variety of different cardiovascular diseases, all of which are preventable. In all cases cardiovascular risk factors, such has high blood pressure, would have been likely to have been present at the time of an NHS Health Check. Interventions lifestyle modification advice and preventative medicines could have been initiated, and these could have decreased the risk of significant cardiovascular events occurring, and their associated long-term morbidity.

13. Several limitations to this study must be acknowledged. This study used data from only three general practices in Wiltshire. This study relies on clinical codes (search terms) being used accurately by the general practices. This includes the coding of NHS Health Check invitations having been sent, the coding of NHS Health Checks having been completed and cardiovascular diseases being coded at diagnosis.

Conclusion

14. Cardiovascular diseases can take many years to develop once risk factors such as high blood pressure have developed. Therefore, it is likely that other people who were invited for an NHS Health Check and who did not attend may subsequently develop cardiovascular disease in the long term.

15. This study has demonstrated the potential poor health outcomes related to not attending for an NHS Health Check when invited. It would be recommended that further efforts are made to increase the uptake of NHS Health Checks and to use the understanding of the reasons for non-attendance to inform promotion activities.

Authors

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Appendix - Anonymised case studies from three Wiltshire General Practices

1. Heart attack

A 50-year-old female was invited for an NHS Health Check in July 2016 but did not attend. She had been a smoker since she was 11 years old. Three months later in October 2016 she attended an accident and emergency department with severe chest pain. An ECG, which shows the heart's electrical activity showed major abnormalities indicating that she was having a life-threatening heart attack.

She was immediately taken for an emergency procedure on her heart, where a large blockage was found in the main blood vessel supplying her heart, and it was unblocked using a stent. Following this procedure her heart stopped beating, but she was revived by doctors and nurses in the hospital.

She was then started on medications to decrease her risk of more heart attacks in future and was seen by a stop smoking specialist nurse in her GP surgery.

Her heart attack was caused by a build-up of fatty materials in the main blood vessel supplying her heart. This is commonly caused by high cholesterol and high blood pressure. These could have been identified in an NHS Health Check and subsequently treated proactively, which could have prevented the need for an emergency procedure. The health care professional performing the NHS Health Check could also have discussed her smoking with her and could have referred her to the stop smoking service.

2. Brain haemorrhage

A 73-year-old male was invited for an NHS Health Check in March 2015 but did not attend. He was previously well, had never smoked and was still working. In December 2017, he was suddenly unable to speak, blind in one eye, and unable to move his right arm and leg. He was rushed to hospital and admitted to the intensive care unit. A brain scan showed a large bleed in his brain and his blood pressure was found to be extremely high.

Medications were started to decrease his blood pressure and he was seen by physiotherapists, to help him regain power in his arm and leg, and speech therapists to help him regain his speech.

When he was discharged from hospital he was categorised as having moderate to severe disability; unable to attend to his own bodily needs without assistance, and unable to walk unassisted.

The brain haemorrhage was caused by uncontrolled high blood pressure. This could have been identified in an NHS Health Check and treated with medications and lifestyle modification.

3. Stroke and irregular heart beat

A 69-year-old male was invited for an NHS Health Check in May 2013 but did not take up the offer. He was previously well and had never smoked. In November

2015, he suddenly developed weakness in his left leg and arm, so went to hospital. A scan of his head showed a blot clot in the brain and he was diagnosed as having had an ischaemic stroke.

He remained in hospital to have more tests looking for the cause of his stroke. One of the tests was a 24-hour heart monitor, which showed that the heart was beating irregularly. He was diagnosed with atrial fibrillation, a heart condition where the heart beats irregularly and often faster than normal.

Untreated atrial fibrillation is a common cause of stroke, as the irregular heart beat can cause blood clots to form in the heart, which then travel to the brain where they become stuck in brain blood vessels and cause a stroke.

Atrial fibrillation could have been identified in an NHS Health Check, as checking for an irregular pulse is a routine part of the health check. Blood thinning medications could then have been started to decrease the risk of a blood clot forming and causing a stroke.

4. Heart failure, kidney failure and high blood pressure

A 70-year-old male was invited for an NHS Health Check in September 2013 but did not take up the offer. He was previously well and had never smoked. In January 2016, he went to his GP because he had been experiencing chest pain and breathlessness when walking.

His GP referred him to a heart specialist doctor who organised an ultrasound scan of the heart, which showed heart failure: the heart was only managing to pump out 50% of the normal amount of blood. Further tests showed that the causes of this were a blockage of one of the main heart valves and blockages in some of the blood vessels supplying the heart. He was also found to have high blood pressure.

In August 2016, he had an operation to replace his blocked heart valve with an artificial valve. He then had another operation where he had a coronary artery bypass graft; a vein from his leg was moved to his heart, to divert the blood supply away from the blocked heart blood vessels. Over this period, he had been started on nine different medications for his heart.

In December 2016, he was admitted to hospital with worsening breathlessness and swollen legs. Blood tests showed that he had now developed kidney failure, and another ultrasound scan of his heart showed that his heart failure had got worse, and his heart was now only managing to pump out 28% of the normal amount of blood. Some more medications were started, and he had a pacemaker inserted, a small electrical device fitted in the chest to help the heart to beat.

The above treatments helped his breathlessness, chest pain and leg swelling, but ultimately there is no cure for heart failure and for this type of kidney failure. High blood pressure and high cholesterol are some of the major causes of blockages of blood vessels in the heart and kidneys, and these could have been identified in an NHS Health Check and subsequently treated.

5. Diabetes

A 40-year-old male was invited for an NHS Health Check in September 2015 but did not take up the offer. He was previously well and had never smoked. In March 2017, he went to his GP with a rash in his groin that his GP thought was fungal, so treated him with an antifungal cream.

Over the next few months the rash recurred several times, so in December 2017 blood tests were performed to look for causes of recurring infections, such as diabetes. Blood tests confirmed that he had type two diabetes, and some of the blood tests taken showed that he had had high blood sugar levels for at least the last two months.

After a diabetes diagnosis was made he was seen by the diabetes specialist nurse who gave him advice about changing his diet and losing weight.

Diabetes could have been identified in an NHS Health Check, as a diabetes risk assessment is performed as part it of the appointment, and this would have triggered further tests for diabetes to be performed. Treatment could have been started earlier to reduce blood sugar levels, which would have decreased the risks of long term high sugar levels, such as kidney disease, heart disease and eye disease.

6. Blockage of blood vessels in the legs

A 73-year-old man was invited for an NHS Health Check in July 2015 but did not take up the offer. The man was a smoker but was otherwise well. In July 2016, he went to his GP with pain in his lower left leg while walking. The GP examined him and found that the blood supply to his lower left leg was significantly decreased. The GP referred him to doctors who specialise in operating on blood vessels in the limbs.

In October 2016, the specialist doctors performed an ultrasound scan of the blood vessels in his legs, which showed that one of the main blood vessels supplying the lower left leg was blocked. He was started on medications to try to stop the problem worsening, with a view to possibly doing an operation in future to unblock the blood vessels if the pain is his leg significantly worsened.

The man was diagnosed with peripheral vascular disease; a disease in which blood vessels supplying the legs become narrowed and sometimes blocked by a build-up of fatty deposits in the blood vessels supplying the legs. The fatty deposits are caused by high cholesterol and high blood pressure, and these could have been identified in an NHS Health Check and treated with medications and lifestyle modification.

7. High blood pressure

A 67-year-old female was invited for an NHS health check in May 2015 but did not take up the offer. She was previously well and had never smoked. In May 2017, she checked her blood pressure at home using a friend's blood pressure machine and found it to be high.

She went to see her GP who asked her to monitor her blood pressure at home for a week to check how high it was on average. Her blood pressure was consistently high so she was started on medications to lower her blood pressure.

Blood pressure is checked as part of an NHS Health Check, so high blood pressure could have been identified earlier and treated.

8. Blockage of blood vessels in the heart

A 63-year-old lady was invited for an NHS Health Check in July 2015 but did not take up the offer. She was previously well, had never smoked cigarettes and no one in her family had suffered from any cardiovascular diseases.

In August 2017, she needed a non-urgent operation for a bladder problem and as part of this had a pre-operative health assessment by the anaesthetist in hospital. She had an ECG, a test which checks the heart's electrical activity, looking at its rate and rhythm. This showed some abnormalities so further heart tests were performed. A test to check the heart's electrical activity while exercising showed that the heart was not receiving enough oxygen while exercising, so she was referred to heart specialist doctors in the hospital.

The heart specialist doctors saw her in their clinic and asked her if she had ever had breathlessness and chest pain while exercising. She reported that she had experienced these symptoms, though had never sought medical advice about them. The heart specialist doctors performed a specialist test looking at the main blood vessels supplying the heart. The test showed that one of the main blood vessels supplying her heart was blocked.

She was diagnosed with coronary artery disease, a disease in which the main arteries supplying the heart become narrowed by a build-up of fatty materials. The main causes of this include high blood pressure, high cholesterol and being overweight; all of which could have been identified in an NHS Health Check. These could have then been treated with medications and lifestyle modification.

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Wiltshire Council

Health Select Committee

6 March 2018

Wiltshire's Sexual Health and Blood Borne Virus Strategy

Purpose of Report

1. The purpose of this report is to seek support for the final Sexual Health and Blood Borne Virus Strategy (Appendix 1) ahead of going to Cabinet in April 2018.

Background

2. Tackling sexual and reproductive health inequality has been a priority both nationally and locally for many years. Improving sexual health and wellbeing presents a significant challenge for public health and the wider health and social care system, as well as for the individuals who experience poor health outcomes as a result of a sexually transmitted infection (STIs), blood borne viruses (BBVs) or an unplanned pregnancy.

3. There is considerable inequality in the distribution of STIs, BBVs and unplanned pregnancies across the population. The 2013 Framework for Sexual Health Improvement placed health promotion and education as the cornerstones of infection and pregnancy prevention by improving awareness of risk and encouraging safer sexual behaviour. Prevention efforts need to include universal and targeted open access to sexual health and contraceptive services with a focus on groups at highest risk of sexual health inequality such as young people, black ethnic minorities and men who have sex with men.

4. In 2017, two health needs assessments (HNAs) (see appendix 2 and 3) were undertaken to enabled us to understand the prevalence of STIs, BBVs and unintended pregnancy within Wiltshire. This intelligence has shown us that although Wiltshire has lower levels of infection compared to the South West and England averages, infection rates are continuing to increase. The data also shows that women are accessing effective contraceptive methods to reduce the risks of unintended pregnancy.

5. These HNAs were produced in order to gain an understanding of the sexual health needs of the population of Wiltshire and to develop a STI and BBV strategy. The HNA documents explore the national policy context and local application. They also identify groups that are most at risk of poor sexual health and examines some of the wider context to sexual health including sexual violence, child sexual exploitation and abuse. The HNAs have also been informed by service user and service provider feedback.

6. Overall the HNAs identified that there are a broad range of sexual health and contraceptive services across the county although we know that the

rurality of Wiltshire poses some challenges to accessing appropriate services. In the development of the HNA it is recognised that there is a gap in the sharing of information across service commissioners which suggests that partnership working in relation to commissioning decisions may not be as effective as it could be to drive sexual health forward in Wiltshire.

7. The consequences of sexual ill health, infection with a blood borne virus, or unintended pregnancy are well documented. Infection with a STI can lead to both physical and emotional difficulties and in some cases, fertility issues if not diagnosed and treated early enough. Certain BBVs remain incurable and can lead to a dramatic reduction in life expectancy. HIV although treatable remains a condition which cannot be completely cured, leading to long term medical implications for anyone infected with the virus, especially if they are diagnosed after the virus has begun to damage their immune system. It is estimated that the lifetime treatment costs for a single person diagnosed with HIV is c.£380,000 but this amount doubles for someone who is diagnosed 'late'.

8. Unintended pregnancy is an issue across the life course for women who are not accessing effective contraception services and can impact on their lives for a very long time. It is estimated that in 2016 there were 302 unintended conceptions in Wiltshire which led to a live birth, which will lead to a public-sector cost of £938,992 per annum. By reducing this number by just 5% Wiltshire could save £49,950 per annum.

9. Our vision is that by 2020 Wiltshire will be a place where individuals and communities are informed, enabled, motivated and empowered to be able to protect themselves and others from acquiring an STI or BBV. Individuals should be able to make informed choices when considering contraception and have easier access to them. We want to ensure that everyone can have safe sexual experiences, free of coercion, discrimination and violence by ensuring sexual rights are protected, respected and fulfilled.

10. As a result of the HNAs, a combined strategy has been developed to ensure we achieve our vision for Wiltshire. The strategy recognises that there is no single solution to achieving positive sexual and contraceptive health and that to be successful we need to rely on a partnership approach between commissioners and providers and wider partner agencies across Wiltshire.

11. The development of the SHBBVS has been informed by an assessment of local needs, together with outcomes from both public and provider consultations. The evidence base for the strategy is based upon key government documents, current NICE guidance and evidence of best practice.

12. This strategy has been developed by Wiltshire Council's Public Health team in partnership with the Sexual Health Partnership Board and a range of partners across Wiltshire.

13. The SHBBVS contributes to the following Wiltshire Council business plan outcomes: Strong Communities (personal wellbeing through a healthier population), protecting the vulnerable (early intervention through prevention

activities) and protection the vulnerable (joined up health and care through greater partnership working).

Main Considerations

14. The SHBBVS provides direction for Wiltshire Council and partner organisations to reduce sexual ill health and blood borne virus transmission, to improve diagnostic and treatment services and reduce unintended conceptions over the next three years. Our vision is that by 2020 Wiltshire will be a place where individuals and communities are informed, enabled, motivated and empowered to be able to protect themselves and others from acquiring an STI or BBV, are able to access the types of contraception they want and able to have safe sexual experiences, free of coercion, discrimination and violence through ensuring sexual rights are protected, respected and fulfilled.

15. This will be the first strategy in Wiltshire to consider the needs of residents in respect of BBVs and as such will start the process of bringing together a range of organisations to work together to achieve the aim of the strategy.

16. There were two stakeholder engagement opportunities, the first with service users and the second with service providers. Both provided useful feedback on how providers delivered their services and what those using services felt they wanted and their views of what was being provided. The SHBBVS is based upon this information in combination with a review of national policy and guidelines.

17. The multi-disciplinary Sexual Health Partnership Board reviewed the HNAs and a draft version of the strategy document and provided feedback which has been incorporated into the final version.

18. Development, implementation and evaluation of the SHBBVS will be driven by the multi-disciplinary Sexual Health Partnership Board who will monitor progress and feedback to the relevant committees and boards throughout the lifetime of the document.

The risk of not implementing the strategy

19. If the decision is taken not to support the Sexual Health and Blood Borne Virus Strategy there could be:

    a) An increase in the level of unintended conceptions across all ages including young people.

    b) An increase in the number of sexually transmitted infections

    c) An increase in the number of blood borne virus infections which will lead to increasing overall health and social care costs

    d) Damage to relationships with partner organisations with whom the strategy has been informed by.

e) Increased costs to services due to duplication and ‘silo’ working on projects.

f) Increased cost to the wider health and social care budget

g) An increase in health inequalities across Wiltshire

Conclusions

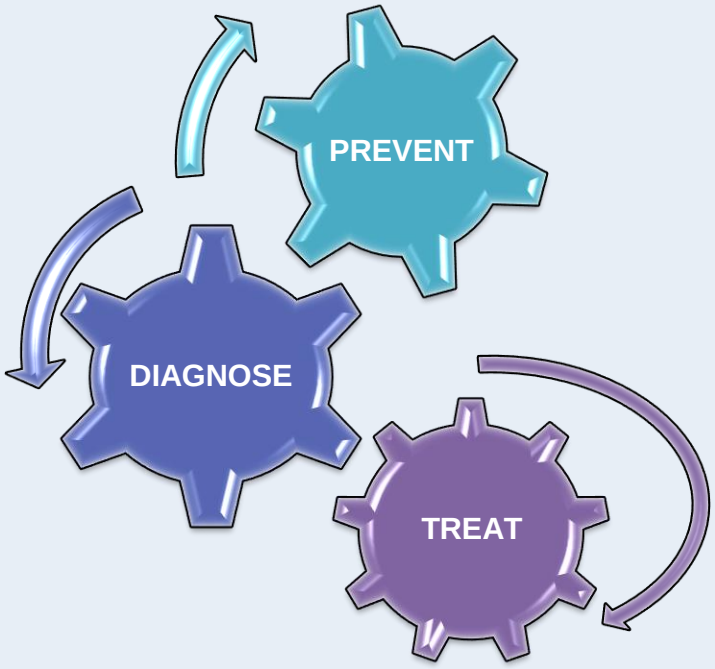
20. The gap analysis contained with the sexual health and blood borne virus HNAs have led to the development of a combined strategy to improve the sexual health and wellbeing of Wiltshire residents. The strategy has identified a vision to ensure that residents are supported to reduce the risk of contracting an STI or BBV, have timely access to diagnosis and treatment services should they become infected to improve their health outcomes and prevent further transmission. The intelligence gained from the HNAs and the subsequent strategy also contributes to the Council’s business plan, the Health and Wellbeing Strategy and is a key contributor to reducing inequality across Wiltshire.

Report Author: Steve Maddern, Consultant in Public Health

19 February 2018

Appendices

Appendix 1: Draft Wiltshire Sexual Health and Blood Borne Virus Strategy
Appendix 2: Sexual Health – Health Needs Assessment
Appendix 3: Blood Borne Virus - Health Needs Assessment



WILTSHIRE

Sexual Health & Blood Borne Virus Strategy 2017-2020

Introduction

This Strategy sets out our vision, aims and objectives for preventing the transmission of Sexually Transmitted Infections (STIs) and Blood Borne Viruses, enabling access to the full range of contraception options and preventing sexual violence in all its forms through improved education, awareness raising and appropriate service provision.

The concept of 'sexual health' does not merely mean the prevention of sexual ill health and the reduction in sexually transmitted infections (STIs) but also includes reproductive health and termination services, specialist teenage pregnancy services as well as services which work to reduce sexual violence, child sexual exploitation, forced marriage, honour based violence and female genital mutilation.

To improve sexual health across Wiltshire we need to deliver effective, equitable and value for money services across a range of providers. These include:

- Free and accessible testing and treatment services for STI infections
- Readily available access to all forms of contraception including free provision for our most vulnerable residents
- Provision of information to promote awareness of an individuals sexual rights to reduce sexual violence and abuse in all it's forms.

In addition to sexual health this strategy also considers the issues of Blood Borne Viruses and the importance of preventing, diagnosing and treating these infections.

Blood borne viruses (BBVs) provide a challenge to services, not just for the nature of the viruses in question which are traditionally considered to be Hepatitis B (HBV), Hepatitis C (HCV) and HIV, but because of the behaviours and lifestyle associated with the main routes of transmission

To reduce BBVs in Wiltshire we need to deliver effective, equitable and value for money services across a range of providers. This includes:

- Delivering evidence-based prevention, test and treatment programmes, maximising coverage and improving access to prevention and testing opportunities.
- Engaging sexual health services and other service providers in BBV prevention including effective condom distribution,
- Ensuring access to HIV and hepatitis testing with rapid results with referral to an evidence-based patient pathway.
- Delivery of effective vaccination programmes to all identified risk groups including occupational and sports related exposure.

Health Needs Assessments have recently been undertaken for both sexual health and blood borne viruses which will provide more detailed information on both topics covered in this joint strategy.

Definitions

What is Sexual Health

Sexually Transmitted Infections	Sexually Transmitted Infections (STIs) are transmitted through unprotected sexual intercourse, other genital contact or via the exchange of bodily fluids (including blood). There are a wide range of STIs, which commonly include Chlamydia, Gonorrhoea, Herpes, HIV, Human Papilloma Virus (HPV) and Syphilis. In 2016 there were 2,334 new STI infections diagnosed in Wiltshire residents which is in line with a nationally increasing trend. As many STIs are becoming harder to treat due to antibiotic resistance the importance of treating infections as quickly and reducing transmission is a public health priority.
Reproductive Health	There are approximately 15 different methods of contraception which allow you to enjoy sex whilst reducing the risk of unintended pregnancy. These methods can be differentiated depending on how they work - barrier methods (e.g. condoms,), hormonal methods (e.g. the pill), intrauterine devices (e.g. IUS or IUD) and sterilization. Women are also able to access emergency hormonal contraception (EHC). There are two oral forms and one form of intra-uterine contraception Cu-IUD which work by stopping or delaying ovulation.

Sexual Violence	The term 'Sexual Violence' covers a wide range of issues, including child sexual exploitation, sexual abuse, sexual assault and female genital mutilation (FGM). Every form of sexual violence requires special management to ensure that both victims and perpetrators are dealt with in the most appropriate way. The health needs of sexual assault victims include the physical health consequences of sexual violence, the risk of pregnancy, contraction of sexually transmitted infections and, for all victims, longer-term health issues such as increased rates of chronic illnesses, poor perceived health and increased use of medical services. The psychological consequences are linked to profound long-term health issues with one third of rape survivors going on to develop post-traumatic stress disorder, relationship problems and longer term psychological needs, mental illness and an increased risk of suicide for abused children when they reach their mid-twenties. The World Health Organisation definition of FGM is: 'all procedure that involves partial or total removal of the external genitalia, or other injury to the female genital organs for non-medical reasons'. FGM has serious health consequences, both at the time of the procedure and into adulthood. There are also long-term emotional and psychological effects from the lasting damage caused by FGM. In Wiltshire in 2015 there were 4 cases of FGM reported.

Definitions

What are Blood Borne Viruses (BBVs)

BBV Definition	A blood-borne virus (BBV) is a virus that is transmitted by blood or other body fluid that may contain blood. Blood-borne viruses may be transmitted if blood, semen or vaginal fluids pass from a person who is infected with the virus into the bloodstream of another person via a break in the skin or mucous membrane.
The BBVs that this strategy considers are Hepatitis B, Hepatitis C and HIV	
Hepatitis B	Hepatitis B causes inflammation of the liver. With acute infection some people experience flu-like symptoms, abdominal pain, jaundice (yellowing of the skin and eyes) and liver failure. Under 5% of people with acute infection go on to become a chronic carrier, in which the person may be asymptomatic (without symptoms) but liver-damage continues to take place and they remain infectious. Long-term complications of being a carrier include cirrhosis (scarring of the liver) and liver cancer. There is a vaccine to prevent infection with the virus which is offered to certain groups at higher risk of infection but there is currently no cure. Within Wiltshire it was estimated in 2015 that 1,956 people were living with the virus.
Hepatitis C	Hepatitis C also causes inflammation of liver, however acute infection is often asymptomatic, jaundice and serious disease is rare. About 80% of those with acute infection will go on to become chronically infected and of those who are chronically infected 75% will have some degree of active liver disease. Long-term complications of chronic infection include cirrhosis (scarring of the liver) and liver cancer. There are effective treatments available to cure individuals infected with this virus. 2015 prevalence estimates indicated that 1,952 people were living with the virus in Wiltshire.
HIV	HIV weakens the immune system against infections and some types of cancer. Infected people gradually become immunodeficient, which results in increased susceptibility to a wide range of infections and diseases that people with healthy immune systems can fight off. The most advanced stage of HIV infection is Acquired Immune Deficiency Syndrome (AIDS). Effective treatments are available to reduce the effects of the virus, but there remains no cure. These treatments can also reduce the possibility of onward transmission of the virus. There were 239 people diagnosed as living with HIV in Wiltshire in 2016

National Context

417,584 diagnoses of STI infections in the UK (2016)

11.8% of STIs were in men who have sex with men

214,000 people in the UK are estimated to be living with Hepatitis C

12,060 people commenced Hepatitis C treatment during 2016/17

Hepatitis B is 50-100 times more infectious than HIV

9,179 cases of FGM were reported in 2016/17

Sexual Offences rate in 2015 was 1.7 per 1,000 individuals

16,046 people tested positive for Hepatitis B between 2010/14

In 2015, 101,200 people were living with HIV in the UK

Approx 85,000 women are raped in England and Wales each year

Information is the greatest weapon to prevent sexual ill health

Approx 12,000 men are raped in England and Wales each year

1,220,224 people attended a specialist service for contraception in 2016

Under 18 conception rate in 2015 was 20.8 per 1,000 women

Vaccination can help prevent Hepatitis B infection

Oral contraception remains the main method used in the UK

GP prescribing rate of Long Acting Reversible Contraception was 44.1 per 1,000 women in 2015

190,406 abortions took place in 2016

Local Context

2,334 people in Wiltshire were diagnosed with a new STI (2016)

1,131 cases in men

1,203 cases in women

1,952 people are estimated to be living with Hepatitis C

22 local pharmacies commissioned to provide emergency contraception

239 people are living with HIV and receiving treatment and care

13.5% of STIs were in men who have sex with men

57% of new STI diagnoses were in young people aged 15-24

Information is the greatest weapon to prevent sexual ill health

4 cases of FGM were reported in 2016

Sexual Offences rate in 2015 was 1.4 per 1,000 individuals

63 cases of Child Sexual Exploitation were investigated in 2015

6,199 people attended a specialist service for contraception in 2016

1,956 people are estimated to be living with Hepatitis B

Under 18 conception rate in 2015 was 14.0 per 1,000 women

40% of people living with HIV are over 50 years of age

GP prescribing rate of Long Acting Reversible Contraception was 57.7 per 1,000 women in 2015

Oral contraception remains the main method used in Wiltshire

1,060 abortions took place in 2016

Strategic Framework

Our vision is that: Wiltshire is a place where all individuals and communities are informed, enabled, motivated and empowered to be able to protect themselves and others from acquiring a STI (or BBV), are able to access the types of contraception they want and are able to have safe sexual experiences, free of coercion, discrimination and violence through ensuring sexual rights are protected, respected and fulfilled.

This will be supported by three key aims of prevention, diagnosis and treatment provision.

Wiltshire aims to:

- Support individuals to reduce their risk of STI and BBVs and enabled to access all forms of contraception through the provision of information and services. This will also increase the awareness of individuals' sexual rights and reduce sexual violence in all its forms
- Individuals will be able to access testing services when needed in a range of venues, using a range of different testing systems, including the review and implementation of new and emerging testing pathways
- Individuals will be able to access appropriate treatment services as early as possible in locations which are most appropriate to them

Wiltshire's priorities are:

- To ensure that information resources are available in a wide range of venues to increase awareness of BBVs and sexual health in all it's forms and reduce the risk of contracting an infection
- To provide opportunities to test and diagnose individuals who have been at risk of contracting a BBV or STI with testing offered at every appropriate and suitable venue
- To reduce unintended pregnancies in all women of fertile age, particularly those under 18
- To reduce all forms of sexual violence through education and awareness raising
- To increase the knowledge and confidence of professionals to assist in the identification of sexual violence and support they can offer victims
- To provide high quality access to sexual health services in a range of venues and locations across Wiltshire
- To ensure that treatment of BBV or STI infection is offered in a timely manner with barriers to access minimised

Wiltshire Sexual Health Strategy - Overview

Our Vision	**Our vision is that: Wiltshire is a place where all individuals and communities are informed, enabled, motivated and empowered to be able to protect themselves and others from acquiring a STI (or BBV), are able to access the types of contraception they want and are able to have safe sexual experiences, free of coercion, discrimination and violence through ensuring sexual rights are protected, respected and fulfilled.**

	Strategic Aim	Outcomes
PREVENTION	To protect individuals from BBV or STI infections and enabled to access all forms of contraception through the provision of information and services. This will also increase the awareness of individuals' sexual rights and reduce sexual violence in all its forms	Information resources will be widely available in a range of venues to increase knowledge of blood borne viruses and sexual health including STI's, contraception and sexual violence
		The full range of contraception options will be available in all primary care and sexual health services
		Individuals most at risk of HBV infection will be actively offered and encouraged to be vaccinated
		Healthcare professionals will discuss the risks of blood borne viruses and sexual ill health with all appropriate patients and actively support them with risk reduction strategies
		Prevention interventions will target people across the life course
		Accurate data will be available from all providers of BBV services to facilitate partnership working and future service planning
		Young people will receive effective RSE education through school settings
DIAGNOSIS	To ensure individuals will be able to access testing services when needed in a range of venues, using a range of different testing systems, including the review and implementation of new and emerging testing systems	A range of 'open access' services will be available across the county to enable easier access
		Drug and alcohol service providers will offer BBV testing to all clients
		Prison services will increase the offer and uptake of BBV screening upon arrival.
		Primary care settings will offer a wider range of sexual health and BBV testing services as part of routine diagnostic tests
		Workforce training will take place to enhance the confidence of staff to undertake STI testing and provide additional contraception services
		Home testing/sampling systems will be available to facilitate additional diagnostic opportunities
		Stigma associated with being diagnosed with a BBV will be reduced
		Services will meet the needs of all sections of our communities
TREATMENT	To ensure individuals will be able to access appropriate treatment services as early as possible in locations which are most appropriate to them	All patients diagnosed with a BBV or STI will be treated in a timely manner in a suitable setting.
		Advice and guidance will be readily available to all clinicians by sexual health specialists to ensure the latest treatment regime is being offered
		Effective referral pathways will be in place to facilitate specialist treatment or care if needed
		Treatment options will be discussed with all patients upon diagnosis of their BBV
		Holistic methods of self-care will be discussed with everyone living with a BBV
		Risk reduction strategies will be discussed with all patients receiving treatments to reduce possible onward transmission

Population Health Needs / National Strategy and Guidance

Health Needs Assessments were undertaken in 2017 for both sexual health and blood borne viruses which will provide more detailed information on both topics covered in this joint strategy.

National strategies and guidance is in place to support the design, development and review of sexual health and of blood borne virus services and these have been used to provide the strategic framework to inform Wiltshire's approach to this strategy. These include:

Sexual health guidance

- A Framework for Sexual Health Improvement in England – Department of Health
- National Teenage Pregnancy Strategy – Social Exclusion Unit
- NHS Choices, Contraceptive Guide – NHS
- Long Acting Reversible Contraception – National Institute of Health and Care Excellence
- The Female Genital Mutilation Act 2003 – UK Government
- Child Sexual Exploitation, definition and a guide for practitioners – Department for Education
- A guide to whole system commissioning for sexual health, reproductive health and HIV – Public Health England
- Sexually transmitted infections and under 18 conceptions: Prevention – National Institute for Health and Care Excellence

Blood Bourne Virus guidance

- A Framework for Sexual Health Improvement in England – Department of Health
- Hepatitis B (chronic) diagnosis and management (CG15) – National Institute for Health and Care Excellence
- Hepatitis B and C: Ways to promote and offer testing to people at increased risk of infection (PH43) - National Institute for Health and Care Excellence
- Improving testing rates for blood borne viruses in prisons and other secure settings – Public Health England.

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Sexual Health Needs Assessment

December 2017

Part of the JSNA family

Wiltshire Council
Where everybody matters

Needs Assessment prepared by:
Stephen Jones / Steve Maddern
Public Health Team
Wiltshire Council
www.intelligencenetwork.org.uk
www.wiltshirejsa.org.uk

Summary

Tackling sexual and reproductive health inequality has been a priority both nationally and locally for many years. Improving sexual health and wellbeing presents a significant challenge for public health and the wider health and social care system, as well as for the individuals who experience poor health outcomes as a result of a sexually transmitted infection (STIs) or an unplanned pregnancy.

There is considerable inequality in the distribution of STIs and unplanned pregnancies across the population. The Framework for Sexual Health Improvement (2013)[26] placed health promotion and education as the cornerstones of STI and pregnancy prevention by improving knowledge of risk awareness and encouraging safer sexual behaviour. Prevention efforts should include ensuring open access to sexual health and contraceptive services should focus on groups at highest risk of sexual health inequality such as young people, black ethnic minorities and men who have sex with men.

The Health and Social Care Act 2012 brought about a significant change in the commissioning landscape across England. The impact of this transition saw the responsibility for the commissioning of sexual health and contraceptive service move from a single commissioning body to three separate organisations. Locally these organisations are Wiltshire County Council; NHS Wiltshire Clinical Commissioning Group (CCG) and NHS England.

Reviewing the data for this HNA has enabled us to understand the prevalence of STIs and unintended pregnancy within Wiltshire. It has shown us that although Wiltshire has lower levels of infection compared to the South West and England averages, infection rates are continuing to increase. The data also shows that women are accessing effective contraceptive methods to reduce their risks unintended pregnancy.

This health needs assessment (HNA) has been produced in order to gain an understanding of the sexual health needs of the population of Wiltshire and to inform the way services are developed and delivered. This document explores the national policy context and local application; it identifies groups that are most at risk of poor sexual health and examines some of the wider context to sexual health including sexual violence, child sexual exploitation and abuse. The HNA has also been informed by service user and service provider feedback.

Overall the HNA identified that there are a broad range of sexual health and contraceptive services although we know that the rurality of Wiltshire poses some challenges to accessing appropriate services. In the development of the HNA it is recognised that there is a gap in the sharing of information across service commissioners which suggests that partnership working in relation to commissioning decisions may not be as effective as it could be to drive sexual health forward in Wiltshire. This has been reflected in the recommendations at the end of this document.

Contents

Background

Local Context

There are an estimated 488,409 [31] people living in the Wiltshire Local Authority area of which 51% of the population is female. Wiltshire is predominantly White British (93%). In 2016 ONS published population projections [32] which estimated Wiltshire's population will steadily grow to 516,000 by 2026. The age structure of Wiltshire is similar to the South West region. However, Wiltshire has a slightly smaller proportion of 20 to 24 year olds which might be a reflection of a lack of a University. Wiltshire will develop a larger proportion of older people and by 2026 the number of people over the age of 65 will for the first time outnumber those under the age of 20. This will impact on how sexual health and contraceptive services are provided to ensure they remain appropriate for the population, especially those most at risk of poor sexual health and wellbeing in comparison to the general population.

The last sexual health needs assessment was undertaken in 2013 to reflect the actions from the Sexual Health South West Quality Assurance Peer Review (2011) and also introduced the then new Public Health Outcomes Framework relating to sexual health at county level.

The Health and Social Care Act 2012 brought about a significant change in the commissioning landscape across England. The impact of this transition saw the responsibility for the commissioning of sexual health and contraceptive service move from a single commissioning body to three separate organisations. Locally these organisations are Wiltshire County Council; NHS Wiltshire Clinical Commissioning Group (CCG) and NHS England.

Wiltshire Council commissions:

- A comprehensive sexual health services including most contraceptive services and all prescribing costs, but excluding GP additionally-provided contraception
- Sexually transmitted infections (STI) testing and treatment, chlamydia screening and HIV testing
- Specialist services, including young people's sexual health, teenage pregnancy services, outreach, HIV prevention, sexual health promotion, services in schools, college and pharmacies

NHS Wiltshire CCG commissions:

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

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 fetal medicine services

The purpose of this HNA is to provide an understanding of the sexual health needs of the population of Wiltshire. The HNA highlights populations at greatest risk of poor sexual health outcomes to enable a greater understanding of need and demand for sexual health services and identify barriers to accessing services and identify opportunities for overcoming them. Finally the HNA should assist in promoting better working between service commissioner's service providers and related services including primary care, drugs and alcohol services and education providers. A gap analysis and recommendations can be found towards the back of this document and will be used to inform a sexual health strategy for Wiltshire.

This report is based upon data that is readily available. In the development of the HNA it is recognised that there is a gap in the sharing of information across service commissioners which suggests that partnership working in relation to commissioning decisions may not be as effective as it could be to drive sexual health forward in Wiltshire. This has been reflected in the recommendations at the end of this document.

It is important to recognise that sexual health is not just the prevention and treatment of sexual ill health but also supporting the provision of reproductive health service and also plays a key role in safeguarding those vulnerable in our communities. This includes the work to increase the uptake of LARC which has been shown to reduce the levels of unintended conception significantly.

National policy

There are several policy documents that support the agenda around sexual health. *A Framework for Sexual Health Improvement (2013)* [26], set the ambition to improve the sexual health and wellbeing of the population. The framework stated that we must recognise that sexual ill health can affect all parts of society. We need to build an honest and open culture to allow everyone to make informed choices around sex and relationships and ultimately reduce inequalities and improve sexual health outcomes.

In Wiltshire we have aspired to achieve the ambitions of the framework by ensuring we undertake a range of health promotion activities through the commissioning of evidence-based services. With these ambitions in mind, locally we have striven to ensure that we prioritised prevention to support the population (both professionals and general public) to build their knowledge around sexual health. We have either delivered or commissioned effective, evidence-based, high quality services that provide timely access to sexual health and contraceptive services. We have worked

to drive down the rates of STI amongst the population and reduce rates of unintended pregnancy.

Public Health England (PHE) published 'Making It Work', a guide to whole system commissioning for sexual health, reproductive health and HIV (2015) intended to safeguard the collaboration between commissioners to ensure that services were developed and delivered efficiently and effectively [27]. In Wiltshire, we have implemented this guidance by ensuring that we put people at the centre of commissioning, and base decisions on assessed needs, hence this HNA. We are committed to continually reviewing existing service provision and developing services to best meet identified needs for Wiltshire communities. We draw on the expertise of clinicians and service users, and the public's views to inform commissioning as is evidenced within this document. As commissioners and service providers we acknowledge that the economic climate requires new thinking and innovation.

It is recognised that there is a need to build relationships across commissioning organisations; by developing strong relationships and dialogue with counterparts to develop local solutions and ultimately understand that there is no one right way – Wiltshire Council is very much the facilitator at local level to make collaborative commissioning for sexual health and reproductive health a reality.

Supporting the delivery of effective, high-quality services is a suite of guidance documents produced by NICE on a range of sexual health topics. This suite of guidance provides evidence-based and best practice recommendations on contraception including the use of LARC methods [15]; HIV testing and how to increase testing uptake by individuals with undiagnosed HIV [28]; and guidance on the prevention of STI infections [29]. In Wiltshire this guidance has been used to ensure that services are designed and delivered using the latest evidence of best practice and that service developments are continually focussed on overall service improvement.

2013 saw the introduction of the national Public Health Outcomes Framework which defined three key sexual health indicators [30]: Under 18s conception rate per 1,000 women (PHOF 2.04); Chlamydia detection rate per 100,000 young people aged 15-24 (PHOF 3.02) and HIV late diagnosis percentage (PHOF 3.04). Wiltshire's performance against these targets is discussed in the chapters to follow.

Sexually Transmitted Infections

Over recent years, the rates of STIs within Wiltshire have been steadily increasing in line with national trend [1]. STIs are transmitted through unprotected sexual

intercourse, other genital contact or via the exchange of bodily fluids (including blood). There are many STIs, which include Chlamydia, Gonorrhoea, Herpes, HIV, Human Papilloma Virus (HPV) and Syphilis. Some STIs are becoming resistant to current antibiotics, therefore prompt and effective treatment is a public health priority

Chlamydia

Chlamydia is the most common bacterial sexually transmitted infection in England with up to 70% of women and 50% of men having no symptoms despite being infected [9]. It can affect everyone but is most common in young people aged under 25 and men who have sex with men. If the infection remains undiagnosed and untreated complications for women include pelvic inflammatory disease, ectopic pregnancy and possible tubal factor infertility; in men Chlamydia can cause infertility, urethritis or epididymitis. Rarely, Chlamydia is a cause of sexually acquired reactive arthritis and Fitz-Hughes Curtis syndrome (a rare type of liver infection).

In 2016 the diagnosis rate for Chlamydia in Wiltshire was lower than in previous years at 1,697 per 100,000 individuals [1]. There has been a gradual decline in the numbers of young people being tested over the past few years and between 2012 and 2016 rates have decreased in England from 26.9 to 20.7%, in the South West from 25.4% to 21.6% and in Wiltshire from 20.5% to 18.3% [1].

Despite Wiltshire consistently having a lower detection rate than both the South West and England averages, this provides the evidence that the screening programme we deliver is appropriately targeting those at risker risk of infection. At the end of 2016 the Wiltshire chlamydia positivity rate was 9.3% against a South West rate of 8.2% [2]. Wiltshire has had a consistently lower Diagnosis Rate Indicator than either the regional or England averages, however a consistently higher rate of positivity indicates that in Wiltshire we are screening those most at risk.

Gonorrhoea

Gonorrhoea is the second most commonly contracted bacterial sexually transmitted infection in the UK [1]. Gonorrhoea is more prevalent in MSM, young adults, and black and minority ethnic populations [1]. Since 2009 the diagnosis of Gonorrhoea has been increasing steadily in England with Wiltshire also seeing an increase [1]. Between 2014 and 2016 Wiltshire saw a substantial decrease in the levels of diagnosis within women, however this was offset by an increase in the levels of Gonorrhoea in men, and in particular within MSM in which there was a 42% increase [4]. In 2016, the diagnosis rate of Gonorrhoea in Wiltshire was 14.6 per 100,000 individuals compared to an England rate of 64.9 [4].

Syphilis

The number of cases of Syphilis has been continuing to rise in the UK over the last decade, although Wiltshire has a relatively low level of syphilis diagnosis each year

and consequently even minor fluctuations in the figures can have a large impact on our disease profile [1].

In 2016 the Syphilis diagnosis rate in Wiltshire was 1.9 per 100,000 individuals compared to an England rate of 10.6 [4]. The 2015 rate in Wiltshire of 2.1 per 100,000 was a significant increase from the 2014 rate which was 1.4 per 100,000 so although this reduction is welcomed there remains concerns about a future increase in infection rates [4].

Herpes

Genital Herpes is caused by the herpes simplex virus (HSV). It is the most common ulcerative STI in the UK and is associated with physical and psychological morbidity. There are two types of HSV infection [11], HSV-1 is a condition of which the majority of people are aware and when an outbreak occurs is commonly referred to as having a 'cold sore', HSV-2 is the form of the virus which is usually referred to as genital herpes, however HSV-1 can also be spread to the genital area [11].

The rate of diagnosis have remained stable over the past 8 years with the exception of 2014 [4] in which there was a large increase in the number of men who were diagnosed following a recurrent outbreak, however this rate fell again in 2015 and in comparison with the South West average as well as the England average, Wiltshire has relatively low levels of Herpes infection [4]. In 2016, the local diagnosis rate was 32.7 per 100,000 compared to the England rate of 57.2 and the South West rate of 49.0 [4].

Genital Warts

Genital Warts are caused by the most common viral STI in the UK, the Human Papilloma Virus (HPV) [1]. Human Papilloma Virus is the name given to a group of viruses that affect the skin and the moist membranes lining the body, such as the cervix. It is a common and highly contagious infection, with over three quarters of sexually active women becoming infected with it at some time in their lifetime. There are more than 100 types of HPV virus and around 40 of these types can affect the genital area [12].

The rate of genital warts in Wiltshire fluctuates each year, however these fluctuations have remained fairly stable over the past five years [1]. In 2016 the rate in Wiltshire was 94.8 per 100,000 which was a marginal increase from the previous year which stood at 94.4 per 100,000 [4].

Human Immunodeficiency Virus (HIV)

HIV is associated with high levels of morbidity, expensive treatment costs, the potential for years of life lost, and has high levels of stigma and discrimination associated with those living with the condition. Diagnosed HIV prevalence (those living with HIV) in the UK has been increasing steadily since the introduction of highly active antiretroviral drugs (HAART) in the mid-1990s due in the main to the success of the treatment leading to longer life expectation and also improvements to quality of life.

The number of new diagnoses both in Wiltshire and the South West are relatively low and in 2015 the total number of people living with HIV receiving treatment and care locally was 221[4]. The 2015 prevalence rate in Wiltshire was 0.72 per 1,000 individuals [1] which is lower than the South West rate of 1.13 and an England rate of 2.26 [1] . In addition, by using national modelling it is considered that a further 40 individuals are infected with the virus but have not been diagnosed.

The profile of infection within Wiltshire is changing over time and can be seen as quite surprising when the majority of health promotion and awareness campaigns have in the past targeted men who have sex with men (MSM) and members of Black African communities. Within Wiltshire the largest ethnic group affected is White individuals and the probable route of infection for the majority of individuals is through heterosexual contact.

The prompt diagnosis of HIV infection is crucial to reduce onward transmission and to avoid damage to the immune system which will occur if treatment is not instituted.

Hepatitis

Hepatitis B and Hepatitis C can both be transmitted through sexual contact although are primarily considered to be Blood Borne Viruses [7] [8]. Hepatitis is inflammation of the liver and over time can cause scarring (cirrhosis) and lead to liver failure and/or cancer. There are two main stages of Hepatitis: first is the acute stage which usually occurs shortly after infection and for the majority of individuals this can lead to the second, chronic stage. Treatment is available for those individuals who become infected with Hepatitis C. A vaccination is available to prevent infection by the Hepatitis B virus.

There is little local data available regarding prevalence rates of Hepatitis, however modelled data suggests that in 2015 there were 1,958 people living with Hepatitis B in Wiltshire and 1,952 people living with Hepatitis C [7] [8]. For more information on Hepatitis, please refer to the Blood Borne Virus Health Needs Assessment.

Reproductive Health

There are approximately 15 different types of contraceptive methods which reduce the risk of unintended conceptions when used correctly. These contraceptive methods can be differentiated depending on how they work. There are barrier methods (e.g. condoms, cervical cap), hormonal methods (e.g. the pill, patch, vaginal ring and sub-dermal implant), intrauterine devices (e.g. IUS or IUD) and sterilization. No contraceptive method offers 100% protection against pregnancy or STIs [13].

On average, hormonal contraception methods are approximately 90% effective [13], and the condom is about 83% effective [13], other barrier methods such as the diaphragm offer a protection rate between 80% and 85% [13]. Currently the most effective methods are the hormonal Implant at 99.9% effective and IUCDs which are 99% effective [13]. These types are known as long acting reversible contraceptive (LARC) methods as they are effective for a minimum of 3 years without needing to be replaced.

Increasing access to LARC for women of all ages is one of the priorities identified in the 2013 'Framework for Sexual Health Improvement in England' and is supported within Wiltshire [14]. The National Institute for Clinical Excellence (NICE) has issued guidance which states that the use of LARCs is a cost effective method of contraception and increasing its uptake will reduce unintended pregnancies [15]. LARC methods are available at all specialist contraception and sexual health clinics in Wiltshire. it should be noted that condoms are the only contraceptive method that also protect against STIs.

Following the Increasing Access to Contraception Programme instituted in Wiltshire in 2013, the prescribing rate of LARC methods is much higher in the county than either the regional or England rates; In 2015 the county rate was 56.1 per 1,000 women compared with 29.8 per 1,000 women for England as a whole. This has been a major contributory factor in reducing unintended conceptions for woman of all ages in Wiltshire.

It is estimated that in 2014 there were 302 unplanned pregnancies in Wiltshire [16] which continued to full term. Reducing this number by 5% by increasing the use of effective contraception, could result in a saving of £46,950 in reductions to education, housing and social service expenditure [16]. A 5% reduction would mean 15 fewer unplanned pregnancies per year and the costs involved through the use of LARC methods would be less than £1,000 [16].

In addition to contraception being used on an ongoing basis, women are also able to access emergency contraception through their GP, sexual health service or pharmacy. A copper intrauterine device (Cu-IUD) is considered by the Faculty of Sexual and Reproductive HealthCare as the preferred method of emergency contraception, however, given choice, the time frame involved and the clinical requirements to provide a Cu-IUD, two oral (tablet) forms of emergency hormonal contraception (EHC) are also available. These are:

- Levonorgestrel - an emergency contraceptive pill which can be taken within 72 hours (three days) of having unprotected sex.
- Ulipristal acetate – an emergency contraceptive pill which can be taken within 120 hours (five days) of having unprotected sex.

These two oral forms of emergency hormonal contraception (EHC) work by stopping or delaying ovulation. EHC be obtained from certain community pharmacies who are participating in the No Worries program, all GP Practices and all sexual health services across Wiltshire. The Cu-IUD devices are generally available at those surgeries who also offer LARC fitting and Sexual Health Services.

As of May 2017 there are 22 community pharmacies commissioned to provide EHC in Wiltshire. This service enables young women who wish to avoid an unintended pregnancy the opportunity to obtain medication in a secure and confidential community setting.

Reducing Teenage Pregnancy

Teenage pregnancy is an important focus both locally and nationally and is one of the three main sexual and reproductive health measures in the Public Health Outcomes Framework [30]. There are both health and social reasons why reducing levels of teenage pregnancy is so important. They include [17]:

- Young mothers under the age of 18 are 22% more likely to be living in poverty at age 30 and much less likely to be employed
- Young fathers are twice as likely to be unemployed aged 30, independent of other deprivation factors
- Children of teenage mothers have a 63% increased risk of experiencing child poverty
- There is a six fold difference in teenage conception and birth rates between the poorest and most affluent communities
- Mothers aged under 18 are at high risk of poor mental health and 3 times more likely to be affected by post-natal depression
- Teenage mothers are 3 times more likely to smoke during pregnancy and have 50% lower rates of breastfeeding
- Children of teenage mothers have higher rates of accidents and behavioural problems; and have an increased risk of adopting risk taking behaviours, including the misuse of drugs and alcohol
- The infant mortality rate of babies born to young mothers is 60% higher than babies born to older mothers.

Since the Government launched its teenage pregnancy prevention strategy for England in 1998[18], there has been a steady reduction in teenage pregnancy across Wiltshire. At the beginning of the strategy the rate of under-18 conceptions was 32.1 per 1,000 women and the under 16 conception rate was 6.0 per 1,000 young women [18]. Effective partnership working has resulted in a 50% decrease in baseline figures. At the end of 2015 Wiltshire's under 18 conception rate was 14.0 per 1,000 young women and our under 16 rate was 3.0 per 1,000 young women [19].

Across Wiltshire there are several community areas where rates of teenage pregnancy are surpassed. Targeted services in Calne, Melksham, Salisbury, Tidworth, Trowbridge and Warminster community areas aim to increase the reduction rates of TP in these areas.

Sexual Violence, Child Sexual Exploitation and Abuse

The term 'Sexual Violence' covers a wide range of issues, including wider domestic abuse issues, sexual abuse, sexual assault and female genital mutilation (FGM). Every form of sexual violence requires special management to ensure that both victims and perpetrators are dealt with in the most appropriate way. Issues of sexual violence as part of a wider domestic abuse agenda are dealt with in the Domestic Abuse Needs Assessment.

Sexual assault and sexual abuse support services are provided via the Sexual Assault Referral Centre (SARC) which for Wiltshire residents is based in Swindon. The aim of a SARC is to provide a service ensuring that victims of serious sexual assault, including rape, receive appropriate urgent medical care and access to counselling, and if they choose, forensic examination to provide evidence to assist police in a criminal investigation. The SARC for Wiltshire is funded primarily from NHS England, the Home Office and the Office of the Police and Crime Commissioner. Smaller amounts of funding are provided by Wiltshire Council and Swindon Borough Council to commission additional emotional support services to young people. Effective partnership working relationships are essential to ensure that this service is able to support victims in the most effective manner possible.

The health needs of sexual assault victims include the physical health consequences of sexual violence, and for rape a risk of pregnancy, contraction of sexually transmitted infections and HIV and, for all victims, longer-term health issues such as increased rates of chronic illnesses, poor perceived health and increased use of medical services. The psychological consequences are linked to profound long-term health issues with one third of rape survivors going on to develop post-traumatic stress disorder, relationship problems and longer term psychological needs, mental illness and an increased risk of suicide for abused children when they reach their mid-twenties.

Overall the sexual offences rate across England is increasing each year with a growing percentage increase each year since 2013. A proportion of this increase is due to individuals being able and willing to report historical offences but there also a growing acceptance and ability of people to report incidents when they happen to ensure that support can be received. The 2015/16 rate for Wiltshire was 1.40 per 1,000 individuals which is a substantial increase from the 2010/11 rate which was only 0.70 [1].

The SARC in Swindon has received an increasing number of referrals each year. Estimates from the local police suggest that numbers will continue to increase by up to 20% over the next five years. Referrals can take many forms although they are initially categorised as either requiring a Forensic Medical Examination or are of a non-medical need. Invariably it is individuals who may have been the victims of more recent incidents that are offered a medical examination as this is the opportunity to collect DNA samples as well as other evidence which may be used in a future police investigation or court proceeding. Although not exclusively, increasing levels in the reporting of cases of historic sexual violence are being attributed to the increase in the number of non-medical referrals which the service has seen since 2013. In 2014/15 the Swindon SARC received 148 referrals requiring forensic medical examinations; a further 360 received a non-medical service [21].

The percentage of under 18 year olds who are accessing the SARC for support has remained relatively stable over the past three years with 36% of all attendees receiving a forensic medical examination in 2012/13 compared to 34% in 2014/15 [21]. For the same time periods the percentage of those receiving non-medical support was 26% in 2012/13 compared to 28% in 2014/15 [21]. These figures are important as the type and availability of emotional support for these young people is different from that provided for adults. For children and young people there is a need to provide age appropriate support which considers both their actual age and their stage of emotional development which may be very different. For younger people the most appropriate way to engage them may be through art or play therapy, whereas for an older young person it may be talking therapies.

While there is no statistically significant difference in terms of ethnicity for those at risk of Domestic Abuse and Sexual Violence, FGM, forced marriage and so called 'honour' based violence are more prevalent in black and minority ethnic communities.

Female Genital Mutilation (FGM)

The World Health Organisation definition of FGM is: 'all procedure that involves partial or total removal of the external genitalia, or other injury to the female genital organs for non-medical reasons'.

FGM has serious health consequences, both at the time of the procedure and into adulthood. There are also long-term emotional and psychological effects from the lasting damage caused by FGM. FGM is under-reported in the Wiltshire area with only 4 cases reported to the Multi Agency Safeguarding Hub (MASH) team. Statistics from the NHS show that nationally 5,700 recorded cases of FGM were made during 2015-16 across the UK [23].

The FGM Act 2003 introduced a mandatory reporting duty which requires regulated health and social care professionals and teachers in England and Wales to report 'known' cases of FGM in under 18's which they identify in the course of their professional work to the police [22]. This duty came into force from 31st October 2015. Women and girls born in Somalia accounted for more than one third (37%) of newly recorded cases of FGM [23]. Of this total number of newly recorded cases 43 involved women and girls who self-reported to have been born in the UK [23].

In 18 cases the FGM was undertaken in the UK, including 11 women and girls who were born in the UK [23]. Where the nature of the UK procedure was known, around 10 were genital piercings [23]. The 5 to 9 year old age group was the most common age range at which FGM was undertaken [23].

Child Sexual Exploitation / Abuse

Child sexual exploitation (CSE) of young people under 18 is defined as: Child sexual exploitation is a form of child sexual abuse. It occurs where an individual or group takes advantage of an imbalance of power to coerce, manipulate or deceive a child or young person under the age of 18 into sexual activity (a) in exchange for something the victim needs or wants, and/or (b) for the financial advantage or increased status

of the perpetrator or facilitator. The victim may have been sexually exploited even if the sexual activity appears consensual. Child sexual exploitation does not always involve physical contact; it can also occur through the use of technology [24].

A child under 13 is not legally capable of consenting to sexual activity. Any offence covered under the Sexual Offences Act 2003 involving a child under 13 is very serious and should be taken to indicate that the child is suffering, or is likely to suffer, significant harm. Sexual activity with a child under 16 is also an offence. Where it is consensual sexual activity it may be less serious than if the child were under 13 years, but may nevertheless, have serious consequences for the welfare of the young person. Consideration should be given in every case of sexual activity involving a child aged 13-15 as to whether there should be a discussion with other agencies and a referral to children's social care to investigate whether there is the potential for child sexual exploitation or abuse.

The Wiltshire Safeguarding Children's Board (WSCB) has a role in setting out the expectations of all agencies in relation to identifying and responding to children who are vulnerable to, and at risk of, sexual exploitation and abuse, as well as responding when sexually exploitation is identified. All agencies have a role in identifying and safeguarding children at risk of or experiencing sexual exploitation and abuse. The WSCB has a specific sub group which considers issues of CSE which meets regularly to review information and ensures processes and procedures and being effectively used to support young people. A key recent development has been the launch of Project Gemstone by Wiltshire Police. This is a specialist team dedicated to working with and supporting victims and those at risk of sexual exploitation. The team is staffed by Police and Social Care staff with additional support from health professionals, including CAMHS. In addition a Missing and Child Sexual Exploitation meeting (MACSE) has been established to focus on CSE perpetrators; previously the CSE business was victim focussed and therefore missed opportunities to disrupt offenders.

Levels of Child Sexual Exploitation within Wiltshire are relatively low compared to some areas of England, although there have been multiple occasions where instances of exploitation have been identified and appropriate action taken. During 2015 63 cases of CSE were investigated with the average age of the victim being between 14 and 16 [25]. The average age of offenders was 17 and the most prevalent model of exploitation is lone offender rather than gang exploitation [25].

Priority Groups

The sexual health and wellbeing of the general population is a priority but there are certain groups which are considered to be at higher risk of infection and unintended pregnancy. Individuals in these vulnerable groups are often indirectly excluded from mainstream services.

Those in vulnerable groups are more likely to experience poor sexual health due to socioeconomic inequalities, meaning those living in deprived areas often are more at risk of negative health outcomes, such as STIs and unintended pregnancies. In addition, there is considerable inequality in the distribution of STIs across the population with particular groups at higher risk such as lesbian and gay communities, black and minority ethnic communities and young people. Tackling these inequalities requires a variety of interventions and approaches such as ensuring open access to services, and health promotion and education to raise awareness of safer sexual behaviours to enable young people to negotiate a safer sex life.

Lesbian, Gay, Bisexual and Transgender Individuals (LGBT)

Men who have Sex with Men, (MSM) is the term used to define men who have sex with other men but who may not necessarily identify themselves as gay or bisexual. MSM are at higher risk of infection and are regularly reported as having higher levels of sexually transmitted infections, including HIV. In Wiltshire 43% of people living with HIV are MSM [3]. Research also shows that those from LGBT backgrounds are less likely to have routine health screening tests than heterosexuals and that less than half of LGBT people make their GP aware of their sexual orientation.

Black and Minority Ethnic Communities (BME)

Sexual health within this group is often perceived to be worse compared to the general population. Examining this issue identified accessing services as a major barrier for those from the BME community. In 2015, 27% of those living with HIV in Wiltshire were from Black and Minority Ethnic Communities [3].

Young People

Young people experience a higher burden of STIs and are more likely to have poorer sexual health outcomes than those aged over 25. In 2016, young people accounted for 43% of all new STI diagnosis in Wiltshire [1] with the most common of these infections being Chlamydia. In addition, the UK has one of the highest teenage pregnancy rates across Western Europe [19] although this figure is reducing the long term impact of pregnancy for young people can be considerable.

Young people within the care system often enter care with poorer health and wellbeing in part due to the impact of poverty, abuse and neglect to which they may have been exposed. This is also likely to be due to lower levels of health awareness and health literacy as educational attendance is often lower. Young people in care share many of the same health risks and problems as their peers but often to a greater degree. [5]

Support, including advice and information on sexual health, Chlamydia screening and contraception is available to young people in care or who are care leavers but there is no data on the provision levels for young people in care requesting this level of support.

Older people

People continue to engage in sexual activity throughout their lives and although risk of pregnancy decreases with age, the risk of STIs occurs at all ages. The 2014 National Survey of Sexual Attitudes and Lifestyles (NATSAL) collected information from individuals up to aged 75. The survey results indicate that 75% of men and 59% of women aged between 55 and 64 report regular sexual activity with these percentages being 57% men and 37% women aged between 65 and 74 [6].

In 2016, 11% of all STIs in Wiltshire were diagnosed in the over 50's [1] and therefore going forward we need to ensure that health promotion messages are also targeted at this age group. The perception of sexual health and contraceptive services focussed on young people can be seen as stigmatising and a barrier to access for older people.

Substance misuse (including injecting drug users)

Drug and alcohol use can influence decision making and contribute to risk taking behaviour, increasing the risk of contracting a sexually transmitted infection or having an unintended pregnancy. The use of recreational drugs carries a risk of contracting Hepatitis B and C as well as HIV (if sharing injecting equipment). The exact prevalence of Hepatitis C Virus (HCV) infection within Wiltshire is unknown due to the levels of undiagnosed individuals within the county, however modelled data suggests that there are approximately 1,952 people living with hepatitis C [8] and 1,958 people living with hepatitis B in Wiltshire [7].

Military Personnel

Serving personnel have access to Military of Defence (MoD) medical services. However, due to the sensitive nature of an individual's sexual health they often choose to attend services outside of the MoD and this can have an impact on local service provision for other residents.

Education on how to prevent the transmission of STIs is essential for all groups, however with military personnel being deployed across the globe to countries with higher levels of HIV and STI infections it is especially important that this is emphasised as part of pre and post deployment discussions. In addition, to working with military personnel it is also important to consider the families and their sexual health as often this can be overlooked.

Prison Population

Wiltshire's HMP Erlestoke is a category 'C' establishment with capacity to house 524 prisoners. When individuals first arrive at the prison they are offered health screening for blood borne virus's including HIV and if under 25 they are also offered screening for chlamydia. Whilst living in the prison, if they wish to discuss their sexual health or

be screened for possible infection they can request an appointment with healthcare staff and the necessary testing will be provided.

At present there is little information in relation to the number of individuals who are requesting support regarding their sexual health as the traditional reporting route of uploading data into the PHE GUMCAD system is not routinely taking place [2].

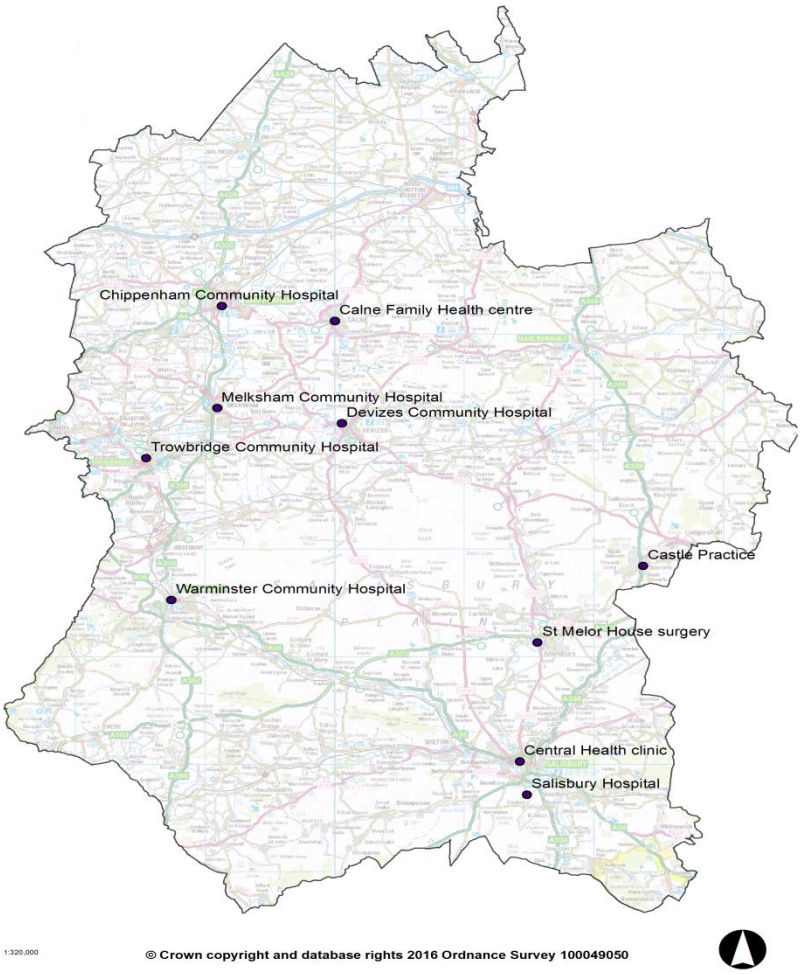
Local Contraceptive & Sexual Health Services

A range of providers within Wiltshire deliver face to face and online services.

Department of Sexual Health – Salisbury Foundation Trust

The majority of services are provided through the Sexual Health department at Salisbury Foundation NHS Trust which is contracted to provide sexual health and contraception services. These services are delivered through a 'hub and spoke' model, with the hub being in Salisbury and spokes being provided in Calne, Chippenham, Devizes, Melksham, Salisbury (2nd site), Tidworth, Trowbridge and Warminster.

Location of Main Sexual Health Services



In addition to face to face services provided by Salisbury Foundation Trust, there is a range of provision offered by other community sites, including: primary care venues; community pharmacies; school health nurses, military healthcare and termination services. Referral pathways between all services exist with signposting encouraged to ensure that individuals receive the most appropriate service possible for their individual needs.

Since 2012 there has been a consistent increase in the numbers of patients accessing Wiltshire based sexual health services and in particular services for testing and treating for STI infections [2]. In 2012 services were used by 4,218 individual patients but by 2015 this had increased to 6,615 (an increase of 37%) [2]. This increase is partly due to improvements in patient flow within services and the availability of services for patients to access. However, this is not a true reflection of the number of appointments which patients are utilising.

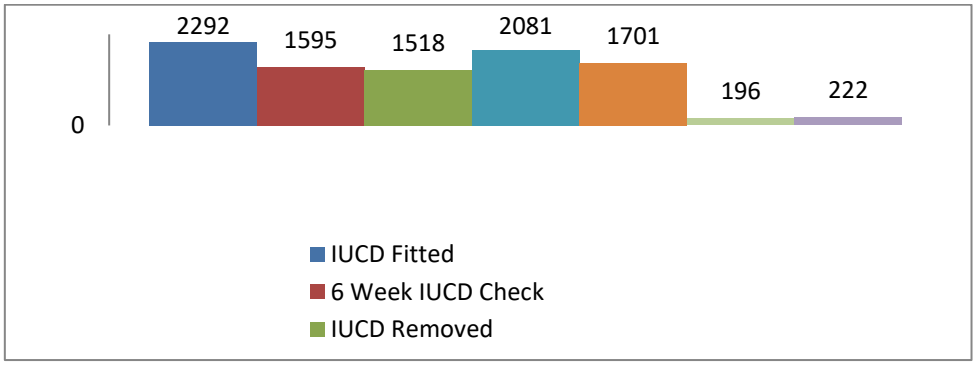
Many sexual health services are open access and therefore individuals have the option to attend any sexual health service of their choice. Residents have the option to access services outside of the county. In 2015 only 61% of Wiltshire patients who accessed a GUM clinic chose to do so using Wiltshire based services, the remaining 39% used a total of 132 different clinical settings across the UK [2].

The services provided by Salisbury Foundation Trust are primarily contraception and sexual health services (CaSH) clinics. The main focus of these clinics is ensuring that women are able to effectively access the various methods of contraception available to them and that any member of the community is able to access testing and treatment for sexually transmitted infections. During 2015/16 they provided 4,105 appointments within the community based clinics in addition to the 1,224 contraception appointments within the main hospital site in Salisbury [2].

Primary Care

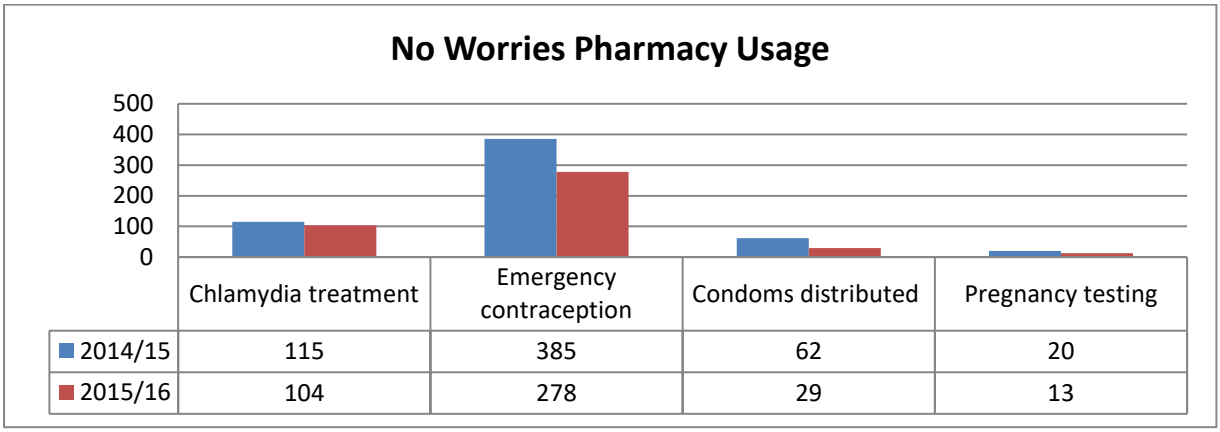
Primary Care within Wiltshire is a key provider of sexual health services and contraception services such as the supply and fitting of LARC methods. In addition to the provision of services within the standard General Medical Services (GMS) contract that GP's sign up to, several them have also chosen to provide additional services through the Wiltshire 'No Worries' service. This is a program of work which enables young people (under 25 years of age) to access Chlamydia testing and treatment, free condoms, emergency hormonal contraception and free pregnancy testing through their own GP surgery or another practice signed up to the scheme without having to make a standard appointment. This has proven to be a well-used service and has contributed significantly to reducing the levels of unintended teenage conception.

During 2015-16 GP surgeries across Wiltshire undertook a wide range of services as part of enhanced provision in relation to sexual health. The below figure shows the level of patient appointments provided for this.



Community Pharmacies

Community Pharmacies can also contract to provide No Worries services: 21 pharmacies across Wiltshire are currently delivering these services. Community pharmacies are often used by young people who may be too embarrassed to use their GP surgery. Data regarding the number of YP using NW services via community pharmacies is given in the table below. There has been a reduction in 2015/16 and this is in part down to the movement of individual pharmacists who have changed locations and may either be working in another county or in a pharmacy which is not part of the No Worries scheme.



	Chlamydia treatment	Emergency contraception	Condoms distributed	Pregnancy testing
2014/15	115	385	62	20
2015/16	104	278	29	13

School Health Nurses

School Nurses are integral to raising awareness of services. Each school may choose whether school nurses are able to offer chlamydia testing, pregnancy testing, condoms and emergency hormonal contraception provision but all school nurses are able to provide information, advice and guidance to a young person who comes to them for support. This ability to raise awareness and demystify sexual health matters facilitates improved access to services and reduces the fear and stigma which sexual health can have for young people.

Military

Military personnel are able to access the medical centres within their bases for sexual health testing and treatment and it is important that these services are promoted to enable and encourage individuals to access them. There is concern amongst some military staff to access services who may know them to discuss a potential sexually transmitted infection and in these cases they are able to access civilian services in the same manner as any other resident of Wiltshire. There is a specialist sexual health unit for military personnel but this is based in Birmingham and tends to only deal with complex sexual health issues rather than standard testing and treatment.

Online Services

The provision of services via the internet has been a major part of our chlamydia screening program since 2009. The numbers of those requesting a test is increasing year on year with over 24,000 tests being taken by young people using the service by the end of August 2016. It enables an individual to order a test kit online, taking the necessary sample at home before mailing it directly to the laboratory for testing. Results are then provided via a text message or via a telephone conversation depending on the test result. Since 2013 we have been providing an online sexual health service to over 5,600 young people each year.

In November 2015 provision of HIV screening via home sampling commenced in Wiltshire. The system uses the same method of ordering and results as the chlamydia screening service with testing kits being ordered online for home delivery and results provided by text or telephone conversation. The provision of an online HIV testing services contrasts markedly with the perception that HIV testing can only be offered and performed within a specialist setting. Each month approximately 30 kits are requested by residents which evidences the acceptability and confidence that this form of testing has with patients. The number of kits ordered fluctuates throughout the year with screening increasing around National HIV Testing Week in November and World AIDS Day in December.

Termination of Pregnancy (Abortion) Services

In England termination is legal for pregnancies up to 24 weeks in gestation although the sooner an abortion is carried out the lower the risk of complications for women. Services across England and Wales have striven to maximise the number of procedures performed within 10 weeks of gestation. Termination services are funded by NHS Wiltshire CCG which commissions both NHS providers and non-NHS providers, with 91% of all terminations for Wiltshire residents being carried out by non-NHS providers in 2016 [20]. This is higher than the England average of 70.4% and substantially higher than the South of England average of 79% [20]. This may be due in part to the rurality of the county and the lack of availability of NHS providers.

In 2016, the Wiltshire rate for completing terminations within 10 weeks gestation was 81.9%, slightly higher than the rate in 2015 which was 79.9% [20]. The under-18 termination rate in Wiltshire has been reducing over time, which is partly explained by the reduction in actual conceptions but may also be due to the choice of some young women to continue with the pregnancy. In 2016, the rate was 7 per 1,000 compared to an England rate of 9 per 1,000 [20].

Service Feedback

Service Users Feedback

In order to gauge the viewpoints of local service users a survey was developed and distributed via a range of agencies including sexual health clinics, youth groups, drug and alcohol agencies. The survey remained open for six weeks and during that time 84 responses were received. The majority of respondents (53) were female which reflects the usage of services in terms of both sexual health and contraception services. This is also the case for sexual orientation where the majority of respondents (65) were heterosexual.

Young people are more at risk of STIs than other age groups and this was reflected in the respondents to the survey. The highest number of respondents were from the 16-25 age group followed by those aged 26-35 who may well be utilising services for contraceptive as well as sexual health purposes. 98% of respondents identified themselves as white and only one person identified as having a physical disability. A further 9 individuals identified as having a learning disability. Although the majority of responses came from the Salisbury area, every community area in Wiltshire was represented in responses.

67% of respondents stated that they have had a sexual health check-up, of which 33% were within the preceding year with 25% having had a check-up within the last 3 years. This suggests that although some Wiltshire residents are accessing local services and taking responsibility for their contraceptive and sexual health needs, work does need to take place to reach those are not accessing services.

Questions regarding where the respondent had accessed services were interesting as they indicated not only the acceptability of the current main provider but also that Wiltshire residents were willing and able to access the community based clinics which are located across the area. Some individuals choose to access services away from where they live or work and it is a recommendation that a review of where individuals are choosing to attend which could then lead to targeted work taking place to reduce this number.

When asked about the information they received from the service they used, 98% were either satisfied or very satisfied with 98% also rating the way they were treated as either satisfactory or very satisfactory. 57% indicated they were very satisfied with the timeliness of service provision with a further 33% indicating they were satisfied. The service provider may wish to consider giving more information to patients on waiting times and clinic availability to moderate patient expectations.

The potential for providing services via online platforms was asked; however the initial question regarding how many respondents had already used this type of service showed only 12% had used online services. This could have been due to the fact that currently the main focus of this service is chlamydia screening which is only open to those under 25 but nevertheless this figure was lower than anticipated. It was encouraging that 76% of respondents would use online screening if it were available

The Public Health team within Wiltshire Council commission a number of primary care and pharmacy venues to provide a range of sexual health services to young people, including chlamydia treatment, emergency hormonal contraception, condom distribution and pregnancy testing; with the service branded as 'No Worries'. Responses received in relation to knowledge of the No Worries service may share the same difficulty as the question about accessing online services as this service is targeted at the under 25 year olds. 59% of respondents had never heard of 'No Worries' but this may in part be down to age. This may again be because the service is targeted at those aged under 25 years

Although many respondents will have used services delivered by the main Sexual Health provider through CaSH clinics, many could have obtained the same advice and treatment through their GP or community pharmacy. 42% of respondents had sought information or advice from their GP on sexual health the majority for emergency contraception, however 74% of respondents had never had a sexual health consultation with a pharmacist.

The survey provided an insight into the locations that respondents would look for information or advice on sexual health issues if they needed it. The three highest places were identified as: from a sexual health clinic (60%); from the internet (55%) or from my GP surgery (43%). When asked where on the internet they would be likely to look for the information they needed the majority of them stated an NHS website which is evidence that there is confidence in the quality and relevance of the information provided.

In terms of service developments the final questions were the most important and when asked how they would rate sexual health services overall, 71% stated they were either good or very good.

Service Provider Feedback

A separate provider survey was developed to explore the views of professionals of which 60 responses were received representing a range of organisations including primary care, education, youth services, healthcare, sexual health services, homelessness and substance misuse services.

The majority of respondents (86%) feel that Wiltshire provides an effective sexual health service to its population; however, 63% felt that it is only partially effective rather than highly effective. When asked what prevents people from accessing sexual health services the two highest responses were that services were not well advertised (65%) and patients are unaware of the range of services they can access (81%). This indicates a need for better publicity and advertising of the locations and availability of these services. This may also address the level of out of county provision if people were more aware of the services available to them locally.

When considering if there were any particularly under-served groups within the county, age groupings appeared to be the area of biggest concern. Respondents could identify more than one group and as such 69% of respondents felt the under 18's needed additional support, 40% felt those 18-25 needed to be catered for more, and

25% of respondents felt those over 40 years of age would benefit from an increase in targeted services. The other group identified as needing additional focus was people with a physical and/or learning difficulty.

Questions around publicity and campaign materials elicited mainly negative responses; 19% felt the amount of campaigning was good or very good and only 20% indicated the range of materials used was good or very good. 32% identified that the clarity of message was good or very good and 30% felt the materials were of relevance to the Wiltshire Population. While this is very concerning, it may be related to the fact that these materials are predominantly distributed to GP surgeries and community pharmacies and many of the respondents had not attended these venues for sexual health services.

Partnership working is a key element to the successful delivery of services, evidenced by the dramatic reduction in the level of teenage conceptions due in the main to organisations working together to ensure information and support is provided at every opportunity. However, when stakeholders were asked whether there was sufficient and appropriate partnership working between services only 51% felt that there was.

There were four main types of partner organisation who felt that additional joint working would help in the provision of services, these were homelessness organisations, substance misuse organisations, schools and midwifery and maternity services.

There was recognition within responses that due to reductions in funding and available time for partnership developments, improvements were taking place but there is still further work is needed.

A large amount of our chlamydia screening and more recently HIV testing is now delivered via online platforms and stakeholders were asked how effective they felt these services were. 77% of respondents identified them to be effective; although as with previous responses 51% felt they were only partially effective which indicates that additional programme support needs to take place to improve this area further.

Survey respondents were finally asked what one thing they would like to see happen to improve services, and this received a wide range of suggestions. They can primarily be clustered into four key areas of development:

- Increased provision of clinical time, particularly in rural areas of the county
- Increased information and awareness raising of available services
- Increased partnership working with organisations working with specific target populations e.g. homelessness, drug and alcohol clients
- Additional support for schools

Overall, the feedback from stakeholders was fairly consistent in its responses. There needs to be improvements in the level of partnership working and an improvement in the level of information being circulated about service availability and what they can be used for.

Identification of Gaps

During the preparation of this HNA consideration has been given to the needs of residents and how those needs are currently being met; or if not what the gaps are in service provision. Below are details of the gaps identified:

Need identified	Demand requested	Current supply	Gaps
Older people are increasingly at risk of STI infection and are not accessing services	Services are more aware of the needs of older people.	Services are open access and can be utilised by older people	Older people are not aware of the risks being taken in their sexual wellbeing.
Commercial sex workers have no services which target their needs	Services are more aware of the additional needs of commercial sex workers	Generic services are provided which can be accessed for support	Commercial sex workers may have additional complex needs which are not able to be catered for by generic service provision
Public Health Outcomes Framework target for Chlamydia screening needs to be achieved	Provision of additional chlamydia testing opportunities	Chlamydia testing kits are available across the county in a wide range of venues	Targeted opportunities need to be developed, particularly for young men who are currently under-represented
Residents are choosing not to access local GUM services	Raise awareness of opportunities to test for STIs within Wiltshire.	Clinical sessions are held across the county and can also be accessed via primary care.	Lack of awareness of community clinics offering sexual health advice and testing
Women not able to access all contraception options via primary care	Women are requesting the full range of contraception to be available at their own primary care venue	All primary care venues offer contraception services or signposting to alternate provision.	Not all primary care venues have trained staff able to provide all forms of LARC contraception.
Better understanding of sexual health services on offer in	A clear understanding of what sexual health services are	All primary care venues will provide a basic level of support and will	Lack of of what sexual health services are being offered

Primary Care venues. **Need identified** Greater awareness of the HIV home sampling project	provided in each primary care venue **Demand requested** Increased awareness of who can access the service and how to access it.	signpost for specialist services **Current supply** Publicity materials have been circulated and media interviews given at start of project	through primary care. **Gaps** Regular awareness raising materials need to be circulated. Professionals need to encourage service uptake by clients
Increased sexual health testing and reporting within HMP Erlestoke	Data needs to be available on the scale and uptake of sexual health services within the prison setting to ensure equity of provision with other Wiltshire residents.	Healthcare will provide sexual health screening for prisoners who request it.	No data is uploaded into the PHE GUMCAD system to monitor level of testing Lack of proactive encouragement of testing opportunities.
Regular data available to commissioners from main sexual health provider to enable service planning and development	Clear data on services provided and geographical location of patients to ensure effectiveness of service offer to meet demands of all Wiltshire residents	Specialist clinical services are provided across the county and also though primary care venues	Ad hoc reports are received by commissioners which does not facilitate service planning and development
Regular reviews of service locations needs to take place to ensure they remain the most appropriate	Services need to regularly review the locations from which their patients are coming from to ensure they are appropriate	9 community based specialist clinics are provided across Wiltshire with additional provision via primary care venues	Ad hoc data is received by commissioners on where patients are travelling from to attend specialist services which does not enable effective review and service development
LARC methods of contraception should be encouraged for all women via primary care venues	Levels of LARC uptake need to be increased to reduce rates of unintended conception	All primary care venues either have trained staff who can fit LARC methods of contraception or referral pathways to other providers	Primary care venues need to increase the number of LARC fitters. Improved discussions need to take place on the benefits of

			LARC methods prior to prescribing other methods
Need identified Little information is shared between Wiltshire Council and Wiltshire CCG regarding sexual health services including abortion services	**Demand requested** Greater partnership working would enable the sharing of information and improvements to services	**Current supply**	**Gaps** Services are operating in isolation as there is no regular sharing of information which could make services more effective and cost efficient
Levels of HIV late diagnosis are too high	Rates of HIV late diagnosis need to be reduced and eventually eliminated	Testing for HIV is available via GUM services, primary care and HIV home sampling for anyone who requests it.	Individuals at risk of HIV infection are not being identified and tested. Individuals do not think they have been at risk and therefore choosing not to access testing opportunities
Lack of community pharmacy provision in all parts of Wiltshire	Community pharmacies in all areas of Wiltshire should be encouraged to offer the No Worries service.	More than 20 community pharmacies across Wiltshire are offering No Worries services.	Certain geographical areas of Wiltshire do not have community pharmacy's willing to operate the No Worries service.
Gaps in sexual health knowledge and awareness exists which can put individuals at risk of poor sexual health outcomes	Effective awareness raising campaigns to increase the knowledge of local residents need to take place	Regular campaigns take place to ensure information is disseminated across locations on a monthly basis	Additional numbers of locations (such as libraries and leisure centres) for information posters and leaflets to be circulated to would enhance opportunities for learning
Lack of regular partnership working amongst service providers	Increased partnership working would enable increases to client knowledge and opportunities for reductions in sexual ill health	A Sexual Health Partnership Board exists to share information and all providers are encouraged to work collaboratively with each other to	More strategic partnership working needs to be encouraged between organisations.

		improve client outcomes	
Need identified	**Demand requested**	**Current supply**	**Gaps**
Lack of emotional support services for young people who have been the victim of sexual assault	Long term psychological damage could be avoided by the early availability of emotional wellbeing and mental health support	Support is available to young people via the CAMHS service once the threshold for support is reached.	Few young people meet the minimum threshold for CAMHS support Support is rare in geographical locations to suit the needs of young people who may have difficulty in travelling.
New technologies are enabling service developments to take place to reduce the need for direct clinician input to diagnostic services	Implementing new services would reduce the need for patients to attend a clinical setting for testing, reducing costs and increasing patient numbers	New partner notification services have been implemented to enable online provision. The chlamydia and HIV home sampling services enables patients to take samples at home and removes the need to access a clinician for testing.	Chlamydia and HIV are the only tests which can be self-taken by Wiltshire residents despite services being available which would enable sampling for other sexually transmitted infections being available.
Additional knowledge and awareness raising is needed for staff who may encounter FGM or honour based violence with their clients	Staff can fell unskilled in how to recognise and respond to possible evidence of FGM or honour based violence	Staff training is available to raise levels of knowledge of FGM and honour based violence	Staff may not recognise the potential opportunities for FGM or honour based violence to become known and have therefore not received training in advance. Basic training needs to be made mandatory with additional opportunities for more in-depth training made available.

Recommendations

The following recommendations have been developed in response to this health needs assessment:

1. A review of service provision including identifying access barriers for specific groups such as older people, commercial sex workers, and people who have been trafficked should be undertaken due to higher rates of sexually transmitted infections within these groups.
2. Public Health in Wiltshire to review the current approach to Chlamydia Screening across the county with a view to the achievement of the Public Health Outcome Framework requirements.
3. Review out of county attendances at GUM clinics in line with access to current service sites to reduce the numbers of residents choosing to access services out of Wiltshire.
4. Review access to LARC within primary care to ensure there is an adequate spread of provision across the county.
5. Develop process to accurately determine the level of sexual health activity undertaken within GP Practices and Community Pharmacy.
6. Increase uptake of online HIV home testing.
7. Improvements in the reporting of attendance for sexual health issues within HMP Erlestoke to ensure a clearer understanding of the level of need.
8. More regular and accurate reports need to be produced by the main sexual health providers to ensure commissioners are able to effectively map what services are being utilised and from where in the county individuals are coming.
9. Commissioners and general practices should examine strategies to ensure that promotion and acceptance of LARC provision in general practice is increased and consistently offered, particularly in those practices where the patient catchment area covers those at highest risk of unintended conception, and / or the most deprived estates and neighbourhoods in the county.
10. Develop partnership arrangements between the local authority and NHS Wiltshire CCG in relation to termination services to ensure that every opportunity is maximised in terms of ongoing contraception usage.
11. Establish a work plan to reduce the levels of late HIV diagnosis.
12. Recruit pharmacies to participate in the No Worries service to ensure there is an effective service across the whole of Wiltshire.
13. Develop and implement effective awareness campaigns to ensure the levels of knowledge and awareness of sexual health and sexual health services are maintained and improved

14. Develop opportunities for better partnership working between commissioners and service providers, in particular the main sexual health provider and specialist agencies such as homelessness and drug & alcohol agencies.

15. Service Providers should consider the use of new technologies such as home testing/screening, online booking systems and online partner notification systems in order to increase the numbers of individuals using services without the need for additional investment in face to face delivery.

16. Provide a specialist emotional support service for young people who have been the victim of sexual violence or abuse.

17. Develop and deliver training sessions regarding FGM and honour based violence to enable staff to feel confident in raising concerns fulfilling their legal responsibilities to report concerns.

References

[1] Public Health England, “Sexual and Reproductive Health Profiles, HIV & STI,” 2017. [Online]. Available: http://fingertips.phe.org.uk/profile/sexualhealth

[2] Public Health England, GUMCAD v2 report, December 2016 [Online]

[3] Public Health England, “Wiltshire Local Authority HIV surveillance data tables” Public Healh England, London, 2015

[4] Public Health England, “Wiltshire Local Authority HIV, sexual and reproductive health epidemiology report (LASER),” Public Health England, London, 2015.

[5] Statutory guidance on promoting the health and wellbeing of looked after children. Department of Health. Department for schools, children and families

[6] The National Survey of Sexual Attitudes and Lifestyles, London, 2014 [Online] Available: http://www.natsal.ac.uk/about.aspx

[7] Public Health England, “Acute Hepatitis B (England): annual report for 2015,” Public Health England, London, 2016.

[8] Public Health England, “Hepatitis C in the UK,” PH England, London, 2017.

[9] Low N, McCarthy A, Macleod J, Salisbury C, Campbell R, Roberts TE et al. Epidemiological, social, diagnostic and economic evaluation of population screening for genital chlamydial infection. Health Technol Assess 2007; 11(8)

[10] Public Health England, South West Sexual Health Quarterly Indicator Report October to December 2015, Bristol, 2016

[11] World Health Organisation, “Herpes Simplex Virus”, January 2017 [Online]. Available: http://www.who.int/mediacentre/factsheets/fs400/en/

[12] Cancer Research UK, HPV and Cancer {Online], Available: http://www.cancerresearchuk.org/about-cancer/causes-of-cancer/infections-hpv-and-cancer/hpv-and-cancer

[13] NHS choices, contraceptive Guide [Online], Available: http://www.nhs.uk/Conditions/contraception-guide/Pages/how-effective-contraception.aspx

[14] Department of Health (2013). A Framework for Sexual Health Improvement in England. Available: http://www.dh.gov.uk/health/2013/03/sex-health-framework/

[15] National Institute for Health and Care Excellence, "Long Acting Reversible Contraception" [CG30], London, September 2014. Available: https://www.nice.org.uk/guidance/cg30

[16] Bayer plc, Unplanned Pregnancy Budget Impact Tool, 2016.

[17] Department for Education and Skills "Teenage Pregnancy: Accelerating the Strategy to 2010", London, 2010. Available: http://webarchive.nationalarchives.gov.uk/20130401151715/http://www.education.gov.uk/publications/eOrderingDownload/DFES-03905-2006.pdf

[18] Social Exclusion Unit "National Teenage Pregnancy Strategy", Social Exclusion Unit, London, June 1999.

[19] Office for National Statistics, "Conception Statistics England and Wales 2015" [Online]. Available: https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/conceptionandfertilityrates/datasets/conceptionstatisticsenglandandwalesreferencetables

[20] Department of Health, "Abortion Statistics for England and Wales 2015", June 2016, [Online]. Available: https://www.gov.uk/government/statistical-data-sets/abortion-statistics-england-and-wales-2015

[21] Swindon Sexual Assault Referral Centre, Collated Statistics 2016

[22] UK Government "The Female Genital Mutilation Act 2003", London 2003. Available: http://www.legislation.gov.uk/ukpga/2003/31/pdfs/ukpga_20030031_en.pdf

[23] Health and Social Care Information Centre "Female Genital Mutilation (FGM) - April 2015 to March 2016, Experimental Statistics, 2016. [Online]. Available: http://content.digital.nhs.uk/catalogue/PUB21206

[24] Department for Education " Child sexual exploitation, Definition and a guide for practitioners, local leaders and decision makers working to protect children from child sexual exploitation". Department for Education, London. February 2017. Available: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/591903/CSE_Guidance_Core_Document_13.02.2017.pdf

[25] Wiltshire Safeguarding Children's Board. "Annual Report 2015/16". [Online]. Available: http://www.wiltshirescb.org.uk/home/annual-report/

[26] Department of Health "A Framework for Sexual Health Improvement in England", Department of Health, London, March 2013. Available: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/142592/9287-2900714-TSO-SexualHealthPolicyNW_ACCESSIBLE.pdf

[27] Public Health England "Making it work, A guide to whole system commissioning for sexual health, reproductive health and HIV". Public Health England, London, March 2015. Available: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/408357/Making_it_work_revised_March_2015.pdf

[28] National Institute for Health and Care Excellence, "HIV testing: increasing uptake among people who may have undiagnosed HIV" [NG60], December 2016 [Online]. Available: https://www.nice.org.uk/guidance/ng60

[29] National Institute for Health and Care Excellence, 2Sexually transmitted infections and under-18 conceptions: prevention" [PH3], February 2007 [Online]. Available: https://www.nice.org.uk/guidance/ph3

[30] Public Health England "Public Health Outcomes Framework Healthy Lives, Healthy People: Improving Outcomes and Supporting Transparency", Public Health England, August 2013.

[31] Office of National Statistics [ONS] mid-year 2016

[32] ONS 2014-based National population projections

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Blood Borne Virus Health Needs Assessment

December 2017

Part of the JSNA family

Wiltshire Council
Where everybody matters

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Summary

This Health Needs Assessment (HNA) was developed to better understand the rate of infection of the population of Wiltshire with the three main blood borne viruses (BBVs): Hepatitis B (HBV), Hepatitis C (HCV) and HIV. This paper describes the epidemiology of BBVs and establishes a baseline for current services delivered, identifies the unmet health needs and gaps in service provision, and makes recommendations to improve the diagnosis, treatment and management of BBVs in Wiltshire. This HNA will inform the development of a Wiltshire Blood Borne Virus Strategy.

This HNA reviewed data from a number of sources already in the public domain. There were some gaps in the data collected and the need for further data is considered in the recommendations. Without accurate data we are unable to develop and coordinate an effective response to either support residents living with BBVs or reduce the potential for them to inadvertently transmit infection to others.

Wiltshire has low prevalence for all three BBVs. However, the often asymptomatic nature of these infections means that the risk of transmission is high; the availability of appropriate services to provide vaccination, testing and treatment will minimise the long-term health impacts.

There are a number of recommendations within this HNA for commissioners to consider and for service providers to action. Implementation of these recommendations via a Wiltshire BBV strategy will enable a much clearer understanding of the impact of BBVs on people's lives in Wiltshire and how we can work across the system to reduce transmission and encourage earlier diagnosis and treatment.

Contents

Background

There are a range of BBVs which can cause ill health. As the greatest burden of ill-health is produced by hepatitis B virus (HBV), hepatitis C virus (HCV) and the human immunodeficiency virus (HIV), this HNA will consider only these 3 forms of BBV

Hepatitis B (HBV) causes inflammation of the liver [1] which can lead to liver cirrhosis and cancers. Transmission of the virus is by a number of blood-borne or bodily fluid transfer routes, including sexual intercourse, sharing of drug-injecting equipment, needle stick injuries, transfusions of blood and blood products, mother-to-baby transmission, skin piercing, sharing contaminated toothbrushes or razors, bites and scratches [1]. HBV is a vaccine preventable disease and vaccination is currently recommended for a number of groups at higher risk of infection

Hepatitis C (HCV) also causes inflammation of liver. Unlike HBV, acute HCV infection is often asymptomatic, jaundice is uncommon and serious disease is rare. Transmission is from contact with blood or bodily fluids from an infected person [1]. There is no vaccination for HCV.

HIV weakens the immune system against infections and some types of cancer. Infected people gradually become immunodeficient, resulting in increased susceptibility to a wide range of infections and diseases which can ordinarily be overcome. Transmission is via contact with blood or bodily fluids from an infected person, as a result of sexual contact, sharing of drug-injecting equipment and transfusions of blood and blood products [5]. Without prophylactic treatment 15% to 30% of infants born to HIV infected mothers are infected with HIV (before, during or shortly after birth through breastfeeding) [5]. HIV can also be transmitted by skin piercing with inadequately sterilised equipment and through needle stick injuries. There is no vaccination for HIV, but transmission can be prevented by practicing safer sex methods. HIV is treatable and with prompt diagnosis and treatment those living with HIV can expect a normal lifespan. When no virus is detectable in the blood, the virus can no longer be passed on.

National Policy

There are a number of BBV policies in place at a national level. Policies and guidance documents of greatest relevance to the Wiltshire population include:

Hepatitis B antenatal screening and new-born immunisation programme – Best practice guidance (2011) [26]. This guidance was developed to provide assistance to commissioners in improving the uptake rate of existing infant HBV immunisation programmes for new-borns who are at risk of HBV infection.

The Hepatitis B: migrant health guide (2014) [27] provides advice and guidance on the health needs of migrant patients for healthcare practitioners. In addition, there is also a Hepatitis C: migrant health guide [27] which provides information to healthcare practitioners on how to support patients who are/have been diagnosed with this condition.

The Hepatitis C in the UK (2017) report is the annual report which brings together national level data from all four countries of the UK on HCV infection, prevalence, burden of disease, prevention, awareness, testing & diagnosis and treatment & care [7].

The Infectious Diseases in Pregnancy Screening (2016): program overview guidance document published by PHE explains the NHS program, its policies and services [28].

Improving Testing Rates for Blood Borne Viruses in Prisons and Other Secure Settings (2014) [29]. This document provides information and resources regarding the new 'opt-out' testing policy being rolled out across prisons and other secure settings.

A Framework for Sexual Health Improvement in England (2013) a guidance document which explores the government's ambitions for improving sexual health and reducing the levels of new HIV infection [30].

Health Promotion for Sexual and Reproductive Health and HIV: Strategic Action Plan 2016 to 2019 (2015) which details PHE's approach to reversing the HIV epidemic [31]. It identifies the key areas for PHE action, and describes how PHE can work with partners at a national and regional level to improve health and reduce inequalities.

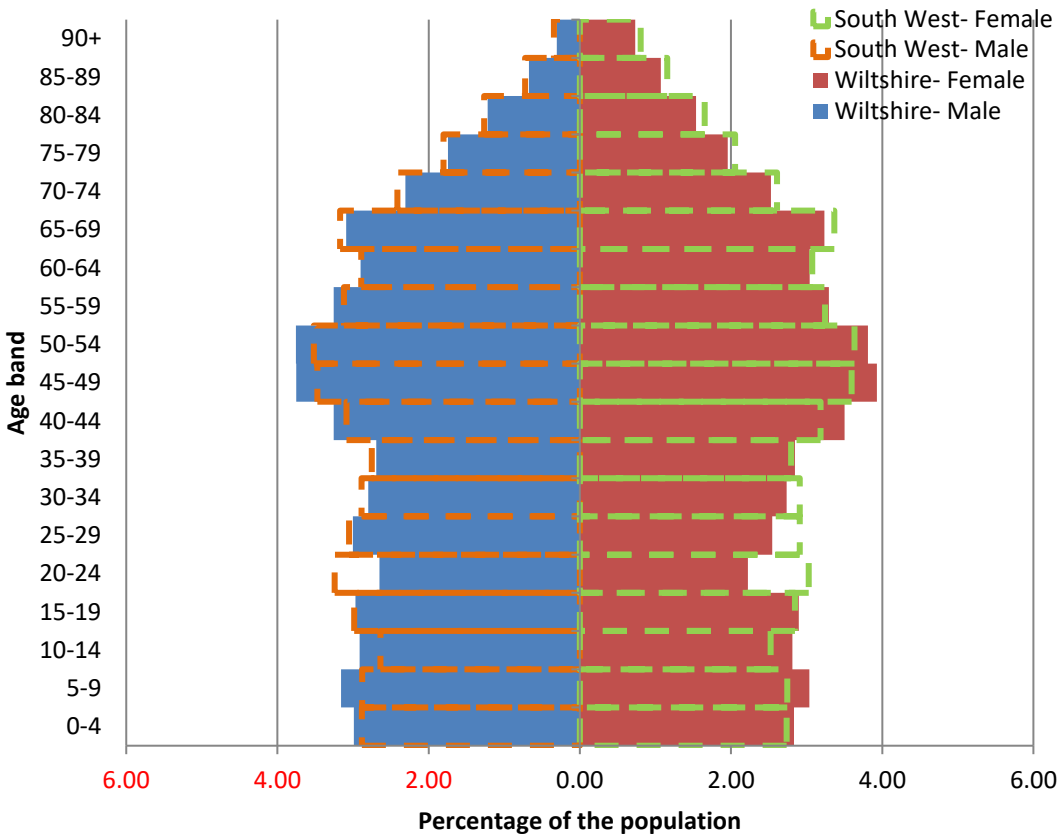
Although there are national policies in relation to BBVs there are no regional or local policies from which action plans can be devised and implemented. Following the publication of this HNA, the first BBV strategy Wiltshire will be developed.

Local Health Needs

Local demographics

There are an estimated 488,409[1] people living in the Wiltshire Local Authority area. The population is expected to grow. 51% of the population is female. Wiltshire is predominantly White British (93%). In 2016 ONS published population projections[2] which estimated Wiltshire's population will steadily grow to 516,000 by 2026. Figure 1 depicts the most recent population pyramid of Wiltshire and the South West region.

Figure 1: Population pyramid for Wiltshire and South West region



The age structure of Wiltshire is similar to the South West region. However, Wiltshire has a slightly smaller proportion of 20 to 24 year olds which might be a reflect the absence of a University. It is thought that the population pyramid in Wiltshire will become top heavy with a larger proportion of elderly and that in 2026 the number of people over the age of 65 will for the first time outnumber those under the age of 20.

The Epidemiology of Blood Borne Virus's

Hepatitis B

HBV causes inflammation of the liver [1]. With acute infection some people may experience flu-like symptoms including sore throat, joint pains, tiredness and nausea as well as abdominal pain, jaundice (yellowing of the skin and eyes) and liver failure. Long-term complications of being a HBV carrier include cirrhosis (scarring of the liver) and liver cancer.

Transmission of the virus is by a number of blood-borne or bodily fluid transfer routes, including sexual intercourse, sharing of drug-injecting equipment, needle stick injuries, transfusions of blood and blood products, mother-to-baby transmission, skin piercing, sharing contaminated toothbrushes or razors, bites and scratches [1]. In the UK, 95% of new chronic HBV infections occur in migrant populations, having been acquired through mother-to-baby transmission in the country of birth. The main high risk groups for HBV can be found in table one below [1].

Table 1: Main high-risk groups for HBV infection [1]

- People born or brought up in a country with an intermediate or high prevalence (2% or greater) of chronic HBV including all countries in Africa, Asia, the Caribbean, Central and South America, Eastern and Southern Europe, the Middle East and the Pacific islands
- Babies born to mothers infected with HBV
- People who have ever injected drugs
- Men who have sex with men (MSM)
- Anyone who has had unprotected sex, particularly:
    - people who have had multiple sexual partners
    - people reporting unprotected sexual contact in areas of intermediate and high prevalence
    - people diagnosed with a sexually transmitted infection
    - commercial sex workers
- Looked-after children and young people, including those living in care homes
- Foster carers and people who adopt children from medium and high prevalence countries
- Prisoners, including young offenders
- Healthcare workers and laboratory staff
- Immigration detainees
- Close contacts of someone known to be chronically infected with HBV

HBV is a vaccine preventable disease and it is currently recommended for a number of groups at higher risk of infection, including most of those outlined in the above table and is particularly important in the context of babies born to infected mothers as infection can take place in 90% of these children.

Prevalence estimates of chronic HBV infection in the South West [22] suggest that 0.49% of the population is infected with HBV. When modelled against the Wiltshire population there were an estimated 1,958 people living with chronic HBV in 2015 [6].

Since not all infected individuals will present to be tested and diagnosed, the real number of new acute infections occurring in Wiltshire is likely to be greater than the number reported. It is estimated that the annual incidence of HBV is 7.4 per 100,000 people [16]. Applying this rate to Wiltshire's population results in an estimated 36 new cases occurring each year, of which only about 4 cases will be diagnosed [22]. The remaining individuals will be unaware, given the asymptomatic nature of the infection, increasing the risk of further transmission.

There appears to be an increasing number of men contracting HBV with data extracted from the Public Health England HPZone database indicating that of the acute cases recorded 69.8% [22] were in men compared to only 30.2% [22] of women. HBV is a vaccine preventable condition and vaccination is widely available for those groups who are at increased risk of contracting the virus. The vaccination programme generally consists of three injections spread over a number of months. Unfortunately this has the consequence of individuals not returning for the second or third dose of vaccine and therefore not being fully protected. Table two below outlines this using information from the sexual health service.

Table 2: Number of HBV vaccinations received in sexual health services for Wiltshire residents, 2011-16 [25]

HBV vaccination	2011	2012	2013	2014	2015	2016
1st dose	95	100	121	106	124	163
2nd dose	62	101	115	100	112	142
3rd dose	62	114	103	83	103	114

Information from the Wiltshire Substance Misuse Service shows that not all individuals at risk of HBV infection are willing to accept and complete the vaccination course. However, vaccine coverage in HMP Erlestoke from 2007 to 2013 has sharply increased from 16% to 94% [22] .

All pregnant women are offered screening for HBV at the earliest contact with their midwife. If the initial offer of screening is declined screening is re-offered at 28 weeks. Pregnant women diagnosed with HBV are notified by the laboratory lead to the Antenatal Screening Coordinator who will then arrange for the patient to have an early consultant obstetrician outpatient appointment and referral to a specialist hepatology clinic. The lead paediatrician in this area will also be informed as they will make clinical decisions about the baby's needs. Unfortunately, local data on the proportion of pregnant women who accept a HBV test is not available.

A national KPI surrounding antenatal screening exists and is the proportion of pregnant women who are HBV positive that attend for specialist assessment within 6

weeks of screening positive. The acceptable target is set at ≥ 70.0% and the achievable target at ≥ 90.0% [14]. In 2015-16, England achieved a level of 73.4% [14] and the South West 72.2% [14]. Performance at the GWH and SDH were both below the acceptable target at 50.0% and 50.0% [14], respectively. However, the actual numbers of women attending for specialist assessment are too small to be reported and therefore there is uncertainty around these figures. The performance at the RUH was 100%, although again actual numbers are low [14].
All clients are offered an HBV test at the same time as they are offered other BBV testing in substance misuse services. The take up rate may be slightly lower as the availability of a trained individual to perform the test at the time of offer is not always possible.

Universal testing for HBV can identify those in the population who have been infected with the virus and these tests can be undertaken in primary care and specialist service settings. There is no reliable data available in relation to the number of tests carried out for individuals at risk of HBV infection, although the numbers of individuals diagnosed is available. Although the long-term health consequences of HBV infection can be mild for most with the condition, serious ill health or death can result for some. The crude mortality rate of HBV related end-stage liver disease/hepatocellular carcinoma in persons less than 75 years of age is 0.076 per 100,000 [6].

Hepatitis C

HCV also causes inflammation of liver. Unlike HBV, acute HCV infection is often asymptomatic, jaundice is uncommon and serious disease is rare. About 80% of those with acute infection will go on to become chronically infected and of those 75% will have some degree of active liver disease. Long-term complications of chronic infection include cirrhosis (scarring of the liver) and liver cancer [1] [4].

Transmission is from contact with blood or bodily fluids from an infected person [1]. In the UK, over 90% of chronic HCV infections are seen in people who currently or previously have injected or shared drug taking paraphernalia [1] [4] , with other risk groups for HCV found in table three below.

Table 3: Main high-risk groups for HCV infection [1]

- People who received a blood transfusion before 1991 or blood products before 1986
- People born or brought up in a country with an intermediate or high prevalence (2% or greater) of chronic HCV including all countries in Africa, Asia, the Caribbean, Central and South America, Eastern and Southern Europe, the Middle East and the Pacific islands
- Babies born to mothers infected with HCV
- Prisoners, including young offenders
- Looked-after children and young people, including those living in care homes
- People living in hostels for the homeless or sleeping on the streets
- HIV-positive MSM

- Close contacts of someone known to be chronically infected with HCV

There is no robust estimate of new cases of HCV per year at a national or local level but available estimates suggest that incidence has remained relatively stable in the UK over recent years. The most recent estimates of the prevalence of chronic HCV infection in England [11] suggest that 160,000 adults are chronically infected with HCV, equating to 0.4% of the adult population. If this prevalence figure is applied to the Wiltshire population for 2016, it is estimated that there are 1,952 people living with chronic HCV in Wiltshire [21].

HCV infection is primarily seen within individuals who have previously injected drugs (54% of recorded local cases), followed by people who currently inject drugs (26% of recorded local cases) [1] [4]. However, during 2016/17 figures received from the Wiltshire Substance Misuse Service indicate that only 53.2% [24] of their active client group actually received a HCV test which may impact on the local data as individuals living with the virus may not be identified,

In 2013, 10% of offenders new to HMP Erlestoke had a HCV test performed within 31 days of reception [20] which may impact on the numbers of individuals who are being identified as already infected with HCV.

There is no vaccine or other medication available which can prevent or reduce the risk of infection from HCV. However, there are harm reduction methods which can reduce the risk of infection; these methods include a needle exchange programme which reduces risk of sharing injecting equipment. Unlike HBV there are effective treatments available that, once infection has taken place, which clear the virus and minimise any long-term health impacts. Treatments for HCV are changing and developing fairly rapidly and consequently the numbers of people able to access and complete treatment is increasing.

Data from Public Health England has identified the numbers of individuals living within Wiltshire who have contracted HCV, but this information cannot be used to determine whether these infections are acute cases (where infection has taken place recently) or chronic cases (where the individual may have been infected some time ago). This data shows that in 2015 there were 39 newly recorded cases of HCV in Wiltshire [21].

As with HBV, one of the key elements of providing services to people at risk of contracting a BBV is the availability of testing. This is especially important in relation to HCV for individual's accessing substance misuse services. Wiltshire Substance Misuse Service (WSMS) offers testing to its clients, however the numbers who are actually testing is relatively low compared to those who accept the offer of a test and could also reflect the rates actually testing for HBV. In 2016-17, 1122 clients were offered HCV testing from WSMS (approximately 56% of all clients seen by the service) of which 1062 completed the test.

Unlike HBV, the long-term health impact of infection with HCV is more serious. Without effective treatment most patients will experience some form of liver disease which may even lead to death. The crude mortality rate of HCV related end-stage liver

disease/hepatocellular carcinoma in persons less than 75 years of age in Wiltshire is 0.46 per 100,000 [7].

HIV

HIV weakens the immune system against infections and some types of cancer. Infected people gradually become immunodeficient, resulting in increased susceptibility to a wide range of infections and diseases which can ordinarily be overcome. During the first few weeks after initial infection, individuals may be asymptomatic or experience a flu-like illness including fever, headache, rash or sore throat.

Transmission is via contact with blood or bodily fluids from an infected person as a result of sexual contact, sharing of drug-injecting equipment and transfusions of blood and blood products [5]. Without prophylactic treatment 15% to 30% of infants born to HIV infected mothers are infected with HIV (before, during or shortly after birth through breastfeeding) [5]. HIV can also be transmitted by skin piercing with inadequately sterilised equipment and through needle stick injuries.

Having another sexually transmitted infection and having multiple sexual partners puts individuals at greater risk of contracting HIV [5]. Transmission is especially efficient between MSM, in whom receptive anal intercourse is a particular risk factor and MSM remain the group most at risk of HIV in the UK. HIV prevalence in the UK is higher among people of black African ethnicity. those groups at high-risk of HIV infection are included in table four below.

Table 4: Main high-risk groups for HIV [1]

- People born or brought up in a country with an intermediate or high prevalence
- Babies born to mothers infected with HIV
- People who have ever injected drugs
- Men who have sex with men (MSM)
- Anyone who has had unprotected sex, particularly:
    - people who have had multiple sexual partners
    - people reporting unprotected sexual contact in areas of intermediate and high prevalence
    - people diagnosed with a sexually transmitted infection
    - commercial sex workers
- Prisoners, including young offenders

In 2015, 9 adult residents were newly diagnosed with HIV in Wiltshire and the rate of new HIV diagnosis per 100,000 population among people aged 15 or above was 2.3 per 100,000 [23]. This brought the total number of people diagnosed as living with HIV in Wiltshire to 221 [23]. Nationally there are an estimated additional 18% of people who have contracted the virus but are unaware of their infection; this would translate itself to an additional 39 individuals within Wiltshire bringing the total number to 260 [12].

In 2015, the prevalence rate of diagnosed HIV infection per 1,000 residents was 0.72 for Wiltshire. This was lower than the South West prevalence of 1.13 per 1,000 and lower than the England prevalence of 2.26 per 1,000 [12]. None of the Middle Super Output Areas (MSOA) in Wiltshire had a prevalence rate higher than 2 per 1,000 which is the NICE trigger for more intensive testing and screening systems to be put into place [23].

From 2011 to 2015 there was a decrease in the rate of new HIV diagnosis from 6.4 to 2.3 per 100,000 within Wiltshire, with the rate being consistently lower than the England rate currently at 12.1 and lower or similar to the South West rate which is currently at 4.5 [12].

In 2015, a breakdown in the demographic profile of the 221 individuals who were receiving treatment shows us that 151 were men and 70 were women, the majority (76.9%) were of white ethnicity, followed by black African ethnicity (17.2%), other ethnicity (4.55%), and black Caribbean ethnicity (1.35%) [23].

With regards to route of infection the majority of people living with HIV probably acquired their infection through sex between men and women (47.96%), followed by sex between men (46.15%), other/not known (4.99%) and injecting drug use (0.90%) [23].

If an individual is at risk of infection there are medications which reduce the likelihood of the virus successfully infecting the body. It takes a few days for HIV to become established in the body following exposure. Post-Exposure Prophylaxis (PEP) drugs given at this time may help the body's immune system to stop the virus from replicating (multiplying) in the infected cells of the body. The cells originally infected would then die naturally within a short period of time without producing more copies of HIV. PEP is a month-long course of drugs and the sooner someone starts taking the medication after exposure to infection the better, but it must be started within 72 hours after a possible exposure to the virus. The PEP drugs are the same drugs that HIV-positive people use to reduce its impact on their body.

A recently approved range of medications known as 'PrEP' is also now available. Pre Exposure Prophylaxis (PrEP) is a course of HIV drugs taken by HIV negative people before being exposed to the HIV virus to reduce the chance of becoming infected. Results in trials have been very successful, with PrEP significantly lowering the risk of becoming HIV positive and without causing major side effects.

One of the key aspects of identifying HIV infection is the availability of testing services. In 2015, an HIV test was offered at 82.7% of eligible attendances at sexual health clinics and 77.7% of those individuals chose to proceed with testing, consequently only 69.2% of eligible individuals attending received a test [12].

All pregnant women are offered screening for HIV at the earliest contact with their midwife. If the initial offer of screening is declined, screening is re-offered at 28 weeks. Pregnant women diagnosed with HIV are notified by the laboratory lead to the antenatal screening coordinator. The antenatal screening coordinator will then arrange

for the patient to have an early consultant obstetrician appointment at which point she is informed of her result and a referral made to the consultant in HIV/GUM. The paediatrician leading in this area will also be informed and an appointment will be offered to discuss the care of the baby. Antenatal screening rates have consistently been above the target rate of 90% at each of the three hospitals, who provide maternity services to the women of Wiltshire.

Although rates of HIV within injecting drug users in Wiltshire are relatively low, it is essential that we monitor this situation and ensure that testing opportunities are provided at every opportunity. In 2016/17 1,995 clients were seen by the main substance misuse provider but only 1,035 (51.9%) were tested for HIV [24].

There was no local data available for HMP Erlestoke on the proportion of new prisoners being tested for HIV or the prevalence of HIV in the population. Testing for HIV is covered by the National Offender Management Service and the recently implemented PHE national prison opt-out BBV testing policy should increase rates of testing.

One of the indicators on the PHE Sexual Health and Reproductive Profiles and the Public Health Outcomes Framework is the percentage of adults (aged 15 or above) newly diagnosed with HIV with a CD4 count <350 cells per mm^3, as this represents those people who are diagnosed only after their immune systems have been damaged – late diagnosis. From 2013-15, in Wiltshire 44.1% of those with newly diagnosed HIV were diagnosed late, which was similar although slightly higher to the figures for the South West (41.1%) and England (40.3 %) [8]. Late diagnosis of HIV is the most important predictor of HIV-related morbidity and short term mortality. Individuals who are diagnosed late have a ten-fold increased risk of death within 1 year of their eventual diagnosis due to probable damage to their immune system which has already taken place, and therefore it is essential these rates as low as possible.

During 2015 Wiltshire Council in partnership with PHE launched an online screening programme for HIV. This enables individuals to order a kit online and to perform the test at home before returning it to an approved laboratory for processing. The result is provided via text or phone call depending on the outcome with follow up support available for results that come back as reactive. This additional method of testing enables those individuals who are unwilling or unable to attend traditional services to access HIV testing services to test and provides a further opportunity for those who are living with HIV but remain undiagnosed to access the treatment and care they require.

Local Service Providers

To understand the current provision of services related to BBVs in Wiltshire and any gaps in service delivery, detailed information about services was collected by use of a provider survey. Questions were adapted according to which service/organisation it was sent to and an appropriate member of staff from each organisation was contacted by email to explain the purpose of the BBV HNA and purpose of the questionnaire.

Information on sexual health services was obtained from consultants in sexual health and HIV and managers of sexual health services. Information on drug and alcohol services was obtained from either the team leader or a health professional part of the organisation. Information on antenatal screening and neonatal vaccination was sought from the antenatal screening coordinator and screening and immunisation manager of NHS England South Central. Information on prison healthcare was sought from the Clinical Liaison Manager, Healthcare HMP Erlestoke, and Inspire Better Health.

It covered the following broad areas:

- Service and organisation details
- Geographical catchment
- Access and availability
- Staffing and capacity
- HBV, HCV and HIV testing
- HBV vaccination
- Referral to specialist services
- Gaps in service and suggestions for improvement

Sexual Health Services

There are three main sexual health services that provide BBV services to Wiltshire residents:

- Department of Sexual Health, Salisbury District Hospital (SDH), Salisbury NHS Foundation Trust
- Swindon Sexual Health, Great Western Hospital (GWH) Great Western Hospitals NHS Foundation Trust
- Contraceptive and Sexual Health Department, Royal United Hospital (RUH), Royal United Bath Hospitals NHS Trust

All of the sexual health clinics are open access venues and patients may self-refer, these account for the majority of patients; the clinics will also take referrals from other health professionals. Appointments at sexual health clinics are available on all days of the week at, at least one of the clinic sites. There is less availability of walk-in clinics but there are slots available at, at least one of the clinic sites, on all weekdays in Wiltshire and four weekdays in Swindon. Evening clinics are available at, at least one of the clinic sites, on four weeknights in Wiltshire and three weeknights in Swindon. The clinic at GWH is the only clinic to offer weekend appointments (Saturday morning).

The sexual health services are well-staffed with multidisciplinary teams consisting of Consultants in GUM and HIV medicine, specialty doctors training in GUM medicine, general practice trainees, band 5 to 7 nurses, health care assistants and health advisors.

No sexual health or BBV outreach services are provided by Salisbury NHS Foundation Trust. Swindon Sexual Health provides outreach contraception nurses for young people and people at risk of sexual exploitation who liaise with clinic nurses and the police and encourage BBV testing. Swindon Sexual Health also holds a clinic once per month for commercial sex workers in Swindon town centre.

The sexual health service provided by Salisbury NHS Foundation Trust refers patients with newly diagnosed HBV or HCV infection directly to the Specialist Hepatology Nurse at SFT and a letter is also sent to the patient's GP. Swindon Sexual Health and the Sexual Health Service at the RUH refer patients with newly diagnosed HBV or HCV infection back to their GP and the GP is asked to refer the patient on to the relevant hepatologist.

For any patient who provisionally tests positive for HIV infection, they are recalled for an urgent repeat test and a discussion with one of the HIV/GUM consultants or one of the specialist nurses. The patient will then be seen within two weeks (or more urgently if required) by a HIV/GUM consultant in clinic for the results and to discuss treatment options

All of the sexual health teams from the three main hospitals in and around Wiltshire undertake awareness raising sessions throughout the year. This includes the provision of training sessions to groups of individuals, displays and public awareness interventions, or media interviews as and when appropriate. This is particularly evident during National HIV Testing Weeks held in November and World AIDS Days in December.

Substance Misuse Services

In Wiltshire there are two main drug & alcohol services, one for adults (Turning Point, Wiltshire Substance Misuse Service) and one for young people aged 17 and under (Motiv8 provided by Developing Health and Independence (DHI)). The Motiv8 service does not provide any testing services for BBVs although they will discuss these infections with clients.

Turning Point is open Monday to Friday 09:00 to 17:00. Access to the service is via drop-in, self-referrals or referrals from a health professional. The service has trained most staff to undertake testing for HBV, HCV and HIV using dried blood spot testing. However, on occasion the service is unable to test clients at the same appointment a test if offered if there are no trained staff available; this results in clients having to be invited back to be tested. A nurse is the BBV lead for the service and she provides positive test results and refers clients on to specialist services.

The service also provides different forms of outreach work. They actively encourage new referrals and clients into treatment by attending GP surgeries and 'Doorway' a drop in project for the homeless. The service also makes use of a mobile recovery bus

and attends local festivals to promote testing for BBVs. Other aspects of the service that are provided are listed below:

- 1:1 support
- Substitute prescribing and recovery based prescribing
- Comprehensive 3 phase group work programme
- Motivational Enhancement Therapy
- 12 sessions of counselling
- Needle & Syringe exchange
- Peer led interventions
- Peer mentoring & volunteering opportunities
- Housing, debt management and benefits advice/support
- Multi-agency working to support individual's needs outside of their substance misuse
- Sign posting & support for carers

Prison Healthcare

In response to evidence of significant under-testing of prisoners for BBVs NHS England, the National Offender Management Service and PHE published their National Partnership Agreement in 2013, which has as one of its priorities the introduction of a national prison opt-out BBV testing policy. Prisoners at reception are informed that tests for BBVs will be performed unless they actively refuse. All prisoners will be tested unless:

- They have been tested in the last 12 months and have NOT subsequently been at risk of infection.
- They are known to be positive for a BBV.
- For HBV If a patient has documented evidence of a negative result and has been fully vaccinated against HBV they do not require further testing for this BBV infection.

If a positive result is received cases are referred on to secondary care for assessment and treatment follow up by a relevant specialist.

In Wiltshire, HMP Erlestoke is the only prison and the opt-out policy is being followed in that all prisoners entering HMP Erlestoke are tested for HBV, HCV and HIV using venous blood samples by the associated primary care team, unless they refuse. Prisoners can also self-refer for BBV testing at any stage. The prison offers ultra-rapid HBV vaccination or combined hepatitis A (HAV) and HBV vaccine to all prisoners depending on clinical need. All newly diagnosed cases of HBV or HCV are referred for specialist care to a clinical nurse specialist at GWH, who visits HMP Erlestoke on alternate Tuesdays. All new diagnoses of HIV are referred for specialist care at SFT and there are no visiting clinicians for HIV care.

In addition to the above the prison's Substance Misuse team also raises awareness of BBVs with prisoners. They discuss BBVs as part of their initial assessment with patients and they perform harm minimisation sessions with them as well. The Substance Misuse team can refer patients for BBV testing at any stage.

Military Healthcare

Wiltshire has a number of military barracks including Larkhill, Bulford, Tidworth, Perham Down, Upavon and Salisbury. There is no Ministry of Defence policy on BBV screening on recruitment but personnel should be screened by army clinicians if they are considered to be at high risk of infection. Recently, the SDH sexual health team have provided training for army clinicians based in the Tidworth, Bulford and Larkhill camp medical centres on testing for sexually transmitted infections, including HBV and HCV and point of care testing for HIV. Post-exposure prophylaxis is also offered by army medical centres if required. If a case of HBV or HCV occurred within one of the personnel in a Wiltshire barrack the PHE Health Protection Team (HPT) North will be informed.

HBV vaccination is offered to all personnel on entry to the UK armed forces unless clinically contraindicated. The traditional vaccination schedule is usually used, as per the 'Green Book', with a booster dose at 5 years. Only in exceptional circumstances are accelerated and super-accelerated schedules used. Testing for sero-conversion is offered 1– 4 months after completion of the primary course to all personnel who are considered to be at high occupational risk of HBV infection.

Public Health

Currently the Public Health team within Wiltshire Council does not have a work stream looking specifically at BBVs. Some local campaign work including the development and distribution of posters together with the distribution of resources developed by Public Health England has taken place, however to date no large initiative has been planned.

Wider Stakeholder Feedback

In addition to asking for information in relation to service provision, additional feedback from professional stakeholders was also sought. This survey was distributed to a wide range of organisations including drug and alcohol support services, sexual health clinics, hepatology departments, primary care and maternity units. Due to the difficulty in identifying and supplying individuals who are living with a BBV a patient / client survey was not completed as part of this HNA.

The sexual health clinics report that walk-in clinics are very popular and sometimes over-subscribed. They are able to meet demand when the team is at full capacity but struggle when they are not fully staffed. Swindon Sexual Health are unable to deliver the sexual health outreach clinics previously being held in the male sauna in Swindon but the team hope to be able to deliver this again in the future. While Swindon Sexual Health provide a once monthly clinic for commercial sex workers there is no specific service in Wiltshire.

In terms of the neonatal HBV vaccination, there was concern that babies who are at high risk of being infected with HBV, due to factors other than being born to a HBV positive mother, may not necessarily be receiving the HBV vaccination at birth. Other risk factors may include a HBV positive household family member or a parent that

injects drugs but is not currently infected with HBV. The antenatal booking form used in the community for SDH does include a question about other family members having hepatitis but apart from this there is not a formalised pathway/guideline for this to happen.

At HMP Erlestoke, there has recently been no link nurse, which means there is no formal handover for ongoing community care to nursing staff from the hepatology specialist nurse. Once a link nurse has been identified this should allow for better communication between primary and secondary care. In addition, blood test requests from the hepatology specialist nurse are not on ICE (electronic pathology system) and have to be handwritten on request forms, which often get returned to be corrected and delay patient care. Finally, there is also some reported concern that only a low level of screening is occurring at HMP Erlestoke Prison although it has been reported that the opt-out BBV screening has now been implemented.

One of the general points made by stakeholders for how BBV services in Wiltshire could be improved was that there should be greater linkage and partnership working between services. There was a suggestion that a Wiltshire-wide BBV working group could be created where professionals could meet to discuss referrals, build closer links and develop understanding of what is happening county-wide. This would also allow for sharing of challenges faced and best practice.

Although this HNA has been developed to ensure that we are able to provide the most effective level of service to local residents, we were not able to consult with them in the preparation of the document. This was due to a number of reasons including the difficulty in identifying individuals who would be willing and able to participate in stakeholder feedback due to the stigma and discrimination which individuals who are living with these infections face. Instead we asked service providers to feedback anecdotal information from their clients to identify what is working well and what needs improving.

Identification of Health Gaps

Need identified	Demand requested	Current supply	Gaps
Reliable, accurate and meaningful data on levels of HBV infection should be available	Service planning should use the correct data to ensure services are provided from an effective evidence base	Data is available from providers upon request for specific information	Data is not coherent and has to be requested on a piecemeal basis
Effective HBV vaccination programmes should be in place with all relevant service providers	HBV is a vaccine preventable infection, with increased vaccination levels fewer individuals will contract the virus	Vaccine is available from specialist providers such as primary care, sexual health clinics and drug and alcohol services	Vaccination levels remain low in certain providers such as drug and alcohol services.
No data is available on the numbers of pregnant women accepting or declining HBV screening	Service planning should use the correct data to ensure services are provided from an effective evidence base	No data is available from any of the three acute trusts providing maternity services for Wiltshire residents	Data should be routinely collected on the number of women offered, accepting or declining HBV screening
Effective referral pathways should be in place for pregnant women diagnosed as HBV positive	All women diagnosed as HBV positive should be referred for specialist care	Referral pathways exist but are not always adhered to within specific timescales	Only one of the three acute trusts providing maternity services is meeting the national target for referral.
Lack of awareness of BBVs, how they are transmitted and treatments available	Greater awareness levels will reduce transmission rates and improve treatment access	Awareness of HIV has improved over recent years; however there remains a lack of awareness around Hepatitis.	Additional information resources should be made available to inform individuals about testing, treatment and prevention initiatives

Need identified	Demand requested	Current supply	Gaps
Reliable, accurate and meaningful data on levels of HCV infection should be available	Service planning should use the correct data to ensure services are provided from an effective evidence base	Data is available from providers upon request for specific information	Data is not coherent and has to be requested on a piecemeal basis
Reliable and accurate data on HCV testing rates should be available from all providers	Effective testing programmes should be developed targeting groups most at risk	Data is currently being provided per individual organisation conducting testing	Data provided is not accurate and is being received from a number of providers with no consolidation
Reduction of HIV late diagnosis rate	People diagnosed with HIV 'late' have reduced life expectancy and poor health	Testing to reduce levels of undiagnosed HIV exist in a variety of settings including primary care, sexual health clinics and via home sampling systems	Current awareness of the range of HIV testing opportunities should be improved and the stigma associated with testing reduced.

Recommendations

1. We need to identify with all provider services what information they are collecting and how it is reviewed for accuracy and completeness.

2. Discussions need to take place with NHS England (Health and Justice) on the collection and provision of data from HMP Erlestoke.

3. An effective range of data should be collected by commissioned drug and alcohol agencies to ensure data is accurate and provides a clear evidence base of BBV testing and vaccinations which have taken place.

4. Development of local BBV awareness raising campaigns should take place using both local and national resources using consistent messaging.

5. Develop support programmes to increase the level of HBV vaccinations within specialist services such as sexual health units and substance misuse services.

6. Develop effective follow up mechanisms for patients who fail to attend for the second or third dose of vaccination.

7. Seek information on the number of HBV screens offered and accepted within maternity services.

8. Improve links with primary care partners to ensure those at greater risk of infection are screened for BBVs.

9. All client facing staff within commissioned drug and alcohol services should be trained to undertake point of care testing for BBVs.

10. Improvements in the referral process for pregnant women who test positive for HBV into specialist hepatology services should take place to meet national targets.

11. Develop a system to monitor referrals into specialist services from non-statutory service providers to minimise those individuals 'lost to follow up'.

12. Information should be uploaded by HMP Erlestoke into the PHE GUMCAD system to ensure effective monitoring of testing and vaccination levels.

13. Increase awareness of the HIV home sampling programme to facilitate additional testing opportunities.

14. Develop local awareness raising campaigns to inform residents how and where they can undertake BBV testing and also to raise general levels of knowledge.

15. Develop resources which 'normalise' attitudes towards those individuals infected with a BBV to reduce levels of stigma and discrimination.

References

[1] Hawker, Communicable Disease Control and Health Protection Handbook, Oxford: Wiley-Blackwell 2012.

[2] World Health Organisation, "Hepatitis B," July 2015. [Online] Available: http://www.who.int/mediacentre/factsheets/fs204/en/

[3] Public Health England, Department of Health, "Immunisation against infectious disease," in *Immunisation against infectious disease (The Green Book)*, London, Public Health England, 2013, pp. 161-185.

[4] World Health Organisation, "Hepatitis C," July 2015. [Online]. Available: http://www.who.int/mediacentre/factsheets/fs164/en/.

[5] World Health Organisation, "HIV/AIDS," November 2015. [Online]. Available: http://www.who.int/mediacentre/factsheets/fs360/en/.

[6] Public Health England, "Acute Hepatitis B (England): annual report for 2015," Public Health England, London, 2016.

[7] Public Health England, "Hepatitis C in the UK," Public Health England, London, 2017.

[8] Public Health England, "Sexual and Reproductive Health Profiles, HIV & STI," 2016. [Online]. Available: http://fingertips.phe.org.uk/profile/sexualhealth

[9] Health Protection Agency, "Migrant Health: Infectious diseases in non-UK born populations in the UK," December 2011. [Online]. Available: http://webarchive.nationalarchives.gov.uk/20140714084352/http://www.hpa.org.uk/Publications/InfectiousDiseases/TravelHealth/1112Migranthealth/

[10] Gay NJ, Hesketh LM, Osborne KP, Farrington CP, Morgan-Capner P, Miller E, "The prevalence of hepatitis C infection in adults in England and Wales," *Epidemiol Infect,* vol. 122, no. 1, pp. 133-138, 1999.

[11] Public Health England, "Hepatitis C: commissioning template for estimating diseases prevalence," March 2014. [Online]. Available: https://www.gov.uk/government/publications/hepatitis-c-commissioning-template-for-estimating-disease-prevalence

[12] Public Health England, "Wiltshire Local Authority HIV, sexual and reproductive health epidemiology report (LASER)," Public Health England, London, 2015.

[13] Public Health England, "Liver Disease Profiles," 2016. [Online]. Available: http://fingertips.phe.org.uk/profile/liver-disease

[14] Public Health England, "NHS screening programmes: KPI reports 2015 to 2016," March 2017. [Online]. Available: https://www.gov.uk/government/publications/nhs-screening-programmes-kpi-reports-2015-to-2016

[15] Hahne S, Ramsay M, Balogun K, Edmunds WJ, Mortimer P, "Incidence and routes of transmission of hepatitis B virus in England and Wales, 1995-2000: implications for immunisation policy," *J Clin Virol,* vol. 29, no. 4, 2004.

[16] National Institute for Health and Care Excellence, "Hepatitis B and C: ways to promote and offer testing to people at increased risk of infection PH43," 2012 updated 2013. [Online]. Available: http://publications.nice.org.uk/hepatitis-b-and-c-ways-to-promote-and-offer-testing-to-people-at-increased-risk-of-infection-ph43

[17] Harris RJ, Ramsay M, Hope VD, Brant L, Hickman M, Foster GR, et al, "Hepatitis C prevalence in England remains low and varies by ethnicity: an updated evidence synthesis," *Eur J Public Health,* vol. 22, no. 2, pp. 187-192, 2012.

[18] National Offender Management Service and Public Health England, "National Partnership Agreement," 2013. [Online]. Available: http://www.justice.gov.uk/about/noms/working-with-partners/health-and-justice/partnership-agreement

[19] Public Health England, "Frequently asked questions (FAQs) to support the opt-out BBV testing policy," October 2014. [Online]. Available: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/365192/BBVs_Frequently_Asked_Questions.pd

[20] NHS Trust Development Authority, Prison Health Reporting System.

[21] Public Health England, Hepatitis C collated laboratory reports, 2015

[22] Public Health England, Hepatitis B collated laboratory reports, 2015

[23] Public Health England, "Wiltshire Local Authority HIV surveillance data tables" Public Healh England, London, 2015

[24] Turning Point Wiltshire, Collated blood borne virus report

[25] Public Health England, GUMCAD v2 report, October 201 [Online]

[26] Department of Health "Hepatitis B antenatal screening and newborn immunisation programme: *Best practice guidance".* Department of Health, London, 2011. Available: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215622/dh_132637.pdf

[27] Public Health England "Communicable diseases: migrant health guide". Public Health England, July 2014. Available: https://www.gov.uk/government/collections/communicable-diseases-migrant-health-guide

[28] Public Health England "NHS Infectious Diseases in Pregnancy Screening (IDPS) Programme". Public Health England, London 2015. Available: https://www.gov.uk/topic/population-screening-programmes/infectious-diseases-in-pregnancy

[29] Public Health England "Improving testing rates for blood-borne viruses in prisons and other secure settings". Public Health England, London, 2014. Available: https://www.gov.uk/government/publications/improving-testing-rates-for-blood-borne-viruses-in-prisons-and-other-secure-settings

[30] Department of Health "A Framework for Sexual Health Improvement in England". 2013 [Online]. Available: http://www.dh.gov.uk/health/2013/03/sex-health-framework/

[31] Public Health England "Health promotion for sexual and reproductive health and HIV: strategic action plan, 2016 to 2019". Public Health England, London, 2015. Available: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/488090/SRHandHIVStrategicPlan_211215.pdf

[32] National Institute for Health and Care Excellence, “Hepatitis B (chronic): diagnosis and management (CG15), 2013. [Online]. Available: https://www.nice.org.uk/Guidance/CG165

[33] National Institute for Health and Care Excellence, “HIV testing: increasing uptake among people who may have undiagnosed HIV” [NG60], December 2016 [Online]. Available: https://www.nice.org.uk/guidance/ng60

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Sponsor

This report was sponsored by Tracy Daszkiewicz, Director of Public Health (interim), Wiltshire Council.

Authors

This report was prepared by Stephen Jones and Steve Maddern, Public Health Team, Wiltshire Council.

Wiltshire Council
Health Select Committee
6 March 2018

Swindon and Salisbury Health-based Place of Safety Temporary Closure Background Briefing

Purpose

1. To provide an update on the Swindon and Salisbury Health-based Place of Safety (PoS) Temporary Closure.

2. Avon and Wiltshire Mental Health Partnership Trust (AWP) Place of Safety facilities in Swindon and Salisbury will close temporarily for a 12 month period to ensure the Trust is able to comply with the new Policing and Crime Act which came out in December and which reduced the maximum time anyone can be detained under Sections 135 or 136 from 72 hours to 24 hours. The closures are also designed to enable AWP to address concerns outlined by the CQC and to make suggested improvements.

3. The facility at Fountain Way in Salisbury will close on Monday Feb 26th with the Place of Safety at Sandalwood Court will closing on Monday March 19th.

4. Both services will be relocated to Green Lane Hospital in Devizes which will operate with four beds, increasing capacity in Wiltshire by one bed.

Background

5. A place of safety is not an admission ward. An individual may be detained using the 1983 Mental Health Act for the purposes of assessing whether that person has a mental disorder and if so whether they require further assessment or treatment**.** People removed to a place of safety are in crisis and usually highly distressed. Most are presenting a risk to themselves and sometimes to others.

6. People detained are not patients; they are detainees until a decision is made as to whether they have a mental disorder that requires further assessment or treatment, or not. A bed is available in the s136 suite, not as a bedroom, but rather to allow rest. It is extremely rare that a person in a section 136 suite would be visited by relatives during their brief stay.

7. There are currently three place of safety suites in Swindon and Wiltshire located in Swindon, Salisbury and Devizes.

Why the PoS suites are being temporarily closed

8. During the Care Quality Commission (CQC) comprehensive inspections of the AWP in 2016 and 2017 the Trust was told by the CQC to make improvements to health based places of safety (HBPoS), which were rated as inadequate. There have been improvements to governance, reporting and escalation protocols since 2016. Improvements in the way that the Trust governed and monitored the HBPoS significantly improved, with new systems and a clearly accountable governance Director and team

put into place. These improvements saw the removal of the section 29A warning notice removed during the 2017 CQC visit.

9. The overall rating from CQC remains as inadequate though. The CQC 2017 report notes that although the Trust had made some improvements to the HBPoS environments there were continued concerns around timeliness of the commencement of assessments within the HBPoS, although the CQC did acknowledge that the trust would not be able to resolve all issues without multi agency solutions.

- The CQC stated that 'There were significant problems accessing beds for people requiring admission to hospital. We saw examples of patients waiting 32 to 50 hours after being assessed in all the place of safety suites before admission to hospital'.

- The CQC stated that 'There was limited access to Section 12 Doctors (a Psychiatrist) who acts as a second opinion in the application of the Mental Health Act (MHA) which was causing delays to Mental Health Act assessments, in order to work within the trust's Section 136 joint protocols and the Mental Health Act Code of Practice'.

- The CQC stated that 'There regularly remained significant delays in assessments commencing at the places of safety. There were significant problems with the availability of section 12 approved doctors. There were times when the Approved Mental Health Professional (AMHP) services were delayed in attending due to the need to attend when the doctor was available or due to problems with their own capacity to respond. Overall 61% of people waited more than 12 hours to be seen for assessment. This was an increase on the level of people waiting 12 hours or more than at our inspection in May 2016.

- The provider should ensure that local guidelines are followed so that the places of safety are staffed with staff trained in prevention and management of violence (PMVA).

- In 2016 the CQC stated 'that the HBPoS in Salisbury and Swindon lacked general space and both environments lacked an outdoor space that could be accessed without using the ward facilities, which created 'mixed' dynamic of ward based patients and detainees within the same area'.

- The provider must demonstrate that action is being taken to ensure that limitations on access to Section12 doctors are not responsible for delays to Mental Health Act assessments in order to work within the trust's Section 136 joint protocols and the Mental Health Act Code of Practice.

- The provider must ensure that there are clear procedures and joint working arrangements in place with local authorities, to ensure assessments take place in a timely manner in the each place of safety and reduce the level of transfers between places of safety.

10. The issues above are known as 'requirements'. Requirements act as a precursor to enforcement and notify providers where they are failing. If providers do not improve then the CQC can move to formal enforcement action which includes warning notices, special measures and prosecution.

11. The full CQC report is available here http://www.cqc.org.uk/provider/RVN

What will change?

12. To meet the CQC's requirements AWP must change the way in which it delivers HBPoS services. Currently the trust has three HBPoS, two in Wiltshire and one in Swindon, which operate a ward based model. A ward based model means that there are 2 extra staff on duty on the ward associated with the HBPoS and that these staff move across to the HBPoS when a person is detained by the Police on section 136. The ward based model has significant disadvantages such as an inability to provide a 3 person PMVA team and an inability to provide tailored service response.

13. The Policing and Crime Act 2017 reduced the maximum time period for which a person can be detained under section 135 or 136 from 72 hours to 24 hours. This is a significant change in the requirement; the system will not be able to meet the revised time period unless there is radical change in the model of care for users of patient safety suites.

14. Without amalgamation of the Salisbury and Swindon HBPoS to a team based approach the service is unlikely to meet the above requirement notices and could move to a further enforcement such as a warning notice or more likely as the trust has a previous warning notice special measures.

15. Therefore once the facilities in Salisbury and Swindon have closed, the service will be provided in Devizes where four suites could be opened, increasing capacity by one and providing a suite with improved facilities suitable for young people under the age of 18. Staff would be available on site with a dedicated team to ensure consistency in safe care. This team would ensure that patients are screened and assessed as soon as they enter the PoS and planning for their discharge will start immediately. It is essential to have this cohort of staff on site, rather than on-call and dispersed around the county to meet the 24 hour maximum detention time.

16. Further to a business case being approved by commissioners and discussions with AWP consultant staff,, there will also be an increase in the availability of 24 hour section 12 Doctor cover.

17. During closures, users from Swindon and Salisbury will be transferred to the PoS suites in Devizes with AWP ensuring patients are provided with transport once they leave the PoS as required.

Benefits from the temporary closures

18. The primary drivers for the proposed temporary closure are improvements to service user experience and the reduction in the length of time a person is detained in order to meet the requirements of the Policing and Crime Act. The proposed changes to the model of care would also mitigate the quality issues to the PoS service identified in the CQC reports of 2016 and 2017.

19. There are a number of other benefits that the service change would bring which have been highlighted under the CQC domains. These are as follows:

Safety

- Purpose built environment at Devizes offers improved safety and quality of environment
- Design enables parts of unit to be managed to respond to specific clinical need e.g. CAMHS, gender
- Consolidating PoS on one site would enable the establishment of a dedicated team of staff who will ensure consistency in safe care
- Recruitment to a specialist team more likely to be successful due to skills/experience opportunity available
- Recording of data in relation to performance incidents will be improved from one service/site
- Environment allows for staff from other agencies to be in the PoS for support without being in the direct clinical space
- Intended reciprocity of Approved Mental Health Professional (AMHP) to undertake assessment to avoid Service User travel between PoS

Effective

- Specialist team of staff will ensure that screening, assessment and planning for discharge will occur immediately on arrival thereby improving flow. This is essential to meet 24 hour limit for assessment
- Consolidation to one site offers the opportunity to develop a training matrix which recognises PoS as a specialist area
- Development of best practice across two STP PoS services
- Provision of dedicated clinic room within unit enables physical health monitoring as required
- Single consolidated unit will enable more effective communication with community teams and urgent care Clinical Hub (Medvivo)
- Provides opportunity for more dedicated medical time to be established

Caring

- Provision of dedicated skilled team will improve quality of care provided
- Environment enables gender specific areas and space for people to be away from their individual rooms
- Improved environmental facilities such as a courtyard for accessing fresh air, a kitchen, a communal space, an assessment room with a bed and an ensuite bathroom
- Space for other agencies to be in the environment in separate areas without encroaching on the personal space of people in the PoS

Responsive

- Co-located AMHPs to increase speed of assessments undertaken with a dedicated team of staff
- Dedicated space to enable Intensive Support Team to undertake crisis community assessments

- Improved time to assessment more likely to reduce conversion rate (to admission/detention). Multi-agency model will reduce likelihood of breach to detention time limits
- Dedicated team available 24/7
- Increased capacity by 33% (1 bed)
- Opportunities for synchronicity with other services in the pathway
- Single service will enable better system resilience
- Patients will be provided with transport home after a PoS episode

Well led

- Single clinical leadership structure with identifiable Clinical Lead and Clinical Director
- Dedicated team will enable supervision to be tailored to the work and requirements of the service
- Dedicated Team Manager and single locality management structure
- Identifiable management will improve inter-agency relationships and enable a responsive escalation process for partners
- Improved ownership of performance for PoS activity by single management structure
- Dedicated team will enable staff development to be tailored to the work and requirements of the service
- Recruitment will be improved as it should be easier to recruit to a specialist team.

Next steps

20. The service will be evaluated at nine months led by the CCG and involving service users.

21. The change in the model should be cost neutral; there should be no increase in activity changes, however, capacity will be increased and more users will access the PoS in Devizes rather than being transferred elsewhere. The South West Strategic Project is developing alternatives to detention which should reduce activity in the longer term.

22. The Trust will ensure users are safely transported home after a period of detention. Transport will be provided as necessary.

23. During the period of the temporary closure providers and commissioners and Healthwatch will obtain feedback and consider the impact the temporary closure is having on the populations of Swindon and Wiltshire and individuals using the service. This will then lead to recommendations to NHS England and NHS Improvement on whether the original place of safety locations should resume or steps would be taken to move towards a formal closure.

24. There will be no physical change to the environments that would prevent Swindon and Salisbury PoS re-opening.

25. During this time period, if the evaluation supports a permanent service change, an assessment will be made by all parties as to whether a public consultation will be required. If there is a requirement to consult, this would be led by the CCG, supported by the Trust and subject to the NHS England assurance process. The consultation will be designed, taking into consideration the responses received as part of the Trust led public consultation in early 2017.

Author: Sarah MacLennan - Associate Director, Communications and Engagement
Wiltshire Clinical Commissioning Group

26 February 2018

Wiltshire Council

Health Select Committee

6 March 2018

Task Group and Programme Boards Representatives Updates

Purpose

To provide an update on recent task group and programme board activity and propose any decisions requiring Committee approval.

1. CAMHS (Children and Adolescents Mental Health Services) Task Group

Membership:

Cllr Phil Alford (Chairman)

Cllr Clare Cape

Cllr Gordon King

Cllr Hayley Spencer

Cllr Fred Westmoreland

Supporting Officer: Natalie Heritage

Terms of Reference:

That the CAMHS Task Group:

a) Consider the governance arrangements for the recommissioned CAHMS service;
b) Explore and understand the new CAHMS model in comparison to the existing model and consider the evidence base for any changes. Then where appropriate, make recommendations to support its implementation and effectiveness;
c) Look at existing data and ensure that the new model's performance will be robustly monitored and benchmarked against this by the council, partners and by the proposed future scrutiny exercise;
d) Consider access and referral points within the new CAHMS model and, as appropriate, make recommendations to maximise take-up by children and young people in need of support;
e) Explore where CAMHS sits within the overall landscape of children and young people's mental health and, within this, consider whether prevention services are effective.

Recent activity:

The CAMHS Task Group met on 17 January 2018 to discuss and agree their Forward Work Programme (attached). Susan Tanner, Head of Commissioning,

attended the meeting to provide advice and guidance on how the Task Group's work could help to add maximum value.

The Task Group will be meeting again on 28 March for a briefing on the re-commissioned CAMHS model. The Task Group's Chairman and Senior Scrutiny Officer are currently working their way through a vast amount of information on the re-commissioned model; most notably around amendments to the CAMHS service and the role CAMHS plays within the overarching mental health strategy. March's briefing will be used to solidify members' knowledge of the new model, ahead of a presentation and briefing from a representative from Oxford Health and James Fortune, Lead Commissioner.

Proposal:

For the Health Select Committee to endorse:

i) The CAMHS Task Group's Terms of Reference, as listed above
ii) The CAMHS Task Group's FWP, as per the attached

2. Adult Social Care Transformation Board – representative update

To receive an update from the representatives on the board on recent and future activities.

Report author: Natalie Heritage, Senior Scrutiny Officer, 01225 718062, natalie.heritage@wiltshire.gov.uk

Terms of Reference and Forward Work Programme

That the CAMHS Task Group:

a) Consider the governance arrangements for the recommissioned CAHMS service;
b) Explore and understand the new CAHMS model in comparison to the existing model and consider the evidence base for any changes. Then where appropriate, make recommendations to support its implementation and effectiveness;
c) Look at existing data and ensure that the new model's performance will be robustly monitored and benchmarked against this by the council, partners and by the proposed future scrutiny exercise;
d) Consider access and referral points within the new CAHMS model and, as appropriate, make recommendations to maximise take-up by children and young people in need of support;
e) Explore where CAMHS sits within the overall landscape of children and young people's mental health and, within this, consider whether prevention services are effective

In regard to adding maximum value to the research process, it is advised that the task group work through the proposed ToR in the following order: D, E, C, B, A

Meeting Date	Subject	Purpose	Outcome	Witnesses/Evidence	Additional Information
17 January 2018	ToR and FWP: agreement	To discuss the proposed ToR and FWP for the task group	For the ToR and FWP to be agreed and for the task group to commence "deep dive" activity	Executive Terence Herbert Susan Tanner James Fortune	
28 March 2018 **[ToRs B and C]**	The re-commissioned CAMHS model	For the task group to consider and discuss the Local Transformation Plan (LTP) and the information which helped to inform the re-commissioned CAMH service	For the task group to be confident of where CAMHS sits within the overall mental health strategy (LTP) and to be aware of the aims and objectives of the re-commissioned model	*Independent Task Group Session with Scrutiny Officer*	Task Group to provide advance notice of questions to James/Michelle, following March's session and ahead of May's meeting. March's meeting will be used to draft these questions.

16 May 2018 **[ToRs B and C]**	The re-commissioned CAMHS model	For the task group to have an additional session on how the re-commissioned CAMHS model is going to run. Information provided would relate to: - Baseline data – how the re-commissioned CAMHS model seeks to improve upon existing service provision	For the task group to fully understand: how the re-commissioned CAMHS model will function; the aims and objectives of the new model; the evidence base for any amendments brought through the re-commissioned model	James Fortune Michelle Maguire (Ted Wilson as optional) *James/Michelle to provide a presentation to the task group*	
19 June 2018* **[ToRs D and E]**	CAMHS service: access and referral points. The position of CAMHS within the overall mental health strategy for Wiltshire	For the task group to explore and understand the experience of a CAMHS user coupled with those that are familiar with the system, as well as those that do not use/have not used CAMHS. For the task group to be confident of the position of CAMHS within the overall Local Transformation Plan (Mental Health Strategy)	For the task group to be able to ascertain how accessible the CAMHS system is and understand the referral process for CAMHS. The task group will be able to clearly see where CAMHS fits into Wiltshire's overall mental health strategy (the Local Transformation Plan) and whether preventative measures are deemed to be effective	C&YP who are using CAMHS and their parents/carers (WPCC) Pupils and teachers from a selection of the 'Thrive Hub' schools & pupils from Hardenhuish School, Chippenham Youth workers GPs C&YP who have not/are not using CAMHS Julian House (Cllr Hubbard to provide contact details) *The task group's line of questioning to centre on 'stress strategies' and determining what access*	15-minute interviews to take place with each of the designated groups. There are 8 groups overall – splitting each group up (e.g. pupils and teachers in a different group) allows for more person-centred evidence to be collected. To ensure a smooth process, a 2-hour slot would be set aside for the task group to conduct their interviews. Including those who have not used CAMHS effectively enables the task group to see how effective the preventative measures are, e.g. is CAMHS a last resort for C&YP? These

				and support available, if C&YP are struggling. SSO to provide a template of interview questions.	individuals will also help to demonstrate where CAMHS is positioned within the LTP, as their mental health needs are being met without needing to utilise CAMHS ***Interim report to go to CSC – reporting on the task group's recommendation/answer to proposed ToR D and E***
September 2018 **[ToRs A, B and C]**	How other authorities are delivering and monitoring their CAMHS service	For the task group to build their knowledge base around how other and similar LAs have designed/commissioned their CAMHS model and how these LAs monitor the performance of their CAMHS	For the task group to have a solid understanding of how CAMHS works in a similar LA to Wiltshire: what evidence has been used to design their CAMHS model; how do they monitor the performance of the CAMHS; who is accountable for the delivery of CAMHS and how is this process managed?	3 LAs: those identified by the Commissioning Team as Wiltshire's Statistical Neighbours: *Gloucestershire* *Oxfordshire* *Somerset* Cabinet Member, Portfolio Holder, Director and Lead Commissioner to be interviewed by the Task Group via Skype by the task group. Each interview session to last 30-minutes.	This exercise will give the task group a solid evidence base from which to scrutinise ToR C, B and A for Wiltshire
November 2018 **[ToRs B and C]**	CAMHS in Wiltshire: service delivery and performance monitoring - background &	For the task group to have a knowledge building session ahead of July's exercise.	For the task group to fully understand the methodology behind the re-commissioned CAMHS contract and how this is collected	James Fortune Sam Shrubsole (Wiltshire Manager for Oxford Health)	

	methodology workshop	Information provided to relate to: methodology. (How is the methodology collected? What are the KPIs of the re-commissioned CAMHS service? Is the same service being maintained?)		Representative(s)/SRO for CAMHS from Oxford Health (Michelle Maguire) Ted Wilson (Wiltshire CCG)	
February 2019 (early Feb)* **[ToRs A, B and C]**	CAMHS in Wiltshire: service delivery and performance monitoring	For the task group to learn what evidence has been used in the re-commissioned CAMHS model (amendments to previous CAMHS offering) –data and methodology to be provided. For the task group to understand who is accountable for the delivery of CAMHS and how this process is facilitated.	For the task group to be confident of how the new CAMHS model can be monitored (data & methodology provided at present to be compared with data & same methodology from April 2019). For the task group to be clear about the governance arrangements for CAMHS; to help enable the process of effective monitoring	Executive Terence Herbert Susan Tanner James Fortune Appropriate representative(s) from the Wiltshire CCG [Governing Body/SRO for CAMHS] Oxford Health – Michelle Maguire Ted Wilson (Wiltshire CCG)	The task group can effectively make a recommendation/answer their ToR of C, B and A above. ***Final report to go to CSC & HSC (September) re ToR C, B and A & whether Executive has responded positively/negatively to earlier recommendations in interim report for ToR D and E.***

* = *dates to align with Children's Select Committee's/Health Select Committee's consideration of the interim report*

Wiltshire Council
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Health Select Committee
Forward Work Programme

Last updated 1 MARCH 2018

Health Select Committee – Current / Active Task Groups			
Task Group	**Details of Task Group**	**Start Date**	**Final Report Expected**
CAHMS Task group			
N/A			

Health Select Committee – Forward Work Programme			Last updated 1 MARCH 2018		
Meeting Date	**Item**	**Details / Purpose of Report**	**Associate Director**	**Responsible Cabinet Member**	**Report Author / Lead Officer**
24 Apr 2018	Briefing (pre-meeting) - Public Health and Public Protection	To receive information on the work undertaken by Public Health and Public Protection	Tracy Daszkiewicz (Director - Public Health and Protection)	Cabinet Member for Adult Social Care, Public Health and Public Protection	
24 Apr 2018	Chairman's Announcement - Adult Care Charging Policy update	At the 9 January 2018 meeting the committee resolved to receive confirmation, possibly via an announcement after 31 March 2018, that all re-assessments had been undertaken.			Sue Geary
24 Apr 2018	Chairman's Announcement - Corporate Peer Challenge	Outcome of the corporate peer challenge will be presented to Cabinet on 27 March			Marie Gondlach

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24 Apr 2018	Chairman's Announcement - Integrated Community Equipment and Support Services - Recommissioning	Cabinet - 27 March 2018 Wiltshire Council and NHS Wiltshire Clinical Commissioning Group (CCG) currently delivers its Integrated Community Equipment and Support Services through a contract with Medequip. This contract, held by the Council on behalf of both commissioners, is due to end on 3 January 2019. Wiltshire Council and Wiltshire CCG want to explore opportunities around commissioning these services jointly.			Marie Gondlach

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24 Apr 2018	Chairman's Announcement - Learning Disabilities In-house Respite Services	Cabinet - 27 March 2018 Wiltshire Council operates 4 residential respite care homes for learning disabilities. Reviews have highlighted ongoing under-usage of the services as a whole. The cabinet report will report on the proposed closure of one of the homes due to under-usage following the outcome of the consultation with usages and their carers.			Marie Gondlach
24 Apr 2018	Obesity and Child Poverty Task Group - Update on recommendations	At its meeting on 14 March 2017 the committee noted the update provided on the implementation of Wiltshire's Reducing Child Poverty Strategy and requested a progress report in 12 months' time.		Cabinet Member for Adult Social Care, Public Health and Public Protection	Jackie Keevan

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24 Apr 2018	Public Health - Annual report 2016-17	The director of public health is required to produce an annual report on the health of the local population in Wiltshire. This year's report for the period 2016/17 takes a whole life course approach with the theme of 'Living longer healthier lives'. Circulated in the Elected Wire on 15 December 2017, the Public Health annual report 2016-17 can be accessed here.	Tracy Daszkiewicz (Director - Public Health and Protection)	Cabinet Member for Adult Social Care, Public Health and Public Protection	Tracy Daszkiewicz
24 Apr 2018	Re-commissioning of the residential rehabilitation (drugs and alcohol) framework for 2019-2022	To re-commission the providers who will form the framework of residential rehabilitation for Wiltshire's drug and alcohol support service users, who wish to be detoxed and rehabilitated from their addictions. The contract will be 3 years with the option of extending this by 2 years. To be considered by Cabinet on 12 June 2018.		Cabinet Member for Adult Social Care, Public Health and Public Protection	Laura Schell, Ceri Williams

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24 Apr 2018	Recommissioning of the Wiltshire Substance Misuse Service - Update	To seek Cabinet approval to begin the commissioning process to retender the Wiltshire Substance Misuse Service (over 18's drugs and alcohol service)		Cabinet Member for Adult Social Care, Public Health and Public Protection	Ceri Williams
24 Apr 2018	Wiltshire Safeguarding Adult Board's - Business Plan	Wiltshire Safeguarding Adult Board's Business Plan 2018/19 and update on work undertaken in 2017/18			Emily Kavanagh
11 Jul 2018	Adult Social Care - update on the implementation of the transformation programme	Following the presentation to the committee prior to the meeting on 9 January 2018 it was agreed that an update would be presented to the committee.	Emma Legg (Director of Adult Care - Access and Reablement)	Cabinet Member for Adult Social Care, Public Health and Public Protection	Catherine Dixon
11 Jul 2018	Briefing (pre-meeting) - Single View	Presentation on the Single View project.			Kevin Marshall
11 Jul 2018	Chairman's Announcement - green paper on care and support for older people	Government to set out proposals to reform care and support by summer 2018. The paper will set out plans for how government proposes to improve care and support for older people and tackle the challenge of an ageing population. Once the green paper is published in summer 2018, it will be subject to a full public consultation.			Marie Gondlach

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11 Jul 2018	Wiltshire Health & Care (Adult Community Health Care Service) - update following CQC report	At its meeting on 9 January 2018, the Committee resolved to receive a further update, possibly in July 2018, providing further information regarding the implementation of actions, and the development of the trust.			Wiltshire Health & Care
11 Sep 2018	Public Health - Annual report to Secretary of State	Likely to be chairman's announcement. Usually published in September.	Tracy Daszkiewicz (Director - Public Health and Protection)	Cabinet Member for Adult Social Care, Public Health and Public Protection	
11 Sep 2018	Update on Strategic Outline Case - consultation results	Update on the information provided at the HSC meeting in September 2017.			
	CCG Commissioning Intentions	(TBC)			CCG
	Cancer care strategies - update	(date TBC) To receive an update following the information provided at the HSC meeting in September 2017.			CCG

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