Open Agenda

Health and Wellbeing Board

Monday 4 March 2019
11.30 am
Ground Floor Meeting Room G02C - 160 Tooley Street, London SE1 2QH

Membership

Councillor Peter John OBE (Chair)	Leader of the Council
Councillor Evelyn Akoto	Cabinet Member, Community Safety and Public Health
Councillor Jasmine Ali	Cabinet Member for Children, Schools and Adult Care
Andrew Bland	Accountable Officer, NHS Southwark,CCG
Cassie Buchanan	Southwark Headteachers Representative
Sally Causer	Executive Director, Southwark Law Centre
Councillor David Noakes	Opposition Spokesperson for Health
Kevin Fenton	Strategic Director of Place and Wellbeing
Ross Graves	Managing Director, NHS Southwark, CCG
Dr Jonty Heaversedge	Chair, NHS Southwark, CCG
Eleanor Kelly	Chief Executive, Southwark Council
Catherine Negus	Healthwatch Southwark
Dr Matthew Patrick	Chief Executive, SLAM NHS Foundation Trust
David Quirke-Thornton	Strategic Director of Children's and Adults' Services
Dr Yvonneke Roe	Clinical Lead for Prevention and Early Action, NHS Southwark, CCG
Paul Rymer	Chief Executive, Community Southwark
Ian Smith	Chair, King's College Hospital NHS Foundation Trust

INFORMATION FOR MEMBERS OF THE PUBLIC

Access to information

You have the right to request to inspect copies of minutes and reports on this agenda as well as the background documents used in the preparation of these reports.

Babysitting/Carers allowances

If you are a resident of the borough and have paid someone to look after your children, an elderly dependant or a dependant with disabilities so that you could attend this meeting, you may claim an allowance from the council. Please collect a claim form at the meeting.

Access

The council is committed to making its meetings accessible. Further details on building access, translation, provision of signers etc for this meeting are on the council's web site: www.southwark.gov.uk or please contact the person below.

Contact
Everton Roberts on 020 7525 7221 or email: everton.roberts@southwark.gov.uk

Members of the committee are summoned to attend this meeting
Eleanor Kelly
Chief Executive
Date: 22 February 2019

Health and Wellbeing Board

Monday 4 March 2019
11.30 am
Ground Floor Meeting Room G02C - 160 Tooley Street, London SE1 2QH

Order of Business

Item No.	Title	Page No.
1.	**APOLOGIES** To receive any apologies for absence.	
2.	**CONFIRMATION OF VOTING MEMBERS** Voting members of the committee to be confirmed at this point in the meeting.	
3.	**NOTIFICATION OF ANY ITEMS OF BUSINESS WHICH THE CHAIR DEEMS URGENT** In special circumstances, an item of business may be added to an agenda within five clear days of the meeting.	
4.	**DISCLOSURE OF INTERESTS AND DISPENSATIONS** Members of the committee to declare any interests and dispensation in respect of any item of business to be considered at this meeting.	
5.	**MINUTES** To agree as a correct record the open minutes of the meeting held on 21 November 2018.	To follow

Item No.	Title	Page No.

6. THEME: TACKLING HEALTH INEQUALITIES

The theme for this Health and Wellbeing Board meeting is 'Tackling Health Inequalities'.

The board will receive presentations from the Council, the NHS Southwark Clinical Commissioning Group and the Chair of the Healthy Communities Scrutiny Commission on the approaches being used to tackle health inequalities in Southwark.

Presentations:

- A public health approach to tackling health inequalities in Southwark

Jin Lim, Consultant in Public Health,

- System wide approaches to tackling inequalities in Southwark

Ross Graves, Managing Director, NHS Southwark Clinical Commissioning Group

- Scrutiny Commission into Health Inequalities

Councillor Barrie Hargrove, Chair of Health Communities Scrutiny Commission

- NHS Long Term Plan and Inequalities

Professor Kevin Fenton, Strategic Director of Place and Wellbeing

OTHER ITEMS OF BUSINESS

7. COUNCIL POLICY AND RESOURCES REVENUE BUDGET 2019-20 1 - 51

To note the Council's Policy and Resources Revenue Budget 2019-20 to be agreed at the Council Assembly meeting on 27 February 2019.

8. BREXIT PREPAREDNESS

To receive presentations from the Council and NHS Southwark Clinical Commissioning Group on preparations for Brexit.

9. LAMBETH, SOUTHWARK AND LEWISHAM SEXUAL AND REPRODUCTIVE HEALTH STRATEGY 2019-24 52 - 188

To approve the new Lambeth, Southwark and Lewisham (LSL) Sexual and Reproductive Health Strategy 2019-24.

10. COMMUNITY SAFETY - YOUTH VIOLENCE

To receive a presentation from Stephen Douglass, Director of Communities and Caroline Thwaites, Assistant Director of Community Safety and Partnerships on Youth Violence in Southwark.

Item No.	Title	Page No.
11.	**HEALTH AND WELLBEING BOARD WORK PLAN 2018-20**	189 - 196
	To note the health and wellbeing board work plan 2018-20 subject to any amendments.	

Date: 22 February 2019

Item No. 2.1	Classification: Open	Date: 27 February 2019	Meeting Name: Council Assembly
Report title:		Policy and Resources Strategy 2019-20 – revenue budget	
Wards or groups affected:		All	
From:		Strategic Director of Finance and Governance	

RECOMMENDATION

That council assembly:

1. Agrees to increase the Southwark element of the council tax for 2019-20 by 2.99%.

2. Agrees the recommendations of the 5 February 2019 cabinet for a general fund budget requirement (after specific grants and use of reserves) for 2019-20 of £290.424m.

BACKGROUND INFORMATION

Revenue Budget

3. On 5 February 2019 cabinet considered a report on the council's policy and resources strategy 2019-20 revenue budget proposals.

4. No amendments were made during cabinet to the recommendations included in the report, which were agreed by cabinet.

5. In total and in the context of resources available, the recommendation of the cabinet was agreed to set a general fund revenue budget requirement for 2019-20 of £290.424m.

KEY ISSUES FOR CONSIDERATION

Revenue Budget 2019-20

6. Table 1 below shows a high level summary of the proposed budget following consideration by cabinet on 5 February 2019. The report and relevant appendices to the cabinet are now attached to this report as appendix A.

Table 1: high level summary budget for 2019-20

	2019-20 £m
Resources	
Retained Business Rates	(125.972)
Business rates top-up	(23.903)
Revenue Support grant	
Total Settlement Funding Assessment (DCLG)	**(149.875)**
Public Health Grant	(26.744)
Section 31 Grant	(4.281)
New Homes Bonus	(12.830)
Additional Social Care Grants (Autumn Budget announcement)	(4.254)
Specific grants	**(48.109)**
Improved Better Care Fund	(13.529)
Supplementary IBCF	(2.223)
Improved Better Care Fund	**(15.752)**
Total Government Funding	**(213.736)**
Business Rate Retention growth	(25.000)
Business Rate Retention collection fund surplus	(1.158)
Council Tax baseline	(107.322)
Council tax change - 2018-19	(3.209)
Council Tax Collection Fund surplus	(3.860)
Total revenue from council tax	**(140.549)**
Total funding before contribution from balances	**(354.285)**
Current contribution (from)/to balances	
A . Total Resources	**(354.285)**
	(290.424)
Previous Years Budget	**348.041**
Inflation	
Employees 2% per annum	4.500
Contractual inflation	3.950
Existing provision	(2.606)
Capital financing	3.809
Commitments & Contingency	
Growth and Commitments	16.206
B . Budget before savings and efficiencies	**373.900**
Net Shortfall before Savings and efficiencies (Current year A+B)	**19.615**
Effective use of resources and efficiencies	(13.905)
Income Fees and Charges	(4.810)
Other Savings	(0.900)
C. Total Savings	**(19.615)**
D. Total budget (Current Year B + C)	**354.285**
E. Funding Shortfall / (Surplus)	**(0.000)**

Southwark Council Tax

7. For the purpose of setting council tax, the council calculates the total budget, less specific grants, less contribution from reserves. For 2019-20 this would be:

	2019-209 £m
Total budget (table above)	354.285
Specific grants (included in table above)	(63.861)
Planned contribution from reserves	0
Total budget requirement	**290.424**

8. All local authorities are required to set their council tax by 11 March each year. This council will set its own tax on 27 February 2019. As in previous years, any delay to this date will mean the council may have to move its council tax instalment date beyond 1 April. This would result in a loss of income to the council from cash flow and could also put at risk the ability of the council to meet its collection targets.

9. Cabinet have recommended setting a 2.99% increase in council tax for 2019-20.

10. The effect on the Southwark element of council tax is shown in the following table:

	Band D		
	2018-19	**2019-20**	**Change**
Southwark Council Tax	1,035.31	1,066.27	2.99%

Consultation

11. The policy and resources strategy 2016-17 to 2019-20 reported to cabinet on 27 January and 9 February 2016 contained a detailed report giving results and analysis from the spending challenge consultation held during 2015.

12. In addition, recommendations from overview and scrutiny committee on 28 January 2019 were considered and accepted by cabinet at their meeting on 5 February 2019.

Chief Finance Officer assurance on robustness of budget estimates

13. In setting out the budget proposals for 2019-20 the strategic director of finance and governance, as the statutory section 151 officer, is assured that the range of spending commitments and proposed savings are being set within the resources available that meet local priorities. The draft budget proposed for 2019-20 is therefore robust.

14. In addition to ensuring that sufficient funds are available to finance the ongoing management of the council services, the strategic director of finance and governance needs to be assured that there is an appropriate level of reserves and balances available. The Local Government Act 2003 requires the chief finance officer to report on the adequacy of reserves held, and requires members to have regard to that report in setting the budget. The Act also gives powers to the Secretary of State to specify a minimum of reserves to be held, but those powers have not yet been applied.

15. The cabinet report included as Appendix A provides information about the use of reserves and balances (paragraphs 95 to 98).

16. Maintaining an adequate level of reserves and balances are therefore key factors in the strategic director of finance and governance's assessment of the robustness of the budget. The relatively low levels of balances and reserves when compared to similar councils in London have been reported to cabinet.

17. The position remains under close review and the s151 officer will continue to make recommendations as appropriate within the policy and resources strategy. He considers the current plans for use of balances to be acceptable and recognises that the budget continues to allow for a contingency that mitigates the risk of shortfalls in savings and income targets or higher levels of commitments arising from unforeseen budget pressures.

18. In setting the budget the council needs to be mindful of the continued uncertainty with regards to future funding. As set out in the cabinet report there are significant uncertainties and complexities regarding the future funding of local government beyond 2019-20, including:

   - Government Spending Review during 2019
   - A new local government needs based funding formula, the Fair Funding Review
   - Redesign of the Business Rates Retention System for 75% retention from 2020-21
   - Resetting of the business rates baseline from 2020-21
   - The future of the London Business Rates Pool
   - An anticipated Green Paper on funding of adult social care
   - Economic uncertainty regarding the outcome of Brexit negotiations and wider economic pressures on inflation, interest rates and area costs within London (especially housing).

19. The impact of these reforms cannot be assessed at this time. The use of the Financial Risk Reserve, the Business Rate Retention Risk and the Brexit Risk Reserve all form part of the mitigation strategy. The risks identified strengthen the importance of maintaining a robust medium term financial strategy within which to plan council business and sustain delivery of essential frontline services. A refreshed financial outlook of the financial position will be presented to cabinet in summer 2019.

Community impact statement

20. The community impact statement is set out in the cabinet report of 5 February 2019 attached at Appendix A.

21. The council works in accordance with the single public sector equality duty contained within section 149 of the Equality Act 2010. This means the council must have due regard to the need to eliminate unlawful discrimination, harassment and victimisation, and advance equality of opportunity and foster good relations between different groups.

22. Transparency and fairness form part of the seven budget principles and are an underlying principle in the Council Plan. As with the budget for 2019-20 and for previous years, each department has undertaken equality analysis/screening on its budget proposals ahead of the final decisions being taken. Where screenings

identify potential impacts more detailed analysis is being carried out and will be developed as proposals are confirmed.

23. Undertaking equality analysis helps the council to understand the potential effects that the budget proposals may have on different groups. The analysis also considers if there may be any unintended consequences and how any of these issues can be mitigated. Analysis is also undertaken to consider any cross-cutting and organisation-wide impacts.

24. For many services the budget proposals will include efficiencies which have staffing implications. As specific proposals are brought forward, and at each stage of implementation thereafter, the different impacts on different categories of staff will be assessed in accordance with the council's reorganisation, redeployment and redundancy procedures.

25. Equality analysis will continue through the cycle of planning and implementation of these budget proposals. In line with our public sector equality duty, any changes to services arising from these proposals will be implemented in such a way so as to not impact disproportionately on any specific section or group in our community. Where necessary, consultation will be undertaken alongside mitigating actions where necessary. In line with the process across the council, information on the equality analysis will be shared with the relevant cabinet members so it can be considered when decisions are taken. The equality analyses will be collated across the council to look for any cumulative impacts.

SUPPLEMENTARY ADVICE FROM OTHER OFFICERS

Director of Law and Democracy

26. The report asks council assembly to agree the recommendations of the 5 February 2019 cabinet for a general fund budget requirement (after use of reserves) for 2019-20 of £290.424m including the impact of a 2.99% council tax increase for 2019-20. In accordance with part 3A of the Constitution, council assembly are required to agree the budget.

27. In respect of all recommendations, council assembly is reminded of the requirement to consider the public sector equality duty as set out in Section 149 of the Equality Act 2010 before reaching a decision.

Legislative framework

28. Section 31A of the Local Government and Finance Act 1992 ("the 1992 Act") provides that the council has an obligation to calculate and agree an annual budget

Restrictions on Voting Under Section 106 of the Local Government Finance Act 1992

29. Section 106 of the 1992 Act applies at any time to a member of an authority, if at that time the member is due to pay council tax payments which have remained unpaid for at least two months.

30. The payments to which the section applies are any type of either sole or joint and several liability for council tax, and any failure to pay any agreed sum of council tax. Therefore members are advised that this section is likely to apply to them if they are currently two months in arrears of any amounts of council tax, even if

they have made any special contractual arrangement with the council to pay off the arrears.

31. If this section applies to any member, he/she at the relevant meeting and as soon as practicable after its commencement, must disclose the fact that the section applies and not vote on any question with respect to this matter.

32. The relevant meetings are those at which any of the following are the subject of consideration, namely:

(a) Any calculation required by chapter III, IV, V of Part 1 of the 1992 Act

The only calculations likely to be made by this authority are those under Chapter III of Part 1 of the 1992 Act, (Chapter IV relates to precepting and Chapter V limitations on council tax (i.e. capping)

The Chapter III calculations include the calculation of the budget requirement, basic amount of tax, the additional requirements because of the special trust funds, the calculation of the tax for the different valuation bands and the basic amount of council tax to be set under Section 30.

(b) Any recommendation, resolution or other decision which might affect the making of any such calculation

This is an extremely wide wording and would extend well beyond merely setting the budget. It applies to virtually any matter where the financial implications directly or indirectly might affect the calculations concerning the council tax. It would therefore apply to decisions concerning the level or extent of services as well as the expenditure, receipt or forgoing of any money.

(c) The exercise of any function under Schedules 2-4 of the Local Government Finance Act 1988 (“the 1988 Act”) and 1992 Act

The functions under either the 1988 or 1992 Acts concern the administration and the enforcement of community charge and council tax respectively.

33. Section 106 of the 1992 Act makes it a criminal offence for a member to vote when prohibited from doing so or to fail to make the necessary disclosure. There is a statutory defence, with the onus of proof on the member, to prove that he did not know that the section applied to him or her at the time of the meeting or that the matter in question was the subject of consideration at the meeting. Prosecutions shall not be instituted except by or on behalf of the Director of Public Prosecutions.

BACKGROUND INFORMATION

Background Papers	Held At	Contact
None		

APPENDICES

No.	Title
Appendix A	Cabinet Report 5 February 2019 Policy and Resources 2019-20 Revenue Budget with appendices A to G

AUDIT TRAIL

Lead Officer	Duncan Whitfield, Strategic Director of Finance and Governance	
Report Author	Robert Woollatt, Interim Departmental Finance Manager	
Version	Final	
Key Decision?	Yes	
Date	15 February 2019	
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	**Comments sought**	**Comments included**
Director of Law and Governance	Yes	Yes
Strategic Director of Finance and Governance	Yes	Yes
Cabinet Member	Yes	Yes
Date final report sent to Constitutional Team		15 February 2019

APPENDIX 1

Item No. 11.	Classification: Open	Date: 5 February 2019	Meeting Name: Cabinet
Report title:		Policy and Resources Strategy 2019-20	
Ward(s) or groups affected:		All	
Cabinet Member:		Councillor Victoria Mills, Finance, Performance and Brexit	

FOREWORD - COUNCILLOR VICTORIA MILLS, CABINET MEMBER FOR FINANCE, PERFORMANCE AND BREXIT

Yet again Southwark Council faces enormous funding cuts in 2019-20 with a loss of £8.6m of general government funding. These funding cuts come at a time of continuing demands and pressures on our services, particularly social care, children's services, education, homelessness and welfare support.

Whilst we welcome the additional one-off social care grant of £4.3m announced as part of the Autumn Budget and the previously announced growth in the Improved Better Care Fund of £3.2m, this only goes part way to meeting the growing demands on children's and adult's social care services. We still await the promised Green Paper on the long-term funding of Adult Social Care and remain concerned that the Government's Budget statement made no mention of any long-term plan for social care funding.

The indicative budget proposals include £5m of Adult Social Care savings in 2019-20 offset by commitments of £4.7m. This demonstrates the investment of the increased Improved Better Care Fund (£3.2m) in protecting homecare, reablement and bed-based care packages and transformation work to improve the health, wellbeing and resilience of vulnerable residents.

We also face significant challenges in Children's Services and Education. Children's Services provide vital support for vulnerable children in our borough and we face great pressures in terms of the cost of placements, particularly residential care for looked after children. Thanks again to the work of our Budget Recovery Board we are able to propose £1.1m of efficiency savings in this area, but to make the budget sustainable we will also inject a further £3.3m for a net growth in the Children's Services budget of £2.2m.

In Education, reduced grant and funding continue to impact on the budget, as well as the increasing demand for statutory SEN education and home to school transport. There are significant pressures on schools funding via the Dedicated Schools Grant. Demand and cost pressures are particularly acute on the High Needs Block where government funding is insufficient. As at 31 March 2018, there was an accumulated deficit of £4.1m, which is forecast to increase to £11m by the end of 2018-19. The council continues to work with the Southwark Schools Forum on a deficit recovery plan, which includes proposals for reductions in central retentions, block transfers as well as reductions in funding to settings. This will be subject to full consultation and equalities impact assessment.

Whilst Southwark is recognised nationally as a leading authority in homelessness prevention, statutory and policy obligations, increasing demand and restricted housing supply mean that temporary accommodation remains a particularly challenging area. Based

on current policy, cost pressures are projected to continue to rise during 2019-20. Efficiency savings and policy changes in relation to the discharge of duty into the private sector and out of borough (along with other initiatives being developed with London Councils) would assist in mitigating this budget pressure. Net growth in Temporary Accommodation budget of £3.2m has been included in the budget proposals.

Local government pay is now the lowest in the public sector. Whilst the government has removed the 1% pay cap, they have not provided any resources to local authorities to help us give our staff the pay rise that they deserve. The budget presented today reflects a 2% 2019-20 pay award, which is estimated to increase the pay bill by £4.5m in 2019-20.

All these pressures, alongside other growing costs such as inflation mean that as well as having to cope with £8m of cuts, we also need to fund £25.9m of additional budget pressures and growth.

However, yet again this year the good news for Southwark is that our continuing growth in homes and in our local economy is providing us with a strong growth in income. We are currently estimating an additional £6.1m of resources available thanks to this growth and the success of our Exchequer Services team in collecting more income that we had previously anticipated.

On a further positive note, the London Devolution Deal and business rate pooling arrangement means the additional income generated from business rates growth, notably within Southwark, will be retained within London, rather than being returned to Government. This has facilitated pan London strategic investment schemes such as the South London Innovation Corridor as well as enabling local initiatives, such as the Positive Futures Fund and Southwark Pioneers Fund to be approved. I am also delighted that we are able to propose a £2million fund to support our groundbreaking commitment to children and youth people's mental health. This money will be specifically for prevention and pastoral care ensuring that every child in Southwark gets the very best start in life and has the health, wellbeing and resilience to fulfil their potential.

We also know the importance that residents place on their local libraries in Southwark, they are places of enjoyment, to socialise, play, study and connect to vital services for all ages. We have a strong record in prioritising and investing in our libraries, despite many years of austerity and government cuts to public services. As such, this updated Policy and Resources Strategy confirms that funding from the London Devolution Deal and business rate pooling arrangement will be used to create a £1m reserve, to cover the next four years, has been put in place. This will ensure that our libraries stay open for years and will support the implementation of the Libraries and Heritage Strategy.

The continued delay in negotiating Britain's exit from the European Union continues to create uncertainty and an increasing risk of a no-deal Brexit with its consequential impact on the economy, the supply chain, the workforce and the demand for services. Accordingly, we have recommended that £2m be set aside to ensure council services are protected and a further £300,000 commitment has been added to the base budget to cover ongoing operational pressures resulting from Brexit. In the immediate term, these funds will be prioritised to support the recommendations made by the Southwark Brexit Panel.

To address the budget shortfall, we have set out proposals totalling £19.615m in the appendices, a combination of efficiency savings (£13.905m), additional income from fees and charges (£4.810m) and other savings of (£0.900m). There has been one change to the proposals published for consultation in January. We have listened to concerns raised about changes to library hours and have removed this efficiency and replaced it with an investment of £1m from the London Devolution Reserve. This effectively offsets the impact of removing

the efficiency saving for the next four years, helping ensure the recently approved Libraries and Heritage Strategy responds effectively to the outcome of the extensive consultation recently undertaken.

Despite these savings and additional income, a budget gap of approximately £3.2m remains and of course, unlike government, the council is legally required to set a balanced budget.

Over the last eight years we have kept council tax low only raising it to protect vital frontline services. After detailed and careful thought, we are proposing that we raise council tax by the maximum permitted 2.99% to close the budget gap. It is never an easy choice to increase council tax, but this ensures that in the toughest of times we are able to protect services for our most vulnerable residents and the services which our residents value and depend on. We recognise the pressure that this can add on low-income households so our Council Tax Reduction Scheme will remain unchanged. This means that approximately 12,000 working age households will continue to receive support and will pay no more than 9p extra a week and that 6,900 eligible pensioners will continue to receive 100% relief.

I would like to thank Overview and Scrutiny committee members for the Budget Scrutiny session that took place on 28 January. We have incorporated into this report their recommendations, particularly their concerns regarding equality of access to our libraries, together with our responses, which we will take forward over the coming months.

RECOMMENDATIONS

That cabinet:

1. Note the recommendations considered at cabinet on 22 January 2019, and that this report has been amended accordingly;

2. Note that the 22 January 2019 report was considered by Overview and Scrutiny committee on 28 January 2019 and agree the response to the recommendations arising (paragraphs 102 - 104);

3. Note that the final local government finance settlement published on 29 January 2019 was unchanged from the provisional settlement published in December (paragraph 24);

4. Note the additional grant of £0.105m in 2018-19 and 2019-20 to support preparations for Brexit (paragraph 28)

5. Note that this report presents the final balanced general fund budget proposals for 2019-20 including:

   - Efficiencies and improved use of resources savings of £13.905m (Appendix C);
   - Income generation proposals of £4.810m (Appendix D);
   - Savings impacting on services of £0.900m (Appendix E);
   - Commitments and growth of £16.206m (Appendix F);
   - Pay Award and contractual inflation of £8.450m; and
   - Debt financing costs of £3.809m.

6. Agree to submit this balanced one year 2019-20 budget to council assembly for approval;

7. Agree the fees and charges as set out in Appendix G (paragraphs 92 - 94);

8. Note that in the summer 2019 cabinet will receive a refreshed outlook of the financial position and specifically an update on local government financing in 2020-21 and beyond.

BACKGROUND AND PURPOSE

9. In September 2016, the cabinet approved the Fairer Future Medium Term Financial Strategy (FFMTFS) and Integrated Efficiency Plan noting the relationship to the Council Plan and the new theme to be fit for the future. The council accepted the four-year finance settlement in line with the final local government finance settlement (February 2016). 2019-20 is the fourth and final year of that four-year settlement. The offer covered the revenue support grant and confirmed that tariffs and top-ups would not be altered for reasons related to the relative needs of local authorities.

10. The Council Plan for the period 2018-2022 contains a range of promises and commitments, which the council will work towards delivering over the coming four years. Financial appraisals will be undertaken as new plans are developed and the financial implications of any approved commitments will be reflected in the 2019-20 budget, refreshed MTFS and capital programme.

11. In 2018-19, London Councils entered into a one-year pilot arrangement for the retention of business rate growth through pooling. Subject to final agreement with the government, it is expected that the pooling arrangement will continue in 2019-20, albeit on less generous terms and with more risk passed to the council.

12. Despite the consistency of funding given by the four-year settlement, there remains continued uncertainty with regard to a number of elements of government funding. These include the New Homes Bonus, Public Health grant, Better Care Funding and Social Care grants. In addition, pay and price inflation and demand pressures need continual review to ensure that budgets set each year are sustainable.

13. The government has expressed a continued commitment to give local authorities greater control over the money they raise locally. Since 2013-14, when the new funding arrangement commenced, the council's reliance on local taxation as an income source has increased, with council tax and business rates growth now representing 49% of net budget requirement for 2019-20. Therefore, a key part of the budget process is for officers to reassess the estimated income from council tax (driven in the main by the number of new homes, council tax banding of these homes, the council tax relief scheme) and Business Rates (driven by the rateable value, appeals and businesses coming into/out of the rating lists).

14. At cabinet on 18 September 2018, the financial remit was considered which included known and estimated resources available at that time, and assumptions regarding the costs of pay awards and inflation. The report concluded with a budget gap of £17.956m. Officers were asked to prepare indicative savings and commitments for 2019-20 in order to balance the budget. Subsequently at Cabinet on 11 December 2018 and 22 January 2019, proposals were considered to address the budget gap. This report provides an update on the work undertaken to reflect the latest information on available resources and proposals to deliver a balanced budget for 2019-20.

15. As set out in September 2018, the budget will be prepared on a one-year basis for 2019-20, recognising that the settlement is indicative and a range of other significant uncertainties relating to the council's financial position. A one-year budget is

considered by the section 151 officer to be the most appropriate strategy at this time given the significant uncertainties and complexities regarding the future funding of local government beyond 2019-20, including:

- Government Spending Review during 2019
- A new local government needs based funding formula, the Fair Funding Review,
- Redesign of the Business Rates Retention System for 75% retention from 2020-21
- Resetting of the business rates baseline from 2020-21,
- The future of the London Business Rates Pool,
- An anticipated Green Paper on funding of adult social care
- Economic uncertainty regarding the outcome of Brexit negotiations and wider economic pressures on inflation, interest rates and area costs within London (especially housing).

Updated Financial Remit

16. In accordance with instructions from the December 2018 and January 2019 cabinet meeting, these budget proposals present a balanced budget. This has been achieved under challenging circumstances, not least in the context of the savings that the council has had to make throughout the austerity period since 2010 and the increased ring fencing of a large element of resources available for adult social care. A summary of the 2019-20 proposed budget can be found at Appendix A.

17. The indicative budgets were set at an assumed level of government funding, as set out in the February 2016 four-year settlement. The council accepted the government's offer of a four year funding settlement for 2016-17 to 2019-20 and received confirmation of this from the government on 16 November 2016.

18. This report outlines all major variations from the 2018-19 budgets. It itemises changes in resources available (e.g. government grant and council tax income) and provides a high-level summary of efficiencies and improved use or resources, income generation and savings that impact on service levels. It also itemises new and emerging growth and commitments that may arise from issues such as price, demand pressures and costs arising from the delivery of council plan priorities.

19. Separate schedules are provided that give details of each element of these variations. Responsibility for each element is retained by the cabinet member responsible for the portfolio and operationally managed by the strategic director for that service (Appendices C, D, E and F).

20. The Policy and Resources Strategy 2019-20 underpins the work of all council departments, ensuring financial sustainability and the best possible level of service for residents. The council remains committed to promoting efficiency as the key driver to reducing costs and minimising the impact of budget decisions on front line services. The Fairer Future promises commit to spending every penny as if it were our own. This promise is reinforced with the Fairer Future Budget Principles. Inevitably, as total resources available continue to reduce, demands increase for services and planned efficiency improvements are delivered, protection of these valued front line services becomes increasingly difficult.

21. This report proposes that a further update be presented to cabinet in the early summer of 2019 to refresh the financial outlook for 2020-21 and beyond, not least in regard to the changes in local government funding.

Government Budget Statement – 29 October 2018

22. On 29 October 2018, the Chancellor of the Exchequer delivered the Budget. As well as the usual updates on the public finances and overall economic outlook, the Budget included a number of policy announcements, the key headlines are set out below (source: London Councils' on the day briefing):

    - £240 million of new funding for Adult Social Care in 2019-20 (Southwark allocation is £1.571m).
    - A further £410 million to support both adult and children's social care in 2019-20 (Southwark allocation £2.683m).
    - The Budget committed to "putting social care on fairer and more sustainable footing" in the forthcoming ASC green paper, although the date of the green paper is yet to be announced
    - The immediate removal of the HRA borrowing cap was confirmed (from 29 October 2018)
    - £420 million of new funding for potholes, allocated based on DfT's need based formula (Southwark allocation £0.558m)
    - Small business retail relief was announced for retail businesses with a rateable value less than £51,000 for two years – this will cost government £900 million and local government will be "fully compensated".
    - £675 million of co-funding will be awarded to local authorities over the next 5 years to help them draw up plans to revitalise high streets.
    - £400 million of capital funding was announced for schools to invest in equipment and facilities in 2018-19.
    - £84 million will be invested over five years to expand programmes for children in care.

23. Not mentioned in the Budget:

    - Any long term plan for children's social care funding
    - No extra funding was found for schools High Needs pressures
    - No recognition of homelessness funding pressures
    - The date or timetable for next years Spending Review.

Local Government Finance Settlement

24. The Secretary of State for Housing, Communities and Local Government announced the Final Local Government Finance Settlement on 29 January 2019. This confirmed the figures published in the provisional settlement on 13 December 2018.

25. The Settlement details the Settlement Funding Assessment (SFA) for 2019-20 together with other grant funding included within Core Spending Power (CSP).

26. The main 2019-20 headlines are set out below:

    - the Settlement Funding Assessment (SFA) agreed as part of the four year settlement will fall by 5.4% in 2019-20;
    - SFA funding confirmed a small increase of £82k from the amount set aside in the original four-year settlement;
    - business rate pilots were confirmed for 2019-20, including the continuation of the London pilot pool;
    - the council tax referendum threshold in 2019-20 will remain at 3% with no changes

to the adult social precept arrangements;
- confirmation of the additional social care funding provided at Autumn Budget 2018, Southwark's allocation being £4.254m;
- the proposed changes to the New Homes Bonus baseline will not go ahead. Southwark's final allocation being £12.830m, an increase of £0.518m from estimate;
- no changes to the previously announced Public Health Grant (£26.744m) and Improved Better Care Fund (£15.752m);
- a one-off distribution of business rates levy surplus, Southwark's allocation being £1.749m.

27. In addition to the announcements affecting 2019-20 the Government published two consultation papers:

- Fair Funding Review – "A review of local authorities' relative needs and resources - Technical consultation on the assessment of local authorities' relative needs, relative resources and transitional arrangements"

- Business Rates Retention – "Business Rates Retention Reform - Sharing risk and reward, managing volatility and setting up the reformed system", a consultation on the proposed 2020/21 Redesign and Reset of the Business Rates Retention (BRR) scheme.

28. Alongside the Settlement, the Government announced that local authorities across England would receive grant funding to support their preparations for Brexit. Southwark's allocation will be £0.210m (£0.105m in 2018-19 and 2019-20).

Settlement Funding Assessment (SFA)

29. The Settlement Funding Assessment (SFA) comprises the core funding sources for authorities defined as Revenue Suport Grant (RSG), retained business rates and business rate top-up. The council's SFA in 2019-20 is £149.875m (£158.440m in 2018-19). For 2019-20, as in 2018-19, the council will no longer receive Revenue Support Grant due to the London Business Rate pooling arrangements meaning that RSG is substituted within baseline business rate funding.

MHCLG Core Spending Power

30. Core Spending Power is the government's measure of the core revenue funding available for local authority services, including council tax. Southwark's 2019-20 spending power is indicated to increase by 2.4% between 2018-19 and 2019-20 in line with the London increase (2.8% nationally). However, it should be noted that the core spending power figures include the new social care funding announced in the Autumn Budget and an assumption that the council will set a council tax increase at the 3% referendum threshold.

Improved Better Care Fund (IBCF)

31. The Better Care Fund was established in 2014-15, with the aim of supporting closer working between Local Authorities and the CCG. The council invoices the CCG for its share of the pooled fund, which is offset against appropriate expenditure.

32. The Improved Better Care Fund totals £15.752m for 2019-20; this is made up of two parts:

- The Improved Better Care Fund (IBCF) that was included as part of the 2016-17 settlement of £13.529m for 2019-20 (£8.088m in 2018-19). This was for the utilisation of local authorities for adult social care

- Following national pressure on adult funding care crisis, supplementary Improved Better Care Fund was announced in spring 2017. This equates to funding for Southwark of £2.223m in 2019-20, a decrease from the 2018-19 allocation of £4.497m. The utilisation of this grant to be agreed with the Health and Well-Being board for adult social care funding pressures.

New Homes Bonus (NHB)

33. New Homes Bonus (NHB) was introduced in 2011 to provide a clear incentive for local authorities to encourage housing growth in their areas. It rewards local councils for each additional home added to the council tax base, including newly built properties and conversions as well as long-term empty properties brought back into use, after deducting demolitions. Following a review of the funding “sharpening the incentive”, the grant reduced in 2017-18. From 2018-19 the grant reduced further as the reward is now based on four years’ growth as opposed to six.

34. A 0.4% baseline was introduced in 2017-18 so that local authorities would need to achieve tax base growth of greater than 0.4% before they receive any NHB funding. The government consulted on proposals to increase the baseline further in 2019-20. However, the provisional settlement confirmed no change for 2019-20.

35. The allocation for 2019-20 is £12.830m, an increase of £1.432m from 2018-19.

36. The Government has announced its intention to explore how to incentivise housing growth most effectively from 2020-21, for example by using the Housing Delivery Test results to reward delivery or incentivising plans that meet or exceed local housing need.

Public Health Grant

37. The Public Health Grant is £26.744m for 2019-20, a 2.6% reduction from 2018-19. Since 2013-14, when Public Health responsibilities transferred to local authorities, grant funding has reduced by an equivalent of 15%, with no inflationary increases. Southwark has the fourth lowest per head public grant allocation of the inner London boroughs.

Additional Social Care funding in 2019-20

38. At Autumn Budget 2018, the Government announced £650m of extra funding in 2019-20 for local authorities for adult and children’s social care services. Southwark’s allocations are confirmed as £1.571m in respect of winter pressures (to be pooled into the Better Care Fund) and £2.683m Social Care Support Grant available for adults and children’s social care. This grant is not ring-fenced and has no restriction of how much should be spent on adult’s or children’s social care.

Business Rates Levy Account surplus

39. As a result of increased growth in business rates income nationally, a surplus has accumulated within the government’s Business Rates Retention levy/safety net account. Southwark’s confirmed allocation is £1.749m. Cabinet agreed to set aside

this ‘one-off’ allocation in the Business Rate Retention Risk reserve to mitigate risk around business rate revaluation, reset and devolution deal.

Dedicated Schools Grant

40. The Dedicated Schools Grant is formula based, calculated by the government with the council passing it on to schools. The Department for Education (DfE) has provisionally set the allocation for 2019-20 at £321.5m, although this will be revised during the year to reflect updated pupil numbers. The figures include the funding for academies, which will be recouped at a later date.

41. Dedicated Schools Grant can be broken down into the following spending blocks:

	2018-19 £m	**2019-20 £m**	**Change £m**
Schools Block	241.9	247.3	5.4
High Needs Block	43.7	44.7	1.0
Early Years Block	27.9	27.8	-0.1
Central Block	1.7	1.7	0
Total	**315.2**	**321.5**	**6.3**

42. In comparison with 2018-19 there is a £5.4m increase (2.2%) in the DSG schools block that mainly relates to the increase in overall pupil numbers. The numbers in secondary schools continue to rise but the primary school pupil numbers are falling. All secondary schools in the Borough are Academies.

43. Whilst there is extra funding in the settlement, costs are rising by more than funding, exasperated further in primary schools where pupil numbers are falling.

44. The education secretary Damian Hinds announced on 15 December that pupils with special educational needs and disabilities (SEND) will receive an additional £350m in funding, £125m would go to councils in 2018-19 and 2019-20 and £100m had been allocated to create more specialist places in schools.

45. The figures within the High Needs Block reflect the additional revenue funding that was announced (£0.7m in 2018-19 and 2019-20). While the funding will help, overall funding remains inadequate to address the increasing need and demand pressures on High Needs provision.

46. The DSG position was a £4.11m deficit at 31 March 2018. In year pressures on the high needs block are expected to be around £7m and therefore the forecast position at 31 March 2019 is a £11m deficit. The deficit position is common across London and also nationally across many LAs and reflects increasing need and demand for SEND provision, the inadequacy of supply of special school places (this is being addressed within the capital programme) and also the inadequacy of funding for the high needs block. By the end of 2017-18, two-thirds of London authorities were overspent on DSG and 13 of those carried a combined deficit of £48m into 2018-19.

47. A strong lobbying stance has been taken with the Government with regard to the inadequacy of funding (including for 16-25yr olds) and also the need for flexibility on DSG block transfers, however even this will become challenging, noting the worsening position of schools from National Funding Formula (NFF) and falling rolls in primary schools. The council is working with Southwark Schools Forum to develop a DSG budget recovery plan for the medium to long term and within the council the Budget

Recovery Board will bring oversight, challenge and support to this process, given the potential risk overall.

Local Taxation

Council Tax

48. The council is committed to the fairer future promise to "keep council tax low". The Southwark element of council tax was frozen from 2008-09 until 2017-18 when financial pressures and the cumulative impact of reduced government funding meant that it was no longer sustainable to hold this position. In accordance with our Council Plan priority and budget principles we have protected our most vulnerable residents, which is why we have maintained spending on frontline services like children's care while doing everything we can to make efficiency savings in other areas.

49. The authority has been able to maintain the eighth lowest level of council tax in London in 2018-19, despite having incurred some of the largest reductions in government grants. Throughout this period, the government applied a cap on any council tax increases. The purpose of this cap is to ensure that 'excessive' council increases occur only where councils have a clear mandate from local people. This level has not been exceeded by Southwark to date and the cap remains in place for 2019-20.

50. Council tax has remained below the charge it would have been if CPI had been applied each year since 2010-11.

51. The Council Tax Relief Scheme continues to provide support for our financially vulnerable residents and the Council has committed to making no changes to the scheme for 2019-20.

ASC precept

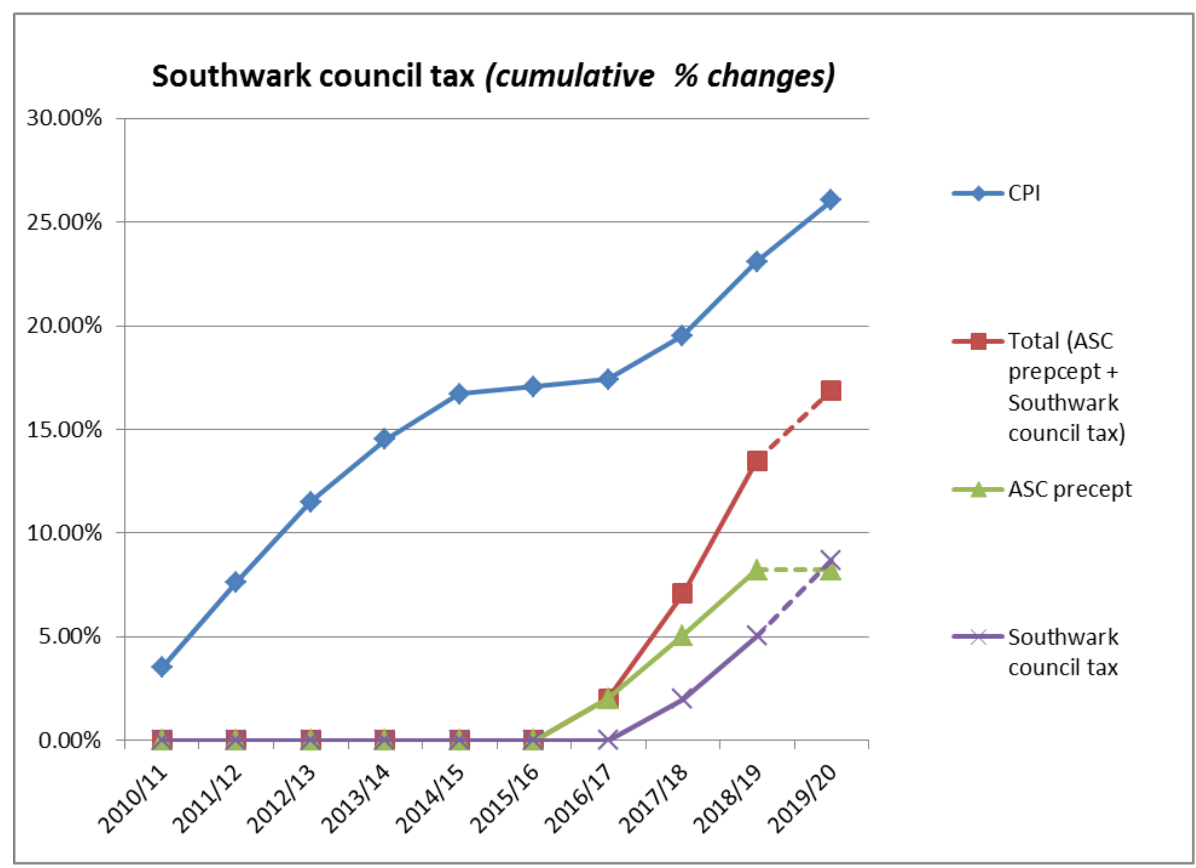
52. In 2016-17, and in line with government guidance, the council applied a 2% precept to help fund adult social care. Of the 33 London boroughs, 26 took advantage of this precept. For 2017-18, government extended the adult social care precept to allow for 6% over 2017-20, with no more than 3% in each of the first two years. A 3% precept was applied in 2017-18 and 2018-19, providing a contribution towards the significant financial pressures within the Adult Social Care budget. No further increase in the precept is permitted.

Southwark Element of the Council Tax

53. 8 of the 13 inner London Boroughs increased their council tax in 2018-19, 23 out of 33 across London, including Southwark. This is indicative of the cumulative impact the financial stress across local authorities in London.

54. In the context of pressures on council finances, the resilience of reserves and the continued year on year reductions in spending power, council tax remains a key source of income for the council. An increase of 2.99% (with no increase for adult social care precept) in council tax amounts to £3.2m income per annum. This is necessary to help achieve a balanced budget and to protect services for our most vulnerable residents.

55. As demonstrated in the graph below, increases in the council element of council tax remains below the charge it would have been if CPI inflation had been applied each year from 2010-11.



56. The impact of an increase in council tax of 2.99% will mean that:

- Residents in Band C properties and below will see a council tax bill rise of around 53p per week (over 60% of residents in the borough live in Bands A-C)
- Approximately 12,000 of the residents continuing to receive support through the local council tax relief scheme (CTRS) will pay no more than 9p extra per week
- The council tax reduction scheme will continue to ensure that 6,900 eligible pensioners will continue to receive 100% relief and will see no rise in their council tax bills.

Council Tax Collection

57. As reported in December 2018 the council tax base is growing in the borough – a direct reflection of the regeneration and investment in new homes. That report recommended that the collection rate be maintained at 97.2%, reflecting current performance and in consideration of the increased collection risk as universal credit is rolled out.

58. The 2018-19 collection fund forecast outturn position is a surplus of £3.860m and this has been accounted for in the council tax calculations for 2019-20.

Business Rates Baseline

59. The government agenda is for local authorities to move towards self-sufficiency and away from dependence on central government. As a step towards this reform, in 2013-14, government changed the funding system to increase reliance on local taxation. Revenue support grant allocations reduce over the period 2013-20, whilst the level of retained business rates increases.

60. If the council remains part of the London Business Rate pool pilot, Revenue Support Grant is substituted with a baseline business rate funding level. As set out in Appendix A, the council will be funded via business rate baseline of £149.875m.

61. The 2019-20 budget includes a forecast assumption that the council's Business Rate Retention income will exceed the baseline funding level by £25.0m (i.e. in total the retained business rates total of £174.875m; consisting of the baseline of £149.875m and £25.0m in excess of this baseline). This is after appropriate provisions have been made for appeals. Furthermore, it is estimated that £1.158m of Business Rate collection fund surplus will be available to support the budget.

62. This ongoing move to self-sufficient local government demonstrates the importance of Southwark's capital investment programme within the borough, either as the lead authority or with partners. Regeneration is the key to ensuring sustainable budget sources as we move closer to reliance wholly on local taxation, either through business rates or through council tax as well as increasing opportunities across the borough for quality of life, jobs and environmental improvements.

Business Rates London Wide Pool

63. In 2018-19, London Councils entered into a one-year pilot arrangement for the retention of business rate growth through pooling. The agreement set out the principles and method for distributing any net financial benefits generated by the pool. Although the first year of the pilot relates to business rates generated during 2018-19, the available distribution will not be finalised until September 2019. However, latest figures from the London Councils indicate that the Pool is on track to deliver the forecast growth.

64. Southwark's share of the total net benefit of the pool will be £10.186m. Recognising that any additional income will be one-off, these receipts will be ring-fenced in a London Devolution Reserve.

65. The London Devolution Reserve resources will be available for one-off initiatives in accordance with council priorities. Initiatives will include:

    (i) £0.5m for the Positive Futures Fund, as approved by Cabinet in December 2018;

    (ii) Funding for the Southwark Pioneers Fund (the amount to be agreed in a separate forthcoming report to Cabinet);

    (iii) A business case is being prepared for Southwark to support the development of the London Counter Fraud Hub. Appropriate provision will be made of up to £1m over the next seven years, subject to consideration and approval of the business case by the Cabinet Member for Finance, Performance and Brexit. The business case will be completed once negotiations on price and service levels have been concluded between CIPFA (the lead contractor) and the London Borough of Ealing who are currently responsible for clienting the contractual arrangements. These negotiations are currently expected to conclude in January.

    (iv) The Cabinet Member for Finance, Performance and Brexit will also be recommending the set aside of some resources to act as a special risk reserve to protect the council against the negative effects of Brexit. While the value of the risks are very difficult to quantify, given current status of negotiations, a sum of £2m is proposed in order to ensure that council services are protected. Specifically,

these are new financial risks over and above those previously provided for relating to any outcome that may arise from Brexit. Specifically, these include costs arising from supply chain, workforce, property and general economic issues. In any event, support will still be expected from government to compensate for these pressures.

(v) A fund of £2m will be created in support of the Council's Health and Wellbeing Board commitment to mental health, specifically prevention and early help for Southwark's children. Notably, this additional investment will help to support a universal schools pastoral care and counselling provision, maintaining high performance and good practice where it already exists and building capacity and capability if required.

(vi) A sum of £1m over four years will be created to support the implementation of the Libraries and Heritage Strategy. The investment will help ensure that the council's ambitions for the service are aligned with strategic priorities and focused on maximising usage and reach, and equality of access for all.

66. The following table summarises the London Devolution Reserve commitments:

Initiative	**£m**
Positive Futures Fund	0.5
Southwark Pioneers Fund	TBC
London Counter Fraud Hub	1.0
Brexit Risk Reserve	2.0
Health and Wellbeing Board commitment to Mental Health	2.0
Libraries and Heritage Strategy	1.0

The balance on the reserve will be kept under review and further reports will be presented to Cabinet to release resources.

67. The financial benefits from the London Business Rates Pooling arrangements also included collective investment through a 'Strategic Investment Pot' designed to promote economic growth. To date £47 million has been awarded to eight major projects that will benefit London's businesses, with a particular focus on digital infrastructure to boost economic growth, including an £8m allocation to the South London innovation corridor to provide workspace, business support and talent development.

68. The Government recently issued an updated prospectus for the continuation of the pilot devolution pooling arrangement into 2019-20, albeit on less generous terms than 2018-19, and with more risk passed to the council. The Provisional Settlement confirmed the London 75% business rates retention pilot for 2019-20, subject to London councils agreeing to go ahead. The December 2018 Cabinet paper delegated any decisions necessary to continue the council's participation in the Pool to the strategic director of finance and governance in consultation with the Cabinet Member for finance, performance and Brexit.

69. As in 2018-19, the first call on any additional resources generated would be used to ensure that each borough and the GLA receives at least the same amount as it would have without entering the pool. Given the increased risk, and the fact that any growth will not be finalised until September 2020, any additional pooled business rate income will not form part of the 2019-20 budget setting process.

Updated budget proposals

70. Through the council's budget cycle, savings and income generation options are presented for consideration which, should these proposals be agreed, contribute towards achieving a balanced budget.

71. The 2019-20 proposals for each Directorate are summarised in the table below and detailed in Appendices C, D, E and F.

	Commitments £000	Efficiencies £000	Income £000	Savings £000	Net impact £000
Adults Social Care	4,739	(4,213)	-	(800)	**(274)**
Children's Services	3,333	(1,010)	-	(100)	**2,223**
Education	-	(337)	-	-	**(337)**
Total Children's and Adults' Services	**8,072**	**(5,560)**	**-**	**(900)**	**1,612**
Environment and Leisure	982	(860)	(3,000)	-	**(2,878)**
Place and Wellbeing	200	(1,207)	(50)	-	**(1,057)**
Housing and Modernisation	3,900	(676)	-	-	**3,224**
Chief Executive's	-	(5)	-	-	**(5)**
Finance and Governance	252	(997)	-	-	**(745)**
Corporate	2,800	(4,600)	(1,760)	-	**(3,560)**
Total	**16,206**	**(13,905)**	**(4,810)**	**(900)**	**(3,409)**

*Commitments within Children's and adults' Services include £7.422m funded from Improved Better Care Fund and additional grant to support adult's and children's social care.

Pay Award

72. The current budget plans for 2019-20 are based on a projected 2% pay rise for all staff. Significant work is currently underway both nationally and within London to reach agreement on pay awards moving forwards. In part, negotiations will be considering the arguments that local authority pay has been disproportionately supressed because of the pay cap and that this situation needs rebalancing. Further, there are concerns to ensure that the lower graded staff are adequately paid and that pay differentials remain appropriate. A provision has been included within the budget plans. The position will continue to be monitored and a further update will be included within the report to cabinet in January, including any relevant financial implications.

Inflation

73. The Consumer Price Index (CPI) 12 month rate for November was 2.3% with domestic inflationary pressures expected to build over the coming months. This budgetary

pressure is recognised in the budget with a £3.950m allocation for contractual inflationary pressures in 2019-20.

Efficiencies and Improved Use of Resources

74. The fairer future promises contain a commitment to keep council tax low by delivering value for money across all of our services. In part, this is met through ensuring that the council is focussed on meeting the budget gap with proposed efficiency savings. The total budget proposals include efficiency savings of £13.905m (detailed in Appendix C).

75. The indicative budget proposals include £5m of Adult Social Care savings in 2019-20 offset by commitments of £4.7m. This demonstrates the investment of the increased Improved Better Care Fund (£3.2m) in protecting homecare, reablement and bed-based care packages and transformation work to improve the health, wellbeing and resilience of vulnerable residents.

76. In Education Services there are savings and efficiencies of £0.337m as the school improvement service moves towards a fully traded model.

77. Environmental and Leisure Services are proposing total efficiency savings and improved use of resources of £0.860m by rationalising litter picking schedules to focus effort where it is most needed, by moving to more environmentally friendly lights and proposed changes in highways sweeping services.

78. Place and Wellbeing directorate are proposing savings of £0.282m through realignment of staffing resources and other efficiencies in service provision and commissioning arrangements and £0.925m savings within the Public Health ring-fenced grant from a combination of efficiencies, service design and economies in commissioning arrangements across the service areas.

79. Finance and Governance are proposing efficiency savings across the department mainly made up of staffing-related savings totalling £0.852m, which reflects the fact that over 70% of the overall expenditure budget is staffing costs. Savings from staffing costs will be achieved through increased efficiency, reduction in caseload and changing what we do and how we work, to become an organisation that is fit for the future. In addition to the staffing related savings, £0.145m of other savings are proposed relating to modernising council and committee meetings, reductions in printing and postage usage and savings arising from external audit contract procurement.

Income Generation

80. As the council looks for ways to protect front line services, consideration is given to maximising the council's income generation by seeking income streams in line with council policies and priorities. The council will seek to generate additional income by reviewing fees, charges and contributions and seeking further opportunities to provide commercial services. This may include introducing charges for some discretionary services and ensuring that we maximise the recovery of our costs. The schedules at Appendix D set out a number of proposals totalling £4.850m generating additional income.

81. The additional income within the Environment and Leisure Department principally relates to £0.7m on the leisure management contract; £1.2m from the introduction and extension of controlled parking zones; and £0.37m from expanding the car club permit scheme, street advertising; and introducing a night time levy and paid subscription for

green waste collections.

82. The decision to invest in Courage Yard will increase commercial rental income resulting in a net benefit to the budget of £1.8m after associated costs.

Savings Impacting on Service Delivery

83. Wherever possible, the aim is to continue to protect front line services from saving reductions. However, the extent of the government austerity measures means that after careful consideration, it is inevitable that some service reductions will be required to balance the budget. The schedules at Appendix E propose savings of £0.9m with potential to impact on service delivery.

84. The significant savings relate to the review of the re-ablement service saving £0.8m.

85. Comprehensive equalities analysis of the impact of these savings will be considered as part of the proposal considerations.

Commitments

86. The commitments within Children's and Adults' services are funded in part from the increase in Improved Better Care Fund allocation of £3.168m and additional grant announced in the governments October Budget of £4.254m.

87. Within Children's Services, commitments include funding of £0.35m for asylum seeking children and £0.3m and the extension of leaving care responsibilities to age 25.

88. Temporary Accommodation and No Recourse to Public Funds continue to be areas of financial pressure. Net commitments of £3.2m and £0.7m are proposed here to ensure these areas of budget riks are sustainable in 2019-20.

89. Other commitments include £0.3m to tackle tree maintenance and inspection work and £0.05m for community toilet scheme.

90. The council of course remains ambitious to deliver a fairer future for all residents and set out comprehensive plans for expanded and new services in its Council Plan for 2018-22, agreed by Cabinet in October and Council Assembly in November. It will be possible to begin delivering on several of these commitments during 2019-20 and this draft budget includes commitments totalling £0.425m to begin the roll-out of Free Healthy School Meals to children in our council nursery schools and school nurseries, to ensure every primary school child is able to see a theatre performance and to offer free swimming lessons to local residents.

91. A detailed list of all commitments can be found in Appendix F. The overarching theme of these commitments is to ensure that service budgets are sustainable, particularly in the context of the reduced availability of reserves to support budget pressures.

Fees and Charges

92. Under Part 3C of the constitution, cabinet is responsible for the approval of new fees and charges and agreement of charging levels in line with the medium term resources strategy.

93. The council's Fairer Future Medium Term Financial Strategy agreed by cabinet on 20 September 2016, sets out the policy to review discretionary fees and charges annually.

In reviewing fees and charges the policy is to increase them to a level that is at least equal to the most appropriate London average except where this either conflicts with council policy, or would lead to adverse revenue implications or would impact adversely on vulnerable clients. These proposals have been prepared in the context of this policy.

94. Detailed fees and charges schedules across all services are set out in Appendix G.

Use of Reserves and Balances

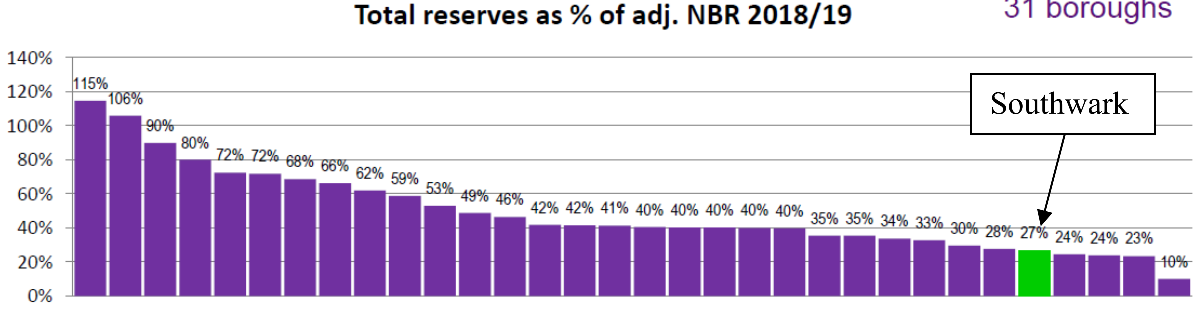
95. The council retains a level of earmarked reserves and these are reported each year within the annual statement of accounts. These reserves are maintained to fund:

- invest to save opportunities, which form part of the modernisation agenda and are expected to deliver future ongoing revenue savings;
- investment in regeneration and development where spend may be subject to unpredictable market and other factors;
- exceptional items or pressures which are difficult to predict and which are not included in revenue budgets or within the capital programme.

96. For a number of years previously, the council had planned for the use of reserves to help smooth the impact of government funding reductions and other budget pressures especially during the period of austerity. Not only did this help to protect council services but it has also allowed time to transition towards new ways of working, productivity improvements and efficiencies.

97. The level of balances remains subject to the scrutiny of the section 151 officer who must ensure that any one off contributions to the budget is appropriate and affordable. In previous years, this judgment has been facilitated by the availability of unused contingency funds as budgets have met their targets. The budget proposals for 2019-20 do not include a planned release of reserve.

98. London Councils conducted a financial stress survey across London that included reviewing the levels of reserves. As demonstrated by the below graph, the council levels of reserves are low relative to the councils budget requirements and other councils. This remains a concern in the context of Southwark's ambitious programme for regeneration and revenue cost pressures across services.



Planned Corporate Contingency

99. It is proposed that the planned corporate contingency of £4m be maintained to support emerging budget pressures during the year. In the current and previous years, this contingency has been essential to manage in year demand and cost pressures. Within the commitments is a proposal to create a Brexit contingency to manage the growing

economic and social risks.

Consultation

100. High-level consultation was conducted on the three-year budget proposals for 2016-17 to 2018-19. The consultation responses received were consistent with prior years' consultations, and were used to inform the budget proposals. A substantial majority of those who responded to this consultation agreed that the council should continue to focus on being more efficient, protecting frontline services and directing resources to those most in need and this is reflected in the budget proposals.

101. Since then consultation on the Voluntary and Community strategy was conducted to ensure that all sections of the voluntary and community sector could contribute to the development of the strategy, and a series of four open invitation listening events was held which attracted over 200 people. The listening events took place in an atmosphere of goodwill. There was also recognition of the need to find new ways of making the most of diminishing budgetary resources. There has also been consultation on the development of the policy and policy drafts through the Health and Wellbeing Board, Children's and Adults' Board, the Forum for Equalities and Human Rights, the council's departmental commissioning network and the council/VCS Liaison Group.

Overview and Scrutiny

102. Cabinet has responsibility for drafting the budget and policy framework for approval by council assembly. This includes publishing proposals and taking into account any response from overview and scrutiny committee in drawing up firm proposals for submission to the council.

103. The Overview and Scrutiny committee (OSC) met on 28 January 2019 to consider the 2019-20 general fund budget proposals as presented to cabinet on 22 January 2018. OSC received presentations from cabinet members and were able to ask questions and seek clarification as necessary.

104. The OSC committee made 8 recommendations which are reported below. Cabinet is asked to consider these recommendations and management response.

	Recommendation	Management Response
1	That Overview & Scrutiny Committee should receive a report on the impact to service users of the reviews of special guardianship orders and care packages	Agreed
2	Overview & Scrutiny Committee welcomes the protection of the community safety budget and recommends that if the scheme for local authority purchasing of police officers is withdrawn, the council should consider how to make best use of the available budget to support the work of the community safety team	Agreed The council is currently in discussion with the GLA and Metropolitan Police about the continuation of the arrangements we have to share the costs of some officers. The council has committed to find additional funding to continue to purchase those officers if necessary. Cabinet will consider how to make best use of any available

	Recommendation	Management Response
		budget to support the work of the community safety team should those police officers not be available.
3	That a robust monitoring system is put in place in respect of changes to library opening hours so that the equalities impact may be analysed – this should be reported to Overview & Scrutiny Committee 6 months after implementation	The saving proposal has been withdrawn. A sum of £1m will be set aside from the London Devolution Deal Reserve to implement the recently approved Libraries and Heritage Strategy over a four year period. This effectively offsets the impact of removing the efficiency option for the next four years. The investment will help ensure that the council's ambitions for the service are aligned with strategic priorities and focused on maximising usage and reach, equality of access and respond effectively to the outcome of extensive consultation recently undertaken.
4	That income raised from environmental measures in the budget are fully aligned with the council's green policies and are communicated to residents in a manner that promotes positive environmental behaviour.	Agreed
5	Overview and Scrutiny Committee welcomes the efficiency saving in respect of LED lighting in the council's Tooley Street office and asks the cabinet member to explore whether similar measures can be brought forward across other council buildings.	Agreed Cabinet will also consider wider 'invest to save' efficiencies beyond LED lighting and how these can be brought forward across all council assets.
6	Overview & Scrutiny Committee supports the rationale for a one-year budget for the coming year and asks the cabinet to consider refreshing the council's budget principles in preparation for the next budget cycle in order to take account of the economic context in which the council is operating. The committee calls on the council to take every opportunity for lobbying and advocacy around local	Agreed Fairer Future Budget principles will be reviewed and brought forward for OSC consideration as part of the 2020-2023 Medium Term Financial Strategy process, taking into account changes to the local government finance arrangements. As part of the review, consideration will be

	Recommendation	Management Response
	government finance.	given to how the council's environmental and social objectives are assessed and incorporated within the budget process.
7	Overview and Scrutiny Committee requests an illustrative outline of how the Brexit support fund (budget reference 424) might be spent, supported by an explanation of the underpinning assumptions and risk profiles	Agreed Cabinet recently received a report from the cross-party Brexit Panel and accepted its recommendations. These included, for example, a commitment to ensure that EU residents and employees of Southwark are supported to gain settled status. Once there is clarity on the detail of the Brexit arrangements, it may be possible to be more precise as to how ongoing and one off resources may be allocated. At this time, precise details of such allocations are not available. On 28 January, the Government updated guidance and announced additional funding for local government to support Brexit transition. Southwark will receive £210,000 over two years.
8	That Overview and Scrutiny Committee should receive the equality impact assessment for the budget and this should be part of the agenda papers in future.	Agreed. Draft equality impact assessments have been circulated to members of OSC.

Next Steps

105. This report presents a balanced budget proposal for the cabinet to submit to Council Assembly on 27 February 2019, in accordance with the constitution.

Community impact statement

106. The council works in accordance with the single public sector equality duty contained within section 149 of the Equality Act 2010. This means the council must have due regard to the need to eliminate unlawful discrimination, harassment and victimisation, and advance equality of opportunity and foster good relations between different groups.

107. Transparency and fairness form part of the seven budget principles and are an underlying principle in the Council Plan. As with the budget for 2018-19 and for previous years, each department will undertake equality analysis/screening on its budget proposals ahead of the final decisions being taken. Where screenings identify potential impacts, more detailed analysis is being carried out.

108. Undertaking equality analysis helps the council to understand the potential effects that

the budget proposals may have on different groups. The analysis also considers if there may be any unintended consequences and how any of these issues can be mitigated. Analysis is also undertaken to consider any crosscutting and organisation-wide impacts.

109. For many services, the budget proposals will include efficiencies which have staffing implications. As specific proposals are brought forward, and at each stage of implementation thereafter, the different impacts on different categories of staff will be assessed in accordance with the council's reorganisation, redeployment and redundancy procedures.

110. Equality analysis will continue through the cycle of planning and implementation of these budget proposals. In line with our Public Sector Equality Duty, any changes to services arising from these proposals will be implemented in such a way to not impact disproportionately on any specific section or group in our community. Where necessary, consultation will be undertaken alongside mitigating actions where necessary. In line with the process across the council, information on the equality analysis will be shared with the relevant cabinet members so it can be considered when decisions are taken. The equality analyses will be collated across the council to look for any cumulative impacts.

SUPPLEMENTARY ADVICE FROM OTHER OFFICERS

Director of Law and Democracy

111. The constitution determines that cabinet consider decisions regarding the strategic aspects of the regulation and control of the council's finances. The council has a legal obligation to set a balanced budget on an annual basis as prescribed in the Local Government and Finance Act 1992 and associated Regulations. The issues contained in this report will assist in the future discharge of that obligation.

112. The council is required under section 149 of the Equality Act 2010 to have due regard to the need to:

- Eliminate unlawful discrimination harassment and victimisation
- Advance equality of opportunity between people who share protected characteristics and those who do not
- Foster good relations between people who share protected characteristics and those who do not.

113. Decision makers must understand the effect of policies, practices and decisions on people with protected characteristics.

114. Equality analysis is the mechanism by which the council considers these effects. The report sets out how it is proposed equality analysis will be undertaken in relation to the budget proposals.

115. It is essential that cabinet give due regard to the council's duty under the Equality Act 2010 and the implications for protected groups in the context of that duty in relation to this decision and future decisions on the budget proposals.

REASONS FOR URGENCY

116. The cabinet is required to prepare a budget proposal for submission to council assembly. This is the last cabinet meeting before Council Assembly on 27 February 2019. The council is required to set a lawful budget by 11 March 2019.

REASONS FOR LATENESS

117. Under the council's constitution there is a requirement for the overview and scrutiny committee to review and challenge budget proposals and this took place on 28 January 2019. The final local government settlement was published on 29 January 2019. Consultation and discussions on budget proposals continued beyond the Cabinet meeting of 22 January. Accordingly, the budget proposals have been updated and additional time has been required to formulate budget options to present a balanced budget to minimise the impact on Southwark residents.

BACKGROUND DOCUMENTS

<table>
<tr><th>Background Papers</th><th>Held At</th><th>Contact</th></tr>
<tr><td>Policy and Resources Strategy: 2019-20 Updated Financial Remit</td><td>160 Tooley Street
PO Box 64529
London SE1P 5LX</td><td>Rob Woollatt
020 7525 0614</td></tr>
<tr><td colspan="3">Link (please copy and paste into your browser):
http://moderngov.southwark.gov.uk/documents/s77446/Report%20Policy%20and%20Resources%20Strategy%20revenue%20monitoring%20report%20including%20treasury%20management%202018.pdf</td></tr>
<tr><td colspan="3"></td></tr>
<tr><td>Council's Fairer Future Budget Principles approved by cabinet (September 2015).</td><td>160 Tooley Street
PO Box 64529
London SE1P 5LX</td><td>Rob Woollatt
020 7525 0614</td></tr>
<tr><td colspan="3">Link (please copy and paste into your browser):
http://moderngov.southwark.gov.uk/documents/s56454/Report%20and%20appendices%202016-17%20PR%20Scene%20setting.pdf</td></tr>
</table>

APPENDICES

No:	Title
Appendix A	Indicative Budget Proposals 2019-20
Appendix B	Departmental Narratives 2019-20
Appendix C	Proposed Efficiencies and Improved Use of Resources 2019-20
Appendix D	Proposed Income Generation 2019-20
Appendix E	Proposed Savings Impacting on Service Delivery 2019-20
Appendix F	Proposed Commitments 2019-20
Appendix G	Proposed Fees and Charges 2019-20

AUDIT TRAIL

Cabinet Member	Councillor Victoria Mills, Finance, Performance and Brexit	
Lead Officer	Duncan Whitfield, Strategic Director of Finance and Governance	
Report Author	Rob Woollatt, Interim Departmental Finance Manager	
Version	Final	
Dated	4 February 2019	
Key Decision?	Yes	
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	**Comments Sought**	**Comments included**
Director of Law and Democracy	Yes	Yes
Strategic Director of Finance and Governance	Yes	Yes
Cabinet Member	Yes	Yes
Date final report sent to Constitutional Team		4 February 2019

APPENDIX A

Indicative Budget Proposal 2019-20

	2018-19 Budget Agreed Feb 18 £m	2019-20 Budget Proposals Jan 19 £m	2019-20 Budget Proposals Feb 19 £m
Resources			
Retained Business Rates	(164.617)	(125.972)	(125.972)
Business rates top-up	6.177	(23.903)	(23.903)
Revenue Support grant			
Total Settlement Funding Assessment (DCLG)	**(158.440)**	**(149.875)**	**(149.875)**
Public Health Grant	(27.469)	(26.744)	(26.744)
Section 31 Grant	(2.320)	(4.281)	(4.281)
New Homes Bonus	(11.398)	(12.830)	(12.830)
Additional Social Care Grants (Autumn Budget announcement)		(4.254)	(4.254)
Specific grants	**(41.187)**	**(48.109)**	**(48.109)**
Improved Better Care Fund (note 1)	(8.088)	(13.529)	(13.529)
Supplementary IBCF (March 2017)	(4.497)	(2.223)	(2.223)
Improved Better Care Fund	**(12.585)**	**(15.752)**	**(15.752)**
Total Government Funding	**(212.212)**	**(213.736)**	**(213.736)**
Business Rate Retention growth	(21.750)	(25.000)	(25.000)
Business Rate Retention collection fund surplus	(3.970)	(1.158)	(1.158)
Council Tax baseline	(98.543)	(107.322)	(107.322)
Council tax change - 2018-19	(2.947)	(3.209)	(3.209)
ASC Council Tax precept - Nil in 2019-20	(2.956)		
Council Tax Collection Fund surplus	(5.663)	(3.860)	(3.860)
Total revenue from council tax	**(135.829)**	**(140.549)**	**(140.549)**
Total funding before contribution from balances	**(348.041)**	**(354.285)**	**(354.285)**
Current contribution (from)/to balances			
A . Total Resources	**(348.041)**	**(354.285)**	**(354.285)**
	(294.269)	**(290.424)**	**(290.424)**
Previous Years Budget	**325.478**	**348.041**	**348.041**
Inflation			
Employees pay award, 2% per annum	4.200	4.500	4.500
Contractual inflation	3.947	3.950	3.950
Existing inflation provision		(2.606)	(2.606)
Capital financing		3.809	3.809
Commitments & Contingency			
Growth and Commitments	32.625	16.206	16.206
B . Budget before savings and efficiencies	**366.250**	**373.900**	**373.900**
Net Shortfall before Savings and efficiencies (Current year A+B)	**18.209**	**19.615**	**19.615**
Savings			
Effective use of resources and efficiencies	(10.928)	(13.905)	(13.905)
Income Fees and Charges	(7.281)	(4.810)	(4.810)
Other Savings		(0.900)	(0.900)
C. Total Savings	**(18.209)**	**(19.615)**	**(19.615)**
D. Total budget (Current Year B + C)	**348.041**	**354.285**	**354.285**
E. Funding Shortfall / (Surplus)	**0.000**	**0.000**	**(0.000)**

APPENDIX B

CHIEF EXECUTIVE

Overview

B.1. The Chief Executive's department comprises the Chief Executive's Office and External Affairs Team.

B.2. The Chief Exec's Office supports the Chief Executive and chief officer leadership team in translating political vision into projects and programmes across the council as well as supporting effective scrutiny function and management of the opposition office. The division also includes the emergency planning and resilience team, therefore creating a direct line between the Chief Executive as the council's most senior responsible officer and the team.

B.3. The External Affairs division comprises policy and public affairs; media; marketing; and cabinet support. As well as this, we manage internal communications for the council and the administration's political assistant. Our services are responsible for managing and enhancing the standing of the council through the development of external and internal communications, public affairs, policy projects and initiatives. The total general fund net budget for the department for 2018-19 is £3.2m.

CHILDREN'S AND ADULTS' SERVICES

Overview

B.4. As reported to Cabinet in September 2018, Children's and Adults' services are forecasting balanced budgets in a context which remains very challenging. Despite ever-increasing demand and cost pressures and uncertainty surrounding the future of funding for social care, the department's transformative approach to prevention, early help and effective support is paying dividends, both in budgetary terms and importantly through quality outcomes for service users.

B.5. Whilst a break-even position is forecast for social care services and core education in 2018-19, the ring-fenced Dedicated Schools Grant (DSG) continues to be of concern. A strong lobbying stance has been taken with Government with regard to the inadequacy of funding (including for 16-25yr olds) and also the need for flexibility on DSG block transfers, however even this will become challenging, noting the worsening position for our schools from the National Funding Formula (NFF) and falling rolls. The council is working closely with Southwark Schools Forum to develop a DSG budget recovery plan for the medium to long term and within the council the Budget Recovery Board will bring oversight, challenge and support to this process.

B.6. The indicative budget to be agreed at Council Assembly in February 2019 proposes Adult Social Care efficiencies for 2019-20 of £5m offset by commitments of £4.7m. This demonstrates the investment of the increased Improved Better Care Fund (£3.2m) in protecting homecare, reablement and bed-based care packages and transformation work to improve the health, wellbeing and resilience of vulnerable residents. It also reflects the allocation of £1.6m one-off funding for Adult Social Care announced in the Autumn Budget statement.

B.7. Children's services continue to manage within budget despite demand and cost pressures, building on the progress already made through practice and service transformation. Rising demand and cost pressures such as unaccompanied asylum seeking children and leaving care responsibilities contribute to a significant challenge as these new duties have been inadequately funded by Government. Recognising these issues, a net budgetary increase of £2.2m is proposed comprised of £1.1m of savings offset by £3.3m of commitments.

B.8. In Education, reduced grant and funding continue to impact upon the budget, as well as the increasing demand for statutory SEN education and home to school transport. In 2019-20 for Education there are savings and efficiencies of £0.3m as the school improvement service moves towards a fully traded model.

B.9. With regard to the Dedicated Schools Grant (DSG), which funds schools, special needs education, early years and some central education functions, the final grant for 2019-20 for the Schools Block is expected in December 2018. There have been very modest increases to both schools and high needs funding in 2018-19.

B.10. There are significant pressures on the high needs block in 2018-19 due to demand and cost pressures across settings and there is insufficient funding from Government to recognise this. As at 31 March 2018 there was an accumulated DSG deficit of £4.1m, which is forecast to increase to £11m by the end of 2018-19. The council continues to work with the Southwark Schools Forum on a DSG deficit recovery plan which includes proposals for reductions in central retentions, block transfers as well as reductions in funding to settings. This will be subject to full consultation and equalities impact assessment. We will concurrently lobby Government for fair funding.

Equalities Analysis

B.11. Initial equalities analysis has been undertaken for each proposal. Consultations have been and will be undertaken for proposals relating to service changes where appropriate. Impact is mitigated by alternative offers of services, support or personal budgets as per service user choice in line with Care Act eligibility, national legislative thresholds and Government guidance; other services are discretionary and universal.

B.12. Further equality analysis is under way and will be collated to look for any cumulative impacts. In line with the process across the council, information on equality analysis will be shared with decision-makers for consideration before any decisions are taken.

B.13. Southwark Council's Fairer Future Promises are reflected in the proposals set forth as is a shift upstream to prevention and early help, recognising the evidence base and the outcomes that can be achieved by offering our residents the right support at the right time, and working in their best interests.

ENVIRONMENT AND LEISURE

Overview

B.14. The Environment and Leisure department delivers services that make a real difference to the everyday lives of all residents and visitors. The majority of the operations are frontline services: they physically improve the environment; they provide opportunities for health and enjoyment, support knowledge and learning or help improve safety and confidence. The department comprises two directorates, Environment and Leisure.

B.15. The department aims to make Southwark's neighbourhoods great places to live, places that are clean, safe and vibrant and where activities and opportunities are accessible to all. We work with our partners to improve health and wellbeing for all our residents.

B.16. The 2018/19 net general budget for the department is £65.6m. The department over the last seven years has achieved savings of £30.2m. The savings options would be delivered alongside the considerable capital spend across the department.

B.17. For the forthcoming year, 2019/19, the department has identified a number of savings options amounting to £3.86m:

- Efficiencies and Improved Use of Resources £0.86m
- Income Generation £3.0m

Efficiencies and Improved Use of Resources

B.18. Efficiency savings of £0.34m are being proposed in our cleansing operations by rationalising our litter picking schedules to focus effort where it is most needed. We are also reviewing our library operations, consistently with our new library strategy and the council plan commitments to keep libraries open when people need them. We have a strong record in prioritising and investing in our libraries, and will continue this investment over the forthcoming four years by setting aside £1m to support the implementation of the Libraries and Heritage Strategy, offsetting the need to make additional savings. We expect to save £0.1m on our street lighting budget by the move to more environmentally friendly lights and savings of £0.17m are proposed in overnight sweeping as services are being reconfigured with early morning hot-spot cleaning to minimise the impact on service provision.

Income

B.19. The council, like a number of other councils, is adopting a more commercial approach to its activities and is proposing to generate additional income of £3m in 2019-20.

B.20. The department will seek to expand its income streams in a variety of ways which includes additional income expected of £0.7m on our leisure management contract. The introduction of controlled parking zones which have already been agreed will bring in £0.5m and meeting the predicted future resident demand for controlled parking zones is expected to generate a further £0.7m. The department also expects to generate additional income of around £0.370m by expanding car club permit scheme and street advertising. The department is also proposing to follow the example of many other London boroughs, by introducing a night time levy and paid subscription for fortnightly green waste collections.

Commitments

B.21. Several initiatives arising from the council plan commitments totalling £0.325m are proposed for 2019-20. These will enable us to set up a community toilet scheme, protect Southwark's biodiversity, re-open the Blue Youth Club, introduce free swimming lessons while we work to develop the expansion of free swim and gym, and start to roll out free visits to the theatre for primary school children.

B.22. In addition, we have carried out a thorough review of our tree stock and the regime for maintenance and inspection. The number of trees that we are responsible for has now been more accurately recorded as 82,000, and to ensure the correct frequency of inspections and maintenance, we are increasing the budget for trees by £0.3m.

PLACES AND WELLBEING DEPARTMENT

B.23. The department consists of four divisions: Regeneration, Planning, Public Health and Community Engagement.

B.24. The department leads on the council's major regeneration schemes, social regeneration and is responsible for developing policies to guide land use and long-term physical development in Southwark.

B.25. The department also aims to improve the health and wellbeing of Southwark's residents and to reduce health inequalities by working closely with local communities, CCG, NHS and the Voluntary Sector and promoting asset based community development in partnership with the voluntary and community sector.

B.26. The total general fund net budget for the department for 2018/19 is £6.2m and savings of £282k are proposed for 2019/20 across the department (excluding the Public Health areas). Savings totalling £212k are delivered through realignment of staffing resources and other efficiencies in service provision and commissioning arrangements. The remaining £70k is being achieved from increased income on planning fees and property leases.

B.27. The Public Health service is funded from a ring-fenced grant of £27.4m and savings of £925k are proposed in line with the expected reduction in grant for 2019/20. These savings are being achieved from a combination of efficiencies, service design and economies in commissioning arrangements across the service areas.

FINANCE AND GOVERNANCE

Overview

B.28. The Finance and Governance Department includes the Director's office which provides strategic leadership for the department and s151 responsibilities; Exchequer Services which encompasses revenues and benefits and housing rent collection, as well as the financial transaction processing teams; the Law and Democracy division responsible for electoral, constitutional and legal services; Professional Financial Services (finance, audit and procurement teams); and the Financial and Information Governance Team.

B.29. In supporting the Fairer Future promises of the council, the department's vision is to "make a positive difference everywhere we engage" and to be "efficient and effective in all that we do". Specifically, Finance and Governance endeavours to help the council to "manage every penny as carefully as local families look after their own household budgets". This budget proposes efficiency savings of £0.997m and commitments of £0.170m.

Efficiencies and Improved Use of Resources

B.30. The efficiency savings across the department are mainly made up of staffing-related savings totalling £0.852m which reflects the fact that over 70% of the overall expenditure budget is staffing costs. Savings from staffing costs will be achieved through increased efficiency, reduction in caseload and changing what we do and how we work, to become an organisation that is fit for the future.

B.31. In addition to the staffing related savings, £0.030m of the savings proposed relate to efficiencies from modernising council and committee meetings; £0.030m from reduction in printing and postage usage from Elections and Registration services; £0.030m from reduced business support provision to legal services; and £0.055m savings arising from external audit contract procurement.

Commitment

B.32. Professional Finance Services is proposing a commitment of £0.095m to re-create a technical financial planning and accounting resource to improve understanding of, and planning for, the changing environment for local government funding and £0.075m to increase resources in the anti-fraud team in order to better detect and prevent fraud.

Equality Analysis

B.33. As specific proposals are brought forward, and at each stage of implementation thereafter, the impacts on different categories of staff will be assessed in accordance with the council's reorganisation, redeployment and redundancy procedures.

HOUSING AND MODERNISATION

Overview

B.34. Housing and Modernisation (H&M) delivers a diverse range of services funded from both the general fund and the ring-fenced housing revenue account (HRA) for landlord services. In delivering the council's vision, as outlined in the Fairer Future Promises, the department aims to maximise investment in its housing stock, build new council homes at council rents and improve performance in all core service areas. The aspiration is to work closely with residents to deliver consistently high quality services, achieve better value for money and continue to support the most vulnerable residents, particularly those in need of temporary housing or who have no recourse to public funds (NRPF).

B.35. Budget proposals are set in the context of the department's continued commitment to protect frontline services as far as possible. For 2019-20 greater efficiency and improved use of resources will deliver savings of £0.6m, plus a further £0.1m impacting on service provision. However, commitments total £3.4m net (£5.4m gross) in respect of temporary accommodation and NRPF specifically. Further detail on the principal budgetary proposals for 2019-20 is outlined below.

Asset Management

B.36. Services comprise aids and adaptations, handypersons and private sector housing renewal and empty homes. Savings achieved through the rationalisation of management across these functions were delivered in 2018-19 without impacting on service delivery but there are no opportunities to deliver further savings at this juncture.

Communities

B.37. The division is responsible for consultation and community engagement with council tenants, homeowners and residents, the civic office, community safety, Prevent and child sexual exploitation and No Recourse to Public Funds (NRPF), which is a persistent budgetary pressure.

B.38. The council has made good progress in managing caseload, but determination of a client's status rests with the Home Office and while cases are proactively escalated, the process is protracted and ultimately not directly within the council's control. Demand remains volatile and the cost/availability of suitable accommodation challenging. The outturn forecast for 2018-19 has been revised following recent procedural changes which have impacted the rate of case resolution and this upward pressure is expected to continue into 2019-20 requiring a further commitment of £0.7m to maintain the budget at a sustainable level going forward.

Resident Services

B.39. Services comprise travellers' sites and supported housing management, which has shared funding arrangements with the HRA. The realignment of the base budget requirement for the Devonshire Grove temporary traveller's site means the saving of £62k can be achieved without any detrimental service impact.

Modernisation

B.40. The modernisation division incorporates information technology and digital services (ITDS), human resources (HR), corporate facilities management (CFM) and organisation

transformation (OT). These services are of a corporate nature and underpin the modernise agenda.

B.41. Facilities management are responsible for ensuring the council's operational estate is both compliant with health and safety regulations and fit for purpose for staff and service users. Cabinet approved a commitment in the current year in order to address inherent budget pressures and stabilise the position going forward. The two existing service provider contracts will co-terminate in June 2020, and a procurement strategy report detailing options for the future delivery of FM services will be considered by Cabinet imminently, which could potentially cost more than the existing arrangements due to external market conditions. Overall there is little scope for savings to be made in this area, other than two small-scale initiatives expected to deliver £0.147m in 2019-20.

B.42. The ICT shared service is still at a relatively early stage of development and there remains a huge amount of work to do to realise the material service benefits and potential efficiencies that a stable, resilient and quality ICT service can bring to the organisation. This has been underpinned by significant capital and revenue commitments and whilst the underlying financial model remains robust in terms of business as usual, there are some additional one-off pressures coming through in the current year which may not be containable within the contingency sum built into the I model. Looking forward, there is currently no expectation that any cashable savings will materialise in 2019-20.

B.43. Reorganisation and rationalisation of the HR and OT services during 2019-20 will deliver savings of £0.272m without impacting service delivery.

Customer Experience

B.44. The division is responsible for a diverse range of functions including the customer service centre (CSC), customer resolution, concessionary travel, registrars and citizenship, coroners and mortuary services and housing solutions/temporary accommodation. Over time the proportion of HRA related activity delivered by the customer service centre has increased and following a detailed review, primary accountability for it moved to the HRA. The general fund proportion of savings arising from the CSC and other jointly funded activities across the division is £0.195m for 2019-20.

Temporary Accommodation (TA) and Housing Solutions

B.45. Southwark is recognised nationally as a leading authority in homelessness prevention, but this remains a particularly challenging area as a result of statutory and policy obligations, increasing demand, restricted housing supply and the impact of Universal Credit (UC) on collection performance.

B.46. Current cost projections indicate a budget shortfall of £3.3m in 2018-19, rising to £4.7m in 2019-20 predicated on the number of households supported in temporary accommodation increasing at a similar rate as the current year. Notwithstanding these cost pressures, cost reductions can also be achieved. These may be addressed through the restructuring of the Housing Solutions service to deliver operational efficiencies and through changes in policy and procedures which will be subject to review. New initiatives, currently being developed through London Councils may also assist in mitigating the position going forward. Overall, subject to the actions described above, the minimum net commitment required for 2019-20 is £2.7m.

B.47. The availability of HRA estate voids (predominantly on Aylesbury) is key to alleviating the current budget pressure for TA, which would otherwise be much greater, but as regeneration progresses the number and incidence of properties will decline adding additional pressure to find suitably affordable housing.

Equalities Assessment Summary

B.48. The department undertakes equality analysis/screening on its budget proposals ahead of final decisions being taken. This helps to understand the potential effects that the budget proposals may have on different groups and whether there may be unintended consequences and how such issues can be mitigated. Analysis is also undertaken to consider any cross-cutting and organisation-wide impacts and continues through the cycle of planning and implementation of these proposals

B.49. In line with our Public Sector Equality Duty, any changes to services arising from these proposals will be implemented in such a way so as to not impact disproportionately on any specific section or group in our community. Where necessary, consultation will be undertaken alongside mitigating actions where necessary. In line with the process across the council, information on the equality analysis will be shared with the relevant cabinet members so it can be considered when decisions are taken. To date no cumulative impacts have been identified through the analysis.

CORPORATE

Overview

B.50. The Corporate budgets include technical accounting budgets such as Minimum Revenue Provision (MRP), treasury income and costs, pension related costs and budgets which impact across the wider council. The £4m contingency budget also sits within corporate to support the wider budget risks.

B.51. For 2019-20, revenue savings of £4.600m have been identified from improved use of resources and commitments of £3.809m.

Efficiencies and Improved Use of Resources

B.52. In accordance with the approved Minimum Revenue Provision policy it is proposed to utilise the flexibility to apply capital resources to fund MRP, reducing the charge to the revenue budget by £4.600m.

Commitments

B.53. As indicated in capital monitoring and treasury management reports, the council has an underlying need to borrow in order to fund the council's capital investment programme. A commitment is included to reflect the additional interest and minimum revenue costs of this for 2019-20, totalling £3.809m.

Equality Analysis

B.54. There are no equality analysis implications for these proposals.

Appendix C: Efficiencies and Improved Use of Resources

	2019-20 £000
Children's and Adults' Services	(5,560)
Housing and Modernisation	(676)
Environment and Leisure	(860)
Places and Wellbeing	(1,207)
Finance and Governance	(997)
Chief Executive's	(5)
Corporate	(4,600)
	(13,905)
Adults' Social Care	(4,213)
Children's Services	(1,010)
Education	(337)
Total Children's and Adults' Services	(5,560)
Public Health	(925)

Department	Division	Reference	Cabinet Member	Description	2019-20 £000	Equalities Analysis Information
Children's and Adults' Services	Adults' Social Care	101	Cllr Jasmine Ali	Bed-Based Care rationalisation - contract management, joint work with NHS and earlier help and community support and reablement	(2,500)	Any impact to be mitigated by reviews of care packages.
Children's and Adults' Services	Adults' Social Care	102	Cllr Jasmine Ali	Care at Home reviews in line with Care Act and enhanced community provision via Hubs	(1,213)	Any impact to be mitigated by reviews of care packages.
Children's and Adults' Services	Adults' Social Care	103	Cllr Jasmine Ali	Workforce - last phase of re-structure delivered through vacancies and turn-over	(500)	See comments. Any formal change to structures would address EA issues as a part of standard council procedures.
Children's and Adults' Services	Children's Services	104	Cllr Jasmine Ali	Management restructure full year effect	(500)	As specific proposals are brought forward, and at each stage of implementation therafter, the impacts on different categories of staff will be assessed in accordance with the council's reorganisation, redundnacy and redeployment procedure.
Children's and Adults' Services	Children's Services	105	Cllr Jasmine Ali	Implementation of Sufficiency Strategy to increase in-house fostering and thereby reduce reliance upon agency fostering	(250)	This is a change to service provision from agency to in house which will not impair or negatively impact upon the quality of provision or care to service looked after children as any changes will be carefully aligned with care planning.
Children's and Adults' Services	Children's Services	106	Cllr Jasmine Ali	Reduction in subsidy for the non statutory Clinical Service due to undertaking more assessment work in-house, commissioning less and NHS funding	(260)	This is a change to service provision from agency to in house which will not impair or negatively impact upon the quality of provision or care to service looked after children as any changes will be carefully aligned with care planning.
Children's and Adults' Services	Education	107	Cllr Jasmine Ali	Management restructure in Education Service – phase II of agreed organisational change	(50)	As specific proposals are brought forward, and at each stage of implementation therafter, the impacts on different categories of staff will be assessed in accordance with the council's reorganisation, redundnacy and redeployment procedure.
Children's and Adults' Services	Education	108	Cllr Jasmine Ali	Reduction in subsidy as a further step towards fully traded school improvement service in line with strategy	(100)	Change in the way the service is funded should have no/minimal impact on staff or service users.
Children's and Adults' Services	Education	109	Cllr Jasmine Ali	Ceasing the subsidy for day nursery provision following an earlier reshape of service provision in the light of changing need	(100)	This flows from a reshape of service provision with one day nursery being re-purposed and another one moving from local authority to voluntary sector provision. Full consultation was undertaken with staff and service users and this was also in accordance with the sufficiency strategy so shoudld have no/minimal impact.

Department	Division	Reference	Cabinet Member	Description	2019-20 £000	Equalities Analysis Information
Children's and Adults' Services	Education	110	Cllr Kieron Williams	Adult Learning College contribution to management overheads in Education service	(87)	No/minimal impact on staff or service users
Housing and Modernisation	Customer Experience – excluding Temporary Accommodation/ Housing Solutions	111	Cllr Stephanie Cryan	Cumulative General Fund savings arising from rationalisation of customer serves provision	(195)	No impact on service users, savings in back office costs. Potential impact on staff.
Housing and Modernisation	H&M Councilwide	112	Cllr Stephanie Cryan	Council-wide postage contract with Royal Mail – default to second class postage, cease franking and move to pre-paid	(92)	No/minimal impact on staff or service users
Housing and Modernisation	Modernise – CFM	113	Cllr Stephanie Cryan	Invest to Save – accelerate installation of LED lighting in Tooley Street complex (part year effect year 1)	(55)	No impact on service users.
Housing and Modernisation	Modernise – HR	114	Cllr Stephanie Cryan	Rationalisation of equipment, supplies and services budget	(35)	No impact on service users.
Housing and Modernisation	Modernise – HR	115	Cllr Stephanie Cryan	Realignment of temporary staffing fee income budget to reflect projected activity	(100)	No impact on service users.
Housing and Modernisation	Modernise – OT	116	Cllr Stephanie Cryan	Realignment of apprentice training budget, costs now recoverable through Apprentice Levy	(35)	No impact on service users.
Housing and Modernisation	Modernise – OT	117	Cllr Stephanie Cryan	Rationalisation of equipment, supplies and services budget	(35)	No impact on service users.
Housing and Modernisation	Modernise – OT	118	Cllr Stephanie Cryan	Planned expiration of two fixed-term posts as part of previous restructuring proposals	(67)	No impact on service users.
Housing and Modernisation	Resident Services	119	Cllr Stephanie Cryan	Devonshire Grove temporary travellers' site – realignment of base budget requirement	(62)	No impact on service users.
Environment and Leisure	Culture	120	Cllr Rebecca Lury	Implementation of the recently approved Libraries and Heritage Strategy. £1m contribution from London Devolution Deal reserve effectively offsets the impact for the next four years.	(250)	The strategy has no clear detrimental impact to any group or protected characteristic as outlined in the Equalities Act or the PSED, and the broad aims and actions programmed are likely to increase participation, representation and accessibility to library and heritage provision within the borough. Consultation with the community is an integral part of delivering this strategy.
Environment and Leisure	Traded Services	121	Cllr Victoria Mills	Lower maintenance costs arising from investment in new efficient and environment friendly street lighting	(100)	No/minimal impact on staff or service users
Environment and Leisure	Waste and Cleaning	122	Cllr Richard Livingstone	Review litter picking and permanent presence to ensure service is delivered where needed and at the right frequency	(340)	No/minimal impact on staff or service users
Environment and Leisure	Waste and Cleansing	123	Cllr Richard Livingstone	Cease the use of mechanical sweepers overnight in our town centres and main roads where this duplicates daytime activity	(30)	No/minimal impact on staff or service users
Environment and Leisure	Waste and Cleansing	124	Cllr Richard Livingstone	Replace overnight manual sweeping with early morning hot-spot cleaning	(140)	No/minimal impact on staff or service users

Department	Division	Reference	Cabinet Member	Description	2019-20 £000	Equalities Analysis Information
Places and Wellbeing	Community and voluntary sector engagement	125	Cllr Rebecca Lury	Reduction in IAG (Information Advice and Guidance) contract - offset by new commitment in Exchequer Services to reflect increase in demand for support regarding Universal Credit	(82)	Commissioniong efficeinceies should meand no/minimal impact on staff or service users. Mitigation in enhancement of service in Local Support Team in Exchequer Services.
Places and Wellbeing	Planning	126	Cllr Johnson Situ	Reduction in staff costs	(50)	As specific proposals are brought forward, and at each stage of implementation therafter, the impacts on different categories of staff will be assessed in accordance with the council's reorganisation, redundnacy and redeployment procedure.
Places and Wellbeing	Property Services	127	Cllr Victoria Mills	Ongoing review of commercial rents/leases and savings in running expenses	(75)	No/minimal impact on staff or service users
Places and Wellbeing	Public Health	128	Cllr Evelyn Akoto	Efficiencies in funding the Southwark Exercise on Referral Programme through better administration and digitalisation	(25)	No/minimal impact on staff or service users
Places and Wellbeing	Public Health	129	Cllr Evelyn Akoto	Realignment of the work of Southwark Smoking Cessation Service to focus on hard to engage smokers and align with NHS funded activities	(70)	Focus on hard to reach smokers and alignment with NGHS should mean no/minimal impact on service users.
Places and Wellbeing	Public Health	130	Cllr Evelyn Akoto	Efficiencies in the delivery of the Southwark Free Healthy School Meals programme due to declining school rolls and promoting greater uptake of the national free school meal programme	(250)	No/minimal impact on staff or service users
Places and Wellbeing	Public Health	131	Cllr Evelyn Akoto	Savings from the roll out of the integrated sexual health tariff across London trusts.	(300)	No/minimal impact on staff or service users
Places and Wellbeing	Public Health	132	Cllr Evelyn Akoto	Redevelopment of the healthy schools programme with increased integration of activities into existing and enhanced school health offers and infrastructure	(100)	Mainstreaming of activirty should mean no/minimal impact on staff or service users.
Places and Wellbeing	Public Health	133	Cllr Evelyn Akoto	Efficiencies in substance misuse budget allocation across a range of service areas due to changing population profiles and improved commissioning of services	(180)	Commissioniong efficeinceies should meand no/minimal impact on staff or service users.
Places and Wellbeing	Regeneration North, South, Capital Works & Development	134	Cllr Johnson Situ	Ongoing review of Business Unit forward plans and related commitments including reduced running costs	(75)	No/minimal impact on staff or service users
Finance and Governance	Exchequer Services	135	Cllr Victoria Mills	Reduction in need for manual processing and administration due to improvements in functionality from recent changes to SAP and associated systems	(92)	No/minimal impact on staff or service users
Finance and Governance	Exchequer Services	136	Cllr Victoria Mills	Rationalisation of requirements for staffing resources following improvements and efficiencies in working practices and digitalisation of customer contact and engagement	(310)	As specific proposals are brought forward, and at each stage of implementation therafter, the impacts on different categories of staff will be assessed in accordance with the council's reorganisation, redundnacy and redeployment procedure.
Finance and Governance	Exchequer Services	137	Cllr Victoria Mills	Reduction in Benefits staffing due to caseload reduction from ongoing Universal Credit transition	(200)	As specific proposals are brought forward, and at each stage of implementation therafter, the impacts on different categories of staff will be assessed in accordance with the council's reorganisation, redundnacy and redeployment procedure.
Finance and Governance	Financial and Information Governance	138	Cllr Victoria Mills	Reduction to staffing budget following completion of service restructuring (Completed in 2018/19)organisation	(30)	No impact on service users, savings on back office costs. Potential impacts on staff. As specific proposals come forward and at each stage of implementation thereafter the different impacts on different categories of staff will be assessed in accordance with the council's reorganisation, redeployment and redundancy procedures.

Department	Division	Reference	Cabinet Member	Description	2019-20	Equalities Analysis Information
					£000	
Finance and Governance	Financial and Information Governance	139	Cllr Victoria Mills	Reduction in external audit contract budget in line with revised fee structure	(55)	No impact on service users.
Finance and Governance	Law and Democracy	140	Cllr Victoria Mills	Implement a post-reorganisation review to deliver a more efficient structure and processes within the Elections Team	(20)	The review will contain a baseline Equalities Impact assessment.
Finance and Governance	Law and Democracy	141	Cllr Victoria Mills	Reduction in printing and postage usage and cost from Elections and Registration services	(30)	No/minimal impact on staff or service users
Finance and Governance	Law and Democracy	142	Cllr Victoria Mills	The digitalisation and other efficiencies in the operation of council meetings has led to a reduction in the budgetary requirement for support costs	(30)	Support and training has been provided to all members where requested to develop their digital skills. Live streaming of meetings is more inclusive.
Finance and Governance	Law and Democracy	143	Cllr Victoria Mills	Review of staffing resource required within Constitutional Team	(40)	As specific proposals are brought forward, and at each stage of implementation therafter, the impacts on different categories of staff will be assessed in accordance with the council's reorganisation, redundnacy and redeployment procedure.
Finance and Governance	Law and Democracy	144	Cllr Victoria Mills	Reduction in the requirement for legal advice in relation to contracts and employment as well as use of specialist external solicitor frameworks	(110)	No/minimal impact on staff or service users
Finance and Governance	Law and Democracy	145	Cllr Victoria Mills	Reduced business support provision to legal services	(30)	No/minimal impact on staff or service users
Finance and Governance	Professional Finance Service	146	Cllr Victoria Mills	Following completion of structural review of PFS, further reduction in available staffing resources to be mitigated by enhanced business partnering approach and necessary improvements to financial management system	(50)	As specific proposals are brought forward, and at each stage of implementation therafter, the impacts on different categories of staff will be assessed in accordance with the council's reorganisation, redundnacy and redeployment procedure.
Chief Executive's	Chief Executive Office	147	Cllr Peter John	Reduction in member expenses budget	(5)	No/minimal impact on staff or service users
Corporate	Strategic Finance	148	Cllr Victoria Mills	Review of funding of provision for debt repayments (MRP) in accordance with Regulations and the Council's approved MRP Policy. Regulations provide flexibility for authorities to choose to fund MRP from capital and/or revenue resources.	(4,600)	No/minimal impact on staff or service users
Total					(13,905)	

Appendix D: Income Generation

	2019-20
	£000
Children's and Adults' Services	-
Housing and Modernisation	-
Environment and Leisure	(3,000)
Places and Wellbeing	(50)
Finance and Governance	-
Chief Executive's	-
Corporate	(1,760)
	(4,810)
Adults' Social Care	-
Children's Services	-
Education	-
Total Children's and Adults' Services	-
Public Health	-

Department	Division	Reference	Cabinet Member	Description	2019-20 £000	Equalities Analysis Information
Environment and Leisure	Parks and Leisure	201	Cllr Rebecca Lury	Expected increase in leisure management contract income	(700)	No/minimal impact on staff or service users
Environment and Leisure	Parks and Leisure	202	Cllr Rebecca Lury	Introduce parking charges in parks across the borough	(200)	The recommendation is not considered to have a disproportionate effect on any particular community or group.
Environment and Leisure	Regulatory Services	203	Cllr Richard Livingstone	Introduction of CPZs in Denmark Hill and Thorburn Square	(500)	No/minimal impact on staff or service users
Environment and Leisure	Regulatory Services	204	Cllr Richard Livingstone	Predicted extension of CPZ's in other parts of the borough in response to local resident demand	(700)	No/minimal impact on staff or service users
Environment and Leisure	Regulatory Services	205	Cllr Richard Livingstone	Expansion of car club bays and operations	(220)	No/minimal impact on staff or service users
Environment and Leisure	Regulatory Services	206	Cllr Richard Livingstone	Increase in income generated by on street advertising	(150)	No/minimal impact on staff or service users
Environment and Leisure	Regulatory Services	207	Cllr Victoria Mills	Introduce Night Time Levy subject to consultation	(200)	Alcohol-related crime and anti-social behavior has the potential to affect all groups of people. It is acknowledged that the cost of the Levy will primarily affect owners of businesses that provide alcohol during the late-night economy. The additional revenue raised however, has the potential to assist residents from all communities. Southwark has a wide range of licensed premises, many which contribute to the late-night economy. As the Levy would be applied equally to all premises selling alcohol after midnight, there is no data to suggest that this would negatively impact any community group in particular. The consultation will establish whether the content of the Late Night Levy is inclusive, appropriate, accessible and beneficial.
Environment and Leisure	Waste and Cleansing	208	Cllr Richard Livingstone	Introduce paid subscription for Green Waste collections in line with majority of London boroughs	(330)	No/minimal impact on staff or service users
Places and Wellbeing	Planning	209	Cllr Johnson Situ	Growth in planning application fee income arising from increases in fee rates set by government	(50)	No/minimal impact on staff or service users
Corporate	Corporate	210	Cllr Victoria Mills	Net increase in commercial portlio income from acquisition of Courage Yard	(1,760)	No/minimal negative impact on staff or service users
Total					(4,810)	

Appendix E: Savings Imapcting on Service Delivery

	2019-20
	£000
Children's and Adults' Services	(900)
Housing and Modernisation	-
Environment and Leisure	-
Places and Wellbeing	-
Finance and Governance	-
Chief Executive's	-
Corporate	-
	(900)
Adults' Social Care	(800)
Children's Services	(100)
Education	-
Total Children's and Adults' Services	(900)
Public Health	-

Department	Division	Reference	Cabinet Member	Description	2019-20 £000	Equalities Analysis Information
Children's and Adults' Services	Adults' Social Care	301	Cllr Jasmine Ali	Reduced costs to be realised through transition from the old model to new model, joint work with NHS, rationalisation of premises, e.g. the move to Castlemead and the All Age Disability Service	(800)	Any impact to be mitigated by reviews of care packages.
Children's and Adults' Services	Children's Services	302	Cllr Jasmine Ali	Realignment of Special Guardianship Order fees to Department for Education (DfE) level	(100)	Change in fee element of rate to carers to a national rate that is set by the Department for Education. Change will be implemented for new entrants and over time at natural transition points for those currently receiving allowances. Full consultation with those affected has already taken place. A full Equality Analysis has been completed and identifies mitigating actions where there are potential impacts and the package of support and advice for Special Guardians has increased including more financial advice on the Special Guardians Allowance.
Total					(900)	

Appendix F: Commitments

	2019-20 £000
Children's and Adults' Services	8,072
Housing and Modernisation	3,900
Environment and Leisure	982
Places and Wellbeing	200
Finance and Governance	252
Chief Executive's	-
Corporate	2,800
	16,206
Adults' Social Care	4,739
Children's Services	3,333
Education	-
Total Children's and Adults' Services	8,072
Public Health	200

Department	Division	Reference	Cabinet Member	Description	2019-20 £000	Equalities Analysis Information
Children's and Adults' Services	Adults' Social Care	401	Cllr Jasmine Ali	Support the total commitment in protecting homecare, reablement and bed-based care packages for our most vulnerable residents, funded partly through the Improved Better Care Fund	3,168	Positive impact.
Children's and Adults' Services	Adults' Social Care	402	Cllr Jasmine Ali	Support the total commitment in protecting homecare, reablement and bed-based care packages for our most vulnerable residents, funded partly through the additional Social Care Grant	1,571	Positive impact.
Children's and Adults' Services	Children's Services	403	Cllr Jasmine Ali	Impact of increasing numbers of unaccompanied asylum seeking children and insufficient grant funding	350	Positive impact.
Children's and Adults' Services	Children's Services	404	Cllr Jasmine Ali	Impact of increase in statutory duties to support care leavers and insufficient grant funding	300	Positive impact.
Children's and Adults' Services	Children's Services	405	Cllr Jasmine Ali	Support the total commitment in Children's Services such as unaccompanied asylum seeking children and leaving care responsibilities, funded partly through the additional Social Care Grant	2,683	Positive impact.
Housing and Modernisation	Communities - NRPF	406	Cllr Victoria Mills	Impact of increasing demand and price pressure from those eligible for support from No Recourse to Public Funds and the rate of case resolution.	700	Positive impact.

Department	Division	Reference	Cabinet Member	Description	2019-20	Equalities Analysis Information
					£000	
Housing and Modernisation	Customer Experience – Temporary Accommodation/ Housing Solutions	407	Cllr Stephanie Cryan	Net impact of cost and demand pressures on temporary accommodation budgets subject to efficiency measures and review of TA policies and procedures.	3,200	Positive impact.
Environment and Leisure	Culture	408	Cllr Rebecca Lury	Re-open the Blue Youth Club and Community Centre in Bermondsey	50	Positive impact on services to young people.
Environment and Leisure	Culture	409	Cllr Rebecca Lury	Ensure that every primary child gets a free visit to the theatre every year	100	Positive impact on services to young people.
Environment and Leisure	Environment	410	Cllr Richard Livingstone	Rent increase at Sandgate Depot	82	No/minimal impact on staff or service users.
Environment and Leisure	Highways	411	Cllr Richard Livingstone	Creation of a Community Toilet Scheme to incentivise local businesses to make their facilities available to the public.	50	Positive impact on the community including particular protected characteristics such as age..
Environment and Leisure	Parks and Leisure	412	Cllr Rebecca Lury	Protect Southwark's biodiversity and make nature accessible for all	50	Positive impact on the community.
Environment and Leisure	Parks and Leisure	413	Cllr Rebecca Lury	Make swimming lessons free for all residents	125	Positive impact on the community.
Environment and Leisure	Parks and Leisure	414	Cllr Rebecca Lury	Trees increased maintenance and inspection	300	No/minimal impact on staff or service users.
Environment and Leisure	Traded Services	415	Cllr Victoria Mills	Electricity costs resulting from installation of lamp column vehicle charging points at locations designated across the borough	55	No/miimal equality impact.
Environment and Leisure	Parks and Leisure	416	Cllr Rebecca Lury	Inreased revenue resources required to operate the Walworth library and heritage centre	170	Positive impact on the community.
Places and Wellbeing	Public Health	417	Cllr Evelyn Akoto	Introduction of Free Healthy School Meals for children in nursery schools and school nurseries.	200	Positive impact on the community.
Finance and Governance	Exchequer Services	418	Cllr Victoria Mills	Transfer of funding to Rightfully Yours Team from the Information and Advice contract for additional demand in needs of those moving to Universal Credit	82	Mitigates reduction elsewhere.
Finance and Governance	Professional Finance Service	419	Cllr Victoria Mills	Re-creation of technical financial planning and accounting resource to improve understanding of, and planning for, the changing enviroment for local government financing and funding and impacts of changes in demand and price in London and with Southwark in particular	95	No/minimal impact on existing staff
Finance and Governance	Professional Finance Service	420	Cllr Victoria Mills	Increase resources in the anti-fraud team in order to better detect and prevent fraud.	75	No/minimal impact on existing staff
Corporate	Corporate	421	Cllr Victoria Mills	Provision for costs arising from London review of remuneration for lower paid staff and implications for spinal points	1,800	Positive impact on staff.
Corporate	Corporate	422	Cllr Victoria Mills	Salary budget increase to reflect revised holiday pay entitlement arising from recent employment tribunal ruling	400	Positive impact on staff.

Department	Division	Reference	Cabinet Member	Description	2019-20	Equalities Analysis Information
					£000	
Corporate	Corporate	423	Cllr Victoria Mills	Increase in business rates on corporate accommodation as a consequence of fall out of transtional protection following revaluation	300	No/minimal impact on existing staff
Corporate	Corporate	424	Cllr Victoria Mills	Support to cover any operational cost pressures, e.g. supply chain, workforce etc arising from Brexit outcome	300	Positive impact on the community.
Total					16,206	

Agenda Item 9

Item No. 9.	Classification: Open	Date: 4 March 2019	Meeting Name: Health & Wellbeing Board meeting
Report title:		Lambeth, Southwark and Lewisham Sexual and Reproductive Health Strategy 2019-24	
Ward(s) or groups affected:		All Southwark wards and all population groups	
From:		Professor Kevin Fenton, Strategic Director of Place and Wellbeing Southwark Council	

RECOMMENDATIONS

The Health and Wellbeing Board is asked to:

- Approve the new Lambeth, Southwark and Lewisham (LSL) Sexual and Reproductive Health Strategy 2019-24; and
- Note that separate detailed action plans will be produced on a yearly basis, delivery of which will be overseen by the LSL Sexual Health Commissioning Partnership Board.

BACKGROUND INFORMATION

1. Southwark Public Health Division has spent the last year authoring a new Sexual and Reproductive Health Strategy for 2019-24, in partnership with teams in Lambeth and Lewisham Councils. A steering group comprised of key public health and commissioning officers led the production of the strategy, developed in line with a multi-stage consultation exercise which commenced early in the process.

2. This strategy updates and replaces the previous LSL Sexual Health Strategy 2014-17.

KEY ISSUES FOR CONSIDERATION

3. Separately, LSL face some of the greatest sexual health challenges in England, including high rates of HIV, STIs, emergency contraception use and abortions.

4. We have young, mobile and diverse populations, and our local sexual health services are modern and popular. Proportionately and in real terms, we spend a significant sum on sexual and reproductive health services, spending between a quarter and a third of the Public Health Grant, to meet both the needs and demands of our populations.

5. As the challenges we face are similar, LSL are in a stronger position to meet the needs of our populations through collaborating on sexual health commissioning and strategy. Through this approach, we are able to effectively pool both financial and human resources to maximise our impact in many areas. However, there remain areas where we commission separately to meet the differing requirements of our boroughs.

6. To underpin our collaboration, we need a clear strategic direction for action. This strategy provides that direction for the next five years.

7. The previous strategy was implemented in 2014, and largely focused on service modernisation and transformation. Since that time, new issues and opportunities have arisen, including declining access to contraception and associated reproductive health indicators, a decline in new HIV diagnoses for the first time since the beginning of the epidemic (in addition to the introduction of pre-exposure prophylaxis (PrEP) as a major factor in HIV prevention), and significant funding reductions from central government coupled with growing demand for services. Lambeth and Southwark introduced and provided proof of concept of STI self testing via e-services as a major part of a local sexual health system, and this has since been adopted and expanded across London.

8. The 2019-24 LSL Sexual and Reproductive Health Strategy is therefore built upon the achievements made under the last strategy, and the challenges that remain. It:

   - summarises the most up to date intelligence and information we have on sexual and reproductive health;
   - summarises the evidence of what works and good practice;
   - sets out our shared vision in four priority areas; and
   - provides a roadmap for achieving this.

9. There are three key components to the strategy:

   - The main strategy document, which is supported by two appendices:
   - A summary of the evidence in each of our priority areas; and
   - A statistical appendix, summarising the current picture and recent trends.

10. A short executive summary will also be published alongside the strategy documentation.

11. Our strategy has four key priorities:

Priority	Vision and key outcomes
Healthy and fulfilling sexual relationships	People are empowered to make their sexual relationships healthy and fulfilling: ▪ People make informed choices about their sexual and reproductive health ▪ People in unhealthy or risky sexual relationships are supported appropriately
Good reproductive health across the life course	People effectively manage their fertility and reproductive health, understand what impacts on it, and have knowledge of and access to contraceptives: ▪ Reproductive health inequalities are reduced ▪ Unwanted pregnancies are reduced ▪ Knowledge and understanding of reproductive health and fertility are increased

Priority	Vision and key outcomes
High quality and innovative STI testing and treatment	The local burden of STIs is reduced, in particular among those who are disproportionately affected: ▪ There is equitable, accessible, high-quality testing and treatment that is appropriate to need ▪ Transmission of STIs and repeat infections are reduced
Living well with HIV	We move towards achievement of 0-0-0: zero HIV-related stigma, zero HIV transmissions, and zero HIV-related deaths: ▪ People living with HIV know their status and are undetectable (=untransmittable) ▪ People living with HIV are enabled to live and age well

12. The strategy is not a commissioning plan. It provides our shared vision, and at a relatively high level, the steps we will take to get there over the next five years. We recognise that within LSL, some areas have further to progress than others and there will be local factors which may be unique to individual boroughs. Therefore, there will be an annual action plan which will include specific actions to deliver this strategy, tailored to each borough's differing progress. Commissioning actions will be taken as necessary following each borough's governance requirements. This approach allows us to collaborate to deliver an overarching strategy and to take local action as needed.

13. Collaborative sexual health work across LSL is overseen by the LSL Sexual Health Commissioning Partnership Board, which meets quarterly with representatives from each local authority public health department and each Clinical Commissioning Group (CCG). Its function is underpinned by a formal tripartite agreement. This body will also oversee the delivery of the new strategy. Annual updates will be provided to the Southwark Health and Wellbeing Board, as they are now.

Policy implications

14. We recognise that good sexual and reproductive health is intertwined with many other areas of health and wellbeing, as well as our wider communities. This joint strategy has therefore been developed to complement and tessellate with a range of other local strategies in each borough, and other strategies at a regional level (e.g. Mayor's Health Inequalities Strategy).

Community impact statement

15. The Equality Act 2010 protects us all from discrimination or harassment as a result of a personal characteristic. Good sexual and reproductive health is not equally distributed in the population. Some groups are more at risk of poorer sexual and/or reproductive health based on a common characteristic, most notably young people, black communities, and MSM.

16. The following characteristics are Protected under the Act:

- Age
- Race
- Gender
- Pregnancy and maternity
- Religion or belief
- Sexual orientation

- Disability
- Gender reassignment
- Marital status

17. While we will continue to commission welcoming, accessible and non-discriminatory services, to reduce inequalities in sexual and reproductive health we also need to commission services aligned with the concept of proportionate universalism. This means that whilst we will maintain open access sexual and reproductive health services for all, we also need to tailor services to those with greater need in order to reduce the impact of poor sexual health in our communities. This theme is threaded throughout the strategy.

Resource implications

18. There are no immediate resource implications, as this is not a commissioning plan. Commissioning plans and other resource implications arising from the annual action plans will be subject to each borough's governance processes.

Legal implications

19. Under their public health duties, local authorities are required by statute to provide open access sexual health services, including free STI testing and treatment, notification of sexual partners of infected persons, and free provision of contraception. Local authorities are responsible for providing:

    - comprehensive sexual health services including most contraceptive services and all prescribing costs, but excluding GP-provided contraception;
    - sexually transmitted infection (STI) testing and treatment, chlamydia testing, and HIV testing;
    - specialist services, including young people's sexual health, outreach, HIV prevention, sexual health promotion, and targeted services, e.g. in schools, college and pharmacies.

20. This strategy underpins the local delivery of these mandated functions.

Financial implications

21. None – see resource implications.

Consultation

22. The involvement of communities is a key part of the work of all parts of the health system. The views of individuals and wider communities are critical to understanding health beliefs, behaviour, and access to services, and are therefore critical in tackling health inequalities and poor health outcomes in the borough. Consultation and co-design are core values for the sexual health system across LSL.

23. The strategy process commenced with a consultation event with professionals and interested parties working in the sector in December 2017, seeking views on key issues, what was working, and what needed attention. This, along with a review of current performance and statistics and an evidence review of effective actions, focused the direction of the strategy.

24. A follow up event was held in September 2018 to consult on the draft strategy, followed up by an online consultation. The event was well attended with

approximately 100 people participating. A small number (n<10) provided views online via the survey as they were unable to attend the event. Following this consultation, a number of aims and objectives were clarified, amended and added.

25. Reproductive health – particularly that of women and people with uteri – is a priority in the new strategy, but it is also an area in which we were lacking understanding of local people's views. Focus groups on contraception and reproductive health were undertaken in May 2018 with a diverse sample of women across LSL, which supplemented what data told us about the needs of local women. The findings are detailed within the strategy and have heavily influenced actions in this area.

BACKGROUND DOCUMENTS

Background Papers	Held At	Contact
None		

APPENDICES

No.	Title
Appendix 1	Lambeth, Southwark and Lewisham Sexual and Reproductive Health Strategy 2019-24
Appendix 2	LSL Sexual and Reproductive Health Strategy 2019-24: Statistical appendix
Appendix 3	LSL Sexual and Reproductive Health Strategy 2019-24: Review of the evidence
Appendix 4	LSL Sexual and Reproductive Health Strategy 2019-24: Summary

AUDIT TRAIL

<table>
<tr><th>Lead Officer</th><td colspan="2">Professor Kevin Fenton, Strategic Director of Place and Wellbeing</td></tr>
<tr><th>Report Author</th><td colspan="2">Sigrid Blackman, Head of Public Health Programmes / Kirsten Watters, Consultant in Public Health</td></tr>
<tr><th>Version</th><td colspan="2">Final</td></tr>
<tr><th>Dated</th><td colspan="2">21 February 2019</td></tr>
<tr><th>Key Decision?</th><td colspan="2">No</td></tr>
<tr><th colspan="3">CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER</th></tr>
<tr><th>Officer Title</th><th>Comments Sought</th><th>Comments Included</th></tr>
<tr><td>Director of Law and Democracy</td><td>No</td><td>No</td></tr>
<tr><td>Strategic Director of Finance and Governance</td><td>No</td><td>No</td></tr>
<tr><td>Cabinet Member</td><td>Yes</td><td>n/a</td></tr>
<tr><td colspan="2">Date final report sent to Constitutional Team</td><td>21 February 2019</td></tr>
</table>

Lambeth, Southwark and Lewisham

Sexual and Reproductive Health Strategy 2019–24

Lambeth, Southwark and Lewisham Public Health Departments

Glossary

The following list provides a glossary of common terms used throughout this strategy.

ART	Anti-retroviral therapy
BAME/BME	Black and minority ethnicities
BASHH	British Association for Sexual Health and HIV
CCG	Clinical Commissioning Group
Chemsex	Sex that occurs under the influence of drugs
CSE	Child sexual exploitation
EHC/EC	Emergency hormonal contraception
EJAF	Elton John AIDS Foundation
EMA	Early medical abortion
FTC	HIV Fast-Track Cities initiative
GHB/GBL	Gammahydroxybutrate / gammabutyrolactone
GP	General practice
HARS	HIV and AIDS reporting system
HIV	Human immunodeficiency virus
HPV	Human papillomavirus
HSV	Herpes simplex virus
LARC	Long-acting reversible contraception
LGA	Local Government Association
LGBTQI+	Lesbian, gay, bisexual, transgender, queer/questioning, intersex and others
LGV	Lymphogranuloma venereum
LSL	Lambeth, Southwark and Lewisham
MC	Molluscum contagiosum
MSM	Men who have sex with men
NHS	National Health Service
OC	Oral contraception
PID	Pelvic inflammatory disease
PEP(SE)	Post-exposure prophylaxis (for HIV) (after sexual exposure)
PHE	Public Health England
PLHIV	People living with HIV
PrEP	Pre-exposure prophylaxis (for HIV)
PSHE	Personal, social, health and economic education
RSE	Relationships and sex education
Sexual health	Sexual health is used interchangeably with sexual and reproductive health
SHL	London's sexual health e-service, 'Sexual Health London'
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
TasP	Treatment as prevention (for HIV)
TOP	Termination of pregnancy; abortion
UDM	User-dependent method (of contraception)
UK	United Kingdom
UNAIDS	Joint United Nations Programme on HIV and AIDS
U=U	Undetectable = untransmittable
Women	In this strategy, the term 'women' (in the context of the reproductive health of those that have sex with men) encompasses both cis women and other people with uteri (e.g. trans men) that have sex with men.

Contents

Glossary 2

1.0 Executive summary 5

2.0 Context 8

- 2.1 What is this document? 8
- 2.2 Why do we need a joint strategy? 8
- 2.3 Inequalities in sexual and reproductive health 10

3.0 Vision 11

- Our vision for sexual and reproductive health 11
- Principles underpinning our strategy 11

4.0 Commissioning responsibilities and local services 12

5.0 Our priorities 14

- 5.1 Healthy and fulfilling sexual relationships 14
- 5.2 Good reproductive health across the life course 20
- 5.3 High quality and innovative STI testing and treatment 31
- 5.4 Living well with HIV 39

6.0 How we will deliver our vision 49

Contact 50

Key facts and figures

Indicators of HIV, sexual health, and reproductive health in our boroughs

Our population: BME, YP and MSM remain at greater risk of poor sexual and reproductive health

Our local services are at the forefront of creating and delivering modern and innovative sexual health provision

Healthy and fulfilling sexual relationships

Good reproductive health across the life course

High quality and innovative STI testing and treatment

Living well with HIV

2017

Lambeth, Southwark and Lewisham councils each launch new integrated services for young people, taking a holistic approach

User-dependent contraceptive methods are the most common form of contraception used in LSL

22,000 new STIs were diagnosed in 2017

8,700

residents have been diagnosed with HIV

Introduction of statutory of RSE offers an opportunity to improve and extend universal RSE

LSL is working to increase access to contraception, including online

We pioneered online STI testing for asymptomatic patients

95–98–97

London became the first city in the world to diagnose, treat and virally supress 95% of people living with HIV

1.0 Executive summary

Lambeth, Southwark and Lewisham (LSL) together face some of the greatest sexual health challenges in England.

We have similarly young, mobile and diverse populations, and our local sexual health services are modern and popular. Our rates of HIV and STIs are the highest in England, and there are persistent inequalities in sexual and reproductive health, with young people, men who have sex with men (MSM), and black and minority ethnic (BME) communities suffering the greatest burden. Sexual health inequalities cannot be addressed in isolation; it must be done in partnership. Due to the similarities in the challenges we face, LSL collaborate on sexual health commissioning and strategy in order to maximise our efforts to meet the significant and ongoing needs of our populations. This strategy assesses the most up to date intelligence and sets out LSL's shared ambitions and priority areas in sexual and reproductive health over the next five years.

Since the publication of LSL's most recent strategy (2014–17), there have been some significant changes in the sexual health landscape. The financial climate for public services (and public health services in particular) is extremely challenging, and not predicted to end in the near future. New, sustainable ways of funding sexual health services have been adopted across London and other parts of England, which despite now meeting the exact costs of sexual health service provision, have represented a considerable reduction in income for many NHS trusts. Demand for sexual health services remains high and is not expected to decline, and people across the country often struggle to access sexual and reproductive health services exactly when they want them. Commissioners and services have had to innovate, and LSL provided proof of concept of STI self sampling via an online service, which has now been adopted across many parts of London to alleviate pressure on sexual health clinics. Finally, the use of pre-exposure propylaxis (PrEP) has transformed HIV prevention and has likely contributed in part to a reduction in new diagnoses, particularly amongst MSM, and work is ongoing to establish how PrEP will form part of the publicly-funded HIV prevention agenda nationally.

There have been considerable improvements in key outcomes since our last strategy was published in 2014, most notably a reduction in new diagnoses of HIV for the first time in the history of the disease in England, and a continued downward trajectory in rates of teenage conceptions. However, gains have not been made equally across our population. BME communities (and black communities in particular) remain at greater risk of poor sexual and reproductive health.

There is an extremely high rate of diagnosed HIV across LSL – it is the highest in England, and over 8,700 of our residents have been diagnosed with HIV. Just over three quarters of people living with HIV in LSL are men, the majority of whom are white. Sex between men is the most common HIV exposure category in Lambeth (66%) and Southwark (58%), but in Lewisham, heterosexual contact is the most common exposure type (54%) of those diagnosed.

New HIV diagnosis rates are falling across LSL, but too many people still receive a late diagnosis, and there are still people living with HIV that are unaware of their status. There remain significant inequalities in those diagnosed late in LSL; people aged 50–64 years, of black African ethnicity, those exposed through heterosexual contact, and women have the highest

rates of late diagnosis. Furthermore, a disproportionate number of HIV cases locally are diagnosed in people living in the 40% most deprived areas.

Across LSL, 22,000 new STIs were diagnosed in 2017, with rates highest amongst men and those aged 20–24. While men have higher rates of STIs across most of the life course, women have higher rates of STIs than men at age 15–19. It is unclear what is driving this pattern, but it may be that young people lack the skills and confidence to negotiate safer sex. There is a general downward trend in new diagnoses of STIs in LSL, with the exception of gonorrhoea and syphilis (which most affect MSM). The increases in these STIs is concerning due to antimicrobial resistance and the severity of syphilis. Given the general burden of STIs in our populations, untreated STIs remain a concern in protecting the reproductive health of residents.

In terms of reproductive health, user-dependent contraceptive methods (e.g. condoms or the pill) are the most common form of contraception used in LSL. This combined with challenging access to services translates to a high use of emergency contraception and abortion, indicating that reproductive health needs continue to be unmet, particularly amongst young, black women.

We know that a large part of improving sexual and reproductive health is supporting people to develop the skills to negotiate the sex (and sexual relationships) that they want to have. Abusive and coercive relationships affect people of all ages, genders and sexualities, but some groups are at higher risk of unhealthy sexual relationships than others, including young women, people with learning disabilities, and people identifying as LGBTQI+. MSM in particular may be at risk through chemsex, as maintaining control of behaviour and choices while under the influence of drugs may be difficult. However, few local data are available on indicators for safe and healthy sexual relationships.

To build on the progress we have made and meet the most salient challenges facing our boroughs over the next five years, we will work together on four key priority areas:

Priority	Vision and key outcomes
Healthy and fulfilling sexual relationships	People are empowered to make their sexual relationships healthy and fulfilling: • People make informed choices about their sexual and reproductive health • People in unhealthy or risky sexual relationships are supported appropriately
Good reproductive health across the life course	People effectively manage their fertility and reproductive health, understand what impacts on it and have knowledge of and access to contraceptives: • Reproductive health inequalities are reduced • Unwanted pregnancies are reduced • Knowledge and understanding of reproductive health and fertility are increased
High quality and innovative STI testing and treatment	The local burden of STIs is reduced, in particular among those who are disproportionately affected: • There is equitable, accessible, high-quality testing and treatment that is appropriate to need • Transmission of STIs and repeat infections are reduced
Living well with HIV	We move towards achievement of 0–0–0: zero HIV-related stigma, zero HIV transmissions and zero HIV-related deaths: • People living with HIV know their status and are undetectable (=untransmittable) • People living with HIV are enabled to live and age well

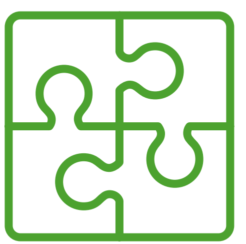
This strategy sets out the actions we will take in each of the priority areas to continue improving sexual and reproductive health in our boroughs over the next five years. We know that this is an ambitious strategy, and we cannot deliver it in isolation. We recognise that within LSL, some areas have further to progress than others and there will be local factors which may be unique to individual boroughs. Therefore, the boroughs will have an annual action plan which will include specific steps to deliver this strategy. This approach allows us to collaborate to deliver an overarching strategy and to take local action as needed. Progress against this strategy will be overseen by the LSL Sexual Health Commissioning Partnership Board in addition to each borough's Health and Wellbeing Board.

2.0 Context

2.1 What is this document?

This report sets out Lambeth, Southwark and Lewisham's (LSL) shared ambitions for sexual and reproductive health (SRH) in our boroughs for the next five years. Our strategy is built on the most up to date intelligence and information we have on SRH, sets out a number of priority areas for action between 2019 and 2024 and what actions we will take to address these priorities.

Appended to this document are two additional resources for readers: a *statistical appendix* which summarises the latest sexual and reproductive health data and intelligence in LSL, and a pack of *evidence summaries* which provides a short summary of the most up to date evidence and guidance in relation to each of our priority areas. The evidence summary pack also includes a full list of references (references are not included in the strategy itself for presentation purposes).



Our strategy is built on the most up to date intelligence and information on SRH and HIV in our communities

2.2 Why do we need a joint strategy?

Separately, LSL face some of the greatest sexual health challenges in England, including high rates of HIV, STIs, emergency contraception use and abortions.

We have young, mobile and diverse populations, and our local sexual health services are modern and popular. Proportionately and in real terms, we spend a significant sum on sexual and reproductive health services, spending between a quarter and a third of the Public Health Grant, to meet both the needs and demands of our populations.

As the challenges we face are similar, LSL are in a stronger position to meet the needs of our populations through collaborating on sexual health commissioning and strategy. Through this approach, we are able to effectively pool both financial and human resources to maximise our impact in many areas. However, there remain areas where we commission separately to meet the differing requirements of our boroughs.

To underpin our collaboration, we need a clear strategic direction for action. This strategy provides that direction.

When our last strategy was published in 2014, we set out to improve sexual health in LSL by building effective, responsive and high quality sexual health services, which effectively meet the needs of our local communities. This focus on service delivery was appropriate for the time, a year after commissioning responsibility transferred to local government. In the period of the last strategy, we:

- Integrated sexual and reproductive health services across our local system, maintaining a high quality of delivery;
- Invested in and developed a new model of online STI testing and provided proof of concept for this type of service (leading to it being adopted across London);

Young people, black communities and MSM are most at risk of poor sexual health

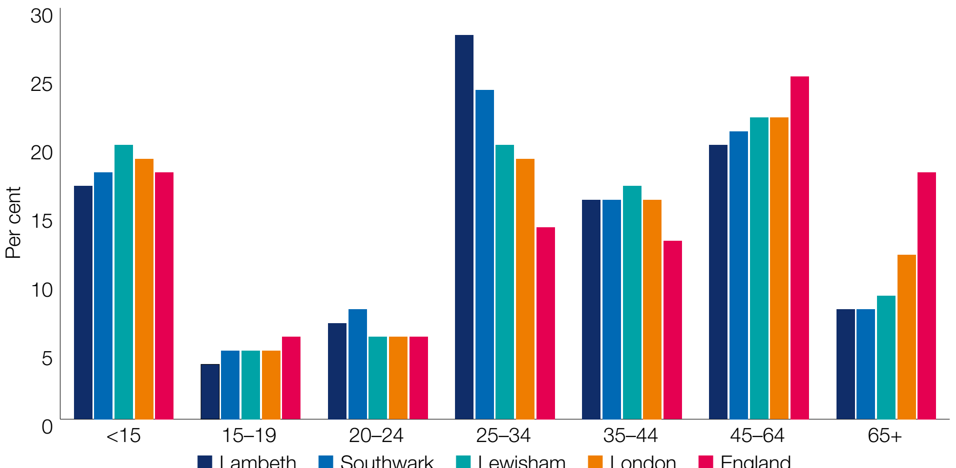
- Commissioned community-focused HIV prevention programmes and rolled out condom distribution schemes; and
- Commissioned innovative and collaborative young people's services with a greater focus on overall wellbeing.

Four years on from our last strategy, some challenges remain, and there have been substantial changes in sexual health and in the system as a whole. There have been improvements in many outcomes, but not experienced by all; a focus on reducing inequalities is more salient than ever. Despite the creation of new ways of accessing sexual health services, demand continues to rise, and access to other settings such as general practice is reported by sexual health service users as being increasingly difficult. The availability of pre-exposure prophylaxis (PrEP) has transformed HIV prevention, especially for men that have sex with men (MSM), but condomless sex is now an increasing challenge, and some STIs are on the rise. The financial climate is ever more challenging, but despite this, we remain committed to investing in prevention and exploring new ways of delivering services.

We're proud of the innovative way we approach sexual and reproductive health service provision in LSL, and we strive to continue to be system leaders over the next five years (and beyond).

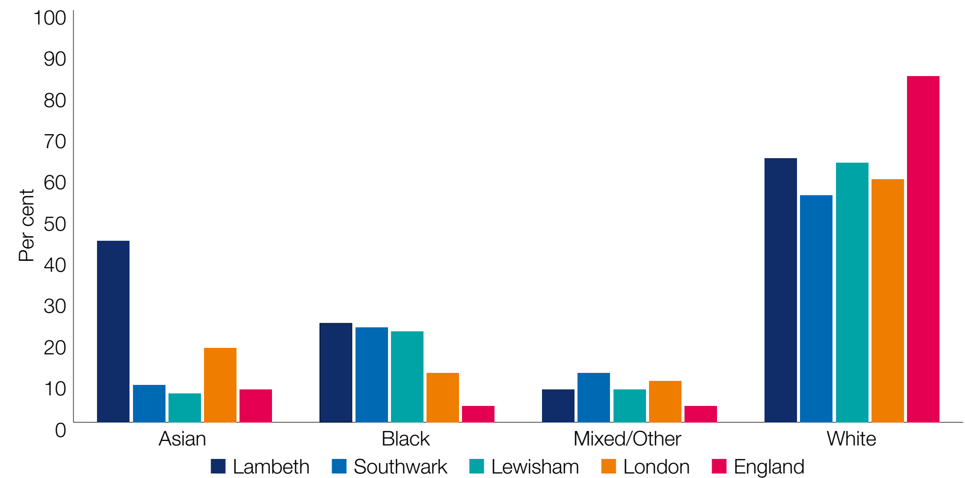
However, we can't make improvements in isolation. We recognise that good sexual and reproductive health is intertwined with many other areas of health and wellbeing, as well as our wider communities. This joint strategy has therefore been developed to complement and tessellate with a range of other local strategies in each borough, and other strategies at a regional level (e.g. *Mayor's Health Inequalities Strategy*).

Age profile in Lambeth, Southwark and Lewisham, 2016



ONS (2018) Revised population estimates: mid-2016

Population of LSL by broad ethnic group, 2016



London Datastore (2018) Ethnic groups by borough

The graphs above show that the populations of LSL are much younger and more diverse, on average, than those of London and particularly England. Young people and BME communities are more likely to suffer from poor SRH, which partly explains the significant SRH needs in LSL.

2.3 Inequalities in sexual and reproductive health

The Equality Act 2010 protects us all from discrimination or harassment as a result of a personal characteristic. Good sexual and reproductive health is not equally distributed in the population.

Some groups are more at risk of poorer sexual and/or reproductive health based on a common characteristic, most notably young people, black communities and MSM.

The following characteristics are protected under the Act:

- Age
- Race
- Gender
- Disability
- Marital status
- Pregnancy and maternity
- Religion or belief
- Sexual orientation
- Gender reassignment

While we will continue to commission welcoming, accessible and non-discriminatory services, to reduce inequalities in sexual and reproductive health we also need to commission services aligned with the concept of proportionate universalism. This means that whilst we will maintain open access sexual and reproductive health services for all, we also need to tailor services to those with greater need in order to reduce the impact of poor sexual health in our communities. This theme is threaded throughout this strategy.

53%
of lesbian, gay, and bisexual young people are never taught about homosexual sex and relationships issues at school

3.0 Vision

Our vision for sexual and reproductive health in LSL

Our vision for maximising sexual and reproductive health for all people in our boroughs focuses on four key priorities:

Healthy and fulfilling sexual relationships

VISION: People are empowered to make their sexual relationships healthy and fulfilling

Good reproductive health across the life course

VISION: People effectively manage their fertility and reproductive health, understand what impacts on it and have knowledge of and access to contraceptives

High quality and innovative STI testing and treatment

VISION: The local burden of STIs is reduced, in particular among those who are disproportionately affected

Living well with HIV

VISION: We move towards achievement of 0–0–0: zero HIV-related stigma, zero HIV transmissions and zero HIV-related deaths

Principles underpinning our strategy

LSL will work collaboratively to deliver our vision, guided by a common set of principles:

We will:

- **WORK IN PARTNERSHIP**, at a local, London and national level
- commission **HIGH QUALITY**, **EFFECTIVE** and **FINANCIALLY SUSTAINABLE** services, and capitalise on **TECHNOLOGICAL INNOVATIONS**
- **LISTEN** to service users' views and experiences and use these to improve what we do
- focus on **REDUCING INEQUALITIES** in sexual and reproductive health
- support the development of a **RESILIENT SEXUAL HEALTH SYSTEM**

Prevention focused and evidence based

4.0 Commissioning responsibilities and local services

We recognise that the commissioning landscape for sexual and reproductive health can be complex.

Various bodies have commissioning responsibilities in this area, which could make delivery of a strategy challenging. This is why the first principle of our strategy is to 'work in partnership' to deliver our shared vision.

While local authorities are responsible for most sexual and reproductive health care, this is not exclusively the case. Since April 2013, local authorities, Clinical Commissioning Groups (CCGs) and NHS England have had commissioning responsibility for the following services:

Local authorities	• Contraception, including any enhanced services commissioned in general practice or pharmacy settings including all prescribing costs – but excluding contraception provided as a service under the GP contract • STI testing and treatment, including chlamydia testing and HIV testing • Sexual health aspects of psychosexual counselling • Any sexual health specialist services, including young people's sexual health and teenage pregnancy services, outreach, HIV prevention and sexual health promotion work, services in schools, colleges and pharmacies
CCGs	• Abortion services • Vasectomy • Non sexual-health elements of psychosexual health services • Gynaecology, including the use of any contraception for non-contraceptive purposes.
NHS England	• Contraception provided as an additional service under the GP contract* • HIV treatment and care, including post-exposure prophylaxis after sexual exposure (PEP(SE)) • 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

*Delegated responsibility to CCGs locally

Public Health England (PHE) supports effective local commissioning by providing data and intelligence, guidance and also commissioning central prevention programmes (e.g. HIV Prevention England).

The commissioning responsibilities outlined above translate into the services and programmes on the following page, mapped against the key priorities of this strategy.

Commissioning responsibilities

	Priority	Healthy and fulfilling sexual relationships	Good reproductive health across the life course	High quality and innovative STI testing and treatment	Living well with HIV
	What does good look like?	• Knowledge, confidence and skills for safe, healthy and fulfilling relationships	• In control of their body and fertility • Understand what factors impact on fertility • Choice and access to a range of contraceptive methods	• Self-sampling of STIs • Access to appropriate testing • High quality clinical services	• Increased HIV testing • Earlier diagnosis • Retention in care • Holistic health management
Commissioner	Council	High quality RSE in schools Targeted work to young people Tackling homophobia, transphobia and misogyny in communities Community outreach / targeted health promotion work Targeted chemsex work	High quality RSE in schools Young people friendly services Knowledge of and access to full range of contraceptive offers Come Correct condom scheme for under-25s Integrated reproductive and sexual health services	High quality RSE in schools Young people friendly services Come Correct condom scheme for under-25s Online STI self-sampling or testing Integrated reproductive and sexual health services Specialist clinical services	Reducing stigma and promoting good sexual health Community outreach / targeted health promotion work Online STI self-sampling or testing Integrated reproductive and sexual health services
Commissioner	Council & CCG	Psycho-sexual health services	Online offer of oral contraception Pharmacy and primary care FGM prevention	Pharmacy and primary care testing	Pharmacy and primary care testing
Commissioner	CCG		High quality abortion services Vasectomy and sterilisation services		HIV-related care and support
Commissioner	NHSE		HPV vaccination Cervical screening Contraception under GP contract	PrEP	HIV treatment services

5.0 Our priorities

5.1 Healthy and fulfilling sexual relationships

What do we mean by 'healthy and fulfilling sexual relationships'?

Our ambition is for all people in our boroughs to be empowered to make their sexual relationships healthy and fulfilling.

We know that a large part of improving sexual and reproductive health outcomes is supporting people to develop the skills to negotiate the sex (and sexual relationships) that they want to have. Much of the work relevant to this topic falls within the remit of safeguarding teams and complementary strategies are available to support this work, addressing domestic abuse, violence against women and girls, and child sexual exploitation, among others.

However, public health has a role supporting relationships and sex education (RSE) in schools. Through effective collaborations, Public Health can promote and encourage partners, agencies, and providers to champion healthy relationships with the aim of supporting people of all ages to understand and identify risky sexual behaviour and prevent abuse.

This chapter therefore serves as the preventative strand of our strategy.

Introduction

Background and policy context

Social relationships are an important determinant of health and wellbeing across the life course.

A positive familial environment provides children with secure attachment and a healthy blueprint for future relationships. Negative, harmful relationships have consequences to physical and emotional health and, in some cases, may drive a cycle of unhealthy behaviour. For this reason, developing an understanding of healthy relationships early in life is critical to equip young people with the knowledge, confidence and control to engage in healthy sexual relationships.

Comprehensive relationships and sex education (RSE) contributes to a young person's safety by supporting them to navigate through their own developmental changes and helping to raise awareness of exploitation or abuse. Despite this, schools currently (as of 2019) have had no statutory responsibility to provide comprehensive RSE. There is strong evidence of the impact of high quality RSE in reducing early sexual activity, teenage conceptions and STIs, and in increasing reporting of sexual exploitation and abuse. Moreover, young people have increasingly reported that lessons from school are their preferred source of information about sex when growing up, further highlighting the importance of appropriate RSE. However, recent national surveys, qualitative studies and local surveys across LSL on RSE have revealed significant inadequacies in the breadth of topics covered and the quality of teaching.

Amendments to the Children and Social Work Act by the Department for Education have legislated statutory RSE across the UK as of September 2020, a delay on the anticipated 2019 start-date. This affords schools (maintained, academy and independent) the opportunity to

'Relationships and sex' is the issue most concerning to young people

Some groups are at higher risk of unhealthy sexual relationships than others, including young women, people with learning disabilities and people identifying as LGBTQI+

develop – alongside health professionals – comprehensive, relevant lessons that address these reported inadequacies and capitalise on our knowledge of vulnerable groups, in particular the lack of RSE sufficiently inclusive of vulnerable women, young LGBTQI+ people and others. Effective collaboration between partners and providers is critical to achieving this. Topical issues of consent – what it looks like, giving it, understanding it can be withdrawn – will also be included. In primary schools, the subject will be taught as 'relationships education,' extending to 'relationships and sex education' in secondary schools. Schools will have flexibility in how these subjects are taught and parents retain the right to withdraw a child from RSE, as they do currently.

The strategic direction for sexual assault and abuse services over the next five years has been set out by NHS England (April 2018) and echoes this emphasis on prevention. It recognises the increasing role of the internet in sexual assault and abuse, and the difficulties faced by vulnerable groups (e.g. LGBTQI+, BAME, those with learning difficulties) in reporting an incident. Knowledge and guidance about healthy relationships is an important resource to enable people to navigate their own sexual experiences and can help people of all ages to identify unhealthy relationship behaviours and give them the confidence to address it. Healthy and fulfilling sexual relationships are important for good reproductive health, and for reducing the risk of acquiring STIs and HIV. Empowering people to make their sexual relationships healthy and fulfilling is an integral part of a holistic sexual and reproductive health strategy.

Current picture

Epidemiology / local needs

We know that sexual health is more than the absence of disease, however, few data are available on the broader aspects, including safe and healthy sexual relationships. Proxy measures can instead be used to indicate general trends and suggest areas of improvement or good practice.

Comprehensive, contemporary RSE can empower people to engage in healthy sexual relationships and may act as a protective factor against future risky behaviour. Local research with young people in Lewisham and Southwark during 2016 and 2017 revealed views that 'relationships and sex' was the issue most concerning to young people and their peers. However, these studies also exposed sparse and inconsistent education about healthy relationships across different schools. Details about what constitutes a healthy or unhealthy relationship and how to spot the signs of abuse (beyond physical) were reported as lacking. When asked about how they would prefer RSE to be provided, young people vocalised a desire for an open, interactive discussion with professionals, more information on the emotional and social aspects of sex, and a general inclusion of healthy relationships. A key part of this is reducing stigma around sex and sexual relationships, and developing professionals' confidence and skills in having these conversations. Additional gaps in knowledge were identified in the legal consequences of sexting (sending sexually explicit photographs or messages via mobile phone) that, despite its prevalence in this age group, remained largely undiscussed in RSE.

2020

By September 2020, all schools will need to deliver RSE

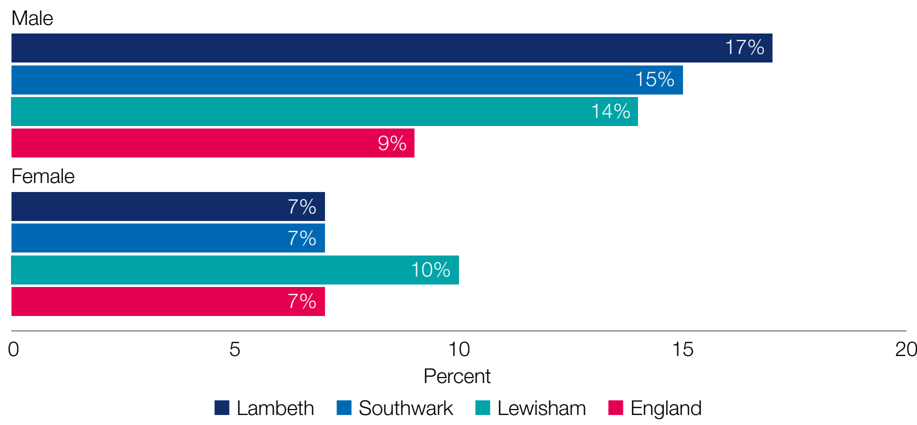
Knowledge and guidance about healthy relationships is an important resource to enable people to navigate their own sexual experiences

Empowering people to define the terms of their sexual relationships and use contraception when desired is an important part of protecting sexual and reproductive health (SRH). Ensuring the equality and accessibility of our contraception services has been a local priority. For young people under 25, condoms and sexual health information are available free of charge through the pan-London distribution scheme *Come Correct*, delivered by Brook across LSL. Condom distribution schemes were recently evaluated nationally and found to be successful nationally. This is reflected in the high number of repeat users (compared to new registrations) locally.

Abusive and coercive relationships affect people of all ages, genders, and sexualities but some groups are at higher risk of unhealthy sexual relationships than others. People identifying as LGBTQI+ may be at greater risk of experiencing abuse in a relationship. The prevalence of domestic abuse in MSM is high: from the age of 16, 49% report experiencing at least one episode of abuse. Given our significant local population of MSM, these figures are cause for concern. The prevalence of abuse in transgender people is even higher; an estimated 80% report experiencing emotional, physical or sexual abuse from a partner or ex-partner. Despite the risk of domestic abuse in these populations, over half (53%) of lesbian, gay and bisexual young people are never taught about homosexual sex and relationships issues at school and therefore may not be sufficiently equipped with the knowledge and skills to engage in the sexual relationships that they want.

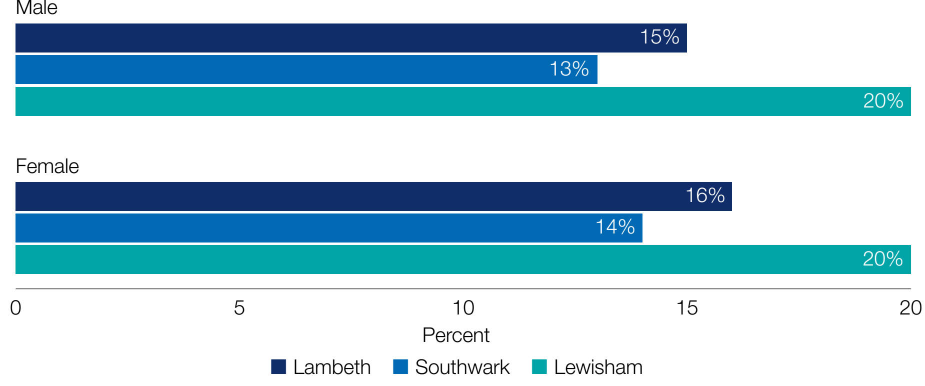
In 2016/17 across London, the rate of domestic abuse-related incidents and crimes recorded by the police was 23 per 1,000; women are nearly twice as likely to have experienced domestic abuse as men. The number of accounts of violence against women and girls in London has increased since 2012 but it remains an under-reported

Re-infection within 12 months all STIs all age groups, 2012–16



PHE (2017) Local authority HIV, sexual and reproductive health epidemiology report (LASER): 2016

Re-infection within 12 months all STIs 15–19 year olds, 2012–16



PHE (2017) Local authority HIV, sexual and reproductive health epidemiology report (LASER): 2016

Re-infection with an STI is a marker of persistent risky behaviour. Across LSL, men are more likely to have a reinfection within 12 months of diagnosis. The proportion of people with a re-infection in LSL is much higher than the rest of England. Teenagers are considered to be at increased risk of re-infection because they are more likely to lack the skills and confidence to negotiate safer sex, and this is particularly the case in Lewisham.

crime. While we lack quantitative data locally, qualitative research has highlighted the prevalence of emotionally abusive behaviour among LSL's population of young people. The 2017 Lewisham Healthwatch report '*Let's Talk About Sex*' revealed young people were rarely identifying controlling behaviour or emotional abuse as evidence of an unhealthy relationship. The 2016 SHEU survey of secondary students in LSL found that 12–17% of students surveyed reported a jealous partner when seeking to spend time with friends and 10–14% said their partner looked through their phone.

Engaging in risky sexual behaviour, e.g. condomless sex, may be one of many indicators of an unhealthy sexual relationship. The rate of new STI diagnoses in LSL has been consistently higher than the London and England average since 2012. Re-infection with an STI indicates ongoing risky behaviour and across LSL men are more likely than women to become re-infected within 12 months of diagnosis. Young people are considered to be at increased risk of re-infection because they tend to lack the skills and confidence to negotiate safer sex. In 2016, twice the proportion of 15–19 year old women were re-infected compared to women of all ages. Lewisham had the highest rate of STI re-infection among LSL from 2012–16, particularly in young people.

'Chemsex' – sex that occurs under the influence of drugs, most commonly crystal methamphetamine, GHB/GBL and mephedrone – has become prominent in some parts of the MSM community. Through local surveys, we know that our population of MSM are more likely to use drugs associated with chemsex than MSM elsewhere in London or England. These substances pose significant health risks and risk of overdose. Qualitative research in Southwark indicated an increased mental health risk (including low self-esteem) for those who partake in chemsex. Research participants also identified vulnerability and risky sexual activity as common concerns since maintaining control of behaviour and choices while under the influence of chemsex drugs may be difficult. As sexual health commissioners, we need to ensure that people who are more likely to engage in risky sexual relationships are also appropriately supported and empowered to make safe, healthy decisions.

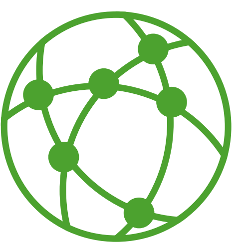
Achievements since the last strategy and ongoing challenges

Achievements since the last strategy

The focus on healthy sexual relationships in this strategy is a new development, in line with local needs and a changing policy context.

The introduction of statutory RSE from September 2020 is a significant achievement for public health and RSE advocates across the UK, and has created opportunities for the development of meaningful, relevant discussions of healthy sexual relationships.

In 2017, Lambeth, Southwark and Lewisham councils each launched new integrated services for young people, taking a holistic approach to the wellbeing of young people. The services focus (to varying degrees) on the provision of services and information on sexual health, substance misuse and mental and emotional wellbeing. Underpinning these services is an acknowledgement that young people take risks, and a shared ambition to support young people with risk-taking behaviours to build resilience, coping strategies and decision-making skills. These services have been in place for a short time, but early outputs and service user engagement is encouraging.



2017
Lambeth, Southwark and Lewisham councils each launched new integrated services for young people, taking a holistic approach to the wellbeing of young people

Ongoing challenges

Data

Insufficient data are available to describe and quantify potential inequalities in achieving healthy relationships. We are working with our partners to explore methods of capturing childhood risk factors (such as adverse childhood experiences), which impact on a child's risk seeking and taking behaviour later in life. We also don't fully understand the needs of sex workers in our boroughs, which may have changed since the previous strategy, and their access to and use of services to support their sexual health.

Detailed needs assessments are on-going and planned to better understand local needs where routinely collected data are not available.

RSE provision

Until RSE is made statutory in 2020, provision will remain inconsistent across schools. As such, there are likely inequalities in children's experiences and understanding of relationships and sex. Individual programmes and workshops have been developed for schools, e.g. the Esteem programme in Southwark that delivers lessons on critical thinking around peer pressure and understanding healthy relationships. However, programmes such as this must be purchased by schools and there is therefore significant variation in provision across the boroughs.

Emerging issues

Youth violence

Serious youth violence (SYV) is a growing issue across London and LSL. Serious youth violence and poor sexual health have a number of shared risk factors. Young people involved in gangs are at risk of significant physical and mental health impacts; however, young women in particular are increasingly recognised as the invisible victims. UK research has exposed widespread sexual abuse of women and girls involved in gangs and in county line drug trade, who are frequently exploited as part of initiations or to pay off debts. Challenging the impact of gang violence and protecting young women and men is a regional and local priority. Among our local efforts is a Southwark school-based, peer-led workshop by The Participation People on understanding healthy relationships. Lambeth is developing its response to serious youth violence which will be informed by a public health approach. Helping young people to recognise and avert risky sexual behaviour and relationships is a critical outcome for this strategy.

Online relationships and safety

In the current landscape, young people face a plethora of emerging challenges that are becoming increasingly difficult to navigate. Relationships are now conducted with a growing online element, exposing children to new risks such as revenge porn and increasing opportunities for online grooming and exploitation. It is therefore critical that young people have the knowledge and the skills to operate safely online.

Relationships are now conducted with a growing online element, exposing children and young people to new risks such as revenge porn and increasing opportunities for online grooming and exploitation

Healthy and fulfilling sexual relationships: what we want to achieve by 2024

The figure below sets out our vision for healthy sexual relationships in LSL, how we will work together to achieve this vision, and the indicators with which we will measure our progress. It is clear that many of these are intertwined. While we will progress many of these objectives collaboratively, our boroughs will have an annual delivery plan which will set out shared and borough-specific actions needed to achieve these objectives in a given year.

Vision

- People have healthy and fulfilling sexual relationships

Outcomes

- People make informed choices about their sexual and reproductive health
- People in unhealthy or risky sexual relationships are appropriately supported

Aims

- We will ensure all young people have access to high quality provision of RSE
- We will increase professional knowledge and skills in contraception and sexual health
- We will ensure people know where to access sexual and reproductive health services
- We will ensure targeted support for those engaging in higher risk sexual behaviours, acknowledging the complexity of this
- We will ensure our prevention activities are appropriately targeted
- We will ensure our services identify harmful sexual relationships early

Objectives

- We will ensure all schools in our boroughs are aware of and appropriately referring into our SRH services
- We will work with education to support evidence-based RSE
- We will train a range of multidisciplinary professionals in healthy sexual relationships and initiating conversations about healthy sexual relationships
- We will encourage all professionals to discuss healthy sexual relationships when the opportunity arises
- We will promote our services to residents and professionals
- We will ensure our SRH services are promoted specifically to groups who are at higher risk of poor SRH
- We will work to ensure appropriate referral to psychosexual services
- We will ensure further integration between sexual health, mental health, and substance misuse services for young people
- We will provide outreach services to reach those most at risk / those marginalised from SRH services
- We will target prevention activities around chemsex, with particular focus on MSM
- We will target prevention to those with HIV/ those whose sexual partner has HIV to ensure knowledge of the health risks of seroadaptive behaviour / condomless sex
- We will ensure appropriate referral pathways to other services
- We will ensure all our staff are trained to identify and appropriately refer cases of female genital mutilation, domestic violence and child sexual exploitation

Key Indicators

- Referrals received from schools to our SRH services
- A school support offer for RSE, covering issues appropriate to the local area
- Number of professionals trained in defined courses
- Referrals from partner organisations into our SRH services
- Number of attendances at YP's SRH services across LSL
- Number of repeat visits in local C-card schemes
- % of sexual and reproductive health pharmacies offer C-card
- Number of attendances of BAME, mixed, and other ethnic groups at adult's SRH services across LSL
- Number of attendances and sustained case load at harm reduction services
- Number of outreach sites in operation at YP's SRH services
- % of young men engaged in YP specialist services
- Number of YP's and adult substance misuse service users in treatment for chemsex
- Number of individual and group engagement sessions by Rise Partnership for BAME heterosexuals and MSM
- Number of defined safeguarding training sessions taken by staff

5.2 Good reproductive health across the life course

What do we mean by 'good reproductive health across the life course'?

Our ambition is for all people – but especially women and people with uteri – in our boroughs to have the skills, knowledge and access to services that allow them to effectively manage their fertility and reproductive health.

The reproductive life course – starting at menarche and continuing through to menopause and beyond – is important for all, although the relative importance of reproductive issues varies between individuals and at different stages of life. Reproductive experiences and choices are embedded in and influenced by societal constructs, with societal and cultural expectations of what is 'normal' affecting how people, and especially women, make their reproductive decisions. There is a need for conversations about reproductive health to be normalised, allowing frank and open discussion, and enabling those who need additional support to reach it.

We recognise the importance of reproductive health on overall wellbeing, and that for many people, this includes the capability to have children and the freedom to decide if and when to do so. The birth rate is declining, as people delay their first pregnancy. This strategy does not focus on conception support, but on the wider factors affecting reproductive health. These include: knowledge and understanding of fertility, reproductive health and contraceptive options; access to high quality contraception and termination services that meet the needs of all and the uptake of screening, vaccination and testing programmes, which affect reproductive health in the long term, including if, when and how women choose to become pregnant. Professionals' knowledge, beliefs and attitudes are as important as those of individuals in improving reproductive health.

This chapter has clear links with our other ambitions in this strategy. Being in a healthy and fulfilling relationship and having access to high quality STI testing and treatment impacts on reproductive wellbeing. Thus, our ambitions in these other chapters will also contribute to delivering good reproductive health across the life course.

Introduction

Background and policy context

Nationally, the integration of sexual and reproductive health services under the umbrella of 'sexual health services' has been a positive development in terms of improving access to a wider range of services and reducing stigma.

However, it has meant that the big issue of STIs has often dominated the national conversation around sexual health, as well as local and regional strategies. We want to redress this balance and focus on improving reproductive wellbeing in LSL.

Reproductive health is an important component of overall health across the life course, and can impact wellbeing at any stage, as well as the wellbeing of children. Consequences of poor reproductive health exacerbate inequalities in health, education and socio-economic status (and conversely, these factors also impact on reproductive health). In the UK, more than three-quarters of women of reproductive age want to either avoid or achieve pregnancy at any given time. Overall, women spend approximately 30 years of life avoiding unwanted pregnancy and therefore require effective contraceptive methods. In Britain, nearly half of pregnancies (45%) are unplanned and one in 60 women (1.5%) experiences an unplanned pregnancy in a year. Unplanned pregnancies are also a missed opportunity to optimise pre-pregnancy health for both woman and child.

Unplanned pregnancies leading to maternity may have long-term costs not only in health terms, but also to local authority housing, education, and social care, and may have additional unintended consequences for the family itself. For example, teenage pregnancies may, in some cases, be costly to both mother and child in regards to the

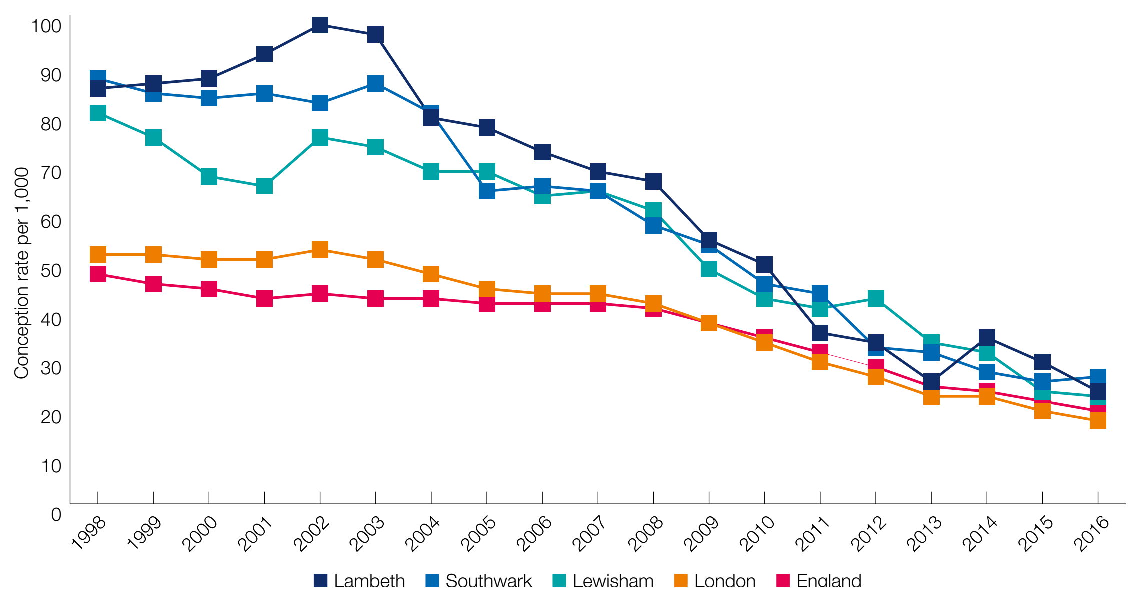
opportunity to complete education, earning potential and future employment. In the whole population, risk factors for unplanned pregnancy include lower educational attainment, younger age, substance misuse and smoking. Some BME groups have higher rates of abortion (an indicator for unwanted pregnancy), and this is the case for black African and Caribbean women in LSL.

Some unplanned pregnancies, regardless of the age of the mother, will become wanted. However, a proportion will result in termination. Access to safe, legal abortion, free from harassment, has a critical role in protecting the reproductive health of women who choose to end a pregnancy.

Terminating a pregnancy has direct costs to the health economy: in 2010, approximately £143m was spent on abortions in England (the number and rate of abortion has stayed approximately stable since). In contrast, publicly-funded contraception to prevent unintended pregnancy is extremely cost-effective and is one of the highest value public health interventions. While NHS and local authority spending on contraception totalled £246.1m in 2016, new analyses in England suggest that every £1 invested in contraception saves these public services £4.64 over a four year period, and £9.00 over 10 years. Benefits include savings that result from avoiding unwanted pregnancies, including healthcare costs (for example birth costs, abortion costs, miscarriage costs and ongoing child health care costs) and non-healthcare costs (such as education costs, welfare costs, children in care costs). Good reproductive health therefore not only an essential contributor to good overall health and wellbeing, but also yields savings for public services.

In 2013, the Government published a national '*Framework for Sexual Health Improvement in England*', which recognised the need to ensure that people have access to the full range of contraception, that women with unwanted

Under 18 conception rate per 1,000 in LSL, 1998–2016



PHE (2018) Sexual and Reproductive Health Profiles

The graph above illustrates a 70% decline in the number of teenage conceptions in LSL since 1998. Numbers remain small, but rates are higher than London and England averages.

pregnancies are supported to make timely, informed decisions, and that local areas develop innovative, value for money interventions and services to respond to needs. The 2018 PHE guidance '*Sexual and reproductive health and HIV: Applying All Our Health*' also emphasised the importance of facilitating easy access to the full range of contraceptive methods in a range of accessible settings. These ambitions remain central to local areas' reproductive health improvement strategies.

The LGA / PHE Teenage Pregnancy Prevention Framework (2018) was published to help local areas address and reduce teenage pregnancy, and suggested key factors for a successful, whole-systems strategy. This approach was first outlined in the 2016 report '*Good progress but more to do: teenage pregnancy and young parents*', by the same authors. This report highlighted the health inequalities experienced by young parents and their children and included best practice case studies. It remains a valuable resource to date.

In June 2018, PHE published the beginnings of a new 5-year framework for reproductive health improvement. This included a survey of women's views on reproductive health (the key findings of which are captured in sections below) and a professional consensus statement on six key pillars of reproductive health, as follows:

1. Positive approach: The opportunity for reproductive health and access to reproductive healthcare, to be free from stigma and embarrassment.
2. Knowledge and Resilience: The ability to make informed choices and exercise freedom of expression in all aspects of reproductive health.
3. Free from violence and coercion: The ability to form enjoyable relationships whilst not fearing or experiencing any form of power imbalance or intimidation.
4. Proportionate universalism: The ability to optimise reproductive health, and social and psychological well-being through support and care that is proportionate to need.
5. User-centred: The ability to participate effectively and at every level in decisions that affect reproductive lives.
6. Wider determinants: The opportunity to experience good reproductive health and ability to access reproductive healthcare when needed free from the wider factors that directly and indirectly impact on reproductive well-being.

Good reproductive health in LSL is thus reflective of a comprehensive, prevention-centred, whole-system approach to reproductive wellbeing that offers support from adolescence through to older age, targeting those most at risk in order to reduce inequalities. At any reproductive stage, individuals should have the ability and freedom to make choices about the aspects of their reproductive lives, and be able to access a range of contraceptive methods and other reproductive support services. Likewise, services need to be arranged to facilitate easy access to the full range of reproductive health services to ensure people continue to enjoy safe and healthy sexual lives.

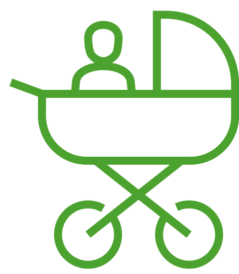
Despite the availability of guidance, improvement frameworks and quality local services, challenges remain in preventing unwanted pregnancy and in ensuring knowledge, uptake and access to contraceptive options across LSL.

Current picture

A declining birth rate and older age of first maternity

There were a total of 13,433 births to women living in LSL in 2016. The general fertility rate (measured as the birth rate) in LSL has been declining since at least 2012. The birth rate is lower in Lambeth and Southwark than it is in Lewisham: in 2016 the birth rate in Lambeth was 47.4 births

£4.64
The amount saved by public services for every £1 invested in contraception



Women are choosing to have children increasingly later in life

per 1,000 women aged 15 to 44 years, compared to a rate of 54.3 per 1,000 in Southwark. Lewisham (63.7 per 1,000) had a similar rate to London (63.6) and England (62.5). This is linked to women choosing to delay their first pregnancy.

The mean age of mothers having their first live child has increased over time nationally. In 2016, the mean age of first time mothers in England was 28.8 years and has been increasing by 0.2 years annually for the previous ten years. A similar pattern can be seen in LSL; hospital admission records show that in 2016/17, the proportion of deliveries to women aged 35 years or above was 33%, 31% and 32% respectively. Between 2014/15 and 2016/17, there has been an increase in the proportion of deliveries to women aged 35 years or above by 2.2% in Lambeth, 1.9% in Southwark and 2.3% in Lewisham suggesting that more women are having children at a later age.

Prevention of HPV

The national human papillomavirus (HPV) immunisation programme was introduced to protect women against the main causes of cervical cancer, which in turn impacts on reproductive health. The national target in England is for 95% of all Year 8 girls to have received at least one dose of the vaccine. LSL did not meet this target in 2016/17, with 90% coverage in Lambeth, 86% in Southwark and 82% in Lewisham. The London coverage rate was 83.8%. There has been a slight improvement in LSL in recent years, although Lewisham remains consistently behind Lambeth and Southwark.

As of July 2018, the Joint Committee on Vaccination and Immunisation recommended HPV vaccination be extended to boys aged 12–13. However, the specifics of this programme remain unknown. Trans men and women, and MSM are eligible for the HPV vaccine up to and including age 45 through sexual health clinics.

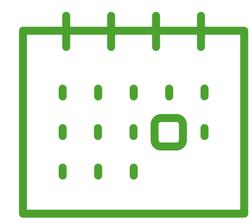
Knowledge and attitudes toward contraception

Contraception is important for all women of reproductive age who have sex with men as it enables them to effectively control if and when they choose to become pregnant. If women do want to become pregnant at some stage, contraception also provides a longer opportunity to address health issues in advance of the pregnancy, leading to better health outcomes for both mother and child. Contraception is not purely a woman's responsibility, but women need to be empowered to make conscious decisions about their reproductive life, and have the knowledge, skills and access to services to allow them to do so.

Relationships and sex education (RSE) in schools provides an opportunity to educate children and young people about safer sex, types of contraception and local support services in order to prevent unintended pregnancy and the transmission of STIs. However, school-based surveys in LSL have revealed poor knowledge amongst young people about where to obtain free condoms, and this is reflected in rates showing that LSL young people experience STIs more than the London and England average. This suggests a missed opportunity to embed discussions of effective methods of contraception (and where to obtain them) when educating children and young people as part of RSE to promote good overall sexual and reproductive health.

Poor knowledge of contraceptive options continues through to adulthood, and is perhaps reflected in high rates of user-dependent methods (UDM) such as the contraceptive pill and condoms. Recent focus groups with women across LSL demonstrated poor knowledge of LARC methods in older women of reproductive age (range: 25–45 years), and while younger women (18–24 years) knew about a wider range of contraceptive methods including LARC, there were misconceptions about their use and safety. We acknowledge that our population is fluid; young people that

Women in LSL are having fewer children since at least 2012



30
The number of years women spend avoiding unwanted pregnancy and therefore requiring effective contraceptive methods

go to school in our area may not stay in our area as adults, and vice versa. However, there is a clear need for improved education as part of RSE in schools, in addition to public awareness campaigns. RSE was anticipated to be made statutory as of September 2019 but this has been delayed until September 2020.

Access to and choice of contraception

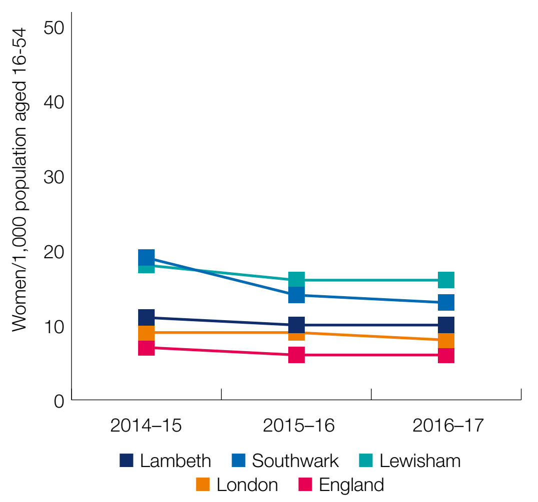
LARC methods are the most effective contraceptives available. Despite this, their use is much lower than UDM. Of women attending SRH services, LSL women are more likely than the national average to choose UDM such as the contraceptive pill or condoms, and this is highest in Lewisham.

Rates of LARC prescription in general practice across LSL are lower compared to prescriptions at sexual and reproductive (SRH) services, with the exception of Lambeth. This is the opposite to England and likely reflects the accessibility of SRH services in our boroughs (and in London in general). Lambeth has better-developed sexual health provision in general practice, and this is reflected in these rates. However, LARC prescribing rates in SRH across LSL are now lower than London. Compared to Lambeth and Lewisham, Southwark rates of GP-prescribed LARC have declined substantially, compared to stable rates of prescription from SRH.

Common issues in general practice preventing the provision of a LARC service include training and difficulty maintaining competency, general practice capacity (longer appointment time, availability of trained staff and chaperones, suitable rooms), and financial incentives (the opportunity cost of providing a different service in the same time).

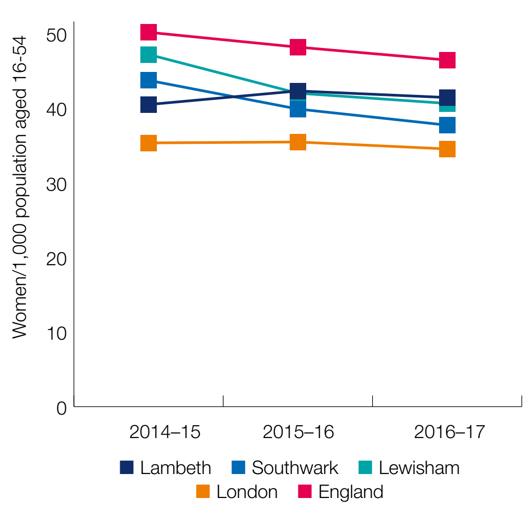
Rates of emergency contraception usage are higher in LSL than England and London, and only in Lewisham have rates of EHC fallen in the past three years. Repeat use of EHC is a significant issue in LSL. 80% of women using EHC

Women provided emergency contraceptives by SRH services per 1,000 population aged 16–54, 2014–15 to 2016–17



NHS Digital (2017) Sexual and Reproductive Health Services, England – 2016-17

Total prescribed LARC per 1,000 in LSL, 2014–16



NHS Digital (2017) Sexual and Reproductive Health Services, England – 2016-17

While rates of prescribed LARC (in SRH settings and in general practice) in LSL are higher than the London average, they are lower than the national average (and rates of prescribing in primary care are particularly low). Rates of EC use in LSL are higher than the London and national averages.

LARC methods are the most effective contraceptives available. Despite this, their use is much lower than UDM

in Lambeth and Southwark pharmacies in 2016/17 self-declared previous use; half of these had used EHC in the last six months (Southwark). This is a strong indicator of unmet reproductive health needs and a major missed opportunity for intervention.

Women who are not using existing contraceptive services should receive opportunistic contraceptive advice when they are in contact with health services for other issues or conditions, for example, after taking emergency contraception, after having an abortion or after having a baby.

Teenage conceptions

Since 1998, LSL has achieved dramatic decreases in teenage conceptions, however, the under-18 conception rate remains higher than in London and England. Teenage pregnancy is more likely to end in abortion than other age groups, and approximately two-thirds of under-18 conceptions in LSL are terminated. The rate of under-18 conception is consistently higher across LSL compared to London and England, which reflects Lambeth's higher starting point and prevalence of risk factors, and which may suggest an unmet need in contraception care. Moreover, this suggests a lack of awareness of, or confidence in accessing other more effective methods of contraception. LARC methods do not depend on daily concordance and have been proven more effective than oral contraception at only one year of use. Despite these benefits, uptake remains low in the UK and in LSL. This suggests that barriers remain in communicating the benefits of LARC or in ensuring that women of reproductive age have easy access to the full range of contraception, including LARC.

Listening to local women

Focus groups on contraception and reproductive health undertaken with a diverse sample of women across LSL in 2018 supplemented what data have told us about the needs of local women, with the following key findings.

Views on contraception

- Women are anxious about unwanted pregnancies and want to be confident in their contraception choices so that they can fully enjoy sex. They also want to know that the contraceptive they use will not have a detrimental impact on their physical and emotional wellbeing now and in the future.
- While they know that contraception is there for them, they have difficulty accessing services when they need it.
- Fairly low level of knowledge and low confidence, combined with false beliefs are reducing their perceived choices.
- Many women feel they aren't always getting the full picture from professionals, and feel the way professional advice is delivered to them can be 'cold' and/or judgemental, failing to take in to account feelings and past experiences.
- Social taboos, stigma and fear of shame and embarrassment are major barriers to accessing contraception services.

The services women want

- Women who don't currently have their contraceptive needs met can be broadly characterised into two main groups:
  - Transactional: Women who know what contraception they want, but are having trouble accessing this;
  - Unsure: Women who don't know which contraception they want or aren't actively seeking contraception, who may need help to decide.
- Services need to be more tailored to meet the needs of all of these women.
- Women described a need for 'whole woman' focused services that consider their wider needs around sex and reproductive health, that helps women feel positive and empowered though a discrete, non-judgemental and comfortable service.
- Women were in agreement about needing more choice in accessing contraception, e.g. whether she has to attend in person, or can access the service remotely through online/phone access and home or local pharmacy deliveries of contraception.

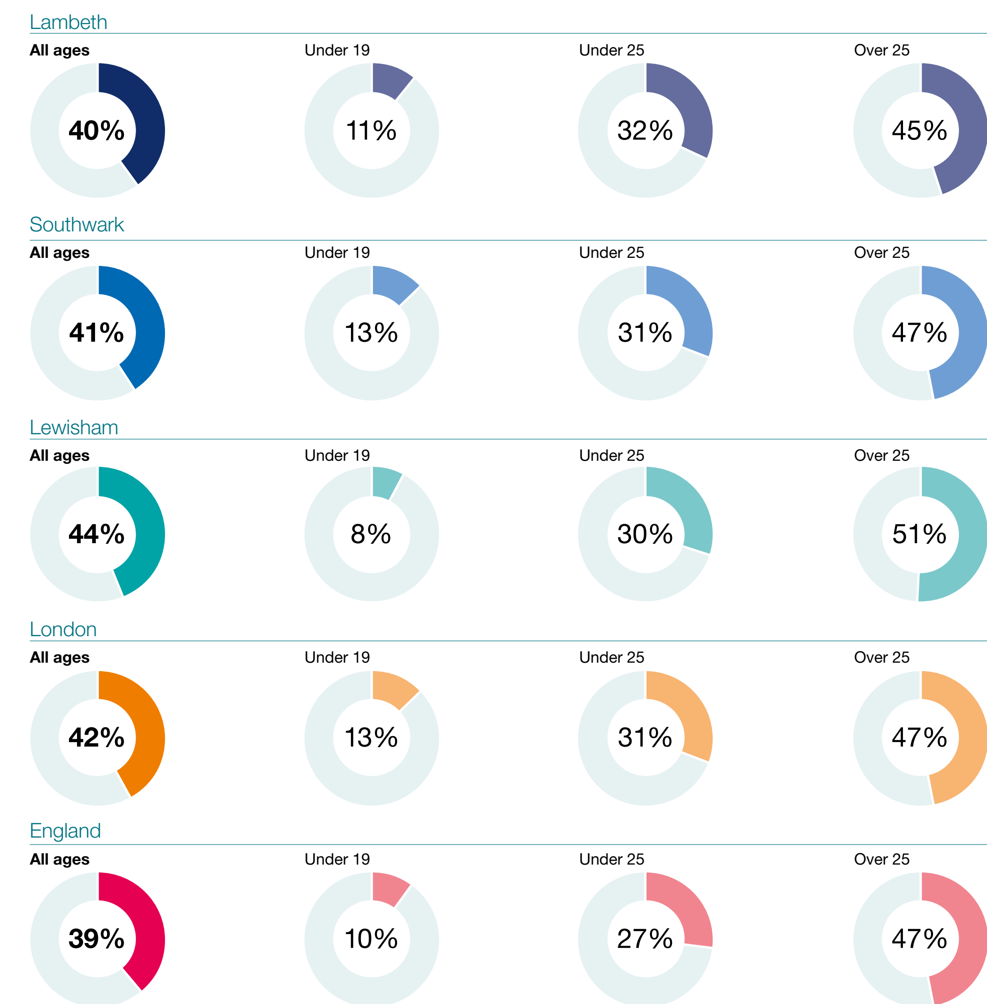
Abortion

Across the life course, the rate of abortion can be viewed as an indicator of a lack of access to contraception services and advice, as well as problems with individual use of contraceptive methods. Analysis suggests there are inequalities in the abortion rates in women aged 15–44 in LSL, with the highest rates among women identifying as black African or Caribbean.

Across LSL, over 40% of abortions in 2017 were among women who had previously had at least one abortion ('subsequent abortions'). This is higher than the England average, and highest in Lewisham (44%). Subsequent abortions are also not distributed equally in the population, with black African and Caribbean women again disproportionately represented. This indicates a lack of access to and/or use of appropriate contraception. New data on subsequent abortions in women aged under 19 years show that the rate of subsequent abortion in this age group declined slightly between 2016 and 2017 (in LSL, London and England), but rates are still too high given their younger age and missed opportunities for intervention. In 2017, 8% of Lewisham women, 11% of Lambeth women and 13% of Southwark women aged under 19 who had an abortion had also had a previous abortion in that year. Rates of subsequent abortion specifically in those over-19 are not available.

The time immediately following abortion is an important period for contraceptive intervention, particularly LARC methods. However, LARC uptake in abortion services in LSL has remained below 45% since 2014/15, and has now declined to around 20%. This may be due to the increase in women choosing early medical abortions (EMAs, under 10 weeks), as opposed to surgical abortion or a later medical abortion. EMAs do not require clinical follow-up and therefore these women may miss out on the opportunity to discuss LARC methods post-abortion. In 2017–18, local clinic data

Proportion of women terminating pregnancy who have had one or more previous abortions, by age, 2017



DHSC (2018) Abortion statistics for England and Wales: 2017

The chance that a woman has had a previous abortion increases with age. Rates of previous abortion in LSL are similar to London, but higher than England. Younger women (under 19) in Southwark are more likely to have had a previous abortion than those in Lambeth or Lewisham, but in older women (over 25), the rate of previous abortion is highest in Lewisham.

for LSL women indicate that 61% of abortions at BPAS and 64% of abortions at MSI were EMAs, slightly higher than the national rate (60%), and trends indicate that EMA uptake rates are expected to increase. Exploring other methods of on-going contraception (e.g. OC) while undergoing termination may serve as a bridging method until LARC is appropriate.

Admissions related to poor reproductive health

Pelvic inflammatory disease (PID) refers to infection and inflammation of the upper female genital tract which may lead to serious complications such as ectopic pregnancy and tubal factor infertility. About one-quarter of cases are caused by untreated STIs. Admissions for PID have been consistently higher in Lewisham than the other LSL boroughs and remains above the national average, but have declined since 2012/13 – by contrast, rates in Southwark and Lambeth have increased (but remain below the national average).

Ectopic pregnancy is a serious condition that usually results in hospital admission. Rates of admission have fluctuated over time. In 2015/16, Southwark had the third-highest rate (140 per 100,000) of ectopic pregnancy in England. All three boroughs' admission rate for ectopic pregnancy is above the national average, and Lewisham is also above the London rate.

High rates of both PID and ectopic pregnancy are a consequence of high rates of STIs locally.

Achievements since the last strategy and ongoing challenges

Achievements since the last strategy

The following have been the most notable achievements in reproductive health in LSL since the publication of our last sexual health strategy:

- A reduction in the number of teenage mothers and teenage pregnancies leading to birth. This has been underpinned by:
  - An ongoing and sustained reduction in teenage pregnancy, both in young women aged under 18 and under 16
  - Of teenage conceptions that have occurred, an increasing majority have not led to maternity
  - Improved access to emergency contraception and termination services
  - The roll-out of the C-Card scheme across the boroughs (though we cannot say that this has had a linear impact on teenage conception rates)
- A slight decline in the rate of abortion in women of all ages
- A slight increase in the proportion of women choosing LARC at sexual health centres
- An increase in the coverage rates for the HPV vaccine for teenage girls, protecting them from future HPV infection.
- The HPV vaccine has now been extended to MSM opportunistically (during 2018), to prevent infection leading to HPV-associated cancers, including anal, throat and penile cancer. However, heterosexual males are currently unable to access HPV vaccination on the NHS.

Women have told us they want to be confident in and understand the impact of their contraception choices, so that they can fully enjoy sex

However, despite these achievements, significant challenges remain. There are still a number of poorer outcomes in reproductive health in LSL, which are driven by ongoing and emerging issues described in this section.

Ongoing challenges

General access to contraception

Since our 2014–17 strategy, services have regularly been at full capacity. Wider system pressures on general practice have meant that it has been reportedly increasingly difficult for many people to access their practice, which has had an impact on GPs being able to meet residents' urgent or ongoing reproductive health needs (e.g. repeat prescriptions, LARC or emergency contraception). More recently, there have been similar pressures on sexual health services, with demand outstripping the number of appointments and walk-in spaces available.

Within LSL, rates of EHC usage are highest in Southwark and local surveys have shown that there is already considerable demand for sexual health services, with patients being turned away from busy clinics, and online services also regularly at capacity. As may be expected, demand for emergency contraception is high and the rate of abortion in LSL (despite a declining trend) remains high and is above the national average. Furthermore, the rate of women taking up LARC following their attendance at an abortion clinic has declined in the last 5 years in LSL, which may lead to ongoing unmet reproductive health needs.

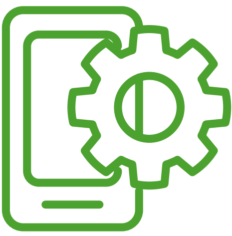
We are operating within the constraints of reducing public health budgets, but we continue to innovate to meet increasing demand. To improve access to reproductive health services, we have moved to provide support in new and innovative ways. New models of practice include leveraging the accessibility, ease and anonymity of pharmacies, and increasingly incorporating an online aspect to our services (for low risk individuals). The condom distribution scheme Come Correct has been popular locally and has capitalised on non-traditional settings (e.g. leisure centres and libraries) to distribute condoms to young people. Our ambitions and ongoing innovations are outlined in more detail in the accompanying action plans.

Inequalities

Like overall health and sexual health, good reproductive health is not equally distributed in the population. If the need for abortion is used as a proxy measure for not having reproductive needs met (abortion being the last intervention to prevent an unwanted maternity), black women in LSL have the poorest reproductive health. The rate of abortion is higher in LSL amongst women describing themselves as of black Caribbean and black African ethnicities. Nationally, women that have sought abortion on more than one occasion are more likely (than those who have had one abortion) to be black, have left school at an earlier age, be living in rented accommodation, report an earlier age at first sexual experience, be less likely to have used a reliable method of contraception at sexual debut and report a greater number of sexual partners.

Not all services work for all people, so a range of responsive universal and targeted services are needed. In developing new and improving reproductive health services, and following on from recent focus groups with local women, we need to understand the issues and barriers around use of contraception, and will be working alongside young, black women in LSL in particular to understand their specific needs and co-design services and programmes.

We also know that there is a growing Latin American population in our boroughs, and we will be working to better understand their sexual and reproductive health needs and tailor our services appropriately.



The use of e-services in sexual health is growing in popularity

The rate of abortion is higher in LSL amongst women of black Caribbean and black African ethnicities

84

Emerging issues and trends

E-services for contraception

The use of e-services in sexual health is growing in popularity. E-services to this point have primarily been for STI testing and treatment, and complement traditional sexual health clinics by enabling appropriate low risk (asymptomatic and non-vulnerable) individuals to self-sample through the usage of kits ordered online and posted to an address of choice. In LSL, women accounted for just under half of the patients attending sexual health clinics that were offered and took up the offer of online instead of clinic testing. While it is clinically appropriate for low risk women to use e-services, this has removed opportunistic contraception consultations in these patients. Service-level data from sexual health clinics indicate a reduction in contraception provision since the channel shift to the e-service was implemented, and we intend to explore this further. It is essential that women using online STI services receive appropriate messaging around contraception, and that there are a range of services in place to meet the contraceptive needs of women in LSL. Furthermore, we will endeavour to ensure that vulnerable people will always be seen face-to-face, as appropriate to their needs.

A pilot of online oral contraception in Lambeth and Southwark proved popular, and there are online contraception options in the commercial market. These developments will feed into how we will meet the vision of this strategy, allowing us to better respond to local needs in a cost effective and modern way.

Fertility awareness apps

A number of app-based methods supporting 'natural family planning' (fertility awareness) have emerged in recent years. These support women in monitoring and recording different fertility signals during their menstrual cycle to estimate when they are likely to get pregnant, and take appropriate action to avoid this if relevant (e.g. abstaining from sex, or using contraception such as condoms). Some of these apps have been promoted as being as effective as the oral contraceptive pill with perfect use (but remain untested in independent clinical trials), and like many user dependent methods, perfect use is uncommon – 7 in 100 women had an unintended pregnancy in a year of typical use of one of the most popular fertility awareness apps. For comparison, condoms are 82% effective when used typically (98% when used perfectly) and the combined pill is 91% effective when used typically (99% when used perfectly). Fertility awareness methods are also affected by factors such as illness, stress, alcohol and travel. Non-user dependent methods remain the most effective form of contraception, and condoms protect against STIs.

Anti-choice protests at abortion clinics

People have a right to access safe and legal abortion, free from harassment. This has a critical role in protecting the reproductive health of women who choose to end a pregnancy. Anti-choice protests at abortion clinics in our boroughs and across London are unwelcome and actively harmful to local people. LSL will uphold the rights of local people to access abortion-related care free from harassment as a key tenet of promoting reproductive health.

New models of practice include leveraging the accessibility, ease and anonymity of pharmacies, and increasingly incorporating an online aspect to our services (for low risk individuals)

Good reproductive health across the life course: what we want to achieve by 2024

The figure below sets out our vision for reproductive health in LSL, how we will work together to achieve this vision, and the indicators with which we will measure our progress. It is clear that many of these are intertwined. While we will progress many of these objectives collaboratively, our boroughs will have an annual delivery plan which will set out the shared and borough-specific actions needed to achieve these objectives in a given year.

Vision

- People effectively manage their fertility/reproductive health, understand what impacts on it, and have knowledge of and access to contraceptives

Outcomes

- Reproductive health inequalities are reduced
- Unwanted pregnancies are reduced
- Knowledge and understanding of reproductive health and fertility are increased

Aims

- We will improve the uptake of chlamydia screening and HPV vaccination
- We will reduce subsequent abortions
- We will ensure there is good access to LARC in the most deprived communities
- We will maintain the reduction in teenage conceptions
- We will ensure that the full range of contraceptive methods is available in a variety of settings, with a specific focus on disproportionately affected groups
- We will ensure professionals make every contact count with women of reproductive age, normalising conversations about reproductive health and contraceptive needs
- We will ensure people are informed so as to make the most suitable choice for them

Objectives

- We will maintain chlamydia detection rates above 2,300 per 100,000 aged 15-24
- We will ensure sexual and reproductive health services remain integrated, to maintain opportunistic screening
- We will reduce variation in HPV vaccine uptake between our boroughs and ensure that 90% of girls across LSL have received at least one dose of the HPV vaccine
- We will reduce the rate of subsequent abortions by 20%, with particular focus on women identifying as black African or Caribbean
- We will respond to what women have told us and create positive, whole woman-focused reproductive health services
- We will ensure that every woman in LSL can have a LARC method fitted in both primary care and in SRH services within 4 weeks of booking
- We will make every contact count in contraceptive care, ensuring that women who are having a LARC removed are fully informed about the options to prevent pregnancy
- We will review options and opportunities to create a centralised booking system for contraceptive care, in order to utilise capacity more effectively
- We will ensure all women post-pregnancy are offered a full choice of contraception, including easy booking of LARC
- We will reduce the repeat use of emergency contraception (EC) in pharmacies to be in line with SRH clinics by ensuring that ongoing contraception is proactively offered wherever EC is available
- We will train a range of multidisciplinary professionals in healthy sexual relationships and initiating conversations about reproductive health
- We will create a co-designed online information resource for residents and professionals to inform decisions around contraception, including understanding what impacts on fertility
- We will work with education to support evidence-based RSE

Key Indicators

- Ectopic pregnancy and PID admissions rates / 1,000
- Chlamydia detection rate / 1,000
- Chlamydia proportion aged 15-24 screened
- Services remain integrated in 2024
- HPV vaccination coverage (%)
- Total rate of subsequent abortions and service level data on abortions by ethnicity
- Abortion rate / 1,000 (all age and u19
- Teenage conception rate / 1,000 (u16 and u18)
- Teenage conceptions leading to abortion (%)
- Creation of women-centred services
- LARC fitting waiting times by setting
- Access to LARC in all settings where contraception is offered
- LARC prescribing rate / 1,000
- Creation of centralised booking system
- Practice audit and take up rates of contraception a) post-abortion and b) following birth
- Repeat EC rates in a) pharmacy and b) SRH services
- Number of professionals trained in defined courses
- Creation of online information resource
- A school support offer for RSE, covering issues appropriate to the local area

5.3 High quality and innovative STI testing and treatment

What do we mean by 'high quality and innovative STI testing and treatment'?

Early access to comprehensive high quality STI testing and treatment services helps to reduce transmission, trace and treat sexual partners, prevent repeat infections and reduce inequalities in sexual and reproductive health.

We are fortunate in LSL to have a number of world-class sexual health centres. Building upon this, we will focus on ensuring quality across the totality of our system, from prevention to testing, treatment and partner management. We believe that this will ensure the best use of capacity within the local sexual health system and support the reduction of the burden of STIs, particularly in young people, MSM and black and other minority ethnic communities unequally affected. We see an opportunity to strengthen the links between sexual health services and education, prevention and promotion activities.

Our sexual health services have a history of innovation: from the integration of sexual and reproductive health provision, to the development of online services. We want to continue to support and foster further cross-sector innovation to meet our dual challenge of ensuring a financially sustainable system and changing the trajectory of STIs in our population.

Introduction

Background and policy context

LSL has some of the highest rates of STIs in England. In 2017, Lambeth had the highest rate of new STI diagnoses nationally, followed by Southwark in third, with Lewisham 11th. This partly reflects our young, ethnically diverse and mobile populations, but also our local provision of modern and accessible STI testing and treatment.

STIs are a significant contributor to and result of health inequalities. We cannot reduce these inequalities without improving the overall sexual and reproductive health (SRH) of key groups, including young people, MSM and black and minority ethnic groups. LSL residents are predominantly young, with a larger proportion of the population aged 25–34 years. We are also more ethnically diverse than England, with approximately one quarter of LSL residents identifying as Black. Furthermore, Lambeth and Southwark have the second and third largest lesbian, gay and bisexual communities in England.

In the five years since the responsibility for commissioning sexual health services transferred to local government, demand for sexual health services and STI testing has increased against a backdrop of reducing Public Health Grants to fund services. This has driven a need for innovation to ensure our services remain fiscally sustainable.

LSL have historically been leaders in innovative SRH services in London. We pioneered online STI testing for asymptomatic patients, and provided proof of concept for e-services as a core part of a cost-effective sexual health system. This approach has since been adopted across London ('Sexual Health London'). Although e-services primarily aim to create capacity at SRH clinics by targeting asymptomatic patients, they may be attractive to people who feel uncomfortable accessing SRH services, thereby improving testing accessibility.

In the five years since the responsibility for commissioning sexual health services transferred to local government, demand for sexual health services and STI testing has increased

We pioneered online STI testing for asymptomatic patients and provided proof of concept for e-services; this approach has now been adopted across London

Condom use remains a primary method of preventing STI acquisition and transmission. The pan-London condom distribution scheme, Come Correct, is delivered by Brook across LSL and provides free condoms and sexual health information to young people under 25 who hold a 'c-card'. C-card schemes for condom distribution were evaluated nationally and found to be successful in engaging young people. Increasing numbers of repeat users compared to new registrations suggest the scheme is popular and acceptable. These schemes are particularly important in reaching young men, who are less likely to visit their GP or specialist sexual health clinics for contraceptives and may otherwise miss out on SRH advice.

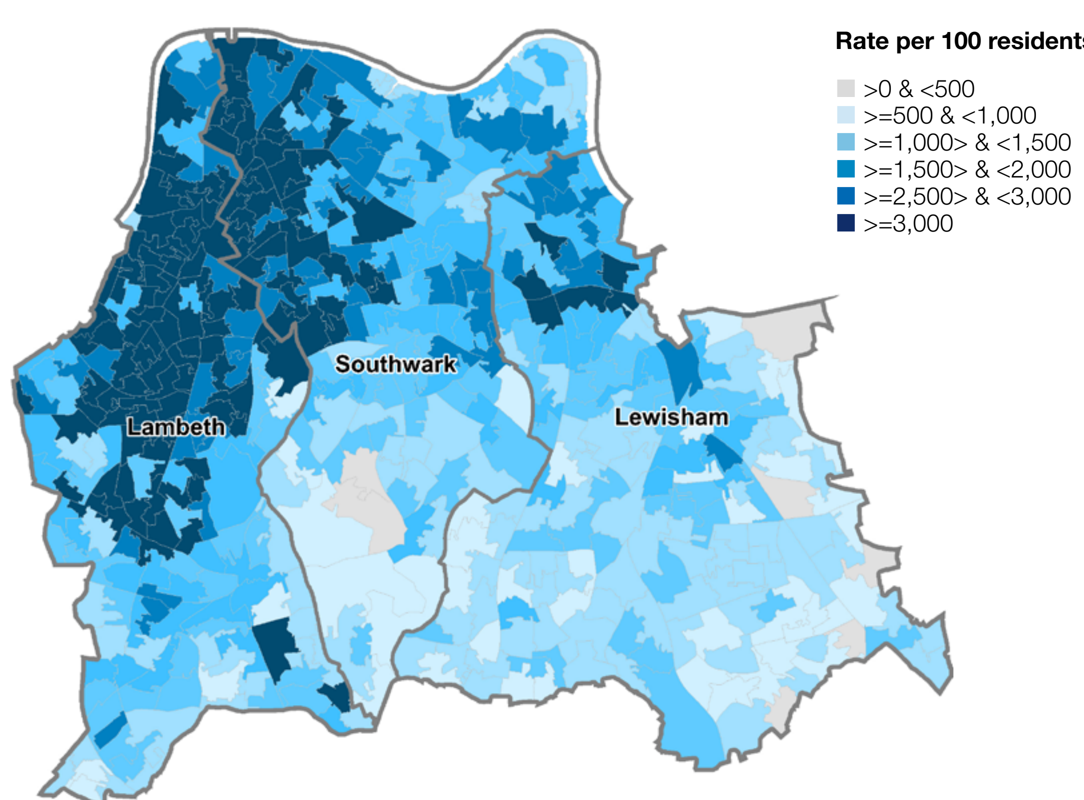
Free condoms are also a core component of the London HIV Prevention Programme, Do It London, of which LSL are major contributors. This element of the programme provides condoms to MSM, primarily in gay venues. Condom outreach to MSM will remain central to a health promotion strategy to reduce STIs alongside PrEP for HIV prevention in the coming years.

The open access nature of services means we have to collaborate across London and enable innovation to meet the diverse needs of our local populations, building on the work of the London Sexual Health Transformation Programme.

Current picture

In 2017, just over 22,000 new STIs were diagnosed across LSL. STIs are unequally distributed within the population and disproportionately affect young people, MSM and some black and minority ethnic populations. Across LSL, there is a strong correlation between areas of deprivation and rates of STIs, highlighting transmission within geographically connected sexual networks and how this contributes to overall health inequalities.

Diagnosis rate of new sexually transmitted infections across LSL, 2017



PHE (2018) HIV and STI web portal (GUMCADv2)

This map illustrates that new diagnoses of STIs are not evenly distributed across LSL, with rates particularly high in northern and central Lambeth, north-west Southwark and north Lewisham. However, lower diagnosis rates in some communities may reflect lower levels of access rather than lower levels of need.

Trends in STI diagnoses are multifactorial and reflect a combination of sexual behaviours, service accessibility and use, diagnostic techniques and surveillance systems. Lambeth, Southwark and Lewisham have historically had some of the highest rates of STIs and HIV nationally. This partly reflects local provision of modern and accessible STI testing and treatment services but also our young, ethnically diverse and mobile populations.

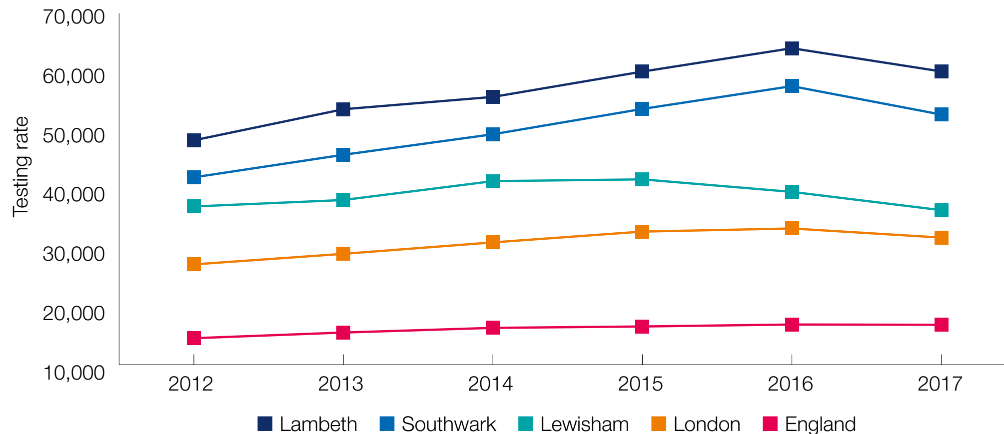
Relationships and sex education (RSE) in schools provides an opportunity to educate children and young people early in life about safer sex, types of contraception and local services, in order to prevent the transmission of STIs. However, school-based surveys in LSL have revealed poor knowledge amongst young people about where to obtain free condoms. LSL young people also experience STIs more than the London and England average. This suggests a missed opportunity to embed discussions of where to obtain condoms, and their use in preventing STIs when educating children and young people as part of RSE to promote good overall sexual and reproductive health.

Many STIs such as trichomoniasis, shigella and hepatitis remain a burden and the cause of considerable activity in sexual health clinics. However, this strategy will largely focus on the five most commonly diagnoses STIs in LSL: chlamydia, gonorrhoea, syphilis, genital warts and herpes.

Chlamydia

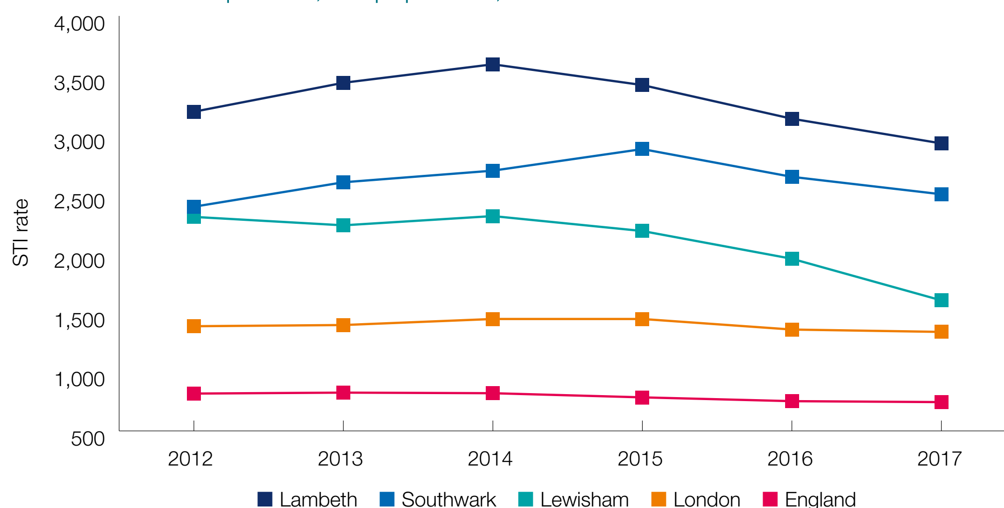
Prevalence of chlamydia in the general population is low and it is likely that many infections are undiagnosed and untreated. About 10% of untreated infections will result in reproductive health complications. Of all chlamydia diagnoses made across LSL in 2016, 61% of these cases were in men and, while chlamydia is more prevalent among men across the life course, the rate among young women (aged 15–19 years) is approximately double that for men. While the chlamydia detection rate across all three boroughs

STI testing rate (excluding chlamydia in under 25 year olds) per 100,000, 2012–17



PHE (2018) Sexual and Reproductive Health Profiles

Rates of new STIs per 100,000 population, 2012–17



PHE (2018) Sexual and Reproductive Health Profiles

Testing rates across LSL are consistently above levels in London and England, substantially so in the case of Lambeth and Southwark (though declined slightly in 2017). The rise in testing rates in Lambeth and Southwark after 2014 may be attributable to the widespread introduction of online STI self-testing. The rates of diagnosed STIs have been declining in recent years across LSL, despite stable rates in London and England.

exceeds the recommended rate of 2,300 diagnosis per 100,000 people aged 15–24 years, it has fallen since 2014 and continues on a downward trend. The reasons for this reduction need to be understood. Increasing the screening rate overall and in young men is a priority.

Gonorrhoea and syphilis

Gonorrhoea is the second most commonly diagnosed bacterial STI, however, its prevalence within the general population is low. Moreover, due to its relatively short period of infectiousness, gonorrhoea is concentrated within groups with higher rates of partner change and partner concurrency. Gonorrhoea infection is a global concern as it has developed resistance to an increasing range of antibiotics and it is estimated that a third of all infections are now resistant to one antibiotic. Gonorrhoea primarily affects men: nine in ten cases in LSL are diagnosed among men, with over three-quarters of those being MSM.

The rate of syphilis diagnosis in Lambeth and Southwark has increased by 103% and 116% respectively since 2008; these are now the highest rates of syphilis nationally. However, this is still considerably lower than the number of Gonorrhoea cases: there were just under 1,000 cases of syphilis in LSL in 2017 compared to over 4,500 cases of Gonorrhoea in the same time period. While rates of syphilis fell from 2015 to 2016, they increased again in 2017 with approximately 850 cases diagnosed. The rate of syphilis diagnosis in Lewisham is similar to London (41 per 100,000) and, while Lewisham has experienced a larger proportional increase since 2008, rates remain at half that of Lambeth and Southwark. Syphilis tends to be associated with high-risk sexual networks.

In Lambeth and Southwark, 90% of syphilis cases in 2017 were in people who identified as gay. This was lower in Lewisham: 78%. Rates by age reveal the greatest burden of syphilis is in the 34–44 years age group. This is significantly older compared to other STIs but reflects the London age distribution. Small outbreaks of syphilis have occurred in male heterosexual groups. In heterosexual women, cases are disproportionately concentrated among black and minority ethnic women. In London, rates of congenital syphilis remain extremely low due to a comprehensive antenatal screening programme.

Across LSL, a third of all diagnoses occur in the primary stage of infection, a third in the secondary phase, and a third early latent. This is particularly worrying as we know that if left untreated, syphilis can spread to the brain or other parts of the body and cause serious, long-term health problems. Genital sores caused by syphilis also make it easier to transmit and acquire HIV infection sexually. Across London, half of MSM cases of syphilis also have HIV. This is concerning as co-infection with HIV increases the risk of central nervous system complications.

Our proportion of early latent cases of syphilis is higher than the London average and suggests a lack of testing uptake in high-risk groups. There is evidence that people with recurrent syphilis infections play an important role in transmission and may be at higher risk of subsequent infections. SRH services should therefore focus on reaching this high risk population. Increasing testing in high risk MSM groups is another priority as is reducing late syphilis diagnosis and improving partner testing and treatment.

Genital warts

Genital warts are caused by infection with specific subtypes of human papilloma virus (HPV), commonly passed on through condomless sex. Genital warts are the third most commonly diagnosed STI in LSL, with just under 2,000 cases diagnosed in 2017. The majority of these are in heterosexuals. Rates of diagnosis were highest among those aged 20–24 across all three boroughs. There are inequalities in the rate of genital wart acquisition, in particular among

mixed ethnic groups in Lewisham and other ethnic groups in Lambeth. The national HPV immunisation programme was introduced to protect women against HPV, the main cause of cervical cancer. This programme was extended to MSM in April 2018 and is expected to help reduce the incidence of genital warts and other HPV-related illnesses, including anal and other cancers though there may be a lag before benefits are observed in full.

Genital herpes

Rates of genital herpes have been broadly stable since 2012. Among these five most common STIs, genital herpes is the only one in which more women are diagnosed than men. As with genital warts, rates of diagnoses are considerably higher in those aged 20–24 years. In young people aged 15–19 years, the difference in diagnoses rates between the sexes is particularly pronounced.

The majority of genital herpes (83%) cases are diagnosed in people who identify as heterosexual, and most in heterosexual women. Rates of diagnosis across the three boroughs vary by ethnicity, with the highest rates in Lambeth 'other' and Lewisham mixed ethnic groups. Asian ethnic groups have the lowest rates of genital herpes across LSL.

Other STIs

While this strategy focuses on chlamydia, gonorrhoea, syphilis, genital warts and genital herpes, the collective burden of other STIs on individual wellbeing and service capacity is important and we must remain agile to emerging diseases. Of particular importance are high risk STIs such as shigella and viral hepatitis, which can be diagnosed and treated in other settings besides sexual health services and for which our services play a vital role in prevention. Shigellosis clusters predominantly associated with sexual transmission in MSM have increased significantly since 2014.

During 2017, there was a Europe-wide outbreak of sexually transmitted hepatitis A virus, with 942 cases in England and Wales alone, primarily affecting MSM in the 25–34 age group. Of these, 414 were from London. Control of the outbreak was confounded by a global hepatitis A virus vaccine shortage and the fragmentation of commissioning responsibilities between NHS England, Public Health England and Local Authorities. As of January 2018, the incident had been de-escalated from enhanced to standard response, however London has been the worst affected region and there will likely be a significant lag-time before diagnoses return to pre-outbreak levels. It remains critical to raise awareness amongst MSM and ensure opportunistic vaccination continues.

Lymphogranuloma venereum (LGV) is a type of chlamydia that infects the lymph node for which surveillance was established in 2004. Diagnoses in LSL peaked in 2014 and have been declining steadily since then, in parallel with chlamydia as a whole. There were 109 diagnoses in LSL in 2017, all of which were in men of predominantly 24–34 years. Despite the decline, it is still vital to maintain a high index of suspicion for LGV and offer asymptomatic testing for HIV-positive MSM as this group is most affected (67.5% of new diagnoses).

Shigella clusters in MSM have increased significantly since 2014, with 1,056 excess male cases reported in London between 2012 and 2016. This population is disproportionately affected by the S. flexneri species which causes severe disease. People living with HIV are particularly vulnerable to a severe, invasive form of shigellosis. Despite the risk, PHE has reported extremely low awareness of shigella among MSM.

There was also a significant London-wide excess of male cases of hepatitis B in 2016, explained at least partly by sexual transmission amongst MSM. LSL has consistently

One-third

The proportion of early latent cases of syphilis is higher than the London average and suggests a lack of testing uptake in high-risk groups

While the chlamydia detection rate across all three boroughs exceeds the recommended rate of 2,300 diagnosis per 100,000 people aged 15–24 years, it has fallen since 2014 and continues on a downward trend

had a significantly higher incidence of hepatitis B than the London average: a mean incidence of 2.54 per 100,000 compared to 1.7 per 100,000 in London.

For shigella and hepatitis A and B, SRH services play a crucial role in raising awareness amongst the most at risk populations as well as key preventative activities such as condom distribution and opportunistic vaccination.

With regards to hepatitis C, admissions and mortality in LSL remain higher than regional and national levels, with local data suggesting that MSM may again be disproportionately affected. This indicates a need for SRH services to work closely with substance misuse services to protect the most vulnerable populations.

Although not clinically severe infections, trichomoniasis and molluscum contagiosum together accounted for over 1,000 new diagnoses in LSL in 2016, affecting mainly heterosexual women. Trichomoniasis has been linked to poor outcomes in pregnancy and to increased HIV transmission, therefore warranting prompt treatment in all patients. Molluscum contagiosum is closely linked with the incidence of other STIs and therefore affected patients should undergo full STI testing.

Risk groups

Sexually transmitted infections contribute to health inequalities and some groups are disproportionately affected by STIs.

Young people

Young people have higher rates of STIs, reflecting their higher rates of sexual activity and partner change, and relatively poorer skills in negotiating safer sex. In LSL in 2016, double the proportion of 15–19 year old women were re-infected with an STI compared to women in all age groups.

Men who have sex with men

MSM report higher rates of partner change and partner concurrency and are more likely to belong to sexual networks which facilitate rapid STI transmission. In LSL, 77% of cases of gonorrhoea and approximately 86% of cases of syphilis were in MSM. Seroadaptive behaviours (modification of sexual behavior based on the person's (perceived) HIV status, the (perceived) status of the partner and/or HIV transmission risk by type of sexual interaction) increase exposure to STIs and may account for this group being disproportionately affected. Moreover, recent literature on HIV PrEP has suggested that use is associated with reduced use of condoms. This may further contribute to the increased risk this cohort faces of STI acquisition. The national HPV vaccination programme was extended to MSM in April 2018 and is expected to help reduce the incidence of genital warts and other HPV-related illnesses including cancers, though there may be a lag before benefits are observed in full.

Black and minority ethnic groups

White and black heterosexual women and black and mixed heterosexual men experience a large burden of STI diagnoses. In Lewisham, chlamydia rates are highest in mixed and black ethnicities. Across LSL, there are complex patterns of STI prevalence by ethnic group and gender. The higher rates of STIs in some black and minority ethnic groups are partly explained by the relationship between socio-economic deprivation and ethnicity, but not fully. There is a complex interplay between cultural and behavioural factors, and access to and use of healthcare services.

Progress to date

Achievements since the last strategy

Since our last sexual health strategy, LSL successfully launched a proof of concept model of online testing of

STIs. SH:24 was an innovative method of encouraging asymptomatic individuals seeking STI testing to self-test at home, thus reducing the burden on sexual health clinics and freeing up capacity within the service to treat symptomatic patients. This pilot spurred the now London-wide sexual health e-service, 'Sexual Health London' (SHL) to provide online STI testing, which was rolled out in LSL in July 2018.

We have achieved fundamental changes to the way in which we finance sexual health services, to ensure value-for-money and effective commissioning. The previous 'tariff' was a flat-rate payment, regardless of intervention type. The integrated sexual health tariff (ISHT) matches payment to the specific costs of an intervention. We acknowledge that despite now meeting the exact costs of an appointment, these new contracts have delivered a significant drop in income for our local trusts, which has contributed to the financial pressures they face. We continue to work closely with our partners to ensure that any service changes will continue to meet the sexual health needs of the population.

Ongoing challenges

LSL have proportionately large groups at higher risk of poor sexual health. Given the prevalence of STIs in our population we need to balance accessible, open-access services with targeted and proactive testing aimed at the most at risk groups (some of whom also access traditional services the least). Recent outbreaks have highlighted that under-testing of certain infections, particularly in MSM, continues to be a challenge.

Sexual and reproductive health services in LSL are at capacity. Fiscal challenges including the reduction of the public health grant have contributed to changes in the way that sexual health services are delivered and commissioners are continuing to innovate to improve the reach and accessibility of our services.

Partner notification of STIs helps to prevent the onward transmission of infections. Our local SRH services actively encourage patients receiving an STI diagnosis to disclose their result to previous partners but this is highly user-dependent. SXT is a local innovation that allows for anonymous online notification of partners. Effective partner notification needs to be built into all parts of the local system.

Emerging issues and trends

PrEP

Pre-exposure prophylaxis has dramatically changed the landscape of HIV prevention. However, PrEP may be associated with a reduction in the use of condoms and an increase in STI acquisition. While these emerging results should not diminish the success of PrEP in preventing HIV transmission, sexual health commissioners and practitioners should be aware of and mitigate against this potential outcome.

Antibiotic resistance

Chlamydia, gonorrhoea and syphilis are three common STIs typically curable by antibiotics. However, over recent years, these STIs have developed a resistance to antibiotic treatment; this is particularly the case with gonorrhoea. In March 2018, the first case of multi-drug resistant gonorrhoea in the UK was identified and the World Health Organisation has warned this infection may soon become untreatable. Local authorities and SRH services must continue to work with PHE and national partners to survey and report any resistant strains, and ensure timely and effective treatment of new cases of STIs in our local population. In the future, the issue of antibiotic resistance may require changes to the practices and working cultures of sexual health professionals.

There is a complex interplay between cultural and behavioural factors, as well as access to and use of healthcare services

High quality and innovative STI testing and treatment: what we want to achieve by 2024

The figure below sets out our vision for STI testing and treatment in LSL, how we will work together to achieve this vision and the indicators with which we will measure our progress. It is clear that many of these are intertwined. While we will progress many of these objectives collaboratively, our boroughs will have an annual delivery plan which will set out the shared and borough-specific actions needed to achieve these objectives in a given year.

Vision

- LSL sees a reduction in the burden of STIs, in particular among those who are disproportionately affected

Outcomes

- Equitable, accessible, high-quality testing and treatment that is appropriate to need
- Reduced transmission of STIs and a reduction in repeat infections

Aims

- We ensure the effective and efficient use of services
- We will tackle the stigma associated with using SRH services
- We will provide targeted services to disproportionately affected populations
- We will maintain high testing rates while focusing on increasing testing in disproportionately affected populations
- We will maximise the input of RSE by linking education, prevention, and promotion to SRH services
- We will maximise the opportunities for condom distribution
- We will increase the effectiveness of partner notification

Objectives

- We will ensure continued online provision of STI testing services
- We will ensure SRH services remain integrated, to maintain opportunistic screening
- We will work with education to support evidence-based RSE
- We will train a range of multidisciplinary professionals in healthy sexual relationships and initiating conversations about reproductive health
- We will re-establish a decreasing trend in the rate of gonorrhoea diagnosis across LSL
- We will maintain chlamydia detection rates above 2,300 per 100,000 aged 15-24
- We will increase STI testing rates in young men to that of young women
- We will increase syphilis and gonorrhoea testing in MSM
- We will increase STI testing in black and minority ethnic groups
- We will ensure all schools in our boroughs are aware of and appropriately refer into our SRH services
- We will continue to provide free condoms to young people in our boroughs
- We will continue to integrate partner notification services in STI testing

Key Indicators

- Number of local users of Sexual Health London
- Services remain integrated in 2024
- A school support offer for RSE, covering issues appropriate to the local area
- Number of professionals trained in defined courses
- Gonorrhoea diagnostic rate per 100,000
- Chlamydia detection rate per 100,000 aged 15-24
- Proportion of STI tests accepted by young men
- Proportion of syphilis tests accepted by MSM
- Proportion of gonorrhoea tests accepted by MSM
- Proportion of STI tests accepted by black and minority ethnic groups
- Referrals received from schools to our SRH services
- Number of repeat visits in local C-card schemes
- % of sexual and reproductive health pharmacies offer the C-Card
- Reinfection rates in young people (15-24)
- Reinfection rates in MSM
- Number of local SXT users
- % late STI diagnoses

5.4 Living well with HIV

What do we mean by 'living well with HIV'?

Our ambition is to prevent the transmission of infection, ensure diagnosis as early as possible and ensure that PLHIV in LSL have the services and support to enable them to live a healthy and fulfilling life.

This means moving towards zero new diagnoses, zero HIV-related stigma and zero deaths related to HIV, in alignment with the Fast Track Cities' aims. We will provide our populations with services and support that will enable them to live and age well with HIV, and prevent new infections and onward transmission.

Thirty years on from the beginning of the HIV / AIDS crisis in the UK, knowledge and understanding of HIV has increased dramatically, bringing real advances in HIV treatment and prevention. An HIV diagnosis today means living with a long-term condition and HIV is no longer the fatal infection that it was 20 years ago. This strategy reflects these changes, reframing HIV as a long-term condition. However, HIV infection is still frequently regarded as stigmatising and has a prolonged 'silent' period during which it often remains undiagnosed. In addition, recruitment and retention in care and treatment is still a critical focus for some of our most at-risk groups.

Encouraging all people to be aware of their HIV status will require a commitment to ensuring accessible testing opportunities are available through a variety of channels and that people at all risk levels are encouraged to know their status. This will continue to drive the number of new diagnoses and late diagnoses down and contribute towards the goal of zero new transmissions.

With advances in treatment, the proportion of people living with HIV who are aged 50 years and over will continue to rise. To ensure that people are able to both live and age well with HIV, it is recognised that specialist HIV services and primary care will need to work together to provide a holistic care approach, managing HIV together with other chronic health conditions.

Our focus in this chapter is therefore to reinforce our commitment to ensuring access to the medical aspects of tackling HIV including strengthening combined prevention efforts and early treatment. We also commit to better understanding the social aspects of HIV, to eradicating the ongoing stigmatisation of those living with HIV and to tackling the new challenges of an aging population.

With advances in treatment, the proportion of people living with HIV who are aged 50 years and over will continue to rise

Introduction

Background and policy context

HIV remains a priority nationally, in London and especially in LSL where diagnosed HIV prevalence rates are the highest in the England. Excluding the City of London, Lambeth and Southwark respectively have the highest rates of prevalence in England.

New HIV diagnosis rates have decreased nationally and in London and 2016 saw three firsts in the 30-year history of the UK HIV epidemic: the number of new HIV diagnoses in MSM fell, the death rate among people with HIV who are diagnosed promptly and on treatment became comparable to the rest of the population, and in London the UNAIDS 90–90–90 targets were met. In 2017, London became the first city in the world to exceed 95–95–95 – that is, 95% of Londoners living with HIV infection were diagnosed, 98% of those diagnosed were receiving treatment and 97% of those on treatment were virally suppressed and unable to transmit the virus.

Widespread use of combination prevention approaches has contributed towards the decline in HIV rates. Combination prevention refers to a set of behavioural, biomedical and structural approaches tailored to local levels of infrastructure and culture as well as to populations most affected by HIV. In the UK, the combination of approaches has included encouraging condom use, promoting the use of PrEP, promoting expanded HIV testing and diagnosis, advocating for self-sampling kits and ensuring prompt treatment when people are diagnosed with HIV and other STIs. Antiretroviral therapy (ART) is now so effective that those on treatment who maintain an undetectable viral load (<200 copies) have effectively no risk of sexually transmitting the virus (undetectable = untransmittable ('U=U')). The London HIV Prevention Programme campaign, Do It London, promotes four key ways to prevent the spread of HIV: regular testing; use of condoms; PrEP and for people living with HIV to receive treatment and have an undetectable viral load (U=U). LSL echoes this strategy locally.

With knowledge of their status and access to effective treatment, people living with HIV (PLHIV) are able to live as long as the rest of the population. As a result, HIV is transitioning away from the life-threatening illness it once was and into a long-term condition that must be managed alongside other age-related conditions and care needs.

In January 2018, London signed up as a Fast-Track City, committing partners across the capital to work together to exceed the UN's 90–90–90 targets and end new infections in the capital by 2030, reduce the negative impact of stigma and discrimination to zero, stop preventable deaths from HIV related causes and to work to improve the health, quality of life and wellbeing of people living with HIV.

Current picture

Epidemiology and local needs

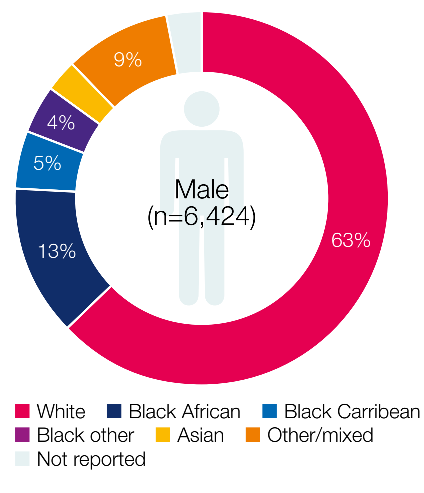
Prevalence

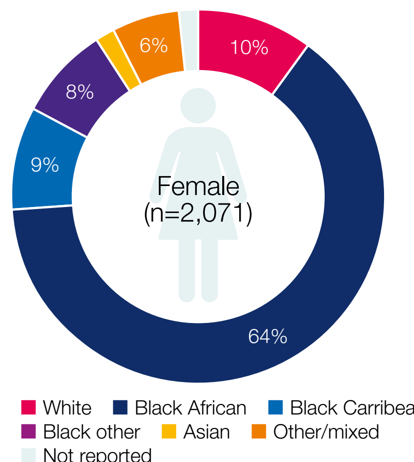
Each borough in LSL exceeds the threshold for 'extremely high prevalence' (as defined by NICE and PHE) of HIV, and the region has the highest rates of HIV in England.

Prevalence in Southwark and Lewisham has fluctuated little in the past five years and is approximately 12.2 per 1,000 people aged 15–59 in Southwark and 8 per 1,000 in Lewisham. In Lambeth, HIV diagnosed prevalence increased up to 2015 but declined in 2017, and is currently 14.6 per 1,000 people - the highest prevalence rate in the country.

There is considerable variation in diagnosed prevalence rates across LSL as illustrated below, and a disproportionate number of new diagnoses are in the most deprived areas (particularly in Lambeth).

Proportion of all diagnosed HIV cases seen for care by sex and ethnicity in LSL, 2017





PHE (2018) Sexual and Reproductive Health Profiles

Across LSL, the majority (76%) of HIV diagnoses are in men. Of all men living with HIV in LSL, nearly two-thirds are white, and of women, nearly two-thirds are black African.

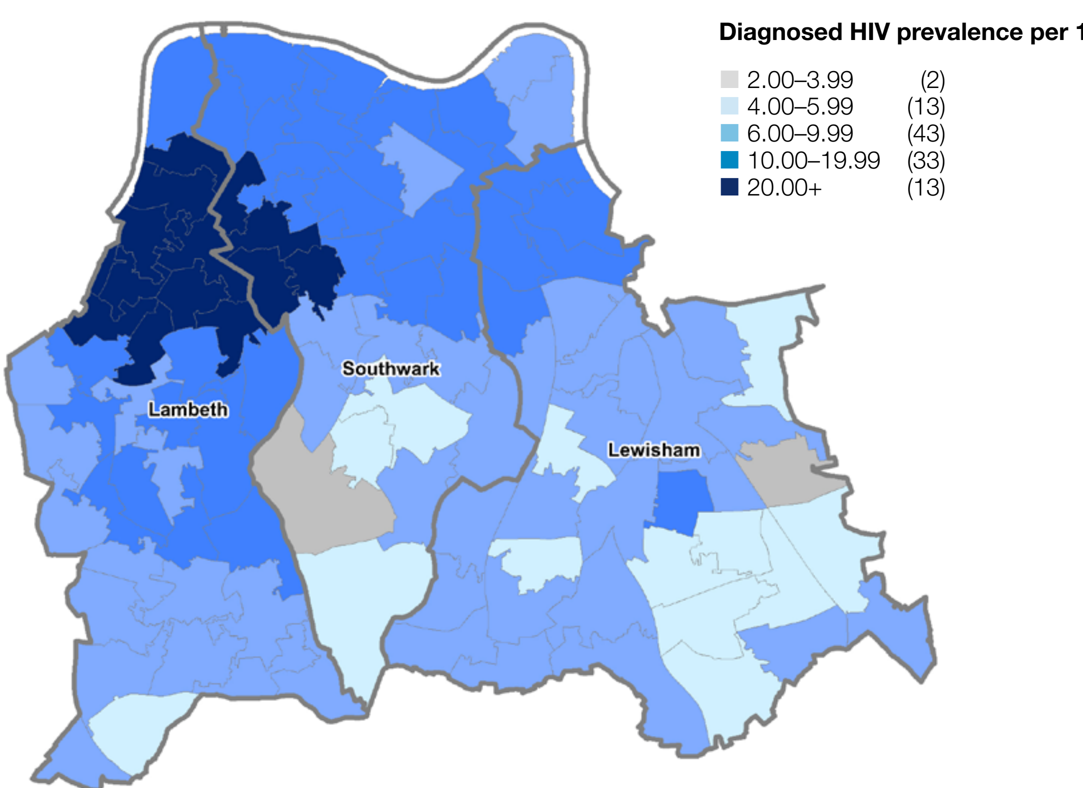
Certain population groups are more likely to be affected by HIV, namely MSM and people identifying as black African. The high prevalence of diagnosed HIV in LSL is driven by a range of factors. All three boroughs have high population turnover, including high rates of external migration. LSL also have a high population of LGBTQI+ people and very diverse populations in terms of ethnicity. Lambeth and Southwark are estimated to have the first and second highest gay and lesbian populations in the country respectively and while there are no estimates available for Lewisham, we can make an assumption of at least 2.7% which is the estimate for London. Additionally, with high rates of HIV among the black African population, our boroughs' ethnic make-up is a significant driver; across LSL, people identifying as black African account for 11% of the population aged 15 years and over.

Testing

HIV testing, including frequent testing among those most at risk of HIV, continues to be one of the most important interventions to identify infection and prevent onward transmission, and is one of the four Do It London strategies to prevent HIV. Providing access to and encouraging testing in our resident population will reduce the number of undiagnosed residents, reduce the time period over which infected individuals are not receiving treatment and prevent onward transmission.

HIV testing coverage is used to monitor progress towards national recommendations on increasing testing and is defined as the proportion of 'eligible new attendees' to specialist sexual health services in whom an HIV test was accepted. Performance against this indicator is poor in LSL where coverage in all boroughs has consistently trended below the overall London rate. There is a decreasing trend in testing coverage in Lambeth and Southwark, though coverage has increased in Lewisham. Given the high prevalence of HIV in LSL, poor performance against this

Prevalence of diagnosed HIV per 1,000 by MSOA, in LSL 2017



PHE (2018) Local authority HIV surveillance data tables

The map above shows that the prevalence of diagnosed HIV is not evenly distributed across LSL. The highest prevalence of diagnosed HIV is an area across north Lambeth and north west Southwark, with a prevalence of over 20 per 1,000 population.

indicator is concerning and we will seek to better understand and address this. We will also encourage increased testing in primary care and A&E settings.

The coverage indicator measures only those tests offered and accepted within specialist sexual health services and therefore does not capture those accessing testing privately, via online channels or in alternative settings (e.g. general practice, hospital settings). Access to testing through specialist services will also show a systematic bias towards certain high-risk groups, such as MSM, who are more likely to access these services regularly.

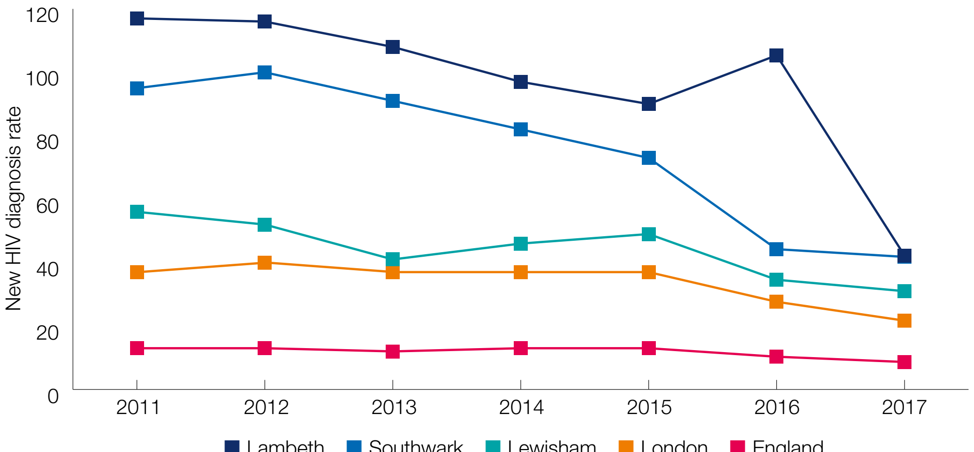
New diagnoses

Total new diagnosis rates have continued to decline nationally year on year. Since 2015, LSL have seen a decline in key risk groups where rates have previously remained stable: MSM and the black African population. The 2017 PHE report *Towards elimination of HIV transmission, AIDS and HIV related deaths in the UK* suggests that the decline among the black African heterosexual population is likely due to changes in migration patterns, with fewer people arriving from high HIV prevalence countries, though this is being reviewed.

However, the decreasing trend in new diagnoses has not been seen across all populations and there has been no significant change in Lambeth and Lewisham, though rates have decreased in Southwark. New diagnoses in heterosexual women and black African men also remain disproportionately high. Sustained effort therefore continues to be required to reduce new infections and onward transmission.

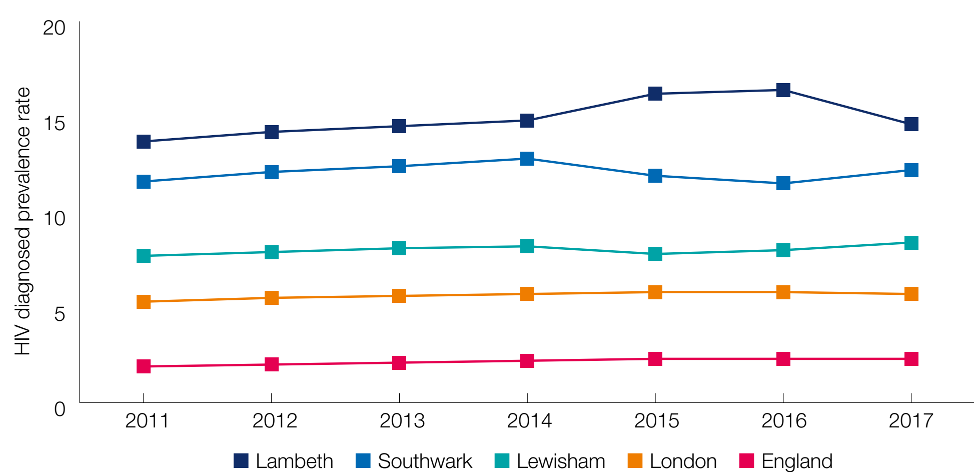
Rates of new diagnoses among residents of LSL continue to trend above both national and London rates, though there are differences between the three boroughs as seen in the accompanying figures.

New HIV diagnosis rate per 100,000 aged 15+ LSL, 2012–2017



PHE (2018) Local authority HIV surveillance data tables

HIV diagnosed prevalence rate per 1,000 aged 15–59 LSL, 2012–17



PHE (2018) Local authority HIV surveillance data tables

An HIV prevalence of more than 5 per 1,000 is considered extremely high – all boroughs in LSL are above this, with Lambeth and Southwark first and second in England, respectively. However, new diagnosis rates have declined across LSL in recent years, with a significant decline in Lambeth due to a large number of cases diagnosed in 2016 being erroneously mapped to St Thomas' hospital (in Lambeth) rather than the patient's area of residence.

Our epidemiological review revealed that in LSL in 2017:

- Rates of HIV diagnosis are highest among those aged 35–64 years.
- The majority (76%) of HIV diagnoses are in men.
- Of all men diagnosed with HIV, 64% were white, and of all women diagnosed with HIV, 64% were black African.
- Sex between men accounts for the majority (53%) of new HIV cases, followed by heterosexual female (14%) and heterosexual male (13%) exposure (as per figure at right).

By understanding the profile of those diagnosed, we can target ongoing efforts to tackle HIV through combination prevention approaches – for example through commissioning community-focused services targeted to black African and Caribbean communities and MSM across LSL.

Late diagnoses

Late diagnosis of HIV infection is associated with increased morbidity and mortality, increased costs to healthcare services, reduced response to antiretroviral treatment and increased risk of onward transmission of HIV. People diagnosed late have a ten-fold risk of death compared to those diagnosed promptly. Reducing late diagnosis is therefore a critical target in our strategy.

Over time, fewer people in LSL are receiving a late HIV diagnosis and efforts to increase testing through a variety of routes (including online and a range of community and healthcare settings) appear to have contributed to this downward trend from 2009–11 to 2015–17.

However, across LSL in 2015–17 more than 25% of people diagnosed with HIV were diagnosed at a late stage of the disease. Late diagnosis was highest in Lewisham where almost 40% of people received a late HIV diagnosis in 2015–17.

In 2016, certain groups had a higher proportion of people with late diagnosis, including those aged 50–64 (53%), those identifying as black African (49%), those identifying as ‘other’ ethnicity (46%), those whose route of transmission was through heterosexual contact (59%) and women (55%).

These data afford us insight into groups who would benefit from outreach programmes and targeted prevention and testing. We know that women and BAME groups are less likely to accept HIV testing and this is reflected in higher rates of late diagnosis. Regular testing is a good way to identify HIV early and routine or opportunistic offers of HIV tests by healthcare professionals (outside of sexual health services) have been shown to be acceptable and facilitate greater uptake of testing, especially in at-risk African communities.

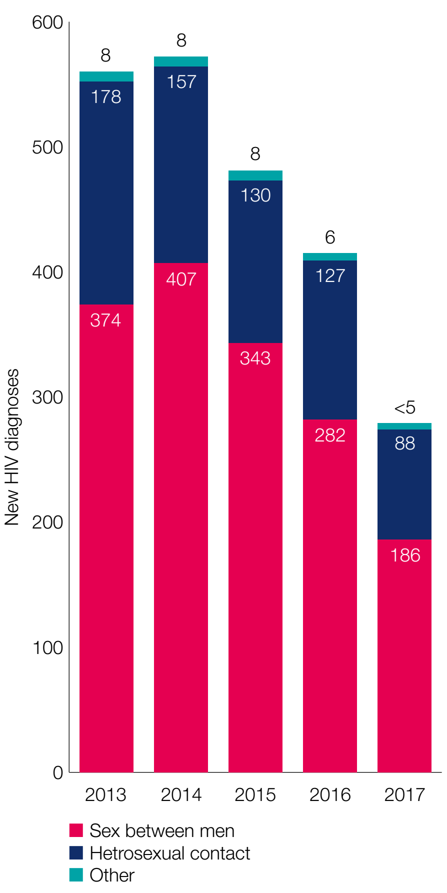
A multi-faceted approach is needed to tackle late diagnosis across LSL, including measures to encourage those at risk to come forward to be tested, and education and support for clinicians, particularly those working in primary care and A&E to improve their knowledge of HIV and testing, including raising the issue.

Engagement in care

Widespread use of effective ART has led to a significant reduction in morbidity and mortality among people living with HIV and is an effective means of reducing HIV transmission. The ‘U=U’ (undetectable = untransmittable) message is growing in recognition. However, individual and public health treatment benefits can only be achieved if PLHIV know their status, access care and have sustained engagement with care on an ongoing basis. Poorer health outcomes are experienced among people living with HIV who engage poorly with care.

The UK has made significant progress in ART coverage in recent decades. 96% of those diagnosed are now accessing

Proportion of new HIV diagnoses by exposure type in LSL, 2013–17



PHE (2018) Local authority HIV surveillance data tables

Sex between men is the leading exposure type in people newly diagnosed with HIV.

treatment and 94% are virally suppressed. In London in 2016, 97.2% of residents with diagnosed HIV were receiving ART. Of these, 96.6% were virally suppressed and were very unlikely to pass on HIV, even if having sex without condoms or use of other preventative interventions in partners such as PrEP.

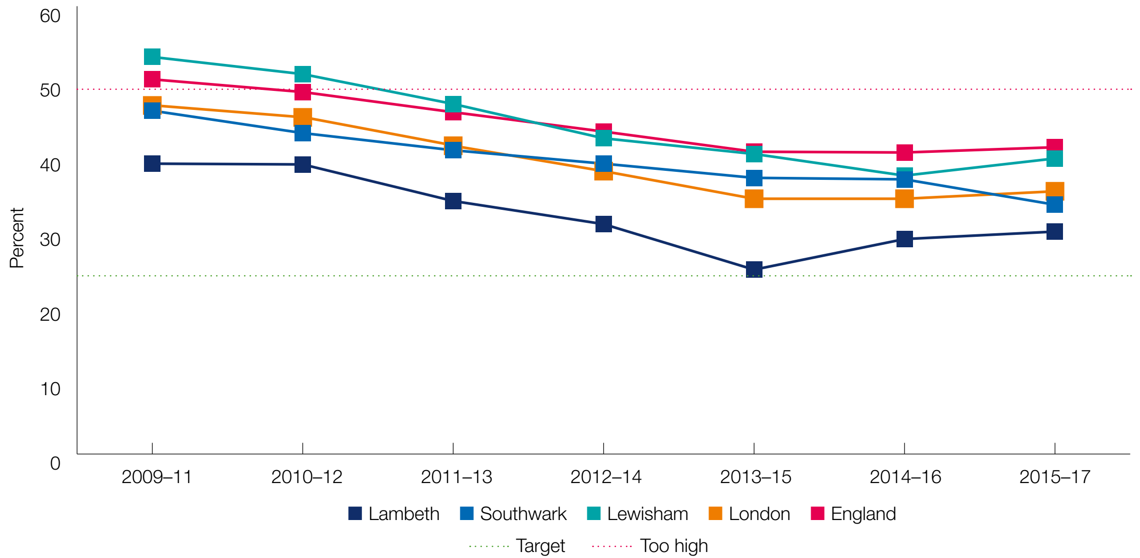
More than 8,700 LSL residents accessed HIV care in 2016. This number has increased steadily in line with new diagnoses and an increased life expectancy. 98% of those accessing care in 2016 were on treatment. However, 2015 data indicates that there remain challenges in retaining a proportion of those diagnosed in care – with just 85% of those diagnosed retained within care at 1 year after diagnosis.

Substance misuse and mental health co-morbidities are risk factors for poor treatment adherence and level of engagement in HIV care is associated with multiple underlying causes and demographic, socio-economic and HIV-related factors. It's therefore key that the services provided in LSL, both in specialist and mainstream community services, cater to the differing needs of PLHIV. A range of approaches are required to improve engagement with care, and we will continue to work to maximise engagement and support adherence to treatment across the boroughs.

PLHIV also have the primary role in managing their condition. Individuals, families and communities are assets that support self-management including:

- Providing information and perspectives about HIV and treatment
- Peer support, including understanding of and assistance with self-management skills
- Reduction in HIV-related stigma

Percentage adults (15+) with late HIV diagnosis among all newly diagnosed adults in LSL, 2009–11 to 2015–17



PHE (2018) Sexual and Reproductive Health Profiles

Late diagnosis rates are pooled over three-year periods. Over time, fewer people in LSL are receiving a late HIV diagnosis. However, in all boroughs in 2015-17, more than 25% (target) of people diagnosed with HIV received a late diagnosis. Late diagnosis was highest in Lewisham where almost 40% of people received a late HIV diagnosis in 2015-17.

Families of people living with HIV, including children, may also have particular health or social needs, as may younger people transitioning from children and young people's specialist HIV services to adult services. The needs of these and other specific groups will be considered when planning services.

One of the greatest successes of HIV care, research and activism is that PLHIV can now lead healthy lives and have similar life expectancies to those of the general population. In 2016, more than one-third of people accessing HIV care in LSL (35%) were aged 50 years and over, compared with 24% in 2012.

There is however evidence that PLHIV are more likely to develop diseases such as diabetes, kidney disease, liver disease and other long term medical conditions associated with age. In addition, a proportion of people experience side effects when taking ART long-term.

Some older people living with HIV can feel stigmatised by both their age and HIV status, and may suffer isolation and loneliness as a result.

Both specialist HIV and mainstream services in LSL and across London will need to adapt to this changing demographic of PLHIV. Co-coordinating care more closely with other health and care services that older people need and focusing on overall quality of life as well as clinical treatment will be essential. Exploring shared care models with primary care and planning for how HIV care will be coordinated with social care, for example in care homes, is essential.

Achievements since the last strategy and ongoing challenges

Achievements since the last strategy

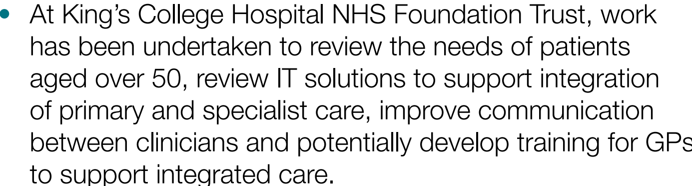
LSL's 2014–17 sexual health strategy set ambitious targets to support PLHIV in leading healthy and fulfilling lives. These included increasing testing rates to ensure residents know their status and are on ART as quickly as possible. We implemented the following projects and system changes:

- Introduction of HIV testing in acute and primary care settings.
- Development and implementation of online STI and HIV self-sampling service, SH:24. This innovation inspired London to procure an online STI and HIV self-sampling service on behalf of most London boroughs, Sexual Health London (SHL), which LSL has now adopted. In addition, LSL bought into the national online HIV self-sampling service, Test.HIV.
- Lambeth host and commission on behalf of London boroughs the London HIV Prevention Programme which runs an award-winning campaign, '*Do It London*', to increase testing and safer sex behaviours, and also has an outreach programme that works with MSM to encourage testing, give advice and increase knowledge around prevention methods.
- Implemented recommendations of the 2010 HIV care and support review, making changes to our local service offer towards an integrated care model in line with the HIV now being a manageable long-term condition. This work has included piloting HIV clinics in GP surgeries and improving the competence and capacity of mainstream advice, welfare and other agencies to respond to the needs of people living with HIV in line with support for those with other long term conditions.

Lambeth host and commission on behalf of London boroughs the London HIV Prevention Programme which runs an award-winning campaign, '*Do It London*', to increase testing and safer sex behaviour

1,000

There are estimated to be around 1,000 people living in LSL who are unaware they are living with HIV



- At King's College Hospital NHS Foundation Trust, work has been undertaken to review the needs of patients aged over 50, review IT solutions to support integration of primary and specialist care, improve communication between clinicians and potentially develop training for GPs to support integrated care.

These achievements were enabled by workforce developments that saw the introduction of more appropriate staff skill mixes to better serve the needs of patients and service users and improve training standards in sexual health.

Ongoing challenges

Tackling stigma and discrimination

HIV-related stigma and discrimination refers to prejudice, negative attitudes and abuse directed at PLHIV. Though it is 30 years from the start of the HIV crisis, stigma and misconceptions around HIV remain and are a barrier to HIV prevention, testing, treatment, care and support. In 35% of countries with available data, over 50% of people report having discriminatory attitudes towards PLHIV.

PLHIV can face stigma, prejudice and discrimination in various spheres of life from services, in the workplace and from their family and friends. They may also experience that some non-specialist services are unable to meet their needs fully because of lack of specialist knowledge or training. These social aspects of the disease are less well understood, but can significantly impact on the ongoing health and wellbeing of PLHIV and their family and friends. Stigma and discrimination can undermine HIV prevention efforts by making people fearful to seek information on HIV information, access services and adhere to treatment.

Providing the right combination of services for the health care of all people living with HIV

PLHIV in LSL are a diverse group of people whose health needs will change as they age. It is critical that HIV specialists and other services continue to evolve to meet the needs of PLHIV, including the management of co-morbidities and other complex health conditions and that they reflect all members of the community that they serve.

Whilst early diagnosis and effective treatment means that people living with HIV can age well, the inevitable effects of ageing cannot be avoided and growing older with HIV can increase the chance of experiencing age-related illnesses earlier. PLHIV also have higher rates of mental health-related co-morbidities than the general population and substance use and addiction disproportionately affect people with HIV.

With increasing numbers of people living and ageing with HIV there will be increasing pressures on a range of services including specialist, primary, mental health and social care services. Complex and fragmented commissioning arrangements, and ongoing budgetary constraints across health and social care, could contribute to a lack of joined up care for PLHIV.

Given HIV is increasingly managed as a chronic disease, and along with other changes in health policy, there is a shifting in the emphasis of care towards partnership between specialist centres and primary care. LSL HIV services must learn from other existing models for co-ordinating long-term care (such as those for cancer) that have similarly evolved from providing specialised treatment to including long-term care, and adapt them as appropriate.

Work at KCH and with other partners towards understanding and designing the elements of a truly integrated care model for PLHIV in LSL has been ongoing for a number of years and actions stemming from this strategy will seek to support and further these efforts.

Undiagnosed and those not on treatment

There are estimated to be around 1,000 people living in LSL who are unaware they are living with HIV. Reviewing and increasing our testing activity (particularly in primary care and A&E), ensuring we are testing the right people and targeting those identified through profiling people who are diagnosed late will be critical to reduce the numbers of undiagnosed. This will include raising awareness among clinicians in general practice and secondary care settings of some indicator conditions that may suggest someone living with an undiagnosed HIV infection.

With the increasing incorporation of e-services in the sexual health system across London, service users must receive appropriate behaviour change messaging to ensure HIV tests are selected whenever possible.

Some residents who receive a diagnosis of HIV decline treatment or are lost to care, putting their health at risk and increasing the risk of onward transmission. Clinical and community outreach services will continue to target most at risk populations.

Data monitoring

Monitoring and the ability to assess the impact of the interventions are dependent on good quality data. HIV and AIDS reporting system (HARS) provides some of the best surveillance data internationally, but this system relies upon complete data being freely given by individuals who trust in the confidentiality of the system, and also being collected, recorded and returned in a timely and accurate manner.

Emerging issues and trends

PrEP

Pre-exposure prophylaxis (PrEP) is highly effective in reducing the risk of acquiring HIV. PrEP is not currently available on the NHS (aside from the Impact trial) but the private purchase of PrEP has been increasingly popular in recent years, particularly amongst MSM, and is supported by testing at sexual health clinics. The PrEP Impact trial is currently recruiting 13,000 participants (and proposed in January 2019 to be doubled) who are at a high risk of HIV, across England, to assess the need and demand for PrEP in those accessing sexual health clinics, and the likely benefit of its use in England. By late October 2018, 9,226 participants had been recruited across 140 sexual health clinics.

Although PrEP is highly effective for preventing HIV infection, research is beginning to highlight an associated decrease in consistent condom use and increase in STIs among MSM using PrEP. A reduction in condom use could also undermine PrEP's population level effectiveness if people stop using condoms and do not use PrEP consistently.

Living well with HIV: what we want to achieve by 2024

The figure below sets out our vision for improving the lives of PLHIV in LSL, how we will work together to achieve this vision and the indicators with which we will measure our progress. It is clear that many of these are intertwined. While we will progress many of these objectives collaboratively, each borough will have an annual delivery plan which will set out the borough-specific actions needed to achieve these objectives in a given year. London has signed up to the Fast-Track Cities target of 0–0–0 (0 HIV stigma, 0 HIV transmissions, 0 deaths from HIV/AIDS). The vision for Lambeth, Southwark and Lewisham is also to move towards achieving this. Therefore, in addition to the specific indicators listed below, we will look to measure overall progress towards this vision, using any future indicators agreed at a London level.

Vision

- To move towards 0-0-0:
  0 HIV stigma
  0 HIV transmissions
  0 deaths from HIV/AIDS

Outcomes

- New HIV transmissions are prevented
- People with HIV know their status and are undetectable = untransmittable
- People living with HIV are enabled to live and age well

Aims

- We will take a combination approach to preventing HIV
- We will increase testing
- We will increase retention in care
- We will improve the quality of life of people living with HIV
- We will tackle stigma in our communities

Objectives

- We will commission HIV prevention and promotion services for most at risk populations, promoting the use of condoms, testing, PrEP and treatment as prevention (TasP)
- We will manage and run the London HIV Prevention programme, amplifying prevention and treatment messages to the wider population
- We will target prevention to those with HIV/ those whose sexual partners have HIV to ensure knowledge of the health risks of seroadaptive behaviour / condomless sex
- We will have an understanding of who is not engaging in care.
- We will maximise access to testing by offering more testing through a variety of channels, specifically primary care and A&E in the first instance.
- We will work with services targeted to those most at risk of HIV, increasing testing and addressing inequalities
- We will ensure our HIV care and support services are fit for purpose and support self-management
- We will work with mainstream service providers to ensure their services are relevant for PLHIV
- We will support the development of integrated care for PLHIV
- We will work with education to support evidence-based RSE

Key Indicators

- Number of residents using PrEP
- STI diagnosis rates
- Numbers of and rates of testing in primary care and A&E initially in addition to testing coverage in specialist SRH services
- Number of individual and group engagement sessions by sexual health promotion programme for BAME heterosexuals and MSM
- Testing coverage in heterosexual men and women
- Rate and number of new diagnoses
- Rate and number of late diagnoses
- Proportion of residents on ART
- Numbers of those retained in care
- Qualitative measures on local stigma from PLHIV
- Quality of life indicators from PLHIV
- A school support offer for RSE, covering issues appropriate to the local area

6.0 How we will deliver our vision

The figures on the previous pages provide the map for how we will achieve our shared vision for sexual and reproductive health in LSL by 2024, and the indicators through which we will measure our progress.

However, we recognise that within LSL, some areas have further to progress than others and there will be local factors that are not applicable to other boroughs. Therefore, our boroughs will have an annual action plan which will include specific steps to deliver this strategy, which will form part of the Public Health business plans. This approach to a joint strategy allows us to collaborate on many areas, but take local action as needed.

Progress against the strategy will be reviewed annually by the LSL Sexual Health Commissioning Partnership Board, which comprises commissioning, Public Health and CCG representatives from each of the three boroughs. Shared actions to deliver this strategy will also be overseen by this board.

This strategy also forms a key part of each borough's Health and Wellbeing Strategy, and so progress will be reported to each of the Health and Wellbeing Boards as locally appropriate.

Contact

publichealth@lambeth.gov.uk

publichealth@southwark.gov.uk

publichealth@lewisham.gov.uk

https://www.lambeth.gov.uk

https://www.southwark.gov.uk

https://www.lewisham.gov.uk

Lambeth, Southwark and Lewisham Sexual Health Strategy 2019-24

Statistical appendix

Produced by Southwark Public Health on behalf of Lambeth and Lewisham councils

December 2018

GATEWAY INFORMATION

Report title:	**Sexual health in Lambeth, Southwark and Lewisham**
Status:	Public
Prepared by:	Nora Cooke O'Dowd
Contributors:	Sigrid Blackman, Public Health Lambeth, Public Health Lewisham, Chris Williamson
Approved by:	Kirsten Watters
Suggested citation:	Sexual health in Southwark, Lambeth and Lewisham. Southwark's JSNA. Southwark Council: London. 2019.
Contact details:	publichealth@southwark.gov.uk
Date of publication:	March 2019

CONTENTS

Introduction	**3**
Healthy and fulfilling sexual relationships	**7**
Good reproductive health across the life course	**10**
High quality STI testing and treatment	**22**
Living well with HIV	**48**

Sexual health is an important public health issue that impacts on broader wellbeing and local health budgets.

BACKGROUND

Poor sexual and reproductive health and ongoing transmission rates of HIV have major impacts on population mortality, morbidity and wider wellbeing, and result in significant costs for health service and local authority budgets.

- Sexual relationships, although an intensely private matter, are a major component of the wellbeing of the whole adult population and of wider society.
- If not successfully treated, STIs can lead to a number of conditions such as pelvic inflammatory disease, ectopic pregnancy, infertility and cervical cancer. Some STIs, most notably gonorrhoea, have demonstrated increasing levels of resistance to antibiotic treatment.

Certain population groups are at particular risk of sexually transmitted infections (STIs).

- Younger people, people from Black ethnic groups and men who have sex with men (MSM) are at increased risk of sexual ill health.
- Sexual health needs vary according to factors such as age, gender, sexuality and ethnicity. However, there are certain needs common to everyone, including high quality information and education enabling people to make informed responsible decisions, and access to high quality services, treatment and interventions.
- Sexual and reproductive ill health is concentrated in many vulnerable and marginalised communities, and improving sexual and reproductive health and HIV outcomes will address these major health inequalities.

References
1. Health promotion for sexual and reproductive health and HIV Strategic action plan, 2016 to 2019

This report underpins the Lambeth, Southwark and Lewisham Sexual Health Strategy 2019-24.

DATA SOURCES

Sexual health need in Lambeth, Southwark and Lewisham is among the highest in the country. The Sexual Health strategy 2019-24 for the area is currently in development.

- Lambeth, Southwark and Lewisham (LSL) have among the highest rates of sexually transmitted infections, HIV and teenage conception rates in England.
- LSL Public Health teams are coming together with key partners and stakeholders to develop a Sexual Health Strategy which looks to ensure our sexual health services are effective, responsive and high quality services, which effectively meet the needs of our local communities.

This intelligence briefing aims to identify the local population needs to inform the strategy through descriptive epidemiology of reproductive and sexual health in LSL, including:

- Describe trends in reproductive health including HPV, contraception and abortion;
- Describe the burden of STIs and HIV, identifying inequalities in diagnoses;
- Begin to develop an understanding of healthy relationships across LSL.

Data presented in this intelligence briefing are drawn primarily from following Public Health England data sources, namely:

- GUMCADv2 - STI Surveillance System (2012 - 2017),
- Local Authority Sexual Health Epidemiology Reports (2016),
- Local Authority HIV surveillance data tables (2012 - 2016),
- Sexual and Reproductive Health Profiles (June 2018 update);
- Other data were pulled from ONS and NHS Digital.

Note: all data up-to-date as at 21 November 2018

Lambeth, Southwark and Lewisham are young and diverse boroughs in inner south east London.

BACKGROUND: DEMOGRAPHY

LSL residents are predominantly young.

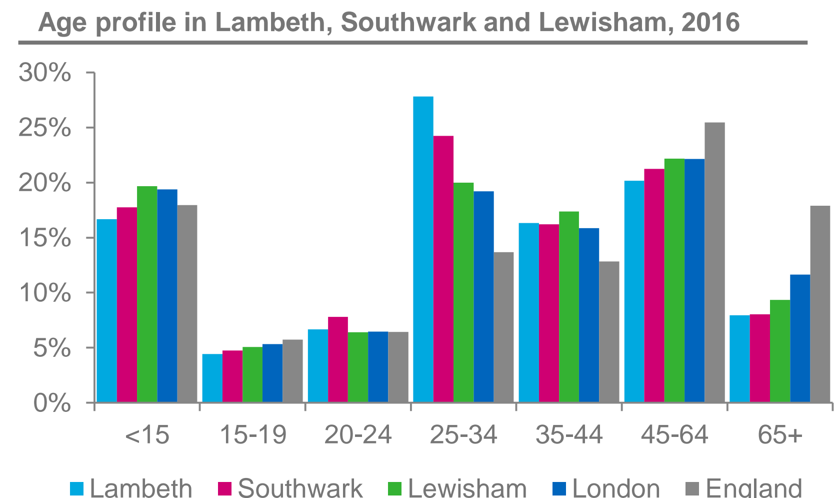
- Lambeth (320k) is the largest borough, followed by Southwark (310k) and Lewisham (300k).
- Southwark and Lambeth have a slightly younger profile than Lewisham and London, with a median age of 33 compared to 35 in Lewisham.
- This stems from a much larger proportion of the population aged 25-34.

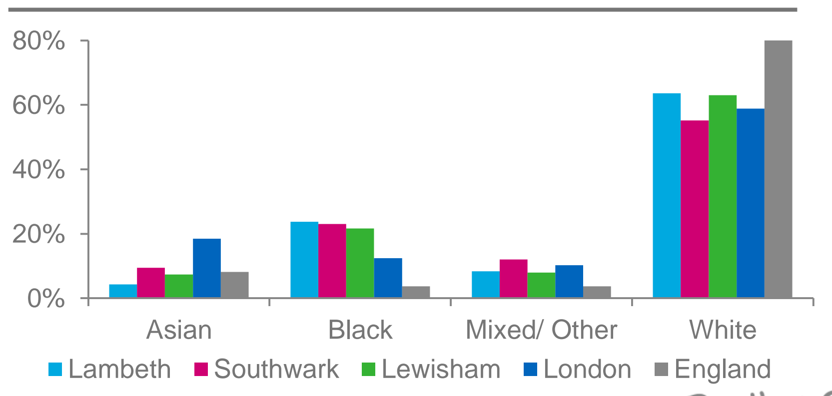
LSL is more ethnically diverse than England.

- The three boroughs are ethnically diverse, with 39% from an ethnic minority backgrounds, compared to 16% nationally.
- Approximately one-quarter of LSL residents are from a Black ethnic background.

A higher proportion of LSL residents identify as gay, lesbian or bisexual.

- Lambeth and Southwark have the 2nd and 3rd largest lesbian, gay and bisexual communities in England, with 6% of adults identifying as gay, lesbian or bisexual, compared to 3% in London.
- Figures on sexual orientation are not available for Lewisham due to a very small sample size and thus we can assume figures there are smaller than Lambeth and Southwark.





References

1. ONS mid-2016 revised population estimates
2. London datastore, Ethnic Groups by Borough
3. ONS 2017, Sub-national sexual identity

Southwark Council
southwark.gov.uk

CONTENTS

Introduction 3

Healthy and fulfilling sexual relationships 7

Good reproductive health across the life course 10

High quality STI testing and treatment 22

Living well with HIV 48

Whilst sexual health is more than the absence of disease, few data are available on the broader aspects.

HEALTHY RELATIONSHIPS IN ADULTHOOD

The World Health Organisation have a working definition of sexual health.

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

However, little data is available on safe and healthy relationships.

- In 2016/17 across London, the rate of domestic abuse-related incidents and crimes recorded by the police was 23 per 1,000.
- The rate of sexual offences in LSL in 2016/17, was just over 2 per 1,000 population.
- Lambeth (59 per 100,000), Southwark (55 per 100,000) and Lewisham (51 per 100,000) have among the highest rates of hospital admissions from violent crime (including sexual violence) in London. There has been a downward trend in recent years.

References

1. WHO, Sexual health, human rights and the law

Teenagers get their information on sex and relationships from school lessons, their parents and friends.

HEALTHY RELATIONSHIPS AT SCHOOL AGE

The schools and students health education unit (SHEU) survey collect data from school going children in LSL and ask questions around sex and relationships.

- When asked what was their main source of information about sex and relationships:
  - In Southwark, 58% of Year 8 boys and 51% of Year 8 girls said school lessons; 55% of boys and 67% of girls said parents. 41% of boys and 44% of girls in Year 10 said their friends.
  - In Lambeth in Year 8, 58% of boys and 60% of 8 girls said school lessons. 57% of pupils said their parents and 37% said their friends.
  - In Lewisham in Year 8, 43% said parents, 37% school and 17% friends. In year 10, friends were the main source of information for 32% of students.

- In Southwark, 63% of pupils responded that they had Relationships and Sex Education (RSE) lessons in the last 6 months, compared to 43% in Lambeth.
  - In Southwark, 32% of pupils responded that their RSE lessons helped them to understand consent, 32% to understand resisting pressure and 22% said the same about contraception.
  - In Lambeth, 57% of pupils said RSE lessons had helped them to understand about healthy relationships. 43% said this about 'sex and the law' and 63% said this about growing up.
  - RSE is being mandated from September 2020. This is an opportunity to better support schools in the delivery of high quality RSE that is tailored to local needs.

- In Southwark, 8% of pupils said that a past or current boyfriend/girlfriend had used hurtful or threatening language to them, 15% said that they get angry or jealous when I wanted to spend time with friends, and 11% said that they kept checking their phone (10% in Lewisham).

References

1. Supporting the Health of Young People in Lambeth
2. Supporting the Health & Wellbeing of Children and Young People in Southwark

CONTENTS

Introduction 3

Healthy and fulfilling sexual relationships 7

Good reproductive health across the life course 10

High quality STI testing and treatment 22

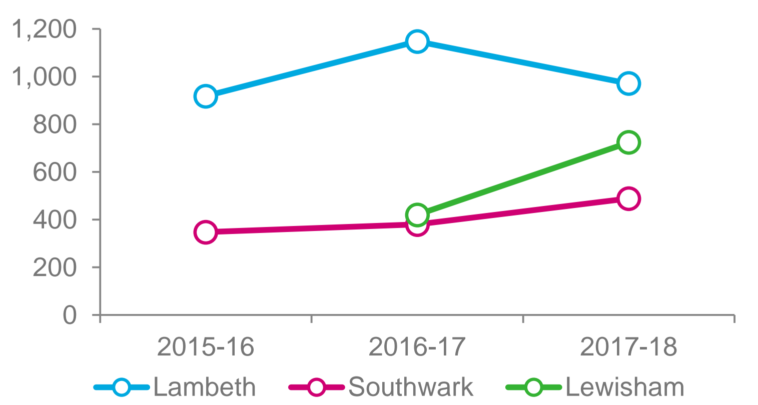
Living well with HIV 48

There were almost 2,200 new Come Correct scheme registrations in LSL and 1,400 repeat visits in 2017-18.

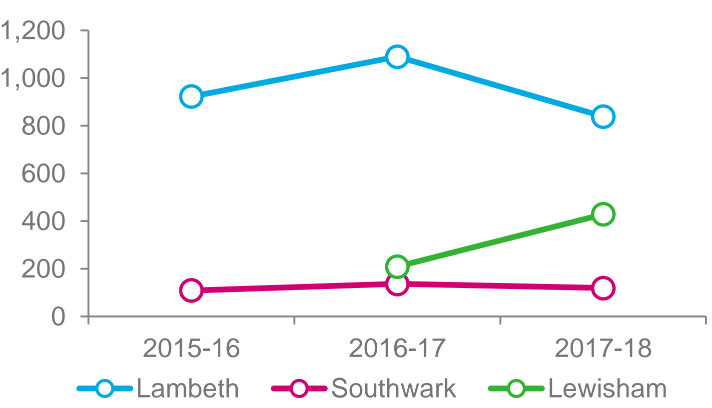
CONTRACEPTION: USER DEPENDENT METHODS

User dependent methods of contraception (e.g. pill, patch or condom) remain popular; almost two-thirds of women in LSL said this was their last main method of contraception.

- Young people aged under 25 can register for the Come Correct (or CCard) scheme to collect condoms or get advice from any outlet displaying the Come Correct logo across LSL.
- In 2017-18, there were just under 2,200 new CCard registrations and 1,400 repeat visits.
- Lambeth had the highest use of the CCard scheme. New CCard registrations increased in Lambeth in 2016-17 but decreased again in 2017-18, as have repeat visits.
- There was an increase in registration in Southwark in 2017-18, but it remains the lowest across LSL.
- The scheme was introduced in Lewisham in 2016-17, and since then there has been an increase in both new registrations and repeat use.



Repeat C-Card visits in LSL, 2015-16 to 2017-18



References

1. NHS Digital, Sexual and Reproductive Health Services, England – 2016-17
2. Come Correct data, London Borough of Lambeth

LARC prescribing rates are lower in GP than SRH services in Southwark and Lewisham, but similar in Lambeth.

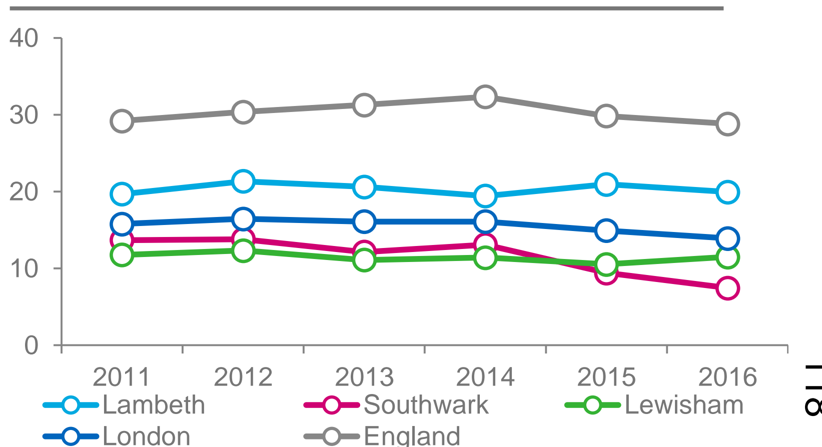
CONTRACEPTION: LARC

NICE encourages the use of Long Acting Reversible Contraception (LARC), which is highly effective as it does not rely on daily compliance.

- LARC is available from GP or Sexual and Reproductive Health (SRH) services. Nationally, LARC prescribing is higher in GPs than SRH services.
- In Southwark and Lewisham LARC prescribing rates are higher in SRH compared to GP services. Lambeth has similar prescribing rates for LARC in GP and SRH.
- This reflects the accessibility of SRH services and the reduced role that GPs play in sexual health in London.

Total LARC prescribing in LSL is above average London prescribing, but below England.

- Southwark had the lowest rates of GP-prescribed LARC in 2016 (7 per 1,000). Rates in SRH services are higher (34 per 1,000) and have remained stable, but total LARC prescribing is lowest in Southwark.
- Rates of LARC prescribing in Lewisham have been broadly stable but low in GPs (12 per 1,000) and have declined in SRH services since 2014.
- Lambeth has had broadly stable LARC prescribing in both GPs and SRH services at around 20 per 1,000.



118

References
1. PHE, Sexual and Reproductive Health Profiles
2. NHS Digital, Sexual and Reproductive Health Services, England – 2016-17

Southwark Council
southwark.gov.uk

Use of emergency hormonal contraception is a proxy for poor contraceptive access and is high in LSL.

CONTRACEPTION: EMERGENCY HORMONAL CONTRACEPTION

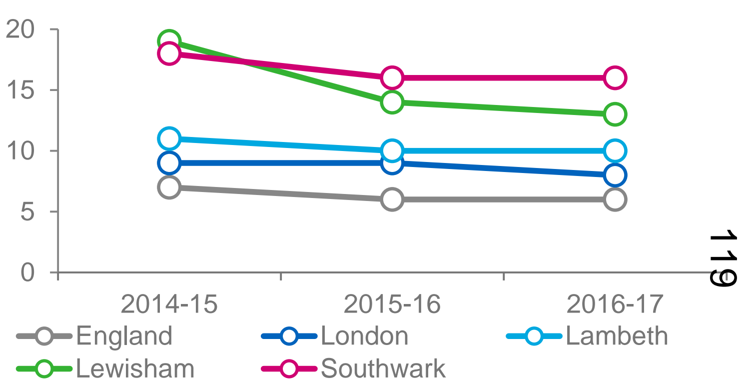
Emergency hormonal contraception (EHC) is an important way (and often the last option) to prevent unwanted pregnancy. It is available in SRH services and pharmacies.

- Rates of women provided with EHC in SRH in LSL are above the London and national averages. With 16 women per 1,000 provided with emergency contraceptives by SRH in Southwark in 2016-17, this is among the highest in the country.
- With only three time points, it's difficult to define a trend, but rates of women provided with EHC have declined slightly in Lewisham while remaining stable in Southwark and Lambeth.
- EHC is also available from community pharmacies across LSL, and is highly accessed (e.g. >10,000 supplies made in Lambeth pharmacies in 2016/17).

EHC use (and especially repeat use) is an indicator of unmet reproductive health needs and a major missed opportunity for intervention.

- Repeat EHC use is high in SRH - 90% of women using EHC in Lambeth and Southwark pharmacies in 2017/18 self-declared previous use, with 60% using EHC within the last 6 months (Southwark).
- This compares to approximately 15% repeat use in Brook young people's clinics.
- EHC use (and especially repeat use) is an indicator of unmet reproductive health needs and a major missed opportunity for intervention.

Women provided emergency contraceptives by SRH services per 1,000 population aged 16-54, 2014-15 to 2016-17



119

References
1. NHS Digital, Sexual and Reproductive Health Services, England – 2016-17
2. Service level data on EHC

The national trends of falling birth rates and the increasing mean age of mothers are amplified across LSL.

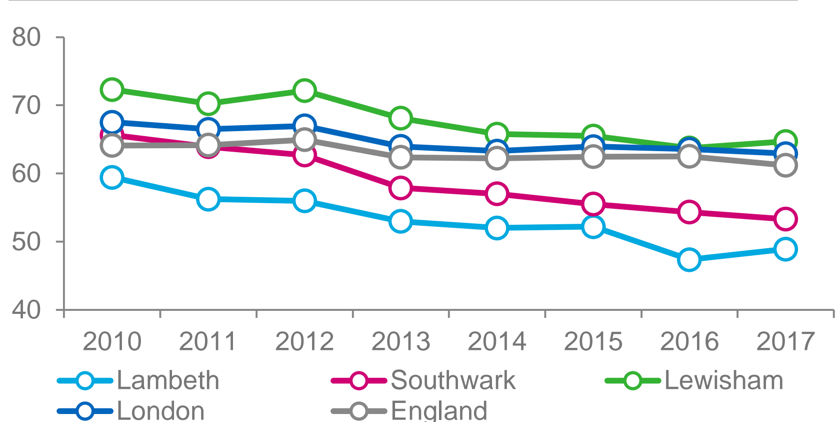
BIRTH RATE

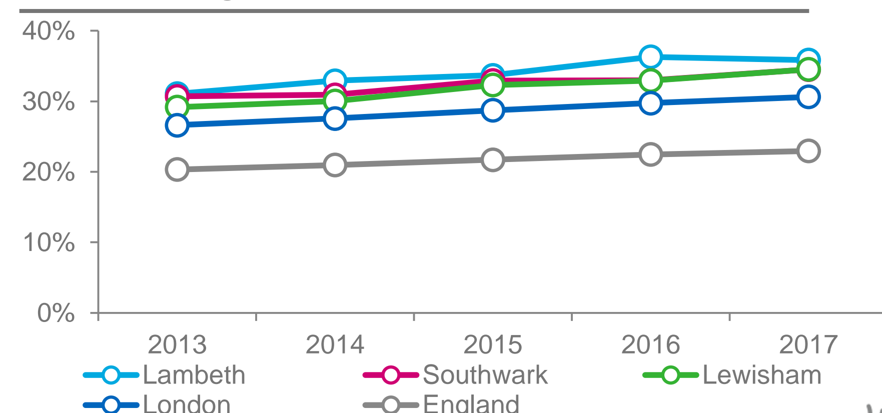
The general fertility rate (GFR) in Southwark and Lambeth has decreased considerably faster than the rest of London and England.

- The general fertility rate is the total number of live births per 1,000 women of reproductive age (ages 15 to 49 years) in a population per year.
- There has been a general downward trend in the general fertility rate across the country since 2010. Lambeth and Southwark have a lower fertility rate than Lewisham or London and the decline in rates have been faster.
- In 2017 there were just under 13,400 live births across LSL.

The mean age of mothers having their first live child has increased over time nationally.

- In 2017, 54% of all live births nationally were to mothers aged over 30; 68% to fathers over 30.
- Nationally the average age of mothers in 2017 increase to 30.5 years, up from 26.4 years in 1975.
- A similar pattern is seen in LSL , but the proportion of mothers aged over 35 is higher than London or England.





References

1. ONS, Births by parents' characteristics in England and Wales: 2017
2. NOMIS Live births in England and Wales : birth rates down to local authority areas, 2017
3. PHE Sexual and Reproductive Health Profiles

Southwark Council
southwark.gov.uk

Teenage conception rates have declined significantly across LSL, but remain higher than London and England.

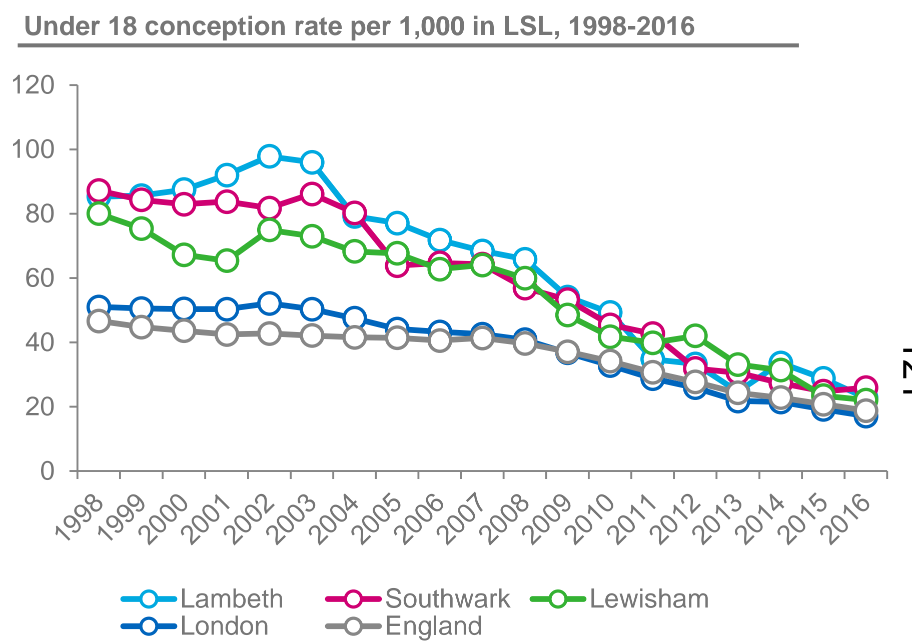
TEENAGE CONCEPTIONS

One in five unplanned pregnancies occur in women aged 16-19 and teenage pregnancies are more likely than others to end in abortion.

- There has been a 70% decrease in the number of teenage conceptions in LSL since 1998.
- While rates of teenage conception have been falling steadily, they remain higher than London and England.
- In 2016, there were over 300 teenage conceptions across LSL. Of those, just over 40 conceptions were in people under the age of 16 (with 17,14,12 pregnancies in LSL respectively) – these rates are also in decline.

Access to contraception is essential, especially for young people, in reducing unplanned pregnancies.

- According to the School Health Education Unit (SHEU) survey, only 20% of pupils in Year 8 and Year 10 Lambeth and Southwark knew where to get condoms for free.



References

1. Wellings K et al (2013) The prevalence of unplanned pregnancy and associated factors in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3). Lancet; 382 (9907): 1807-1816.
2. PHE Sexual and Reproductive Health Profiles

Over 5,500 abortions took place across LSL in 2017, 58% of which were medical abortions.

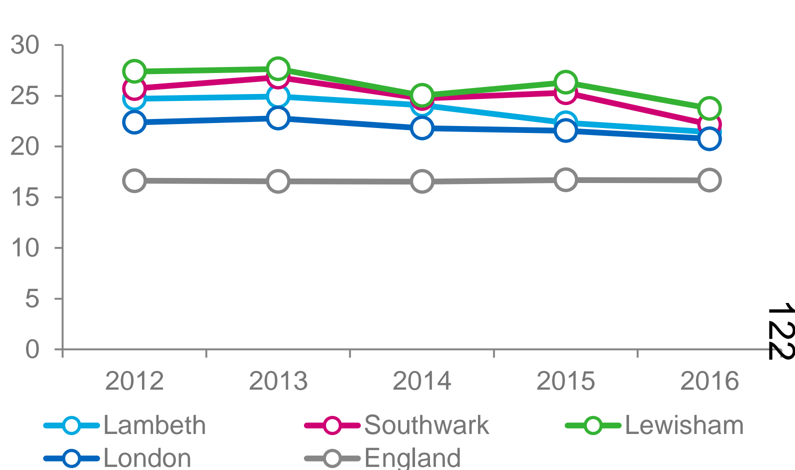
ABORTION

The abortion rate is an indicator of lack of access to good quality contraception services and advice, as well as problems with individual use of contraceptive method.

- Across LSL in 2017, almost 5,500 abortions took place.
- Looking at rates between 2012 and 2016, abortion rates in LSL and London are notably higher than England.
- Local analysis suggest that abortion rates in women aged 15-44 were highest among women from Black African and Caribbean ethnic backgrounds and typically lower in Asian, Chinese and other ethnicities across LSL.*

The number of early medical abortions taking place each year is increasing.

- Nationally, medical abortions are increasingly performed – 65% of all abortions in 2017 compared to 34% in 2007, as surgical abortions decline. In LSL in 2017, 58% of all abortions were medical abortions.
- Early medical abortions (up to 10 weeks) accounted for 63% of all abortions in LSL in 2017/18.



References
1. London Borough of Lewisham, Public Health Team analysis. *Kings College Hospital excluded.
2. PHE Sexual and Reproductive Health Profiles
3. Department of Health, abortion statistics, 2017

Two-thirds of teenage pregnancies end in abortion. Subsequent abortions occur in 42% of all abortions.

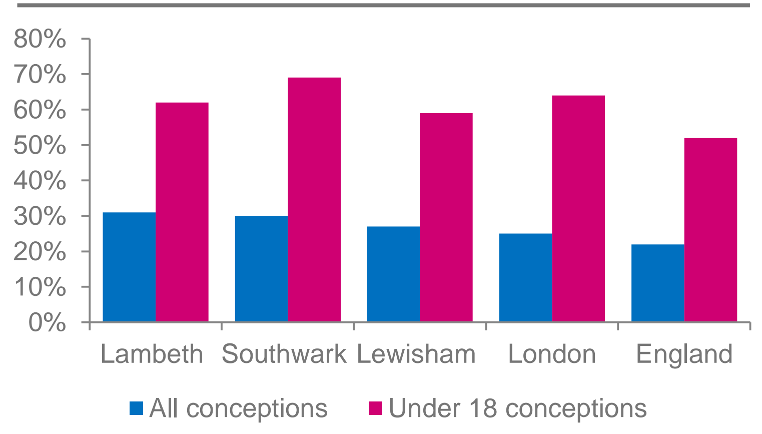
ABORTION

Most teenage conceptions are unplanned and are more likely to end in abortion than other age groups.

- Two-thirds of teenage pregnancies ended in abortion across LSL in 2016: Lambeth (69%), Southwark (72%) and Lewisham (63%).
- By contrast, the percentage of all conceptions leading to abortion were one-third: Lambeth (31%), Southwark (30%), Lewisham (27%).

The chance that a woman has had a previous abortion increases with age as it allows longer time for exposure to pregnancy risks.

- In women from LSL having an abortion in 2017, 42% had previously had an abortion – this increases to almost half in women over 25.
- Repeat unintended pregnancy and subsequent abortion is a complex issue.
- A total 11% of women aged under 19 who had an abortion in 2017 had previously had an abortion, which compares to 13% in London.



Proportion of abortions in women who have had a previous abortion, by age, 2017

	All ages	Under 19	Under 25	Over 25
Lambeth	40%	11%	32%	45%
Southwark	41%	13%	31%	47%
Lewisham	44%	8%	30%	51%
London	42%	13%	31%	47%
England	39%	10%	27%	47%

References

1. ONS, Conception Statistics, England and Wales, 2016
2. Abortion statistics for England and Wales: 2017

LARC is an effective way of preventing subsequent abortions, however uptake after abortion is decreasing.

LARC AFTER ABORTION

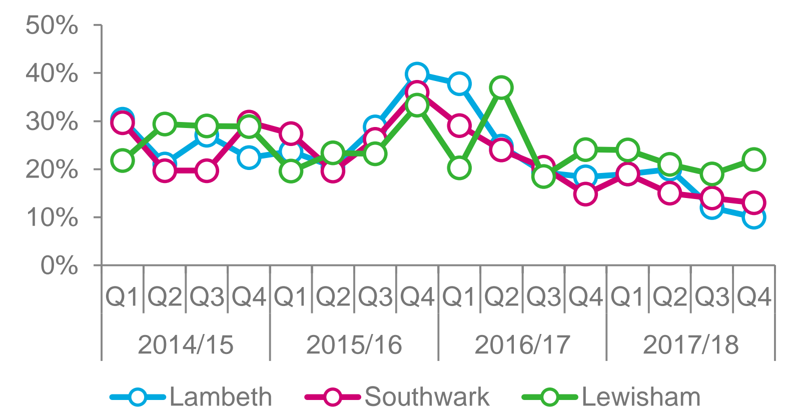
LARC is an effective way of preventing subsequent abortion. The proportion of women choosing LARC after an abortion is decreasing.

- Women who choose to commence LARC immediately after abortion have a significantly reduced likelihood of undergoing another abortion within 2 years.
- In 2017/18, less than one in four women chose LARC after abortion.
- The proportion of women in LSL taking LARC following an abortion has been decreasing in Marie Stopes International (MSI), whereas the pattern is less clear in British Pregnancy Advisory Service (BPAS).
- MSI South London are currently running one post-EMA LARC clinic a week, which is usually fully subscribed and they are looking at ways to increase capacity. BPAS are considering a similar arrangement.
- Kings College Hospital (KCH), which provides late and complex abortions provide 5-8% of all abortions, but data were not available.

LARC uptake after abortion MSI, 2014/15 – 2017/18

50%
40%
30%
20%
10%
0%
Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3 Q4 Q1 Q2 Q3
2014/15 2015/16 2016/17 2017/18
Lambeth Southwark Lewisham

LARC uptake after abortion at BPAS, 2014/15 – 2017/18



References

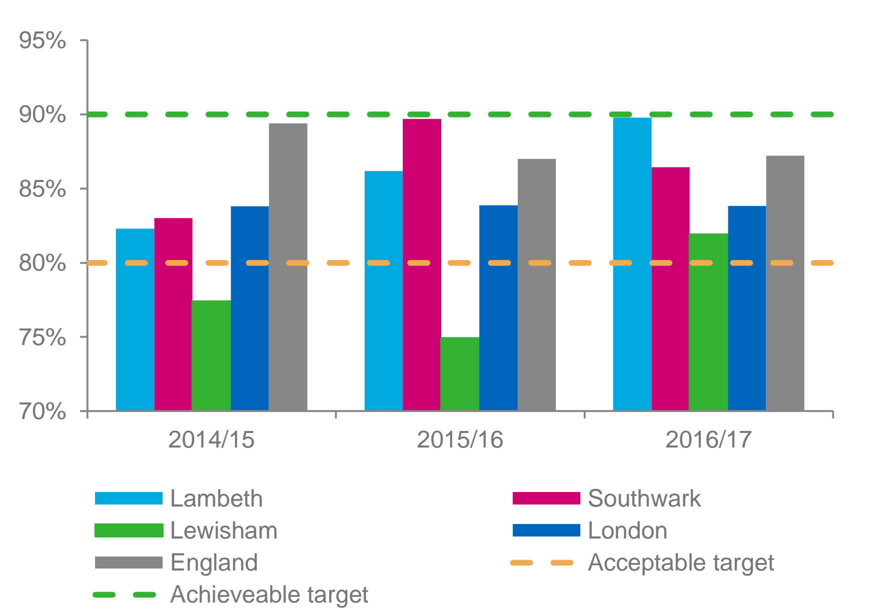
1. NHS Digital, Sexual and Reproductive Health Services, England – 2016-17
2. FSRH 2017, FSRH Guideline Contraception After Pregnancy

In 2016/17, over 80% of girls across LSL in Year 8 had one dose of the HPV vaccination.

HPV VACCINATION

The national human papillomavirus (HPV) immunisation programme was introduced to protect girls against the main causes of cervical cancer.

- PHE set an acceptable target of 80% for population vaccination coverage for one dose (females 12-13 years old) and a 90% achievable target.
- The proportion of Year 8 (12-13 year old) girls vaccinated with at least one dose of HPV by the end of summer 2017, was 90% in Lambeth, 86% in Southwark and 82% in Lewisham.
- All boroughs fall within the acceptable range, though Lewisham has had consistently lower coverage than other boroughs in LSL.
- Following a successful pilot, HPV vaccination in men who have sex with men up to the age of 45 is currently being rolled out across LSL through sexual health clinics.



125

References

1. WHO 2011, Comprehensive Cervical Cancer Control: A guide to essential practice (C4 GEP)
2. PHE Sexual and Reproductive Health Profiles

Rates of pelvic inflammatory disease admissions are highest in Lewisham, but are decreasing.

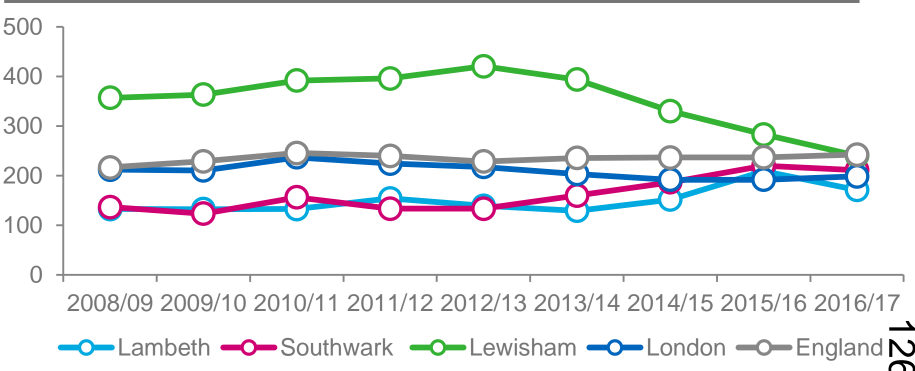
REPRODUCTIVE HEALTH

Pelvic inflammatory disease (PID) refers to an infection of the upper female genital tract which may lead to serious complications e.g. ectopic pregnancy and infertility.

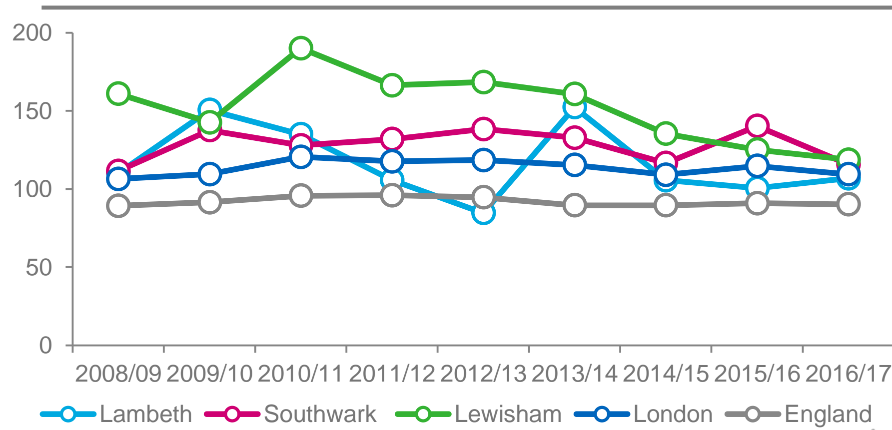
- Across LSL in 2016/17, there were just over 500 cases of pelvic inflammatory disease.
- Admissions for PID were higher in Lewisham than any of the other boroughs, but have declined since 2012/13 – by contrast, rates in Southwark and Lambeth have increased.
- It is estimated that approximately one-quarter of cases are caused by untreated STIs.

Ectopic pregnancy – a complication of pregnancy in which the embryo attaches outside the uterus – usually results in hospital admission.

- There were just under 300 admissions for ectopic pregnancies across LSL in 2016/17.
- Rates of admission for ectopic pregnancy have fluctuated over time, particularly in Lambeth.
- Previous abdominal surgery, STI and smoking all increase the risk of ectopic pregnancy.



126



References

1. PHE Sexual and Reproductive Health Profiles
2. Ectopic Pregnancy Trust, Factors increasing risk of ectopic pregnancy

Reliance on user dependent methods of contraception may contribute to high rates of EHC and abortion in LSL.

REPRODUCTIVE HEALTH SUMMARY

User dependent contraceptive methods (e.g. condoms, or the pill) are the most common form of contraception used in LSL with high use of EHC, particularly in Southwark.

- Two-thirds of women in LSL reported user dependent methods as their main method of contraception.
- LARC does not rely on daily compliance. Prescribing rates of LARC across LSL are lower than England, but higher than London. Southwark has the lowest total LARC prescribing in LSL.
- Use of EHC is high, particularly in Southwark. Repeat use of EHC is also high with 60% of women self-declared previous users within the last 6 months.

Birth rates are falling, as are teenage conceptions. Abortion rates have remained stable and continue to be higher amongst under-18 than other age groups.

- Birth rates are falling and the average age of mothers increasing. Teenage pregnancy in LSL has drastically declined, but remains higher than London – 300 teenagers become pregnant each year.
- Abortion rates have remained broadly stable. In 2016, almost 5,500 abortions took place across LSL – two-thirds of conceptions in under 18s ended in abortion compared to one-third of all conceptions.
- Across LSL, 42% of women having an abortion in 2017 had previously had an abortion. LARC following an abortion LARC is an effective way of preventing subsequent abortions, but has been falling partly due to an increase in medical abortions.

If not successfully treated, STIs can lead to a number of conditions such as pelvic inflammatory disease, ectopic pregnancy, infertility and cervical cancer.

- HPV vaccination coverage to protect girls against the main causes of cervical cancer is consistently lower in Lewisham than other boroughs, but did increase to within the acceptable range in 2016/17.
- Lewisham has had the highest rates of pelvic inflammatory disease and ectopic pregnancies, however this has converged with the rest of LSL over time.

CONTENTS

Introduction	**3**
Healthy and fulfilling sexual relationships	**7**
Good reproductive health across the life course	**10**
High quality STI testing and treatment	**22**
Living well with HIV	**48**

Approximately 16% of the LSL population aged 15-64 used sexual health clinics in 2017.

SEXUAL HEALTH SERVICES

During 2017, almost 112,000 LSL residents visited a sexual health clinic.

- Almost 112,000 residents of LSL attended sexual health services across England; with almost 170,000 attendances in 2017. This suggests that approximately 16% of the LSL population aged 15-64 attended sexual health services in 2017.
- Four of the five services most commonly visited by LSL residents are within the LSL region with the exception of the Dean Street Clinic. An online service, SH:24 was the most commonly used, although relatively few people in Lewisham used this service.
- Almost two-thirds of all sexual health attendances by LSL residents take places in these five sexual health clinics.
- Over half (58%) of the 140,000 people who attend services in the LSL region were resident in the area suggesting there is considerable fluidity in where people access services. Residents from Bromley, Wandsworth, Chelmsford, Greenwich, Croydon are the most common external boroughs of people attending local services. Residents from Chelmsford predominantly used SH:24.

Number of all LSL residents and attendances at sexual health clinics, including breakdown for top five clinics, 2017

Sexual health clinics	Total number of patients					Attendances
	Lambeth	Southwark	Lewisham	LSL patients	%	LSL attendances
SH24 online	8,994	10,267	899	20,160	18%	20,520
Dean Street Clinic	6,303	3,889	2,099	12,291	11%	26,466
Burrell Street Sexual Health Clinic	4,475	6,343	1,267	12,085	11%	19,098
King's College Hospital NHS Foundation Trust	4,156	6,676	1,204	12,036	11%	17,947
Waldron Health Centre	148	1,561	10,896	12,605	11%	24,013
Other Clinics	18,543	12,989	10,962	42,494	38%	61,716
Total	**42,619**	**41,725**	**27,327**	**111,671**	**100%**	**169,760**

References
1. GUMCADv2 Report: Patient Flow Summary

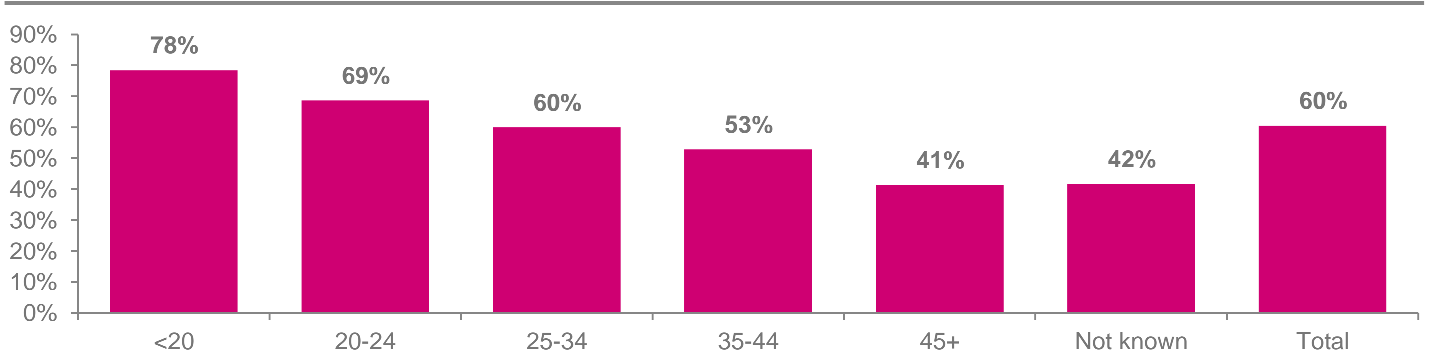
The service user population is young, with a high proportion of women, particularly in younger age groups.

SERVICE USER POPULATION

Data on first attendances at sexual health clinics were pulled from GUMCADv2 for the 2017 calendar year for the nine clinics in LSL.

- Service user data drawn from nine clinics across three providers: Kings College Hospital, Guys and St Thomas' NHS Foundation Trust and Lewisham and Greenwich NHS Foundation Trust.
- Younger people attend services more than older people – 41% of service users were aged 25-34, 23% aged 20-24 and 9% aged under 20.
- Overall, 60% of the service user population are women. Gender and age also interact, with 78% of users under 20 being women and this gradually decreasing to a low of 41% in those aged over 45.
- Across all clinics, 80% of service users identify as heterosexual, 13% gay or lesbian and 2% bisexual.
- Ethnicity is the most poorly recorded demographic characteristic – 13% have no ethnicity recorded. The two largest ethnic groups were White (42%) and Black (27%).

Proportion of service users in 2017 who are female by age group.

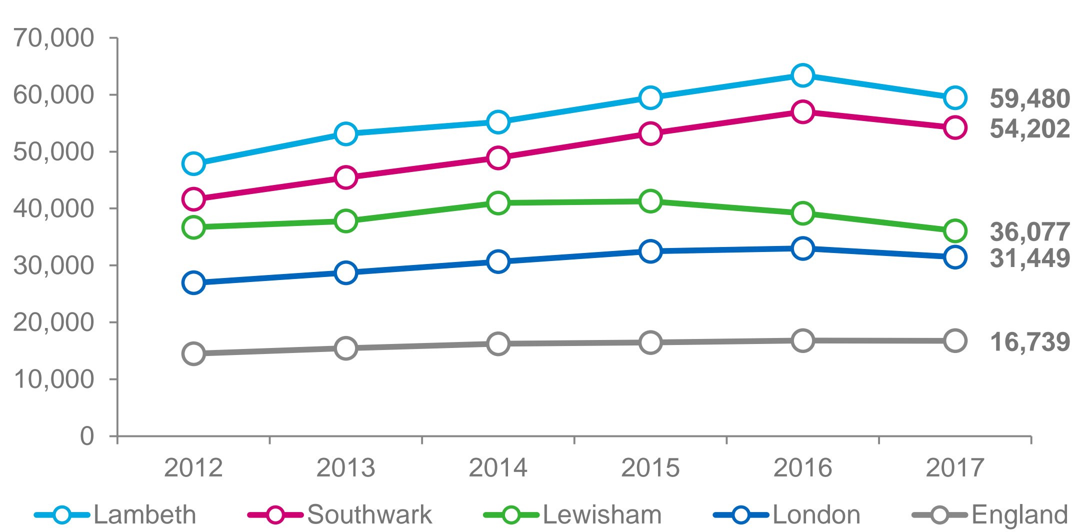


Rates of STI testing across LSL are consistently above levels in London and England.

STI TESTING

Early detection and treatment of STIs can reduce long-term consequences, such as onward transmission, infertility and ectopic pregnancy. As STIs are often asymptomatic, frequent testing, particularly in risk groups is crucial in early detection and treatment.

- In 2017, almost 350,000 tests were carried out for syphilis, HIV, gonorrhoea and chlamydia (aged over 25) among people accessing sexual health services in LSL.
- While STI testing rates in Lambeth and Southwark plateaued in 2017, they are substantially higher than in 2012. Over the five year period testing rates in Lewisham have remained broadly stable.
- Testing rates across LSL are consistently above levels in London and England, substantially so in the case of Lambeth and Southwark.



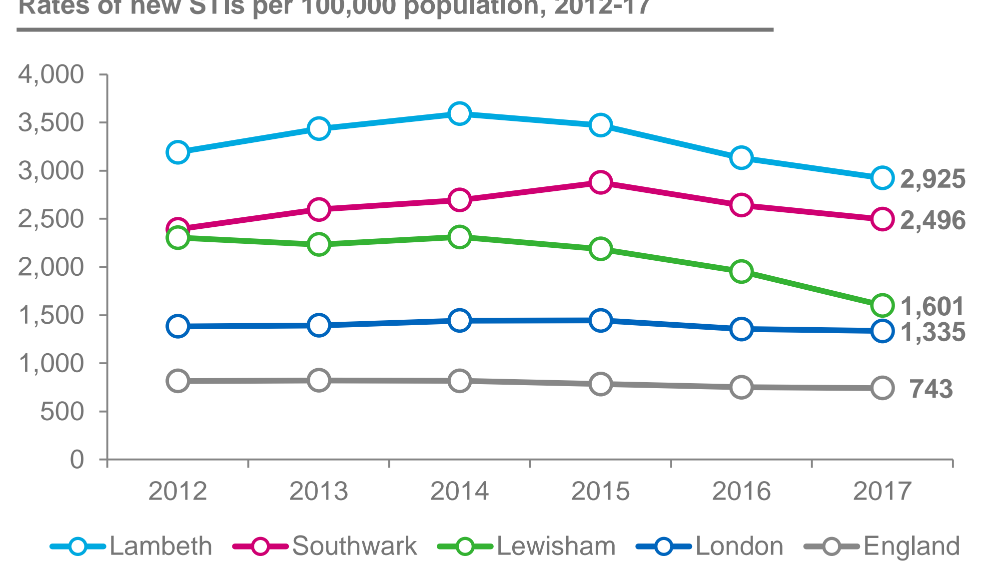
References
1. PHE, Sexual and Reproductive Health Profiles

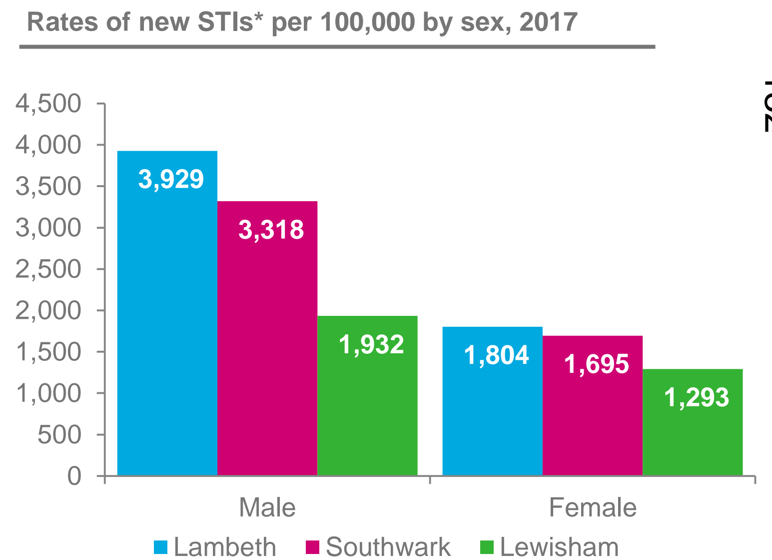
Rates of new STI diagnosis in Lambeth, Southwark and Lewisham are amongst the highest in England.

NEW STI DIAGNOSES

All new STI diagnoses among people accessing specialist and non-specialist sexual health services each calendar year are collected in the GUMCADv2 system.

- In 2017, just over 22,000 new STIs* were diagnosed across Lambeth, Southwark and Lewisham
- Lambeth had the highest rate of new STI diagnoses in England in 2017, followed by Southwark in third, and Lewisham 11th. In recent years there has been a downward trend in new STIs overall.
- Rates of new STIs are considerably higher in men than women.





References

1. PHE Sexual and Reproductive Health Profiles
2. GUMCADv2 – Including CTAD, GUM & Non-GUM Services only

* New STIs covers a broad range of STIs beyond five most common STIs e.g. chancroid, scabies & shigella.

There is substantial variation in the diagnosis rate of new STIs across the region.

NEW STI DIAGNOSES

Lambeth
Southwark
Lewisham

Rate per 100,000 residents

- >0 & <500
- >=500 & <1,000
- >=1,000 & <1,500
- >=1,500 & <2,000
- >=2,000 & <2,500
- >=2,500 & <3,000
- >=3,000+

Diagnosis rate of new sexually transmitted infections across LSL, 2017

There is substantial variation in the diagnosis rate of new STIs across the region.

- New diagnoses of STIs are not evenly distributed across LSL, with rates particularly high in northern and central Lambeth, north-west Southwark and north Lewisham.
- However the picture is complex. Lower diagnosis rates in some communities may reflect lower levels of access / attendance rather than lower levels of need.

References

1. GUMCADv2
2. © Crown copyright and database right 2018, Ordnance Survey (0) 100019252

Men are more likely than women to become re-infected with an STI within 12 months of diagnosis.

RE-INFECTION

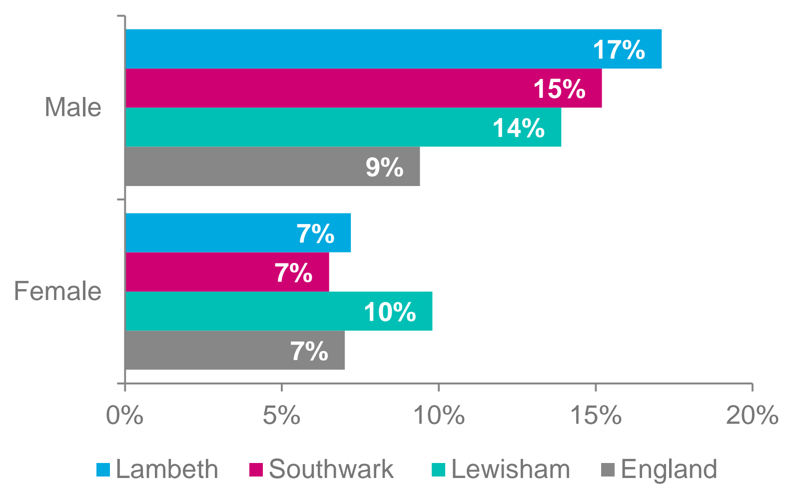
Re-infection with an STI is a marker of persistent risky behaviour.

- Across LSL, men are more likely to have a reinfection within 12 months of diagnosis. Lambeth has the highest rate of re-infections among men (17%) and Lewisham the highest among women (10%).
- The proportion of people with a re-infection in LSL is much higher than the rest of England.

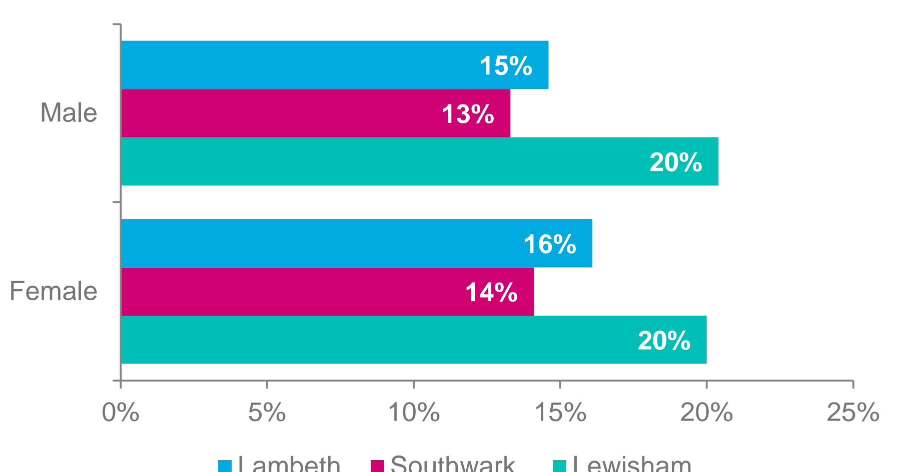
Teenagers are considered to be at increased risk of re-infection because they are more likely to lack the skills and confidence to negotiate safer sex.

- In 2016, double the proportion of 15-19 year old women were re-infected as women of all ages.
- By contrast, a smaller proportion of men aged 15-19 were re-infected in Lambeth and Southwark than men of all ages, but a higher proportion of 15-19 years olds in Lewisham.

Re-infection within 12 months. All STIs, all age groups, 2012-16



Re-infection within 12 months. All STIs, among 15-19 year olds, 2012-16



References

1. PHE, Local authority HIV, sexual and reproductive health epidemiology report (LASER): 2016

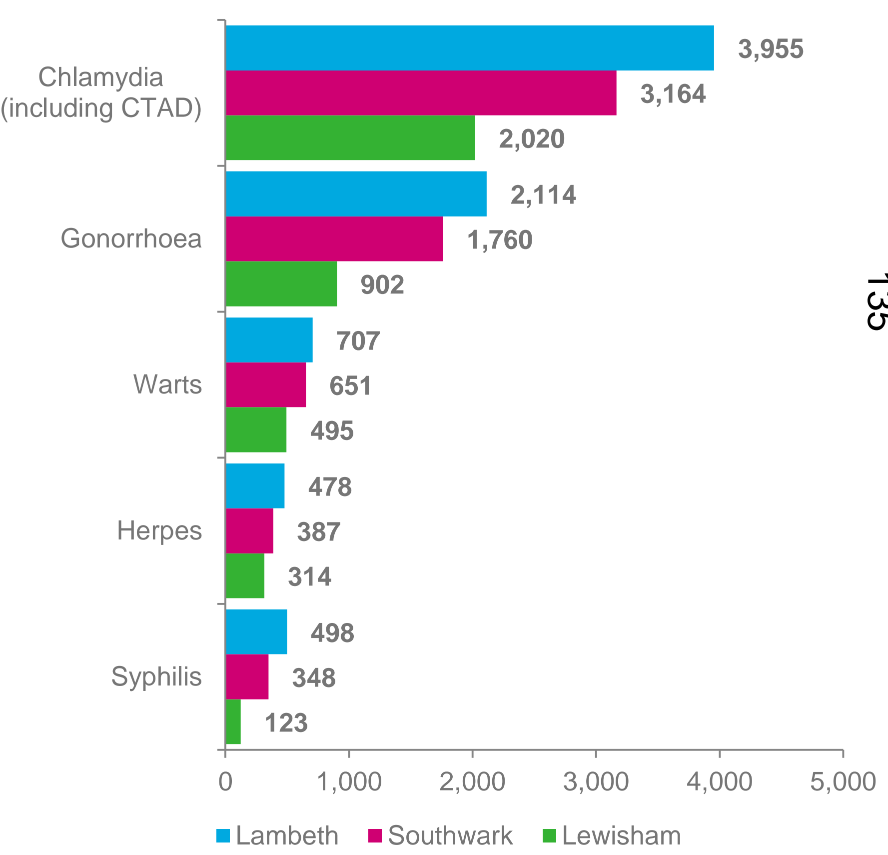
Chlamydia, gonorrhoea, syphilis, genital herpes and warts are the most common STIs – 16,000 cases in LSL in 2017.

COMMON STIS

Chlamydia, gonorrhoea, genital herpes, syphilis and genital warts are the most common STIs

- Mirroring the national picture, chlamydia is the most commonly diagnosed STI across the three boroughs, with over 9,000 new cases in LSL during 2017.
- Gonorrhoea is the second most common STI across the three boroughs.
- It is important to recognise that the majority of cases are diagnosed in sexual health clinics, and consequently the number of cases may be a measure of access to sexually transmitted infection (STI) treatment, as well as a measure of sexual health need.
- The following slides present more detailed analysis of each of the top five sexually transmitted infections in turn.

Count of the five most commonly diagnosed STIs, LSL 2017



135

References
1. PHE, Sexual and Reproductive Health Profiles

Chlamydia is the most commonly diagnosed STI in LSL, with diagnosis rates highest amongst those aged 15-24.

CHLAMYDIA - OVERVIEW

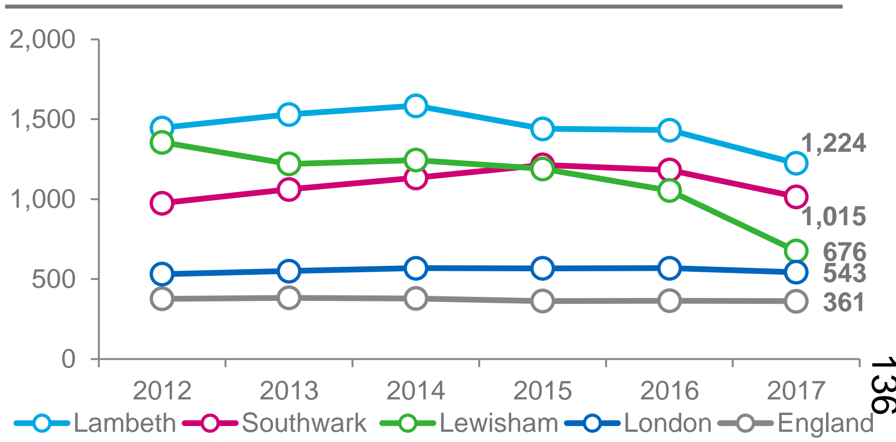
Chlamydia is by far the most common sexually transmitted infection (STI) in the UK.

- Chlamydia is a bacterial infection, usually spread through unprotected sex.
- It is particularly common in sexually active teenagers and young adults.

Chlamydia is the most common STI in LSL with over 9,000 cases diagnosed in GUMCAD and non-GUMCAD services in 2017 and rates are at least double that of London.

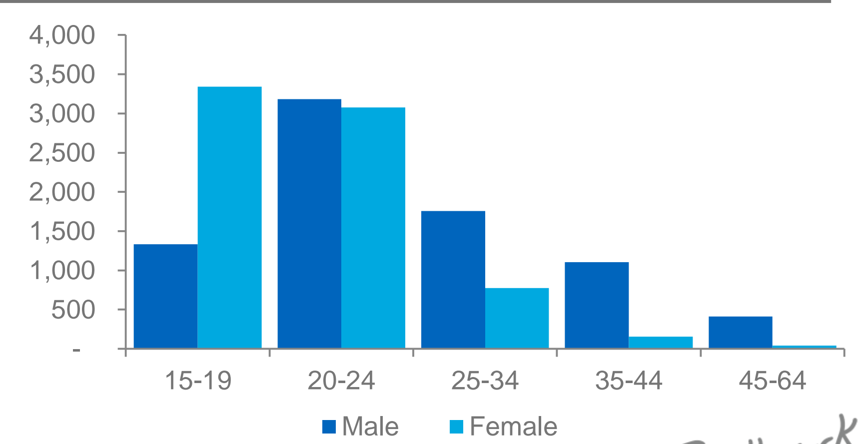
- Rates of chlamydia are decreasing in LSL, particularly in Lewisham where the rate has almost halved since 2015.
- Looking at rates of chlamydia by age group (excluding CTAD), it's clear that rates are considerably higher among young people, particularly those aged 20-24.
- The diagnosis rate of chlamydia is higher among men (979 per 100,000) than women (605 per 100,000), with the exception of the 15-19 year age group where the rate among women is approximately double that for men.

Rates of chlamydia diagnosis in LSL, 2012-17



136

Rates of chlamydia diagnosis in LSL by sex and age group, 2017



References

1. PHE Sexual and Reproductive Health Profiles (including GUM, CTAD and Non-GUM services)
2. GUMCADv2 – Excluding CTAD. GUM & Non-GUM Services only
3. NHS Choices

Southwark Council
southwark.gov.uk

Chlamydia diagnosis rates are higher among men than women across almost all ethnic groups.

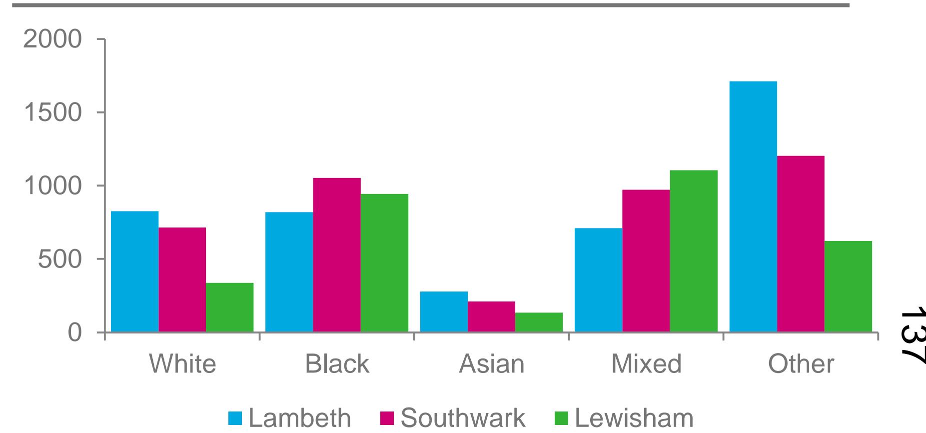
CHLAMYDIA - ETHNICITY

Rates of chlamydia diagnosis vary by ethnicity and borough

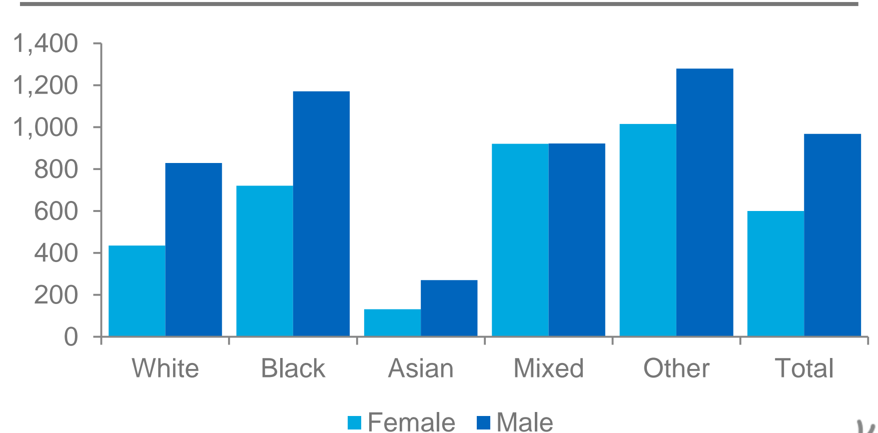
- In Lambeth and Southwark, the highest rates of chlamydia are seen in mixed and Other ethnic groups. In Lewisham chlamydia rates are highest in mixed and Black ethnicities.
- Rates are lowest in Asian ethnic groups across all boroughs.

Broadly, men have higher rates of chlamydia than women across all ethnic groups

- Chlamydia rates are higher amongst men than women across all ethnic groups in LSL with the exception of those stating mixed ethnicity, where diagnosis rates are similar.
- The only exceptions to this at borough level, is that women have higher rates of chlamydia than men in Other ethnic groups in Southwark and in mixed ethnic groups in Lewisham.



137



References

1. PHE Sexual and Reproductive Health Profiles (including GUM, CTAD and Non-GUM services)
2. GUMCADv2 – Excluding CTAD. GUM & Non-GUM Services only

Most of the chlamydia cases diagnosed in LSL are among men and in people who identify as heterosexual.

CHLAMYDIA - SEXUALITY

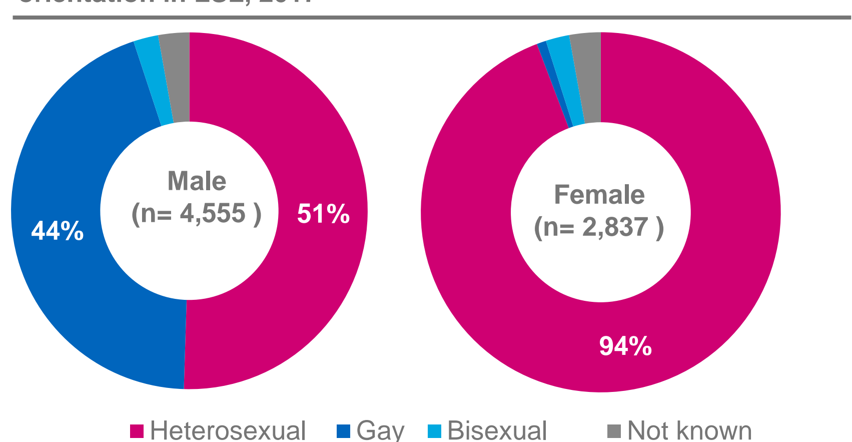
The majority of chlamydia cases are diagnosed among people who identify as heterosexual.

- Just over 7,400 cases of chlamydia were diagnosed in GUMCAD clinics across LSL in 2017: 61% of these cases were in men.
- In women, 94% of chlamydia diagnoses were among those who identified as heterosexual, compared to 51% of all male diagnoses.
- Of all chlamydia cases diagnosed in men across LSL, 44% were in men who identify as gay, but this varied by borough: Lambeth (54%), Southwark (43%) and Lewisham (29%) where population identifying as gay is smaller.

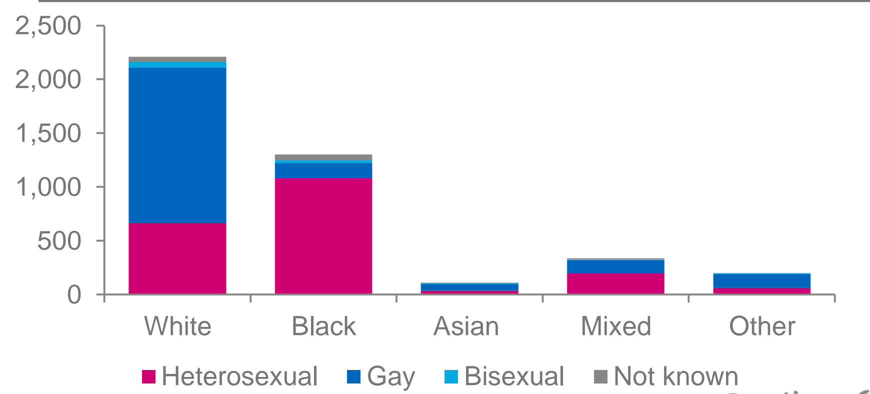
The proportion of all diagnosed cases by sexual orientation varies by ethnicity

- The largest total number of cases are seen in White and Black men, due to population structure.
- The majority of cases diagnosed in White men are amongst men who identify as gay, whilst the majority of cases diagnosed in Black men were in those who identified as heterosexual.
- Due to small numbers of women identifying as categories other than heterosexual, only the male ethnic breakdown is provided.

Proportion of all diagnosed chlamydia cases by sex and sexual orientation in LSL, 2017



Proportion of all chlamydia diagnoses in men in LSL by ethnicity and sexuality, 2017



References

1. PHE Sexual and Reproductive Health Profiles (including GUM and Non-GUM services, and excluding CTAD)
2. GUMCADv2 – Excluding CTAD. GUM & Non-GUM Services only

Southwark Council
southwark.gov.uk

After a decrease in 2016, gonorrhoea increased again in 2017 across LSL and London.

GONORRHOEA - OVERVIEW

Gonorrhoea is often used as a marker for rates of unsafe sexual activity.

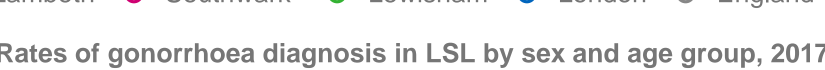
- Gonorrhoea is caused by bacteria called Neisseria gonorrhoeae or gonococcus.
- People who change partners frequently are at increased risk of gonorrhoea.

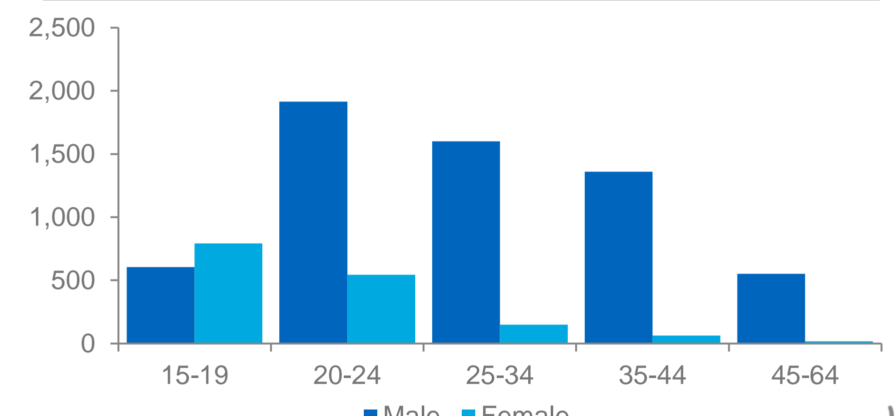
Gonorrhoea is the second most common STI in LSL with almost 5,000 cases in 2017.

- Gonorrhoea rates in Lambeth and Southwark are considerably higher than Lewisham, which is similar to London rate.
- Gonorrhoea rates increased across LSL in 2012-2015, and decreased in 2016 only to increase again in 2017.
- Rates are highest among people aged 20-24 across LSL (1,182 per 100,000).
- Men have higher rates of gonorrhoea than women across all age groups, with the exception of 15-19 year olds.
- Reinfection within 12 months is higher for gonorrhoea than all STIs among men in Lambeth and Southwark, but not in Lewisham and not for women.

Rates of gonorrhoea diagnosis in LSL, 2012-17

1,000
800
600
400
200
0
2012
2013
2014
2015
2016
2017
654
565
302
228
79
Lambeth
Southwark
Lewisham
London
England





References

1. PHE Sexual and Reproductive Health Profiles (including GUM, CTAD and Non-GUM services)
2. NHS Choices

Southwark Council
southwark.gov.uk

Rates of gonorrhoea are considerably higher in men than women across all ethnic groups.

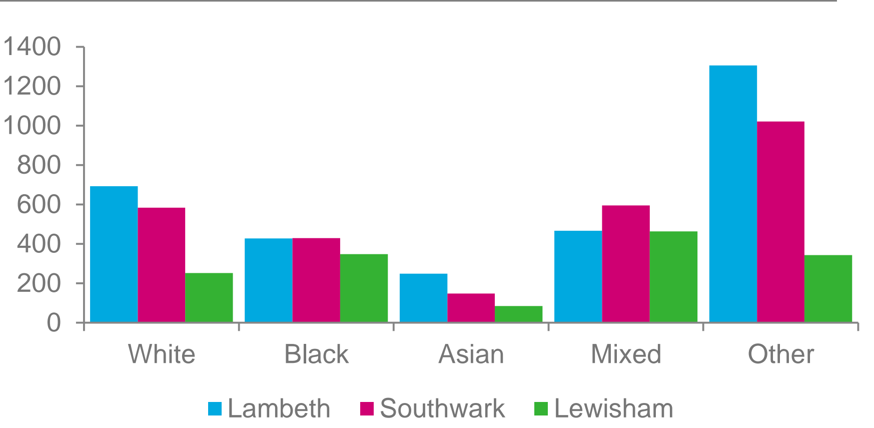
GONORRHOEA - ETHNICITY

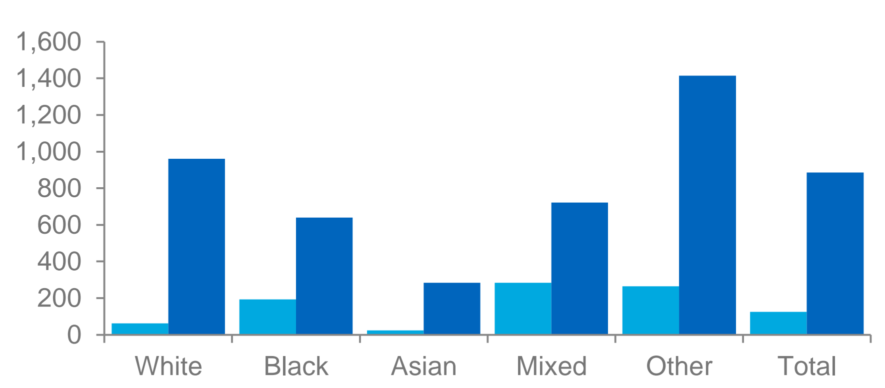
Rates of gonorrhoea vary substantially by ethnicity and borough.

- People from Asian ethnic groups have lower rates of gonorrhoea than other groups.
- People from Other ethnic groups have the highest diagnosis rates in Lambeth and Southwark, with those from a mixed ethnic background having the highest rates in Lewisham.
- Men have considerably higher rates of gonorrhoea, across all ethnicities.

The first case of N. gonorrhoeae with antibiotic resistance was declared in England in early 2018.

- Prompt diagnosis, prescribing guideline adherence, identifying and managing potential treatment failures effectively, and reducing transmission are key to reducing the spread of treatment resistant strains.





References

1. PHE Sexual and Reproductive Health Profiles (including GUM, CTAD and Non-GUM services)
2. GUMCADv2 – Excluding CTAD. GUM & Non-GUM Services only
3. Multi-drug resistant gonorrhoea in England: 2018
4. PHE Local authority HIV, sexual and reproductive health epidemiology report 2016: Southwark.

Nine in ten cases of gonorrhoea in LSL are diagnosed in men with over three-quarters of those identifying as gay.

GONORRHOEA – SEXUALITY

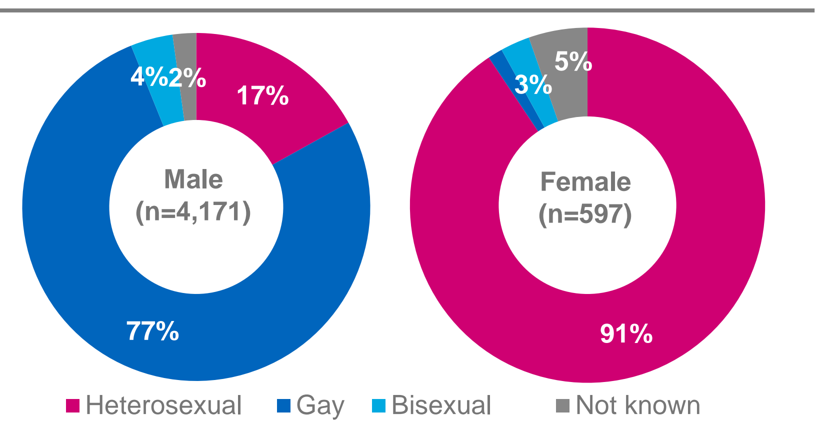
Gonorrhoea is most commonly diagnosed among men who identify as gay.

- Of all 4,800 cases of gonorrhoea diagnosed in LSL in 2017, 87% were diagnosed in men.
- Of all those diagnosed with gonorrhoea, 91% of women identified as heterosexual and 77% of men identified as gay.
- The proportion of men diagnosed with gonorrhoea who identify as gay varied by borough: Lambeth (82%), Southwark (77%) and Lewisham (65%).

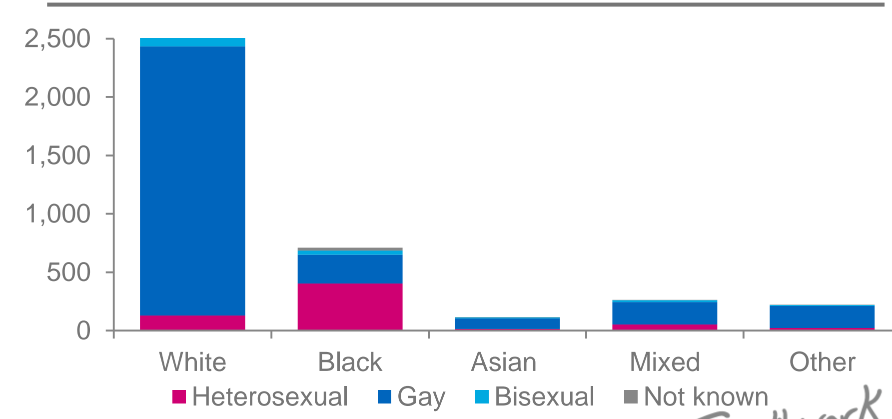
The proportion of all diagnosed cases of gonorrhoea by sexuality varies by ethnic group

- In people from White ethnic backgrounds who were diagnosed with gonorrhoea, 90% identify as gay, compared to 35% of those from Black ethnic backgrounds.
- Due to small numbers of women identifying as categories other than heterosexual, only the male ethnic breakdown is provided.

Proportion of all diagnosed gonorrhoea cases by sex and sexual orientation in LSL, 2017



Proportion of all gonorrhoea diagnoses in men in LSL by ethnicity and sexuality, 2017



References

1. PHE Sexual and Reproductive Health Profiles (including GUM, CTAD and Non-GUM services)
2. GUMCADv2 – Excluding CTAD. GUM & Non-GUM Services only
3. Multi-drug resistant gonorrhoea in England: 2018

Southwark Council
southwark.gov.uk

Syphilis rates in Lambeth and Southwark are very high compared to London and are increasing.

SYPHILIS - OVERVIEW

Syphilis is an important public health issue, particularly among men who have sex with men (MSM).

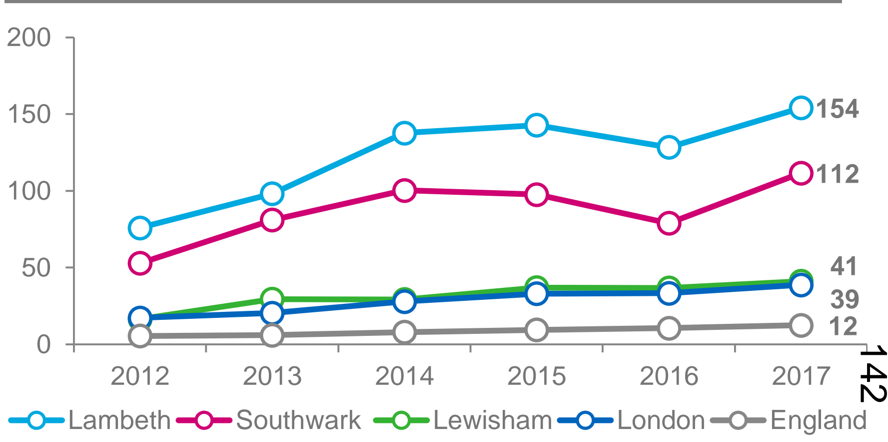
- If left untreated for a long period, syphilis can spread to the brain or other parts of the body and cause serious, long-term problems.
- Genital sores caused by syphilis also make it easier to transmit and acquire HIV infection sexually.

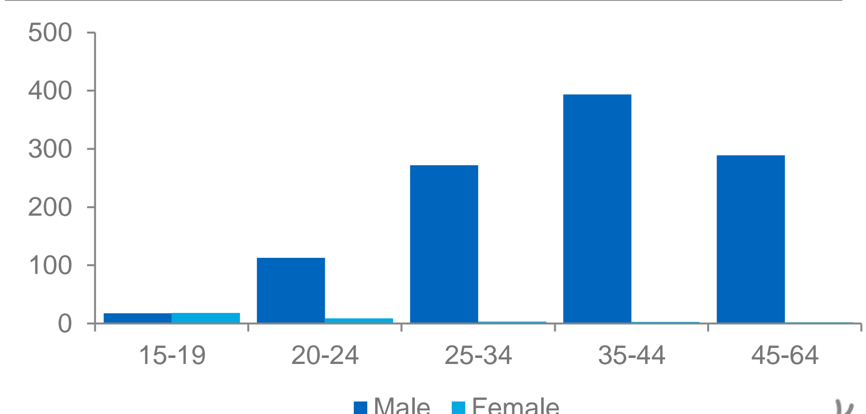
The rate of syphilis diagnosis has increased over the past decade.

- There were just under 1,000 cases of syphilis diagnosed in LSL in 2017; up from 406 in 2012.
- Men accounted for almost all cases.
- Rates of syphilis in Lambeth and Southwark are considerably higher than London, while Lewisham had a comparable diagnosis rate.

The age profile of people with syphilis is older than the other five most common STIs.

- By contrast to other STIs which are commonly seen in young adults, syphilis is most common among those aged 35-44 and has been growing in this age group over time.





References

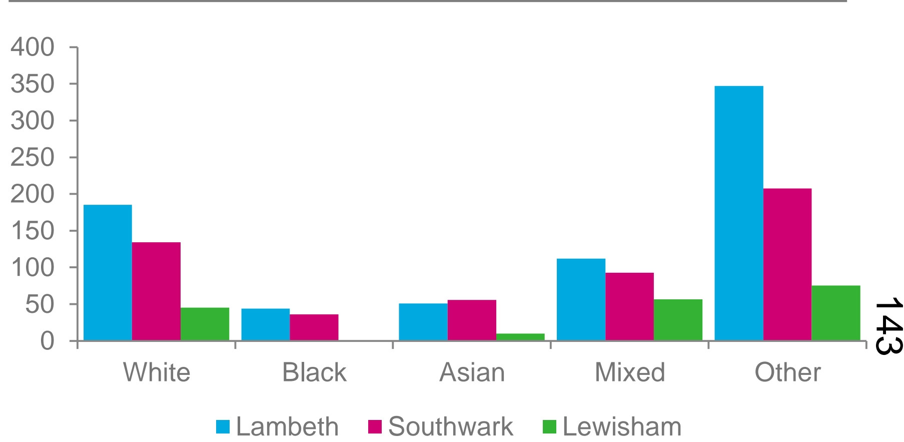
1. NHS choices
2. PHE, Sexual and Reproductive Health Profiles
3. CDC, Syphilis - CDC Fact Sheet (Detailed)
4. GUMCADv2 – Excluding CTAD. GUM & Non-GUM Services only

Rates of syphilis vary by ethnic group and are highest amongst those from Other ethnic groups.

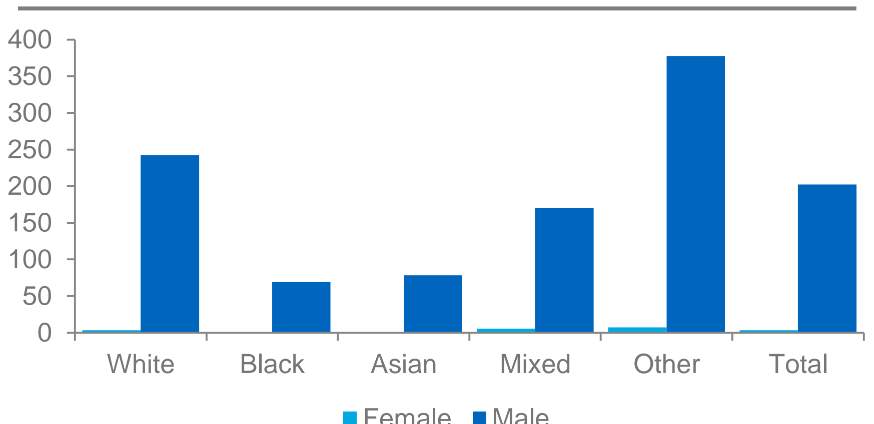
SYPHILIS – ETHNICITY

Rates of syphilis are considerably higher among those from Other ethnic groups across LSL

- Rates of syphilis are very low among Black and Asian ethnic groups across all boroughs.
- In Lambeth, rates of syphilis are considerably higher among Other ethnic groups.
- White ethnic groups also have relatively high rates of syphilis.



143



References

1. PHE Sexual and Reproductive Health Profiles
2. GUMCADv2 – Excluding CTAD. GUM & Non-GUM Services only

Syphilis cases are predominantly found amongst men who have sex with men.

SYPHILIS - SEXUALITY

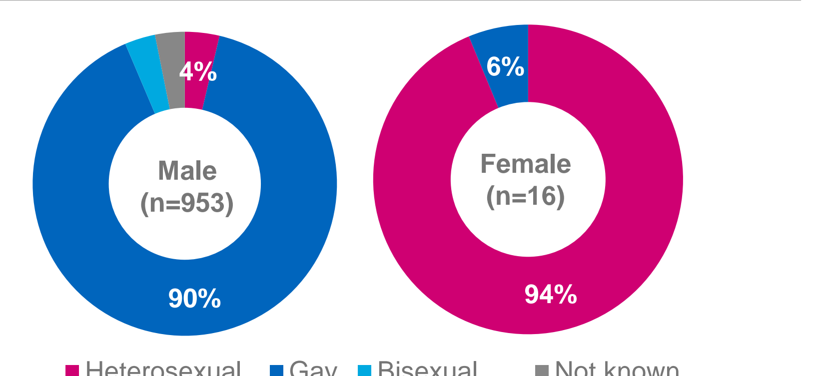
In LSL syphilis is predominantly found in men who have sex with men.

- Of the 1,000 cases of syphilis diagnosed in 2017, 98% of these were diagnosed in men.
- Within the 953 men diagnosed with syphilis, 90% were in men who identified as gay.
- The majority of cases were seen in men from White ethnic backgrounds.
- Due to small numbers of women with syphilis, only the male ethnic breakdown is provided.

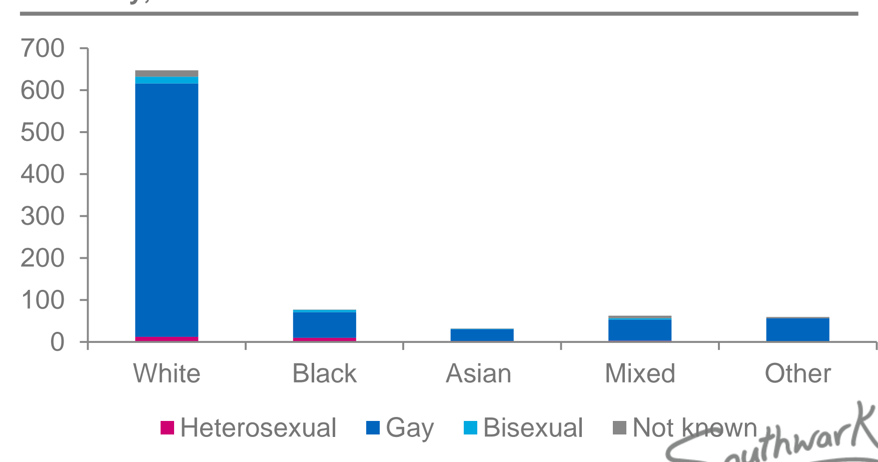
New syphilis diagnoses are evenly split in three: primary, secondary and early latent.

- Across LSL the three stages of diagnosis are roughly equal – Southwark (29%) has the lowest proportion of secondary stage cases and Lewisham (35%) the highest.
- Across South East London (LSL plus Greenwich) syphilis diagnoses in heterosexual men (51%) and women (44%) are more likely to be primary stage than in MSM (33%).

Proportion of all diagnosed syphilis cases in men by sex and sexual orientation in LSL, 2017



Proportion of all syphilis diagnoses in men in LSL, by ethnicity and sexuality, 2017



References

1. PHE Sexual and Reproductive Health Profiles
2. GUMCADv2 – Excluding CTAD. GUM & Non-GUM Services only
3. Syphilis epidemiology in South East London 2017 data sector supplement to the London update

Southwark Council
southwark.gov.uk

The highest rates of genital warts occur among those aged 20-24 and among people who identify as heterosexual.

GENITAL WARTS - OVERVIEW

Genital warts are caused by infection with specific subtypes of human papillomavirus (HPV).

- Genital warts is a common sexually transmitted infection (STI) passed on through condom-less sex.
- A new opportunistic HPV vaccination programme for MSM is being rolled out across SRH clinics.

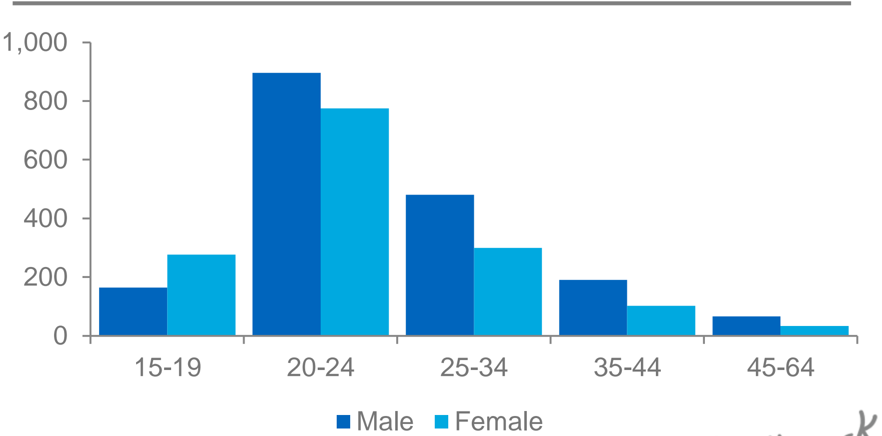
Genital warts are the third most commonly diagnosed STI in LSL with just under 2,000 cases diagnosed in 2017.

- Rates of genital warts decreased across LSL between 2012 and 2017.
- Lambeth and Southwark still have rates of genital warts higher than London, but Lewisham is now in line with the London rate.
- Diagnosis rates of genital warts are substantially higher among those aged 20-24 across all boroughs.
- Rates among men are higher than their female counterparts across all age groups except 15-19 years old.

Rates of genital warts in LSL, 2012-17

400
300
200
100
0
2012 2013 2014 2015 2016 2017
219
209
166
143
104
Lambeth Southwark Lewisham London England

Rates of genital warts in LSL by sex and age group, 2017



References
1. PHE Sexual and Reproductive Health Profiles
2. GUMCADv2 – Excluding CTAD. GUM & Non-GUM Services only

Genital warts vary by ethnicity, with particularly high rates amongst Other ethnic groups in Lewisham.

GENITAL WARTS - ETHNICITY

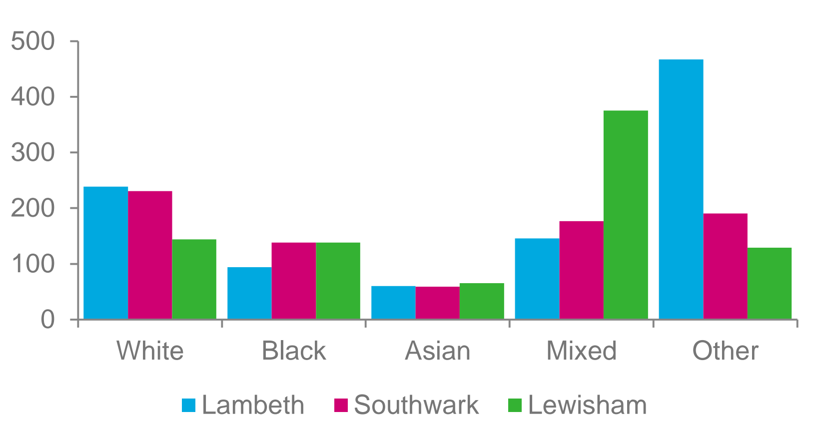
Genital warts rates vary between different ethnic groups and across the three boroughs.

- Rates of genital warts are notably highest amongst people from Other ethnic groups in Lambeth and mixed ethnic groups in Lewisham.
- Across all boroughs, rates of genital warts are lowest in Asian ethnic groups.

Rates of genital warts vary by sex across ethnicity but are mainly higher among men

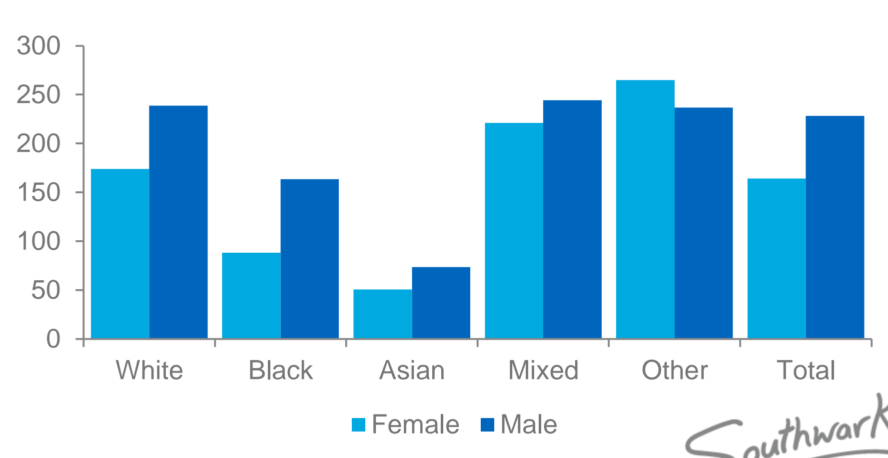
- In LSL as a whole, rates of genital warts are higher among men than women across all ethnic groups with the exception of Other ethnic groups

Rates of genital warts in LSL by ethnicity, 2017



146

Rates of genital warts in LSL by sex and ethnicity, 2017



References
1. PHE Sexual and Reproductive Health Profiles
2. GUMCADv2 – Excluding CTAD. GUM & Non-GUM Services only

Southwark Council
southwark.gov.uk

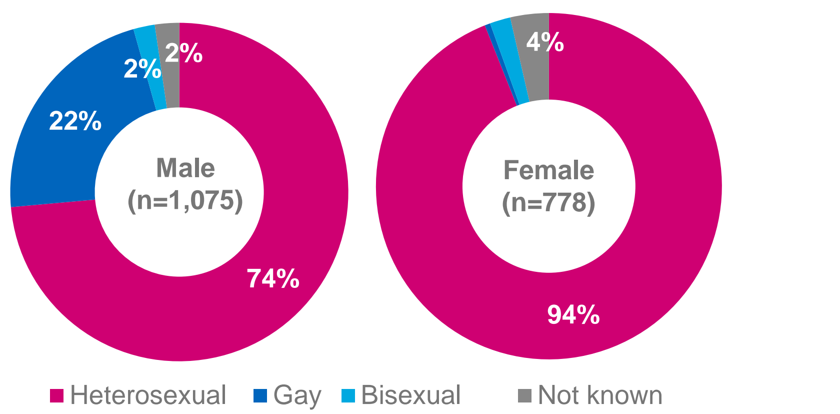
Genital warts are mostly diagnosed in people who identify as heterosexual and slightly more in men.

GENITAL WARTS - SEXUALITY

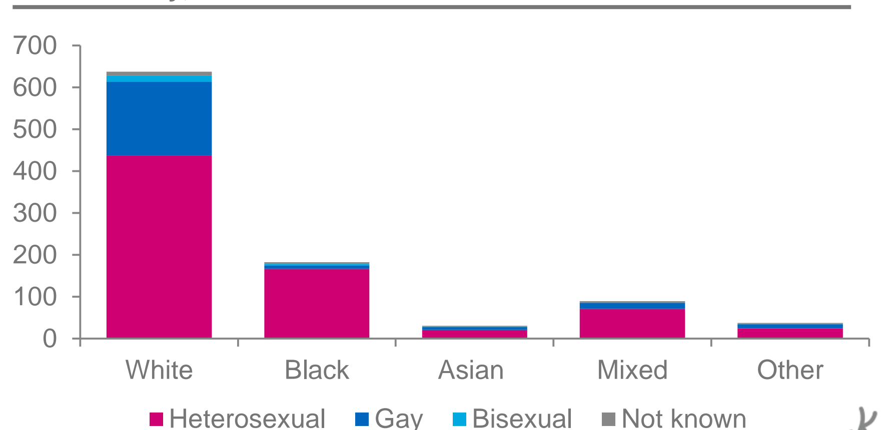
The majority of cases of genital warts are diagnosed in people who identified as heterosexual.

- Of just under 2,000 cases diagnosed in LSL in 2017, 58% were in men.
- For both men (74%) and women (94%), the majority of genital warts cases are diagnosed in people who identify as heterosexual and this split was similar across all boroughs.
- Just under one in five men diagnosed with genital warts identified as gay.
- The majority of the cases diagnosed in men who identified as being gay were in men from White ethnic groups.
- Due to small numbers of women identifying as categories other than heterosexual, only the male ethnic breakdown is provided.

Proportion of all diagnosed genital warts cases by sex and sexual orientation in LSL, 2017



Proportion of all genital warts diagnoses in men in LSL by ethnicity and sexuality, 2017



References
1. PHE Sexual and Reproductive Health Profiles
2. GUMCADv2 – Excluding CTAD. GUM & Non-GUM Services only

Southwark Council
southwark.gov.uk

Rates of genital herpes are highest among women and people aged 20 to 24 years.

GENITAL HERPES - OVERVIEW

Genital herpes is the most common ulcerative sexually transmitted infection.

- Passed on through vaginal, anal and oral sex, blisters can take months or years to appear.

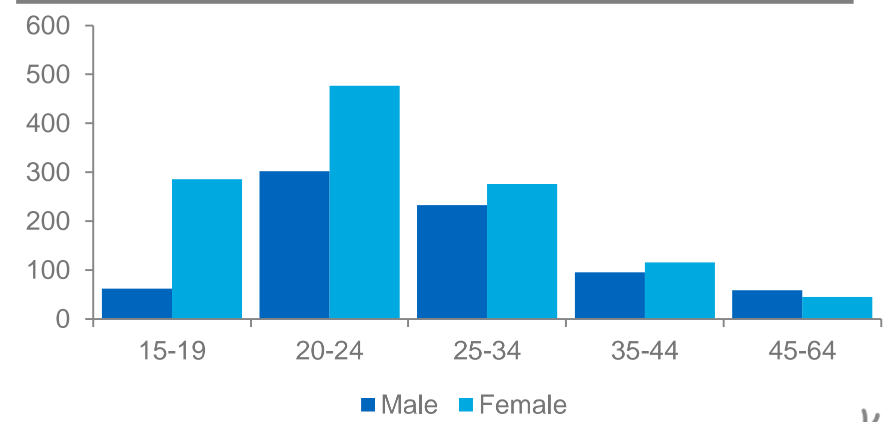
With just under 1,200 new cases diagnosed in LSL in 2017, genital herpes is the fourth most common STI.

- Rates of genital herpes have been broadly stable since 2012, both locally and nationally.
- Genital herpes is the only one of the five most common STIs where more women are diagnosed than men.
- Rates of genital herpes are considerably higher among those aged 20-24 across LSL , with this pattern seen across all three boroughs.
- Differences in the diagnosis rate of genital herpes are particularly pronounced in the 15-24 year old age groups and narrow after that.

Rates of genital herpes in LSL, 2012-17

250
200
150
100
50
0
2012
2013
2014
2015
2016
2017
148
124
105
91
57
Lambeth
Southwark
Lewisham
London
England

Rates of genital herpes in LSL by sex and age group, 2017



References

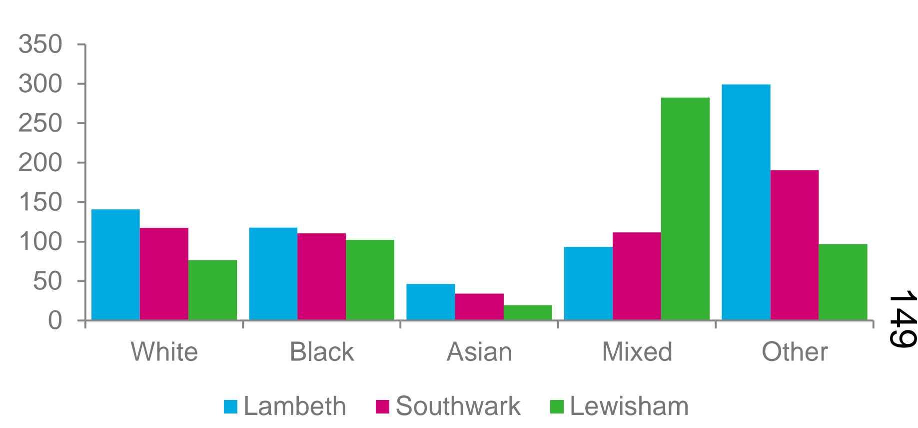
1. PHE Sexual and Reproductive Health Profiles
2. GUMCADv2 – Excluding CTAD. GUM & Non-GUM Services only

Rates of genital herpes vary by ethnic group and are higher amongst women than men in almost all groups.

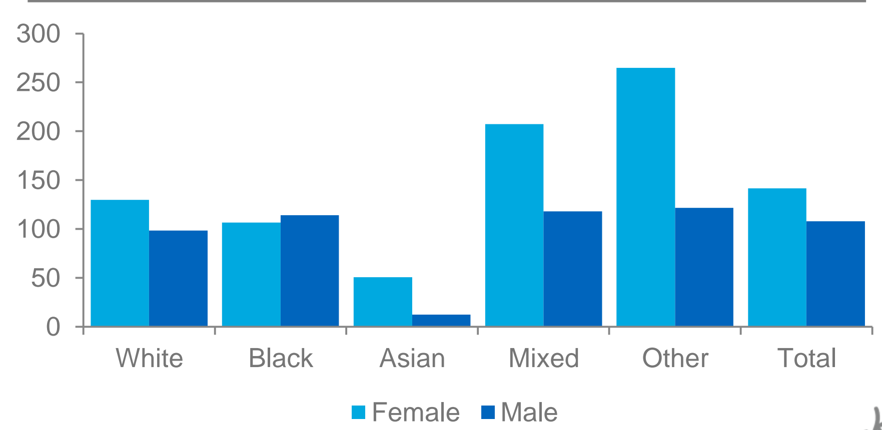
GENITAL HERPES – ETHNICITY

Rates of herpes are considerably vary by ethnic groups across LSL.

- In Lewisham, the highest rates of genital warts were seen mixed ethnic groups. However, in Lambeth & Southwark, Other ethnic groups have the highest diagnosis rate of genital warts.
- Diagnosis rates are lowest among those from an Asian background across all three boroughs.
- Rates of genital herpes are higher in women than men across all ethnic groups, with the exception of people from Black ethnic groups, where rates are broadly comparable between the sexes.



149



References

1. PHE Sexual and Reproductive Health Profiles
2. GUMCADv2 – Excluding CTAD. GUM & Non-GUM Services only

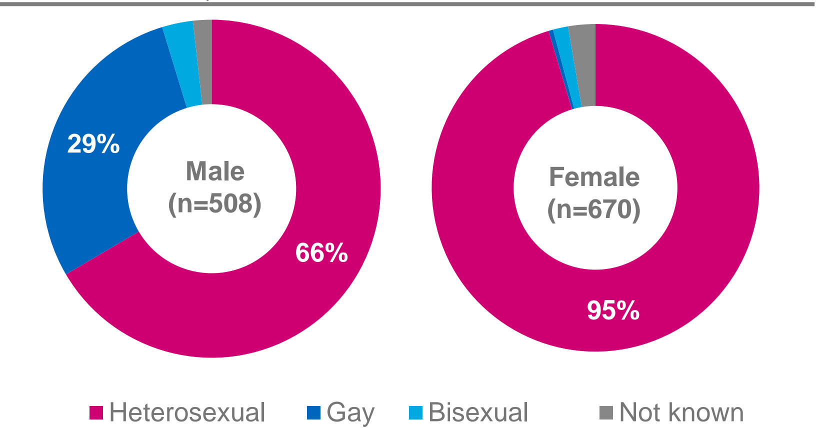
Just over half of genital herpes cases in LSL are diagnosed in women who identified as heterosexual.

GENITAL HERPES – SEXUALITY

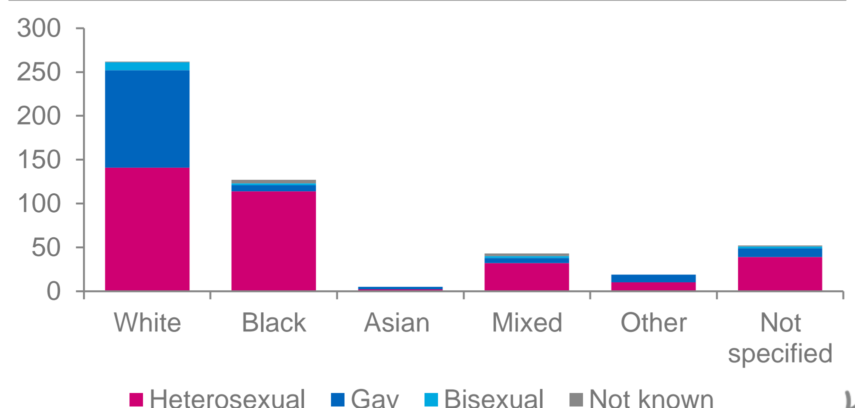
Genital herpes is most commonly diagnosed in women and people who identified as heterosexual.

- Of the 1,200 cases of genital herpes diagnosed in LSL during 2017, 57% were among women.
- The majority of genital herpes cases are diagnosed in people who identify as heterosexual in both men (66%) and women (95%) – accounting for 83% of all diagnoses.
- In addition, one-third of men diagnosed with genital herpes identified as being gay and this varied by borough: Lambeth (36%), Southwark (31%) and Lewisham (13%).
- The majority of men who identified as gay with a diagnosis of genital herpes were from White ethnic backgrounds.
- Due to small numbers of women identifying as categories other than heterosexual, only the male ethnic breakdown is provided.

Proportion of all diagnosed genital herpes cases by sex and sexual orientation in LSL, 2017



Proportion of all genital herpes diagnoses in men in LSL, by ethnicity and sexuality, 2017



References

1. PHE Sexual and Reproductive Health Profiles
2. GUMCADv2 – Excluding CTAD. GUM & Non-GUM Services only

In LSL 22,000 new STIs were diagnosed in 2017, with rates highest among men and those aged 20-24.

SUMMARY

There is a high burden of sexual ill-health across Lambeth, Southwark and Lewisham.

- In 2017, just over 22,000 new STIs* were diagnosed across the three boroughs.
- Lambeth had the highest rate of new STI diagnoses in the country in 2017, followed by Southwark in third, and Lewisham had 11th highest rate. However, there is a downward trend in new STIs.
- The most common STIs are chlamydia, gonorrhoea, genital warts, genital herpes and syphilis.
- While most STIs are decreasing, rates of gonorrhoea and syphilis are increasing. This is of particular concern to due anti-microbial resistance and the severity of syphilis.

Rates of STIs are highest among men, except in those aged 15-19 years.

- Rates of new STIs are considerably higher in men than women – amongst the five most common STIs, genital herpes is the only STI that has higher rates among women.
- The exception to the male/female divide is age – women have higher rates of STIs than men at age 15-19. It is unclear what is driving this pattern, but it may be that teenagers lack the skills and confidence to negotiate safer sex.

Rates of STI are highest among those aged 20-24 years with the exception of syphilis.

- Rates of STI diagnosis are particularly high in the 20-24 year age group in chlamydia, genital warts and herpes. Gonorrhoea is also high among 20-24 year olds, but rates remain high in those aged 25-44, particularly in Lambeth and Southwark.
- Syphilis is distinctly different – the highest rates are seen in those aged 35-44. This may be as a result of people living with latent syphilis for years before diagnosis.

References

1. GUMCADv2 – Excluding CTAD. GUM & Non-GUM Services only

* New STIs covers a broad range of STIs beyond five most common STIs e.g. chancroid, scabies & shigella.

Chlamydia and herpes are most common in women, gonorrhoea, warts and syphilis in men.

STI SUMMARY – SEXUALITY

Certain STIs are more common among men and women, depending on their sexuality.

- There is a high population of people who identified as gay or lesbian in Lambeth (6.1%) and Southwark (5.8%). Lewisham figures are smaller. A much smaller number of women identify as lesbian than men who identified as gay, which provides less stable estimates for this group.
- The disease burden differs for each STI. The cells shown in red below represent the groups with the largest proportion of all cases e.g. almost 9 in 10 cases of syphilis are diagnosed in gay men.
- Chlamydia and herpes are most common in women who identified as heterosexual, gonorrhoea and syphilis most common in men who identified as gay and genital warts most common in men who identified as heterosexual.

Proportion of the five most common STIs diagnosed by sex and sexuality in LSL 2017

		Chlamydia	Gonorrhoea	Warts	Herpes	Syphilis	5 most common STIs – Total
Male	Heterosexual	31%	15%	43%	29%	4%	26%
	Gay	27%	67%	13%	12%	88%	40%
	Bisexual	1%	3%	1%	1%	3%	2%
	Not known	2%	2%	1%	1%	3%	2%
Female	Heterosexual	36%	11%	39%	54%	2%	28%
	Lesbian	0%	0%	0%	0%	0%	0%
	Bisexual	1%	0%	1%	1%	0%	1%
	Not known	1%	1%	2%	2%	0%	1%
Total number of STIs		**7,437**	**4,776**	**1,853**	**1,179**	**969**	**16,214**

References

1. GUMCADv2 – Excluding CTAD. GUM & Non-GUM Services only

The LSL region have among the highest rates of STIs in England. Gonorrhoea and Syphilis are increasing.

STI SUMMARY – MOST COMMON STIS

Chlamydia is the most commonly diagnosed STI with 9,000 new cases in LSL in 2017.

- Chlamydia rates have been decreasing since 2015 across LSL.
- Men account for 61% of all cases – 50% of these identified as gay, 44% heterosexual. The majority (65%) of men from White ethnic backgrounds diagnosed with chlamydia identified as gay whilst the majority (83%) of men from Black ethnic backgrounds diagnosed with chlamydia identify as heterosexual.
- Almost all (94%) women diagnosed with chlamydia identified as heterosexual .

Gonorrhoea is the second most common STI in LSL with almost 5,000 cases in 2017.

- Gonorrhoea rates increased in 2017 after a decrease in 2016.
- Men account for 87% of all cases – three quarters of these men identify as gay. The large majority (90%) of men diagnosed from ethnic White backgrounds identified as gay, whereas the majority (57%) of men diagnosed from Black ethnic backgrounds identified as heterosexual.
- Almost all (91%) women diagnosed with gonorrhoea identified as heterosexual.

There were just under 1,000 cases of syphilis diagnosed in LSL in 2017.

- Rates of syphilis in Lambeth and Southwark are considerably higher and are increasing.
- Syphilis is almost exclusively diagnosed in men who identified as gay.

Just over 2,000 cases of genital warts were diagnosed in LSL in 2017.

- Rates of genital warts have been steadily decreasing.
- Men account for 58% of all cases – three quarters of these men identified as heterosexual. The majority of men diagnosed from White (68%) and Black (91%) ethnic backgrounds identified as heterosexual.
- The majority (94%) of women diagnosed with genital warts identified as heterosexual.

There were just under 1,200 cases of genital herpes diagnosed in LSL in 2017.

- Rates of genital herpes have remained stable.
- Women account for 57% of all cases – the only one of the five most common STIs which affects more women than men. The majority of both women (95%) and men (66%) diagnosed identified as heterosexual.
- The majority (54%) of men diagnosed with warts from White ethnic backgrounds identified as heterosexual and a larger (90%) majority of men from Black ethnic backgrounds.

References

1. GUMCADv2 – Excluding CTAD. GUM & Non-GUM Services only

Southwark Council southwark.gov.uk

CONTENTS

Introduction 3

Healthy and fulfilling sexual relationships 7

Good reproductive health across the life course 10

High quality STI testing and treatment 22

Living well with HIV 48

LSL has amongst the highest diagnosed prevalence and new diagnosis of HIV in England.

HIV PREVALENCE

LSL has amongst the highest rates of diagnosed prevalence of HIV in England.

- Across the three boroughs in 2017, almost 8,500 people are seen in care for HIV.
- Lambeth and Southwark have the 2nd and 3rd highest diagnosed prevalence of HIV in England, Lewisham the 6th highest.
- HIV prevalence of more than 5 per 1,000 is considered extremely high – all boroughs in LSL are above this.

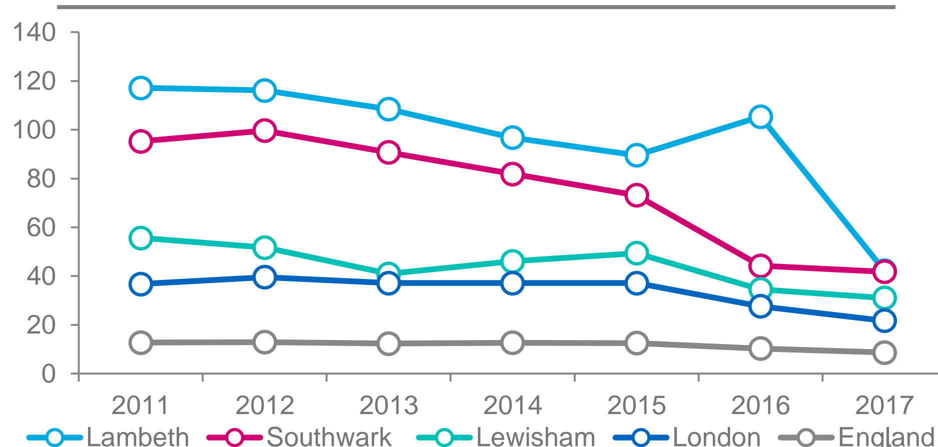
New HIV diagnosis provides a timely insight into onward HIV transmission.

- Lambeth has the 2nd highest new diagnosis rate in the country, Southwark the 3rd and Lewisham the 8th.
- It is important to note an inconsistency in recording of new HIV diagnoses in Lambeth in 2016. A large number of cases diagnosed in 2016 were erroneously mapped to St Thomas' hospital (i.e. Lambeth) rather than the patient's LSOA.

HIV diagnosed prevalence rate per 1,000 aged 15-59 LSL, 2012-17

20
15
10
5
0
2011 2012 2013 2014 2015 2016 2017
Lambeth Southwark Lewisham London England

New HIV diagnosis rate per 100,000 aged 15+ LSL, 2012-2017



References

1. PHE Sexual and Reproductive Health Profiles
2. GUMCADv2 – Excluding CTAD. GUM & Non-GUM Services only

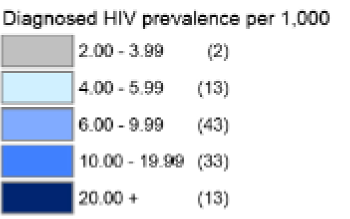
Diagnosed prevalence of HIV is above 20 per 1,000 across an area of North Lambeth and North West Southwark.

HIV DIAGNOSED PREVALENCE

Southwark

Lambeth

Lewisham



Prevalence of diagnosed HIV per 1,000 by MSOA, in LSL 2017

Diagnosed prevalence of HIV is high across much of the borough

- In particular, in the North of Lambeth and the North-West of Southwark, the diagnosed prevalence is higher than 20 per 1,000 population

- The South of Southwark and South East of Lewisham of less than 6 per 1,000 population. HIV prevalence of more than 5 per 1,000 is considered extremely high.

References

1. Local authority HIV surveillance data tables

Highest HIV diagnosis seen in those aged 35-64, men of White ethnicity and women of Black African ethnicity.

HIV DEMOGRAPHICS

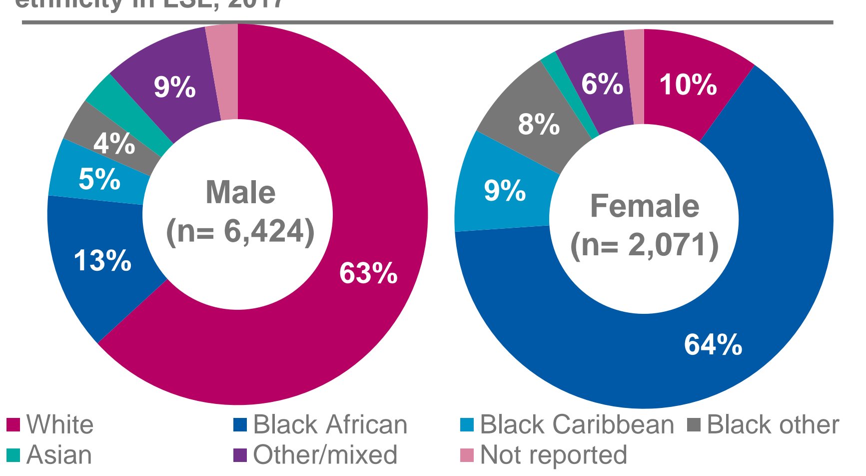
The ethnic breakdown of people with HIV across LSL is very different among men and women.

- Across the three boroughs in 2017, almost 8,500 people are seen in care for HIV.
- The majority (76%) of HIV diagnoses are in men.
- Of all men diagnosed with HIV, 63% were White, and of all women diagnosed with HIV, 64% were Black African.
- Just under 300 new cases of HIV were diagnosed in LSL in 2017 – a 50% decrease in the number of cases compared to 2012.

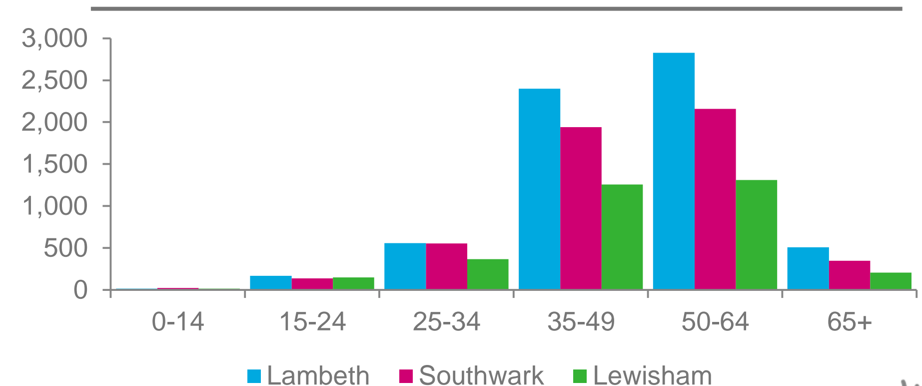
HIV prevalence in LSL is highest between the ages of 35 and 64.

- Rates of HIV diagnosis are highest among those aged 35-49 and 50-64 years.
- A disproportionate number of HIV cases (39%) are diagnosed in people living in the 20% most deprived areas across LSL.
- The proportion of people with HIV in treatment increased between 2011 and 2015: Lambeth (95%), Southwark (94%), Lewisham (93%).

Proportion of all diagnosed HIV cases seen for care by sex and ethnicity in LSL, 2017



Rates of HIV diagnosed per 100,000 persons by age in LSL, 2017



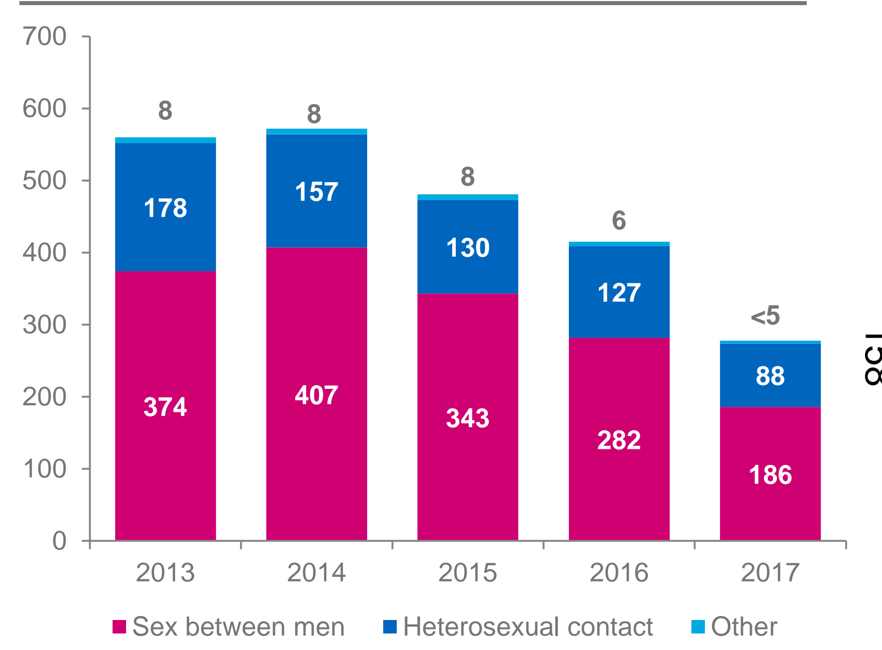
References
1. PHE Sexual and Reproductive Health Profiles
2. Local authority HIV surveillance data tables

Sex between men accounts for more than half of the new HIV cases in LSL each year.

HIV EXPOSURE – NEW DIAGNOSIS

Sex between men is the leading exposure type in people newly diagnosed with HIV.

- In 2017, just under 300 people received a new HIV diagnosis across LSL. The total number of new HIV diagnoses has been decreasing over time.
- Sex between men accounted for two-thirds (67%) of new HIV cases, and heterosexual contact another third (32%) in LSL in 2017.
- Just over 1% were through other exposure routes i.e. mother to child transmission, injecting drug use and blood products.
- The proportion of all cases where the exposure type was unknown increased from 4% in 2014 to 15% in 2015 and 21% in 2016 (data not shown). This information may not be captured at time of diagnosis but during further attendances for care, thus completeness increases with reports from subsequent years.



References

1. Local authority HIV surveillance data tables
2. Lambeth Public Health analysis, using HARS data.

Early diagnosis is crucial to reduce the impact of HIV, however, more than one in four receive late diagnosis.

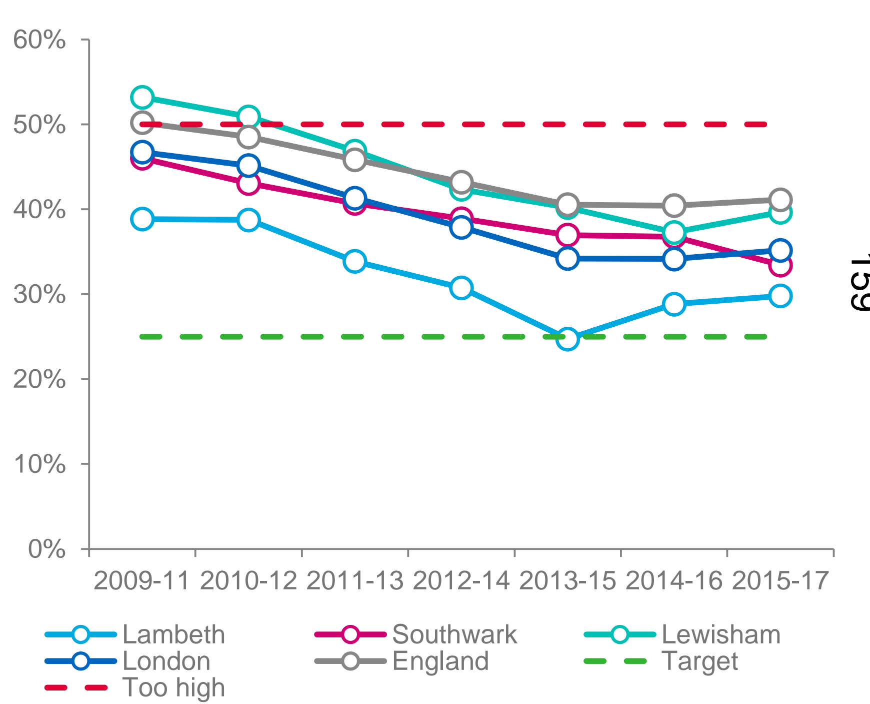
HIV LATE DIAGNOSIS

People diagnosed late with HIV have a ten-fold risk of death compared to those diagnosed promptly.

- People living with HIV have the same life expectancy as anyone else if treatment starts early.
- Over time, fewer people in LSL are receiving a late HIV diagnosis. However, in all boroughs in 2015-17 more than 25% (target) of people diagnosed with HIV received a late diagnosis.
- Late diagnosis was highest in Lewisham where almost 40% of people received a late HIV diagnosis in 2015-17.
- The promptness of diagnosis could be improved across the whole area as more than one in four people in LSL receive a late diagnosis.

In 2016, certain groups had a higher proportion of people with late diagnosis:

- Those aged 50-64 (53%);
- Black African ethnicity (49%) and Other ethnicity (46%)
- Exposure through heterosexual contact (59%)
- Women (55%)



159

References
1. PHE Sexual and Reproductive Health Profiles
2. King's Fund, 2017. The future of HIV services in England. Shaping the response to changing needs

An increasing number of people with HIV receive ART which has improved life expectancy, but stigma remains.

LIVING WELL WITH HIV

People diagnosed with HIV are living longer and HIV is now considered a long-term condition.

- HIV is evolving from a life-threatening infection to a long-term, manageable condition.
- Between 1996 and 2010, life expectancy in 20-year-olds starting ART increased by approximately 9 years in women and 10 years in men.
- As people with HIV live into older age, they are likely to develop additional co-morbidities. HIV services that originally tackled acute infections now also need to provide long-term condition management in partnership with GPs, care homes and others.

The majority of people diagnosed with HIV are engaged in care, most of these receive ART.

- It's estimated that 94% of people diagnosed with HIV access care. In 2016, 8,741 people were accessing care for a HIV diagnosis across LSL.
- The proportion of people diagnosed with HIV and accessing care who are receiving anti-retroviral therapy (ART) has been steadily increasing over time, from 85% in 2011 to 98% in 2016.

Despite improved treatment and increased life expectancy for people living with HIV, stigma remains an issue.

- Stigma has a significant impact on the physical and mental wellbeing of people living with HIV.
- Experiences of discrimination are common, and stigma is linked to lower adherence to treatment and worse treatment outcomes. HIV prevention is also dramatically hindered by stigma: studies have linked it to increased risk, non-disclosure and avoidance of health services, including those which may prevent transmission of HIV.

References

1. The Antiretroviral Therapy Cohort Collaboration, 2017, Survival of HIV-positive patients starting antiretroviral therapy between 1996 and 2013: a collaborative analysis of cohort studies.
2. HIV is Now a Manageable Long-Term Condition, But What Makes it Unique? A Qualitative Study Exploring Views About Distinguishing Features from Multi-Professional HIV Specialists in North West England.
3. King's Fund, 2017. The future of HIV services in England. Shaping the response to changing needs

New HIV diagnosis rates are slowing, however too many people still receive a late diagnosis.

HIV SUMMARY

There is an extremely high rate of diagnosed HIV across LSL:

- The diagnosed HIV prevalence across the three boroughs is among the highest in England with just over 8,500 people living with a diagnosis.
- New HIV diagnosis provides a timely insight into onward HIV transmission. Whilst rates of new diagnosis are high in the area, they remain stable and have even fallen in Southwark.
- Just under 300 new cases of HIV were diagnosed in LSL in 2017 – a 50% decrease in the number of cases compared to 2012.

At risk groups:

- The majority (76%) of people living with a HIV diagnosis are men. Of all men living with a HIV diagnosis, 64% were White, and of all women diagnosed with HIV, 64% were Black African.
- Rates of HIV diagnosis are highest among those aged 35-49 and 50-64 years.
- Sex between men accounted for two-thirds (67%) of new HIV cases, and heterosexual contact another third (32%) in LSL in 2017.
- A disproportionate number of HIV cases (39%) are diagnosed in people living in the 20% most deprived areas across LSL.

Late diagnosis:

- An increasingly smaller proportion of people receive a late HIV diagnosis, but LSL boroughs still failed to meet the 25% target in 2015-17.
- In 2016, certain groups had a higher proportion of people with late diagnosis: those aged 50-64 (53%), Black African ethnicity (49%) and Other ethnicity (46%), those exposed through heterosexual contact (59%) and women (55%).

Find out more at
southwark.gov.uk/JSNA

People & Health Intelligence Section

Southwark Public Health

Lambeth, Southwark and Lewisham Sexual and Reproductive Health Strategy 2019-24

Summary of the evidence

Lambeth, Southwark, and Lewisham
Public Health Departments

August 2018

What is this document?

This document summarises the evidence and good practice underpinning the LSL Sexual and Reproductive Health Strategy 2019-24. The four chapters of our strategy draw on these evidence reviews and the accompanying intelligence pack to set out our plans for the coming years. References for all evidence and statements within our strategy are provided within this document, and not within chapters themselves.

Contents

Healthy and fulfilling sexual relationships 3
Good reproductive health across the life course 7
High quality and innovative STI testing and treatment 11
Living well with HIV 15
References 18

HEALTHY AND FULFILLING SEXUAL RELATIONSHIPS

Social relationships are an important determinant of health and wellbeing across the life course. A positive familial environment provides children with secure attachment and a healthy blueprint for future relationships.[1] Exposure to domestic abuse and unhealthy relationships, as a victim or witness, is associated with poorer emotional wellbeing and physical health.[2] The mental and physical consequences of abuse may increase a victim's risk of further exploitation and may be associated with related risk factors for poor health, such as substance misuse and risky sexual behaviour.[3, 4] In some cases, domestic abuse is cyclical and those who were themselves victims may go on to perpetrate abuse or continue to enter into unhealthy interactions.[5] For this reason, developing an understanding of healthy relationships early in life is critical to equip young people with the knowledge, confidence and control to engage in healthy interpersonal relationships.[6]

Comprehensive relationships and sex education (RSE) contributes to a young person's safety by supporting them to navigate through their own developmental changes and helping to prevent exploitation or abuse. Despite this, schools have had no statutory responsibility to provide comprehensive RSE and the most recent government guidance is now 17 years old.[7] In Lambeth, Southwark and Lewisham (LSL), RSE is largely taught through science and through personal, social, health and economic (PSHE) education programmes at school. PSHE sits alongside the national curriculum and covers three broad themes: health and wellbeing, relationships, and living in the wider world. There is strong evidence of the impact of high quality RSE in reducing early sexual activity, teenage conceptions, sexually transmitted infections (STIs) and in increasing reporting of sexual exploitation and abuse.[7-9] Moreover, young people have increasingly reported that lessons from school are their preferred source of information about sex when growing up,[10-12] highlighting the importance of appropriate RSE. However, important issues such as coercion, navigating the practicalities of consent, social media, online safety and same-sex relationships are topics poorly covered by current curricula.[7] The majority of young men and women surveyed in the recent Natsal-3 report felt they should have known more when they first felt ready to have some sexual experience;[12] 62% of these cited lessons at school as their primary source of sex education. Among the additional topics they wanted to learn more about were sexual feelings, emotions and relationships. Alongside a focus on risk and unhealthy relationships, high quality RSE should emphasise the positive aspects of healthy sexual relationships, including negotiating the sex that you want. A recent national survey revealed that 60% of students hadn't learned about sexual pleasure.[13] Young people should not be dissuaded from sexual relationships for fear of coercion or abuse. Instead, they should be properly equipped with the necessary information to negotiate safe and pleasurable sex when and how they want it. In order to deliver frank discussions around sex, however, teachers must be open and comfortable discussing the topic. Unfortunately, qualitative studies from the UK and abroad have highlighted that many teachers feel uncomfortable or embarrassed having these conversations.[11]

As of September 2020, RSE will become statutory across the UK, a delay on the anticipated 2019 start-date.[14] This affords schools (maintained, academy, and independent) the opportunity to develop – alongside health professionals – comprehensive, relevant lessons that address these reported inadequacies and capitalise on our knowledge of vulnerable groups, in particular the lack of RSE sufficiently inclusive of our vulnerable women, young LGBTQI+ people and others. Topical issues of consent – what it looks like, giving it, understanding it can be withdrawn – will also be included. In primary schools, the subject will be taught as 'relationships education,' extending to 'relationships and sex education' in

secondary schools. Schools have flexibility in how these subjects are taught and parents retain the right to withdraw a child from RSE, as they do currently.

The strategic direction for sexual assault and abuse services over the next five years (2019-2024) has been set out by NHS England[15] and echoes this emphasis on prevention. It recognises the increasing role of the internet in sexual assault and abuse and the difficulties faced by vulnerable groups (e.g. LGBTQI+, BAME, and those with learning difficulties) in reporting an incident. Knowledge and guidance about healthy relationships is an important resource in navigating sexual experiences and can help people of all ages to develop an awareness of unhealthy behaviour and the confidence to address it. Facilitating healthy and fulfilling relationships is therefore important in preventing future unhealthy relationships and poor reproductive health, and reducing the risk of acquiring STIs and HIV. It is an integral part of a holistic sexual and reproductive health strategy.

Knowledge of healthy relationships is an important tool for all children and young people. However, some are more likely to suffer from unhealthy sexual experiences and relationships and thus may have additional need for information about risk factors and warning signs. Women are disproportionally affected by domestic violence across the life course and are nearly twice as likely to have experienced domestic abuse than men.[16] The number of accounts of violence against women and girls in London has increased since 2012 but it remains an under-reported crime.[17, 18] Coercive or controlling behaviour was introduced as a new offence in December 2015[19] and research has suggested that these behaviours are highly gendered, with women being the predominant victims.[20] The Crime Survey for England and Wales was updated in 2017 to include related questions to better capture the nuanced aspects of unhealthy relationships and abuse.[16]

From the age of 16, 49% of gay and/or bisexual men report experiencing at least one episode of domestic abuse. This is compared to only 17% of men overall.[5] The prevalence of abuse among transgender people is even higher: 80% reported experiencing emotional, physical or sexual abuse from a partner or ex-partner in 2010.[21] Despite the prevalence of domestic abuse in these populations, over half (53%) of lesbian, gay, and bisexual young people are never taught about homosexual sex and relationships issues at school.[22] The lack of information available in traditional settings such as schools may drive some young people to seek advice and support from adult-oriented groups, for example online forums where they may be vulnerable to exploitation.[23] Rates of intimate partner violence are higher among those with a physical or mental disability; they are between two to three-fold higher odds of being a victim.[24] In addition, any child living in a household in which there is intimate partner violence or a regime of intimidation or control is at increased risk of experiencing, and also perpetrating, violence as an adult.[5] While many of these children may be reached by school-based interventions, special attention should be paid when they come into contact with health or social services. RSE lessons must therefore be inclusive of all levels of disability, sexual orientation, and life circumstances to ensure equal access to information.

The term ‘chemsex’ has become prominent in some parts of the MSM community and describes sex that occurs under the influence of drugs, most commonly crystal methamphetamine, GHB/GBL and mephedrone. Locally, we know that our population of MSM are more likely to take drugs associated with chemsex than MSM elsewhere in London or England.[25] These substances pose a significant health risk and risk of overdose. Anecdotal evidence from qualitative research in Southwark revealed an increasing mental health risk (including low self-esteem) for those who partake in chemsex.[26] Vulnerability and risky sexual activity were also a common concern as maintaining control of behaviour and choices while under the influence of chemsex drugs may be difficult. As sexual health

commissioners, we need to ensure that people in risky sexual relationships are also appropriately supported to make safe and healthy decisions.

Child sexual exploitation (CSE) is a significant concern in LSL as it is elsewhere, and we know through internal analyses that exploitation is linked with gang-related activity and with drug running across county lines. The responsibility of safeguarding children and identifying exploitation should be embedded within all professional practices. Children and young people at risk for, or currently being sexually exploited may present with physical injury, addiction, poor mental health and repeat use of emergency hormonal contraception, among others, and may interact with a range of professionals.[27] Training on identifying and referring cases of CSE should therefore be available across all services. Sexual health professionals are uniquely placed to discuss sexual activity and relationships with a young person and should be mindful of deteriorating health, disclosure of multiple partners or repeat visits for STI treatment.[27] Schools reach the majority of children and therefore have an important role to play in both preventative education and identifying CSE and abuse.[28] They tend to see the same group of children over time and can identify changes in behaviour or health. Evidence suggests that education programmes may increase the likelihood of a child disclosing abuse[29] and that a whole-school approach of zero tolerance for abuse, alongside longer-term lessons through RSE that teach young people about healthy relationships may be effective in preventing CSE.[28, 30, 31]

In the current landscape, young people face a plethora of emerging challenges that are becoming increasingly difficult to navigate. Relationships are now conducted with a growing online element. Sexting may be construed as modern-day flirting, however, sending explicit photographs among under 18-year-olds is a criminal offence.[32] Similarly, new forms of online abuse such as revenge porn (the non-consensual sharing of sexual content) are becoming increasingly recognised offences.[33] It is therefore critical that young people be informed of how to operate safely online. Notre Dame RC School in Plymouth was recently highlighted by Ofsted for their modernised PSHE programme.[34] At the suggestion of sixth form and year 10 students, they implemented peer-led workshops focusing on social media, coercion, and how to end a relationship safely. Students particularly liked being taught by older students and reported feeling more comfortable engaging with them on these topics.[34] Highlighting the grey areas before abuse begins may empower students to identify and prevent an abusive relationship from developing.

Findings from the 2016 Healthwatch Southwark report, 'Young Voices on Sexual Health,' revealed that education about healthy relationships was sparse and inconsistent across different schools.[35] Details about what constitutes a healthy or unhealthy relationship and how to spot the signs of abuse (beyond physical) were reported as lacking. When asked about how they would prefer RSE to be provided, young people vocalised a desire for an open, interactive discussion with professionals, more information on the emotional and social aspects of sex and a general inclusion of healthy relationships. Healthwatch Lewisham ran a series of workshops with young people aged 11-19 years in 2017 and found that 'relationships and sex' was the issue most concerning to young people and their peers.[17] Additional gaps in knowledge were identified in the legal consequences of sexting that, despite its prevalence in this age group, remained largely undiscussed in RSE.[17] Qualitative research identifying best practice in RSE has suggested that young people prefer to be taught by someone other than a teacher or tutor, as it might be uncomfortable or blur boundaries between them.[36] Peer educators were well respected, however, their credibility was in some cases undermined by youth. External sexual health professionals were preferred as they were perceived as providing greater confidentiality.[36]

Empowering people to define the terms of their sexual relationships and use contraception when desired is an important part of protecting sexual and reproductive health (SRH). Ensuring the equality and accessibility of our contraception services remains a local priority. For young people under 25, condoms and sexual health information are available free of charge through the pan-London distribution scheme Come Correct, delivered by Brook across LSL. Condom distribution schemes were recently evaluated nationally and found to be successful in engaging young people. This is reflected in the high number of repeat users (compared to new registrations) locally.

For LSL's young and diverse population, knowledge and guidance about healthy relationships is an important resource in navigating their own sexual experiences; this is largely provided by school-led RSE. These lessons could benefit from integrating input from young people, such as employing external educators and widening the breadth of discussion to increase engagement in both the messages being delivered, and in local services. While information should be made available universally, vulnerable groups such as children exposed to domestic abuse, LGBTQI+, and children and young people with disabilities may benefit from targeted support.

GOOD REPRODUCTIVE HEALTH ACROSS THE LIFE COURSE

Reproductive health is important across the life course and can impact overall health at any stage. Consequences of poor reproductive health exacerbate inequalities in health, education and socio-economic status.

In Britain, nearly half of pregnancies (45%) are unplanned and one in 60 women (1.5%) experiences an unplanned pregnancy in a year.[37] Some unintended pregnancies do not lead to live-births; 52% and 12% of unplanned pregnancies are estimated to end in abortion and miscarriage respectively.[38] Having a child can put enormous financial and emotional pressure on couples and children born to mothers under the age of 20 have a 63% higher risk of living in poverty.[39] Moreover, teenage mothers themselves are 22% more likely to be living in poverty by age 30, compared to first time mothers over 24 years.[39] One in five 16-18 year-olds not in education, employment or training is a teenage mother.[39] Both physical and emotional health may also be affected. Sexually transmitted infections (STIs) such as chlamydia and gonorrhoea can cause pelvic inflammatory disease, which may increase a woman's risk of ectopic pregnancy or infertility.[40] Human papilloma virus (HPV) can cause genital cancers in men and women that, in some cases, may lead to infertility.[41, 42] Difficulties conceiving may strain relationships and cause stress to both mother and father. Furthermore, postpartum mental health in the three years following birth is likely to be poorer in mothers under 20 years.[39]

Reproductive ill-health incurs financial costs to the individual and to the state. For example, unplanned pregnancies leading to maternity may have long-term costs to local authority housing, education, and social care.[43] Teenage pregnancies may, in some cases, be costly to both mother and child with regards to earning potential and future employment.[43] Terminating a pregnancy has direct costs to the NHS: in 2010, approximately £143m was spent on abortions.[44]

In contrast, publicly-funded contraception to prevent unintended pregnancy is extremely cost-effective and is one of the highest value public health interventions. While NHS and local authority spending on contraception totalled £246.1m in 2016, new analyses in England suggest that every £1 invested in contraception saves these public services £4.64 over a four year period, and £9.00 over 10 years.[38] Benefits include savings that result from avoiding unwanted pregnancies, including healthcare costs (for example birth costs, abortion costs, miscarriage costs and ongoing child health care costs) and non-healthcare costs (such as education costs, welfare costs, children in care costs). Good reproductive health therefore not only is essential contributor to good overall health and wellbeing, but also yields savings for public services.

In the UK, women spend approximately 30 years of life avoiding unwanted pregnancy and therefore requiring contraceptives.[40, 45] The median age of first heterosexual intercourse is considered to be 16 for both men and women,[46] though national estimates suggest almost one-third of young people have had sex before this age.[47] Most information pertaining to reproductive health for young people is provided by relationships and sex education (RSE) lessons, parents, and health professionals,[10] however, there are notable issues in awareness of free and available reproductive health services among young people. A 2016 survey of school-aged children in Lambeth, Southwark, and Lewisham (LSL) revealed only 20% of young people reported knowing where to get free condoms[48-50] and STI rates in young people are higher in LSL than the regional and national average, and than in other age groups. This suggests a missed opportunity to embed discussions of contraception

when treating young people with STIs and to promote good overall sexual and reproductive health (SRH).

Unfortunately, challenges remain in ensuring equality in knowledge of contraceptive options and access to preferred methods. The rate of under-18 conception is consistently higher across LSL compared to London and England,[51] which represents an unmet need in contraception care as well as a failure to comprehensively tackle the wider determinants of teenage pregnancy. Moreover, this suggests a lack of awareness of or confidence in accessing other more effective methods of contraception. Long acting reversible contraceptives (LARC), in contrast to user-dependent methods ((UDM) e.g. condoms, oral contraceptives (OC)), do not depend on daily concordance and have been proven more clinically effective than OC at only one year of use.[52] Despite these benefits, uptake remains low in the UK at about 12% of women aged 16-49, compared to 25% for OC and 25% for male condoms.[53] In Lambeth and Lewisham, the rates of GP-prescribed LARC have remained relatively stable since 2011.[51] In Southwark, the rate has decreased to 7.5 per 1000 women, the fifth-lowest rate among London boroughs.[51] This suggests that barriers remain in communicating the benefits of LARC or in ensuring that women of reproductive age have easy access to the full range of contraception, including LARC.

RSE in schools provides an opportunity to reach young people at risk for becoming pregnant and deliver messages around contraception and reproductive health. These should be accurate and aligned with information from healthcare professionals. Advice relating to contraception should be culturally appropriate, non-judgemental, and given according to the needs of each individual.[47] An example of best practice is highlighted in Shropshire County Council, who invested in their RSE curriculum to tackle high levels of teenage pregnancy. Collaboration was achieved between school nurses, parents, and school staff in order to train teachers to deliver targeted, evidence-based messages on reproductive choices and challenges.[39]

Pharmacies play a vital role in offering accessible SRH services, in particular to young people who may feel uncomfortable visiting their GP or a sexual health clinic. Pharmacies tend to have consistent and long opening hours, allow for relative anonymity, do not require appointments, and are usually more conveniently located than GP surgeries or sexual health clinics.[47, 54, 55] However, the current model of sexual health provision in pharmacies across LSL is disjointed and is not contributing to improved reproductive health outcomes. LSL has high rates of abortion and repeat abortion, and highly accessed emergency hormonal contraception (EHC) services at pharmacies. In Lambeth and Southwark, 80% of women accessing EHC declared previous use and, in Southwark, 50% of these had used EHC in the past 6 months. Under the current model of provision, most pharmacies are unable to provide on-going contraception alongside EHC and must refer to GP or sexual health clinics. This fragments the patient pathway and increases the risk of unmet contraceptive need and unintended pregnancy. In response, sexual health provision in pharmacies across the three boroughs is being reshaped to most effectively support women seeking contraceptives and reproductive and advice.

Online offers of contraception may also be a way of improving access. The Southwark- and Lambeth-based online service SH:24 has been delivering online OC since March 2017 as part of a pilot scheme, providing free OC to local women. The service has also begun an offer of paid OC for women not living in Lambeth and Southwark, which has proven extremely popular. While private supply of contraceptives is not suitable for everyone, the observed demand has demonstrated it is an acceptable way of improving access for a subset of the population.

Finally, school- or community-based drop-in clinics can be an effective method of reaching young people and improving their access to SRH services. Bristol City Council successfully established a network of drop-in clinics at secondary schools, run by a sexual health nurse and youth worker. They were able to reach nearly two-thirds of the population of young people; 5,000 pupils attended a drop-in service in one year to discuss healthy relationships, contraception, and sexual health.[39]

Contraceptives such as condoms should also be made available in non-traditional settings, for example at leisure centres and libraries, to improve access for young people. The pan-London condom distribution scheme Come Correct is delivered by Brook across LSL and provides free condoms and sexual health information to young people under 25 who hold a ‘c-card’. C-card schemes for condom distribution were recently evaluated nationally and found to be successful in engaging young people.[56] High numbers of repeat users compared to new registrations suggest the scheme was popular and acceptable.[56] In LSL, there has been an increase in c-card registrations and in repeat users, compared to 2016.[57] These schemes are particularly important in reaching young men, who are less likely to visit GP or specialist sexual health clinics for contraceptives and may otherwise miss out on SRH advice.[10]

The reproductive health of both men and women may be affected by some STIs. HPV is of particular concern for its ability to cause cancer of the cervix, vulva, vagina, penis and anus. While not all types of HPV cause cancer, an estimated 90% of cases of anal cancer relate to HPV infection.[42] and, of the approximate 3,100 cases of cervical cancer reported each year in the UK, nearly all are related to viral infection.[41] In 2011-2013, Lambeth had the highest rate of cervical cancer registrations of all London boroughs.[51] Sexually active individuals should be reminded of the importance of condoms in reducing the risk of contracting HPV (and other STIs) through intercourse.[41] Since 2008, a vaccine against the two most common cancer-related types of HPV has been available free of charge to girls aged 12-18 through the NHS.[58] At present, the NHS does not offer the vaccine to young men, despite the relationship between HPV and male cancers.[58] However, in April 2018, Public Health England introduced a nationwide HPV vaccination programme for men who have sex with men aged 45 or younger, as this group is likely to receive little indirect protection from female vaccination.[59] All women aged 25 or over, irrespective of vaccination status, are invited for cervical screening through the NHS Cervical Screening Programme.[60] The programme aims to identify abnormal cervical cells early to prevent the development of cancer. Most treatment for cervical cancer will result in infertility.[60]

Some unintended pregnancies, regardless of the age of the mother, will become wanted; however, a proportion will result in termination. Access to safe and legal abortion care, free from harassment, has a critical role in protecting the reproductive health of women who choose to end a pregnancy. Since our previous strategy, access to high quality abortion services has improved; however, inequalities persist across LSL in terminations of pregnancy (TOP). The TOP rate per 1,000 population is consistently higher among Black African and Black Caribbean populations in the three boroughs, reaching over 50 per 1,000 population in some areas.[61] LSL should seek to address the underlying drivers of these inequalities, for example cultural preferences for barrier methods of contraception.[62]

After delivery or between pregnancies is an often unrecognised period during which women require effective contraception.[63, 64] Short inter-pregnancy periods increase a woman’s risk of complications in the subsequent pregnancy, including preterm birth, low birthweight and stillbirth,[65, 66] and thus present a critical time to intervene. Furthermore, during pregnancy, women are frequently in contact with healthcare professionals and are therefore accessible to information about, and supply of contraception. This is especially important for vulnerable

women who are at high risk for future unintended pregnancy (i.e. young women, women who have had previous children removed).[67] National guidelines recommend that professionals providing care to pregnant women be able to offer their chosen method of contraception following pregnancy or termination, or facilitate access to these services.[67] Female and male sterilisation should be included among the range of available methods of contraception discussed within the context of a patient's individual circumstances.[68] Support for effective, appropriate contraception should continue for as long as a patient is sexually active, extending through menopause and into old-age.

Good reproductive health is thus reflective of a comprehensive, whole-system approach to reproductive wellbeing that offers support from adolescence through to old-age. At any reproductive stage, individuals should understand the range of contraceptive methods available to them and be aware of how best to access them.[69] Likewise, services need to be arranged to facilitate easy access to the full range of reproductive health services. As people move through life, their personal circumstances should continue to be at the centre of the discussion of preferred contraceptives, ensuring they continue to enjoy safe and healthy sexual relations.

HIGH QUALITY AND INNOVATIVE STI TESTING AND TREATMENT

Sexually transmitted infections (STIs) facilitate the transmission of HIV, cause a number of cancers and contribute to poor sexual and reproductive health and overall wellbeing.[70, 71] The sequelae of untreated STIs include infertility, ectopic pregnancy, and harmful impacts on mental health and sexual relationships.[52, 72, 73] Furthermore, STIs are a significant contributor to health inequalities, which in turn increase a person's risk of poor sexual health and limit their access to prevention, testing and treatment; STIs remain one of the most common acute conditions. A total of 422,147 new diagnoses of STIs were reported for England in 2017, of which 48% were chlamydia, 14% genital warts, and 11% gonorrhoea.[70, 71] The overall number of new STI diagnoses in 2017 was similar to that of the previous year, however, there have been notable differences in the trends of particular infections.[70, 71] Syphilis and gonorrhoea diagnosis rates increased by about 20% relative to 2016, there was a 7% relative decrease in genital warts, while chlamydia incidence remained stable.[71]

Lambeth, Southwark and Lewisham (LSL) have historically had some of the highest national rates for STIs. In 2017, Lambeth had the highest rate of new STI diagnoses in England in 2017, followed by Southwark in third, with Lewisham 11th.[51, 74] This partly reflects local provision of modern and accessible STI testing and treatment services but also our young, ethnically diverse, and mobile populations.

To reduce inequalities, we need to improve the sexual and reproductive health (SRH) of key groups including young people, men who have sex with men (MSM), and Black and minority ethnic groups (BAME).[40] Lambeth, Southwark, and Lewisham residents are predominantly young, with a larger proportion of the population aged 25-34 years.[51, 75] We are also more ethnically diverse than England: approximately one quarter of LSL residents are from a Black ethnic background. Furthermore, Lambeth and Southwark have the second and third largest lesbian, gay, and bisexual communities in England.[74] We therefore have a large population at higher risk of poor sexual health.

Tackling the burden of STI requires both disease-specific interventions as well as wider intervention at several levels as detailed in national guidance.[40] At the population level, it is integral to build an honest and open culture and reduce sexual health stigma, while at the community level it involves ensuring adequate access to contraception such as through condom distribution schemes as well as access to testing and treatment of STIs in a variety of settings, especially for high risk groups.[40] Screening for common STIs like chlamydia should be offered routinely and opportunistically to young people. Protecting people against reinfection through having timely and effective treatment, and appropriate and effective partner notification pathways in place is crucial. Incorporation of education and access to correct and timely information is important plan and can be achieved through use of evidence-based online services and websites such as "Sexwise",[40] but importantly, starting early through effective delivery of RSE in schools.

Correct and consistent condom use remains the principal intervention for preventing STIs and reducing transmission. The pan-London condom distribution scheme Come Correct is delivered by Brook across LSL and provides free condoms and sexual health information to young people under 25 who hold a 'C-card'. C-card schemes for condom distribution were recently evaluated nationally and found to be successful in engaging young people.[56, 77, 78] High numbers of repeat users compared to new registrations suggest the scheme was popular and acceptable. In LSL, there has been an increase in C-card registrations and in repeat users, compared to 2016. These schemes are particularly important in reaching young men, who are less likely to visit GP or specialist sexual health clinics for

contraceptives and may otherwise miss out on SRH advice. Further work needs to be done, however, to engage BAME in these distribution schemes given contraceptive usage in general is lower in this population.[62]

Part of the success in managing to maintain such services through a financially challenging period has been through introduction of innovative methods of access. This is most apparent in web-based access to STI testing and treatment. A randomised trial conducted in Lambeth and Southwark in 2014-15 found that e-STI testing delivered through SH:24 increased uptake of STI testing across all groups including those at highest risk.[79] An added advantage of this method is that traditional structural and social barriers to STI testing may be overcome through online service delivery and home-testing.[80] Service innovations to improve STI treatment rates once diagnosis is confirmed vie e-STI testing continue to be active areas of research.[79] Self-testing online services have since been extended across London (now 'Sexual Health London') with the aim of freeing capacity at SRH clinics by targeting asymptomatic patients, ensuring those most in need of a face-to-face intervention receive one.

A diverse range of pathogens can be sexually transmitted and, while complications vary widely, all contribute to the burden of poor health.[40] Five STIs from the bulk of diagnoses seen both across England and in LSL: chlamydia, gonorrhoea, syphilis, genital warts, and genital herpes.[74] Several others such as shigella, hepatitis, lymphogranuloma venereum (LGV), trichomoniasis and molluscum contagiosum (MC) form a much smaller percentage of overall STI burden.[71, 79]

Chlamydia remains the most common STI diagnosed across England and LSL. In 2017, 9,000 cases were diagnosed in LSL with reported rates in Lambeth and Southwark over double that of London and triple that of England.[51, 74] Untreated chlamydia can lead to several gynaecological and urological complications such as pelvic inflammatory disease and epididymitis.[81] The chlamydia detection rate in 15-24 year olds is an important indicator of good sexual health.[72] All three boroughs in LSL have met and exceed the recommended rate of 2,300 per 100,000 people. Young people remain at greatest risk of chlamydia and annual opportunistic screening of sexually active people aged 15-24 years is recommended.[82] Chlamydia testing should be offered in a range of settings to increase opportunistic testing, including primary care, online, outreach and termination of pregnancy services, however, a decrease of around 8% in testing was observed between 2016-17 nationally.[71] This represents a continued decline that has only been somewhat compensated for by increases in the provision of online SRH services.[51, 83]

Rates of gonorrhoea diagnosis have risen sharply from 2016 to 2017 nationally and locally. This is particularly concerning alongside the increasing prevalence of azithromycin- and recently, ceftriaxone-resistant gonorrhoea.[84, 85] Gonorrhoea was the second most prevalent STI in LSL in 2017, with diagnosis rates 4-8 times greater in Lambeth (654 per 100,000), Southwark (565), and Lewisham (302) compared to England (79). Men in general have higher rates of diagnosis across all ages. In LSL, gonorrhoea remains concentrated in certain groups, particularly MSM and BAME.[51, 74] Similarly to chlamydia, frequent gonorrhoea testing allows for timely diagnosis, treatment, prevention of serious complications, and onward transmission through case and partner management.[85]

A syphilis outbreak was declared in 2017. Nationally, a total 7,137 cases of syphilis were reported in 2017, of which just under 1,000 were diagnosed in LSL residents.[71, 74] the disease can remain latent and asymptomatic for many years before manifesting with dermatological, neurological and cardiovascular symptoms.[86] Rates of syphilis diagnosis in Lambeth and Southwark were higher than in London in 2017, while rates in Lewisham were

similar to England. Nearly all (98%) of cases in LSL were in men with those aged 35-44 most affected.[51] Syphilis is also most common among individuals who are at higher risk of other STIs, such as HIV.[87] The highest number of cases of syphilis in over half a century were recorded in 2017 and, in response, PHE is developing an action plan to help address these rising rates especially among vulnerable groups.[40] This may require greater national coordination of efforts as well as innovative approaches such as targeted social media messaging to raise awareness of outbreaks when they occur.[88] Screening HIV-positive men and MSM for syphilis every three months has also been demonstrated to improve detection.[87]

Cases of genital warts continue to decline with a 90% decrease reported since 2009 nationally.[51] This decline has been mirrored in LSL though rates are still higher than the national average. The rate of diagnosis in Lambeth and Southwark (219 and 209 per 100,000 respectively) in 2017 was double that reported for England.[74] The introduction of a school-based HPV vaccine for girls is believed to have been the key driver in this reduction.[73] This success has instigated a roll out of the vaccine in MSM population to tackle increasing rates in this group.[71]

The incidence of genital herpes (HSV) has remained relatively stable nationally and in LSL. New diagnosis rates in London were 54 per 100,000 compared to Lambeth, Southwark and Lewisham respectively (148, 124 and 105 per 100,000). It remains the only STI which is more prevalent in women in LSL.[74] Many genital herpes infections are asymptomatic, however, they can cause severe systemic disease in neonates and facilitate HIV transmission.[89] Routine testing for genital HSV is not recommended unless symptomatic or in targeted groups where partners are affected or multiple partners are involved.[90, 91]

Several other less prevalent, high-risk STIs are also treated through SRH services across LSL hence preventative strategies here are also important.[40] Viral hepatitis remains high on the public health agenda with the commitment from PHE to the WHO Strategy on elimination of hepatitis C as a major public health threat by 2030.[92] Rates of hepatitis B reported in LSL are also higher than the London average with an incidence of 2.54 per 100,000 compared with 1.7 per 100,000 in London.[51] Males and MSM in particular have been disproportionately affected. In addition, hepatitis A immunisation recommendations have been updated following the ongoing outbreak primarily affecting MSM in England: to opportunistically vaccinate all MSM attending SRH clinics without previous evidence of vaccination for hepatitis A and B, and to educate around preventative activities and condom distribution.[93, 94]

Lymphogranuloma venereum cases peaked in 2014 but have been declining since. Of LGV diagnoses made in England in 2016, 91.7% were among MSM, 73.4% lived in London and 67.5% were HIV-positive. Clinicians are advised to always consider LGV testing and to maintain high suspicion in these high-risk groups.[95]

Shigella has been traditionally associated with travel to lower income countries where sanitation is poor. However, since 2009, case numbers in England (particularly in MSM) have increased dramatically. Work undertaken by PHE in London highlighted that education and understanding of shigella remain low despite attempts for engagement through social media campaigns, posters and through sexual health clinics. Although cases among men have fallen in recent years, SRH clinics and health protection teams must continue to provide advice to SRH professionals on how to prevent spread and protect themselves.[96]

Molluscum contagiosum and trichomoniasis together encompassed over 100 new diagnoses in LSL in 2017 although they are less clinically severe infections (with the exception of infections in those with late-stage HIV).[97] BASHH recommends that all individuals presenting

with molluscum contagiosum should be given a full STI screen.[97] Trichomoniasis is associated with reproductive morbidity and increased rates of HIV transmission hence prompt treatment and contact tracing are recommended on diagnosis.[98]

Several vulnerable groups are disproportionately affected by STIs – young people, MSM, and Black communities. Young people aged 15-24 years still experience the highest diagnosis rates of most STIs.[40] Historically, young women have had higher rates of genital warts however this has seen a significant decline with the introduction of a UK school-based HPV vaccine.[73] Relationships and sex education (RSE) in schools provides an opportunity to educate children and young people early in life about safer sex, types of contraception and local support services, in order to prevent the transmission of STIs. However recent work has revealed that nearly a third of schools lack good RSE and updates in government guidance are now needed (in anticipation of statutory RSE being introduced in September 2020), with consultation work underway.[11] A Cochrane review in 2016 revealed that too much RSE provision placed emphasis on abstinence or delayed sexual initiation rather than provision of information about contraceptives, for example.[99] School-based surveys in LSL have reinforced these results, demonstrating poor knowledge amongst young people about where to obtain free condoms. This is reflected in rates showing that LSL young people experience STIs more than the London and England average. This suggests a missed opportunity to embed discussions of effective methods of contraception (and where to obtain them) and safer sex when educating children and young people as part of RSE to promote good overall sexual and reproductive health.[56]

MSM bear the burden of many types of STIs, with the main challenges among MSM being the large relative increases in gonorrhoea (21%), chlamydia (17%) and syphilis (17%) observed nationally in 2017 compared to 2016, and mirrored in LSL.[51] Several behaviours likely explain these trends including increased condomless intercourse, multi-partner sex facilitated by geosocial networking applications, and a rise in ‘chemsex’. This may also be partly explained by an increasing availability of HIV pre-exposure prophylaxis (PrEP). While PrEP has dramatically changed the landscape of HIV prevention, recent literature on coincident outcomes have suggested PrEP use may be associated with a reduction in the use of condoms and an increase in STI acquisition.[100] Research in England via the Impact trial continues. The national extension of targeted MSM HPV vaccination is expected to help reduce the incidence of genital warts and HPV-related cancers, though a lag is expected before full benefit is observed.[71]

With regards to ethnicity, the highest rates of STI diagnoses are among Black Caribbean and Black ‘other’ groups. Rates of STIs across England are highest in urban areas – especially in London – reflecting areas of higher deprivation. We know that Black communities are more likely to live in the more deprived areas of our boroughs.[101] Interventions and services should be informed by the opinions and experiences of BAME groups to ensure services are attractive and sensitive to the needs of specific communities.[75, 102] Engagement with faith communities and leaders in creative ways has also been shown to yield better participation in SRH services.[75]

Trends in STI diagnoses therefore highlight several areas for concern both nationally and in LSL, especially with regards to drug-resistant gonorrhoea, rising rates of syphilis, and an apparent increase in condomless sex. For LSL, strategies are needed that increase STI testing, aid targeted condom distribution services and use of condoms, and provide effective access to treatment. This is most crucial in those groups who are at greatest risk of STI acquisition. Engaging ‘hard to reach’ groups, especially in an environment of austerity, will require continued innovative approaches and testing methods informed by those communities to ensure appropriate reach of services.

LIVING WELL WITH HIV

HIV remains a national and regional priority, particularly in Lambeth, Southwark and Lewisham (LSL) where diagnosed HIV prevalence rates are among the highest in the country; Lambeth has the highest rate of HIV diagnosis in England. These high diagnosed HIV rates are, in many ways, an indicator of the success of policy and action, but also a reflection of our communities. With knowledge of positive HIV status and access to effective treatment, the mortality rate of people with HIV is now comparable to the rest of the population.[103] As a result, HIV has transitioned away from the life-threatening illness it once was and into a long-term condition that must be managed alongside traditional age-related illness. Health and social care practitioners must adapt their thinking to mirror the evolution of this disease and to appropriately support and manage comorbidities in people living with HIV (PLHIV) in a non-discriminatory way.

In 2014, UNAIDS set out an ambitious treatment target for HIV globally: that by 2020, 90% of all people living with HIV would know their HIV status, 90% of all people with a diagnosed HIV infection would be on treatment (antiretroviral therapy (ART)), and that 90% of all people on treatment would be virally supressed.[104] These aims are supported by current communications and campaigns around HIV: that ‘undetectable = untransmittable’. In 2016, London achieved and surpassed these 90-90-90 targets: 90% of Londoners with HIV were diagnosed, 97% were on treatment, and 97% of those receiving ART were virally supressed.[105]

In January of 2018, London signed up to the Fast-Track Cities (FTC) Initiative, an international pledge to accelerate local responses to HIV and AIDS, including reaching the 90-90-90 goal.[106] As a testament to our commitment, London has set a more ambitious target to reach 0-0-0: ‘zero HIV-related stigma and discrimination, zero new HIV infections, and zero preventable deaths from HIV-related causes’. London has also pledged to improve the health, quality of life and wellbeing of people living with HIV across the capital. Regionally, LSL contributes to and hosts the pan-London prevention programme ‘Do It London’, which provides far-reaching campaigns, free condom distribution, outreach and rapid HIV testing services. Furthermore, the Elton John AIDS Foundation (EJAF) has invested £2 million into primary care and community groups in LSL to increase HIV testing and support people diagnosed with HIV to engage in care.

HIV elimination is also a national objective. Public Health England’s (PHE) strategic action plan ‘Health promotion for sexual and reproductive health and HIV (2016-2019)’ aims to decrease HIV incidence in populations most at risk of infection and to reduce the rate of late and undiagnosed HIV.[43] They also encourage adapting combination approaches to prevention. These involve deploying a set of behavioural, biomedical and structural approaches tailored to local such as levels of infrastructure, local culture as well as populations most affected by HIV. In the UK and particularly London, we have made considerable efforts to encourage condom use, promote expanded HIV testing and diagnosis (including self-sampling), and ensure prompt treatment and the use of pre-exposure prophylaxis (PrEP).

Both the private market and the national PrEP trial (the Impact trial) have revealed acceptability and demand for PrEP – particularly amongst men who have sex with men (MSM). The advent and accessibility of PrEP is a turning point for HIV, affording the freedom to engage in sex with an HIV positive partner safely and without fear or distress. Widespread acceptance and use of PrEP also works to combat the stigma once associated with HIV by reducing the marginalisation of those living with the virus.

These accomplishments are laudable, however, inequalities remain across LSL from HIV testing uptake to treatment and engagement in care. Anyone can contract HIV but people from some groups or parts of the world are more likely to be affected. Locally, the highest HIV diagnosis rates are seen in those aged 35-64, men of White ethnicity and women of Black African ethnicity.[74] Sex between men accounts for more than half of the new HIV cases in LSL each year. The number of new HIV diagnoses in MSM fell for the first time since the beginning of the HIV epidemic, likely driven by increased private use of PrEP and frequent testing. This decreasing trend has not been seen across all populations, however. New diagnoses in heterosexual women and Black African men remain proportionately high. In the UK and internationally, engagement of other at-risk groups including women, BAME communities, and trans people in the uptake of PrEP as a method of HIV prevention in trials has been much poorer than MSM, and more specific work to engage these groups will be required in a future commissioned PrEP service.

HIV testing, including frequent testing among those most at risk of HIV continues to be one of the most important interventions to identify current HIV infection and prevent onward transmission. Providing access to, and encouraging frequent testing has the potential to reduce the number of people unaware of HIV infection, the time with which people live with undiagnosed infection, and provides the opportunity for prompt HIV treatment. ART is now so effective that those who are treated and have an undetectable viral load (<200copies) have levels of virus that are untransmittable, even if having sex without condoms. Despite our local demographics and high prevalence of HIV, LSL testing coverage has consistently trended below the regional average.[51] This is a strong indicator to us as sexual health commissioners that more must be done to ensure those most at risk of HIV are receiving prompt testing and treatment.

In December 2015, PHE launched a national self-testing service funded by local authorities that allows users to order free HIV test kits online. This provides an accessible, easy-to-use alternative to traditional testing and help to empower individuals to take control of their sexual health. This service has been particularly successful at engaging MSM, which has decreased the attributable HIV testing in sexual health clinics and may in turn be partially responsible for the proportional rise in new diagnoses in women and Black African men.

Our concerted efforts to increase testing, timely diagnosis, and treatment have helped to improve the life chances of those who contract HIV and over time, fewer people in LSL are receiving a late HIV diagnosis. Nonetheless, in all LSL boroughs in 2014-16 more than 25% (target) of people diagnosed with HIV received a late diagnosis.[74] Late diagnosis is highest in Lewisham where almost 40% of people received a late HIV diagnosis in 2014-2016, closely followed by Southwark. Across LSL in 2016, certain groups had a higher proportion of people with late diagnosis: those aged 50-64 (53%), Black African ethnicity (49%) and Other ethnicity (46%), those whose exposure to HIV was through heterosexual contact (59%), and women (55%).[74] These data afford us insight into groups who would benefit from outreach programmes and targeted prevention and testing. Late diagnosis is the most important predictor of morbidity and premature mortality among people with HIV and increases the risk of HIV transmission; it is therefore a critical target for reduction in our strategy.

Effective, timely treatment allows PLHIV to lead long and largely unencumbered lives. However, stigma and discrimination remain primary barriers to engagement across the course of HIV. A national survey of perceived stigma was undertaken by Stigma Index UK in 2015/16.[107] In London, while almost all (94%) participants reported someone in their social circle was aware of their HIV status, those of Black and other minority ethnicities were less

likely to have disclosed their status.[107] Among those who reported feeling stigmatised, sexual rejection was the most common cause of concern. The majority (59%) of patients who had disclosed their HIV status to their GP felt well supported, however, 13% reported having avoided seeing the GP when required. These experiences were broadly similar to that of PLHIV in the UK overall.[107]

Education and campaigns aimed at young people and the general public may help to normalise HIV and reduce the marginalisation of those affected. Stigma and discrimination have also been suggested to influence adherence to ART.[108] A large systematic review of retention in care among adult PLHIV[109] found that substance use, physical comorbidities (e.g. hepatitis C infection), and certain demographics were less likely to remain engaged in care. Key demographics identified as risk factors for becoming lost to care included being from an ethnic minority group. Sexual health professionals must recognise these added risk factors and, where possible, programmes and services should be designed to best support and engage these groups. A synthesis of qualitative evidence suggests that shifting the responsibility of holistic care and support away from clinicians onto lay workers or peer counsellors may nurture a positive outlook and increase retention in care.[108]

As PLHIV generally continue to live longer and age, it is critical that our services evolve to meet the complex needs of this population. The mental wellbeing of PLHIV is associated with adherence to treatment and overall quality of life.[110] Unfortunately, PLHIV are more likely to experience depression and anxiety, which may negatively impact treatment outcomes.[110-114] Mental health and wellbeing should be considered and supporting throughout the life course of PLHIV. As PLHIV age, they may also be affected by physical comorbidities. These may be routine age-related illnesses, however, certain conditions may be exacerbated by HIV infection and treatment, and vice-versa.[115] In terms of STIs specifically, in Lambeth and Southwark in 2017, 90% of syphilis cases were in people who identified as gay; this was slightly lower in Lewisham (78%).[74] Genital sores caused by syphilis make it easier to transmit and acquire HIV infection sexually. Across London, half of MSM cases of syphilis also have HIV.[74] This is concerning as co-infection with HIV increases the risk of central nervous system complications. PLHIV are also most affected by lymphogranuloma venereum (LGV), a type of chlamydia that infects the lymph node. In LSL, 67.5% of LGV diagnoses in 2017 were in HIV-positive MSM. Finally, tuberculosis (TB) is one of the most common co-infections with HIV,[116] with PLHIV being at 16-27 times greater risk of developing TB than those without HIV infection.[117] Alongside these particular conditions, as PLHIV age, like the rest of the population they may develop common age-related illnesses such as cardiovascular disease and dementia.[118-120] It is therefore essential that HIV care evolves to include a wide range of professionals that effectively manage HIV as a long-term condition, acknowledge and support the social care needs and wellbeing of PLHIV, and are prepared to recognise and treat as routine communicable and non-communicable diseases.

Acquiring, living with, and ageing with HIV affects a significant proportion of LSL residents. While significant achievements have been made in reducing the incidence of HIV and improving the quality of life of those living with HIV, approaches must remain agile to address the changing landscape of HIV support. Specialist HIV services and primary care must work together to deliver holistic, person-centred care, managing HIV alongside with other chronic and acute health conditions. Strengthening our combined prevention approaches, promoting timely testing and treatment, and improving our understanding of the social aspects of HIV will support PLHIV in LSL to access the services and care they need to live a long, healthy and fulfilling life.

REFERENCES

1. The mental health of children and young people in England. Public Health England, 2016
2. Radford L, Corral S, Bradley C, Fisher H, Bassett C, Howat N, et al. Child abuse and neglect in the UK today. NSPCC, 2011
3. Shepherd W, Lewis B. Working with children who are victims or at risk of sexual exploitation: Barnardo's model of practice. Barnardo's, 2017
4. Beckett H, Brodie I, Factor F, Melrose M. "It's wrong… but you get used to it" A qualitative study of gang-associated sexual violence towards, and exploitation of, young people in England. University of Bedfordshire and Office of the Children's Commissioner's Inquiry into Child Sexual Exploitation in Gangs and Groups, 2013
5. Domestic violence and abuse: multi-agency working. Guideline PH50. NICE, 2014
6. Sex and relationships education factsheet. Family Planning Association; 2011.
7. Sex and relationships education (SRE) for the 21st century. Supplementary advice to the Sex and Relationships Education Guidance DfEE (0116/2000). Brook, PSHE Association, Sex Education Forum, 2017
8. Kirby D. Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases. Washington, DC: National Campaign to Prevent Teen and Unplanned Pregnancy, 2007
9. Public Health draft guidance; School, college and community-based personal, social, health and economic education focusing on sex and relationships and alcohol education. NICE, 2010
10. Hagell A, Shah R, Coleman J. Key Data on Young People. Association for Young People's Health, 2017
11. Pound P, Denford S, Shucksmith J, Tanton C, Johnson AM, Owen J, et al. What is best practice in sex and relationship education? A synthesis of evidence, including stakeholders' views. BMJ open. 2017;7(5):e014791.
12. Tanton C, Jones KG, Macdowall W, Clifton S, Mitchell KR, Datta J, et al. Patterns and trends in sources of information about sex among young people in Britain: evidence from three National Surveys of Sexual Attitudes and Lifestyles. BMJ open. 2015;5(3):e007834.
13. Heads or tails? What young people are telling us about SRE: Sex Education Forum; 2016 [cited 2018 8 February]. Available from: https://www.sexeducationforum.org.uk/resources/evidence/heads-or-tails-what-young-people-are-telling-us-about-sre.
14. Schools to teach 21st century relationships and sex education [press release]. Department for Education2017.
15. Strategic Direction for Sexual Assault and Abuse Services: Lifelong care for victims and survivors: 2018 - 2023 NHS England, 2018
16. Statistical Bulletin: Domestic abuse in England and Wales: year ending March 2017. Office for National Statistics, 2017
17. Let's Talk About Sex Lewisham. Healthwatch Lewisham, 2017
18. Violence against women and girls. London Assembly Police and Crime Committee, 2016
19. Serious Crime Act 2015. 2015 c.9. Part 5. Domestic abuse. Section 76.
20. Myhill A. Measuring coercive control: what can we learn from national population surveys? Violence against women. 2015;21(3):355-75.
21. Roch A, Morton J, Ritchie G, LGBT Youth Scotland, Equality Network. Abuse out of sight out of mind: transgender people's experiences of domestic abuse. LGBT Youth Scotland and the Equality Network [online]. 2010
22. The School Report. Stonewall, 2012
23. Fox C. 'It's not on the radar.' The hidden diversity of children and young people at risk of sexual exploitation in England. Barnardo's, 2016
24. Domestic Abuse (Updated September 2014). BMA Board of Science 2007
25. Bourne A, Reid D, Hickson F, Torres Rueda S, Weatherburn P. The Chemsex Study: drug use in sexual settings among gay and bisexual men in Lambeth, Southwark & Lewisham. Sigma Research, London School of Hygiene & Tropical Medicine.
26. The use and impact of club drugs in Southwark. Southwark's JSNA. Southwark Council: London. 2017.
27. Child Sexual Exploitation: A guide for health practitioners. Scottish Government, 2017
28. Bovarnick S, Scott S. Child Sexual Exploitation Prevention Education: A rapid evidence assessment. Barnardo's, 2016

29. Walsh K, Zwi K, Woolfenden S, Shlonsky A. School-based education programmes for the prevention of child sexual abuse. The Cochrane database of systematic reviews. 2015(4):CD004380.
30. Preventing Child Sexual Abuse: the role of schools. Children's Commissioner, 2017
31. Hale D, Coleman J, Layard R. A model for the delivery of evidence-based PSHE (Personal Wellbeing) in Secondary Schools: CEP Discussion Paper No 1071. Centre for Economic Performance, London School of Economics; 2011.
32. Sexting: NSPCC; [cited 2018 8 February]. Available from: https://www.nspcc.org.uk/preventing-abuse/keeping-children-safe/sexting/.
33. Ending violence against women and girls strategy: 2016-2020. HM Government, 2016
34. Ofsted examples of good practice in personal, social and health education: Ofsted; 2015 [cited 2018 8 February]. Available from: https://www.gov.uk/government/collections/ofsted-examples-of-good-practice-in-personal-social-and-health-education.
35. Young Voices on Sexual Health. Healthwatch Southwark, 2016
36. Pound P, Langford R, Campbell R. What do young people think about their school-based sex and relationship education? A qualitative synthesis of young people's views and experiences. BMJ open. 2016;6(9):e011329.
37. Wellings K, Jones KG, Mercer CH, Tanton C, Clifton S, Datta J, et al. The prevalence of unplanned pregnancy and associated factors in Britain: findings from the third National Survey of Sexual Attitudes and Lifestyles (Natsal-3). Lancet. 2013;382(9907):1807-16.
38. Contraception: Economic Analysis Estimation of the Return on Investment (ROI) for publicly funded contraception in England. Public Health England, 2018
39. Good progress but more to do: teenage pregnancy and young parents. Public Health England and Local Government Association, 2016
40. Sexual and reproductive health and HIV: applying All Our Health. Public Health England, 2017
41. Vaccinations: HPV Vaccine: NHS; [updated 31 October 2017; cited 2018 8 February]. Available from: https://www.nhs.uk/conditions/vaccinations/hpv-human-papillomavirus-vaccine/.
42. Anal Cancer: Cancer Research UK; [updated 5 May 2016; cited 2018 8 February]. Available from: http://www.cancerresearchuk.org/about-cancer/anal-cancer/risks-causes
43. Health promotion for sexual and reproductive health and HIV Strategic action plan, 2016 to 2019 Public Health England, 2015
44. Montouchet C, Trussell J. Unintended pregnancies in England in 2010: costs to the National Health Service (NHS). Contraception. 2013;87(2):149-53.
45. Mann S. Public Health England's holistic focus on women's reproductive health: The Faculty of Sexual and Reproductive Healthcare; [updated 13 June 2017; cited 2018 8 February]. Available from: https://www.fsrh.org/blogs/dr-sue-mann-on-public-health-englands-holistic-focus-on-womens/.
46. Mercer CH, Tanton C, Prah P, Erens B, Sonnenberg P, Clifton S, et al. Changes in sexual attitudes and lifestyles in Britain through the life course and over time: findings from the National Surveys of Sexual Attitudes and Lifestyles (Natsal). Lancet. 2013;382(9907):1781-94.
47. Contraceptive services for under 25s. Public health guideline 51: National Institute for Health and Care Excellence; 2014 [updated October 2017; cited 2018 8 February]. Available from: https://www.nice.org.uk/guidance/ph51.
48. Supporting the Health & Wellbeing of Children and Young People in Southwark. A summary report of the Health & Wellbeing Related Behaviour Survey. Schools Health Education Unit, 2016
49. Supporting the Health of Young People in Lambeth. A summary report of the Health & Wellbeing Related Behaviour Survey. Schools Health Education Unit, 2016
50. Supporting the Health of Young People in Lewisham. A summary report of the Health & Wellbeing Related Behaviour Survey. Schools Health Education Unit, 2016
51. PHE Fingertips: Sexual and Reproductive Health Profiles: Public Health England; 2015 [cited 2018 8 January]. Available from: https://fingertips.phe.org.uk/profile/SEXUALHEALTH.
52. Sexually transmitted infections and under-18 conceptions: prevention. Public health guideline 3: National Institute for Health and Care Excellence; 2007 [cited 2018 8 February]. Available from: https://www.nice.org.uk/guidance/ph3.
53. Long-acting reversible contraception. Clinical guideline 30: National Institute for Health and Care Excellence; 2005 [updated September 2014; cited 2018 8 February]. Available from: https://www.nice.org.uk/guidance/cg30.
54. Parsons J, Adams C, Aziz N, Holmes J, Jawad R, Whittlesea C. Evaluation of a community pharmacy delivered oral contraception service. The journal of family planning and reproductive health care. 2013;39(2):97-101.

55. Todd A, Copeland A, Husband A, Kasim A, Bambra C. Access all areas? An area-level analysis of accessibility to general practice and community pharmacy services in England by urbanity and social deprivation. BMJ open. 2015;5(5):e007328.
56. Condom Distribution Schemes in England 2015/16. A survey of English Sexual Health Commissioners. Public Health England, 2017
57. LSL Come Correct Q3 Report 2017 (internal data).
58. HPV vaccination programme for men who have sex with men [press release]. Public Health England2018.
59. Cervical Screening: NHS Choices; 2015 [updated 6 August 2018; cited 2018 8 February]. Available from: https://www.nhs.uk/conditions/cervical-screening/
60. Cervical Cancer: Cancer Research UK; 2017 [updated 11 October 2017; cited 2018 8 February]. Available from: http://www.cancerresearchuk.org/about-cancer/cervical-cancer/living-with/fertility.
61. BPAS-MSI internal analysis (2017).
62. Saxena S, Copas AJ, Mercer C, Johnson AM, Fenton K, Erens B, et al. Ethnic variations in sexual activity and contraceptive use: national cross-sectional survey. Contraception. 2006;74(3):224-33.
63. Cameron S. Postabortal and postpartum contraception. Best practice & research Clinical obstetrics & gynaecology. 2014;28(6):871-80.
64. Aiken AR, Aiken CE, Trussell J, Guthrie KA. Immediate postpartum provision of highly effective reversible contraception. BJOG : an international journal of obstetrics and gynaecology. 2015;122(8):1050-1.
65. Bigelow CA, Bryant AS. Short Interpregnancy Intervals: An Evidence-Based Guide for Clinicians. Obstetrical & gynecological survey. 2015;70(7):458-64.
66. Smith GC, Pell JP, Dobbie R. Interpregnancy interval and risk of preterm birth and neonatal death: retrospective cohort study. Bmj. 2003;327(7410):313.
67. CEU Clinical Guideline: Contraception After Pregnancy – January 2017. Faculty of Sexual and Reproductive Health, 2017
68. CEU Clinical Guidance: Male and female sterilisation. Faculty of Sexual and Reporudive Health, 2014
69. A framework for Sexual Health Improvement in England. Department of Health, 2013
70. Whitlock GG, Gibbons DC, Longford N, Harvey MJ, McOwan A, Adams EJ. Rapid testing and treatment for sexually transmitted infections improve patient care and yield public health benefits. International journal of STD & AIDS. 2018;29(5):474-82.
71. Sexually transmitted infections and screening for chlamydia in England, 2017. Health Protection Report. Public Health England, 2018
72. Sexual health, reproductive health and HIV in England: A guide to local and national data (Revised December 2017). Public Health England, 2018
73. Mohammed H, Blomquist P, Ogaz D, Duffell S, Furegato M, Checchi M, et al. 100 years of STIs in the UK: a review of national surveillance data. Sexually transmitted infections. 2018.
74. Sexual health in Southwark, Lambeth and Lewisham. Southwark's JSNA. Southwark Council: London. 2018.
75. Black and minority ethnic men who have sex with men: Project evaluation and systematic review. Public Health England and De Montfort University Leicester, 2016
76. Managing outbreaks of Sexually Transmitted Infections Operational guidance. Public Health England, 2017
77. Sexually transmitted infections: condom distribution schemes. NICE guideline 68: National Institute for Health and Care Excellence; 2017 [cited 2018 21 August]. Available from: https://www.nice.org.uk/guidance/ng68.
78. Kinsella K, Cross R, South J. An evaluation of the condom distribution scheme (C-Card) with young people in Northeast England. Perspectives in public health. 2014;134(1):25-30.
79. Wilson E, Free C, Morris TP, Syred J, Ahamed I, Menon-Johansson AS, et al. Internet-accessed sexually transmitted infection (e-STI) testing and results service: A randomised, single-blind, controlled trial. PLoS medicine. 2017;14(12):e1002479.
80. Denison HJ, Bromhead C, Grainger R, Dennison EM, Jutel A. Barriers to sexually transmitted infection testing in New Zealand: a qualitative study. Australian and New Zealand journal of public health. 2017;41(4):432-7.
81. Opportunistic Chlamydia Screening of Young Adults in England An Evidence Summary. Public Health England, 2014
82. National Chlamydia Screening Programme (NCSP): Public Health England; 2003 [updated 18 July 2017; cited 2018 20 August]. Available from: https://www.gov.uk/government/collections/national-chlamydia-screening-programme-ncsp#programme-overview.

83. Barnard S, Free C, Bakolis I, Turner KME, Looker KJ, Baraitser P. Comparing the characteristics of users of an online service for STI self-sampling with clinic service users: a cross-sectional analysis. Sexually transmitted infections. 2018;94(5):377-83.
84. Guidance for the detection of gonorrhoea in England Public Health England, 2014
85. Update on investigation of UK case of Neisseria gonorrhoeae with high-level resistance to azithromycin and resistance to ceftriaxone acquired abroad. Health Protetion Report. Public Health England, 2018
86. French P. Syphilis. Bmj. 2007;334(7585):143-7.
87. Cantor AG, Pappas M, Daeges M, Nelson HD. Screening for Syphilis: Updated Evidence Report and Systematic Review for the US Preventive Services Task Force. Jama. 2016;315(21):2328-37.
88. Thomas DR, Williams CJ, Andrady U, Anderson V, Humphreys S, Midgley CM, et al. Outbreak of syphilis in men who have sex with men living in rural North Wales (UK) associated with the use of social media. Sexually transmitted infections. 2016;92(5):359-64.
89. Genital herpes: Public Health England; 2013 [cited 2018 20 August]. Available from: https://www.gov.uk/guidance/genital-herpes.
90. Herpes: Centres for Disease Control and Prevention; 2017 [cited 2018 20 August]. Available from: https://www.cdc.gov/std/herpes/default.htm.
91. 2015 BASHH CEG guidance on tests for Sexually Transmitted Infections. BASHH Clinical Effectiveness Group, 2015
92. Hepatitis C in England 2018 report. Public Health England, 2018
93. Hepatitis A vaccination in adults: temporary recommendations. July 2018 update. Public Health England, 2018
94. Hepatitis B: vaccine recommendations during supply constraints: Public Health England; 2017 [updated 12 July 2018; cited 2018 20 August]. Available from: https://www.gov.uk/government/publications/hepatitis-b-vaccine-recommendations-during-supply-constraints.
95. Recent trends in Lymphogranuloma venereum (LGV) diagnoses in the United Kingdom: 2003-2016. Health Protection Report. Public Health England, 2017
96. Update on the epidemiology of Shigella in adults in London, 2012 to 2016 Excess of cases in men who have sex with men. Public Health England, 2017
97. Fernando I, Pritchard J, Edwards SK, Grover D. UK national guideline for the management of Genital Molluscum in adults, 2014 Clinical Effectiveness Group, British Association for Sexual Health and HIV. International journal of STD & AIDS. 2015;26(10):687-95.
98. Kissinger P. Trichomonas vaginalis: a review of epidemiologic, clinical and treatment issues. BMC infectious diseases. 2015;15:307.
99. Lopez LM, Bernholc A, Chen M, Tolley EE. School-based interventions for improving contraceptive use in adolescents. The Cochrane database of systematic reviews. 2016(6):CD012249.
100. Holt M, Lea T, Mao L, Kolstee J, Zablotska I, Duck T, et al. Community-level changes in condom use and uptake of HIV pre-exposure prophylaxis by gay and bisexual men in Melbourne and Sydney, Australia: results of repeated behavioural surveillance in 2013-17. The lancet HIV. 2018;5(8):e448-e56.
101. Furegato M, Chen Y, Mohammed H, Mercer CH, Savage EJ, Hughes G. Examining the role of socioeconomic deprivation in ethnic differences in sexually transmitted infection diagnosis rates in England: evidence from surveillance data. Epidemiology and infection. 2016;144(15):3253-62.
102. Fish J, Papaloukas P, Jaspal R, Williamson I. Equality in sexual health promotion: a systematic review of effective interventions for black and minority ethnic men who have sex with men. BMC public health. 2016;16(1):810.
103. Towards elimination of HIV transmission, AIDS and HIV-related deaths in the UK. Public Health England, 2017
104. 90-90-90 - An ambitious treatment target to help end the AIDS epidemic. UNAIDS, 2014
105. London joins Fast-Track Cities initiative to reduce new HIV infections [press release]. Mayor of London2018.
106. Fast-Track Cities [cited 2018 20 August]. Available from: http://www.fast-trackcities.org/about.
107. HIV in the UK: Changes and Challenges; Actions and Answers. The People Living With HIV Stigma Survey UK 2015. 2015
108. Hall BJ, Sou KL, Beanland R, Lacky M, Tso LS, Ma Q, et al. Barriers and Facilitators to Interventions Improving Retention in HIV Care: A Qualitative Evidence Meta-Synthesis. AIDS and behavior. 2017;21(6):1755-67.

109. Bulsara SM, Wainberg ML, Newton-John TRO. Predictors of Adult Retention in HIV Care: A Systematic Review. AIDS and behavior. 2018;22(3):752-64.
110. Kaaya S, Eustache E, Lapidos-Salaiz I, Musisi S, Psaros C, Wissow L. Grand challenges: Improving HIV treatment outcomes by integrating interventions for co-morbid mental illness. PLoS medicine. 2013;10(5):e1001447.
111. Mental Health and HIV: HIV.gov; [updated 8 May 2018; cited 2018 20 August]. Available from: https://www.hiv.gov/hiv-basics/staying-in-hiv-care/other-related-health-issues/mental-health.
112. Owe-Larsson B, Sall L, Salamon E, Allgulander C. HIV infection and psychiatric illness. African journal of psychiatry. 2009;12(2):115-28.
113. Erdbeer G, Sabranski M, Sonntag I, Stoehr A, Horst HA, Plettenberg A, et al. Everything fine so far? Physical and mental health in HIV-infected patients with virological success and long-term exposure to antiretroviral therapy. Journal of the International AIDS Society. 2014;17(4 Suppl 3):19673.
114. Miners A, Phillips A, Kreif N, Rodger A, Speakman A, Fisher M, et al. Health-related quality-of-life of people with HIV in the era of combination antiretroviral treatment: a cross-sectional comparison with the general population. The lancet HIV. 2014;1(1):e32-40.
115. The future of HIV services in England: shaping the response to changing needs. The King's Fund, 2017
116. Tuberculosis and HIV co-infection: Avert; [updated 2 July 2018; cited 2018 20 August]. Available from: https://www.avert.org/living-with-hiv/health-wellbeing/tuberculosis.
117. Tuberculosis and HIV: World Health Organization; [cited 2018 20 August]. Available from: http://www.who.int/hiv/topics/tb/en/.
118. Petoumenos K, Worm SW. HIV infection, aging and cardiovascular disease: epidemiology and prevention. Sexual health. 2011;8(4):465-73.
119. So-Armah K, Freiberg MS. Cardiovascular disease risk in an aging HIV population: not just a question of biology. Current opinion in HIV and AIDS. 2014;9(4):346-54.
120. Cohen RA, Seider TR, Navia B. HIV effects on age-associated neurocognitive dysfunction: premature cognitive aging or neurodegenerative disease? Alzheimer's research & therapy. 2015;7(1):37.

Lambeth, Southwark and Lewisham

Sexual and Reproductive Health Strategy 2019–24 – Summary

Lambeth, Southwark and Lewisham Public Health Departments

1.0 Executive summary

Lambeth, Southwark and Lewisham (**LSL**) together face some of the greatest sexual health challenges in England.

We have similarly young, mobile and diverse populations, and our local sexual health services are modern and popular. Our rates of HIV and STIs are the highest in England, and there are persistent inequalities in sexual and reproductive health, with young people, men who have sex with men (MSM), and black and minority ethnic (BME) communities suffering the greatest burden. Sexual health inequalities cannot be addressed in isolation; it must be done in partnership. Due to the similarities in the challenges we face, LSL collaborate on sexual health commissioning and strategy in order to maximise our efforts to meet the significant and ongoing needs of our populations. This strategy assesses the most up to date intelligence and sets out LSL's shared ambitions and priority areas in sexual and reproductive health over the next five years.

Since the publication of LSL's most recent strategy (2014–17), there have been some significant changes in the sexual health landscape. The financial climate for public services (and public health services in particular) is extremely challenging, and not predicted to end in the near future. New, sustainable ways of funding sexual health services have been adopted across London and other parts of England, which despite now meeting the exact costs of sexual health service provision, have represented a considerable reduction in income for many NHS trusts. Demand for sexual health services remains high and is not expected to decline, and people across the country often struggle to access sexual and reproductive health services exactly when they want them. Commissioners and services have had to innovate, and LSL provided proof of concept of STI self sampling via an online service, which has now been adopted across many parts of London to alleviate pressure on sexual health clinics. Finally, the use of pre-exposure propylaxis (PrEP) has transformed HIV prevention and has likely contributed in part to a reduction in new diagnoses, particularly amongst MSM, and work is ongoing to establish how PrEP will form part of the publicly-funded HIV prevention agenda nationally.

There have been considerable improvements in key outcomes since our last strategy was published in 2014, most notably a reduction in new diagnoses of HIV for the first time in the history of the disease in England, and a continued downward trajectory in rates of teenage conceptions. However, gains have not been made equally across our population. BME communities (and black communities in particular) remain at greater risk of poor sexual and reproductive health.

There is an extremely high rate of diagnosed HIV across LSL – it is the highest in England, and over 8,700 of our residents have been diagnosed with HIV. Just over three quarters of people living with HIV in LSL are men, the majority of whom are white. Sex between men is the most common HIV exposure category in Lambeth (66%) and Southwark (58%), but in Lewisham, heterosexual contact is the most common exposure type (54%) of those diagnosed.

New HIV diagnosis rates are falling across LSL, but too many people still receive a late diagnosis, and there are still people living with HIV that are unaware of their status. There remain significant inequalities in those diagnosed late in LSL; people aged 50–64 years, of black African ethnicity, those exposed through heterosexual contact, and women have the highest

rates of late diagnosis. Furthermore, a disproportionate number of HIV cases locally are diagnosed in people living in the 40% most deprived areas.

Across LSL, 22,000 new STIs were diagnosed in 2017, with rates highest amongst men and those aged 20–24. While men have higher rates of STIs across most of the life course, women have higher rates of STIs than men at age 15–19. It is unclear what is driving this pattern, but it may be that young people lack the skills and confidence to negotiate safer sex. There is a general downward trend in new diagnoses of STIs in LSL, with the exception of gonorrhoea and syphilis (which most affect MSM). The increases in these STIs is concerning due to antimicrobial resistance and the severity of syphilis. Given the general burden of STIs in our populations, untreated STIs remain a concern in protecting the reproductive health of residents.

In terms of reproductive health, user-dependent contraceptive methods (e.g. condoms or the pill) are the most common form of contraception used in LSL. This combined with challenging access to services translates to a high use of emergency contraception and abortion, indicating that reproductive health needs continue to be unmet, particularly amongst young, black women.

We know that a large part of improving sexual and reproductive health is supporting people to develop the skills to negotiate the sex (and sexual relationships) that they want to have. Abusive and coercive relationships affect people of all ages, genders and sexualities, but some groups are at higher risk of unhealthy sexual relationships than others, including young women, people with learning disabilities, and people identifying as LGBTQI+. MSM in particular may be at risk through chemsex, as maintaining control of behaviour and choices while under the influence of drugs may be difficult. However, few local data are available on indicators for safe and healthy sexual relationships.

To build on the progress we have made and meet the most salient challenges facing our boroughs over the next five years, we will work together on four key priority areas:

Priority	Vision and key outcomes
Healthy and fulfilling sexual relationships	People are empowered to make their sexual relationships healthy and fulfilling: • People make informed choices about their sexual and reproductive health • People in unhealthy or risky sexual relationships are supported appropriately
Good reproductive health across the life course	People effectively manage their fertility and reproductive health, understand what impacts on it and have knowledge of and access to contraceptives: • Reproductive health inequalities are reduced • Unwanted pregnancies are reduced • Knowledge and understanding of reproductive health and fertility are increased
High quality and innovative STI testing and treatment	The local burden of STIs is reduced, in particular among those who are disproportionately affected: • There is equitable, accessible, high-quality testing and treatment that is appropriate to need • Transmission of STIs and repeat infections are reduced
Living well with HIV	We move towards achievement of 0–0–0: zero HIV-related stigma, zero HIV transmissions and zero HIV-related deaths: • People living with HIV know their status and are undetectable (=untransmittable) • People living with HIV are enabled to live and age well

This strategy sets out the actions we will take in each of the priority areas to continue improving sexual and reproductive health in our boroughs over the next five years. We know that this is an ambitious strategy, and we cannot deliver it in isolation. We recognise that within LSL, some areas have further to progress than others and there will be local factors which may be unique to individual boroughs. Therefore, the boroughs will have an annual action plan which will include specific steps to deliver this strategy. This approach allows us to collaborate to deliver an overarching strategy and to take local action as needed. Progress against this strategy will be overseen by the LSL Sexual Health Commissioning Partnership Board in addition to each borough's Health and Wellbeing Board.

Agenda Item 11

Item No. 11.	Classification: Open	Date: 4 March 2019	Meeting Name: Health and Wellbeing Board
Report title:		Health and Wellbeing Board Work Plan 2018-20	
Ward(s) or groups affected:		All	
From:		Strategic Director of Place and Wellbeing	

RECOMMENDATION

1. That the health and wellbeing board note the work plan for 2018-2020 (Appendix 1) subject to any amendments.

BACKGROUND INFORMATION

2. The forward work plan enables the board and officers to have strategic oversight of matters pertaining to the future work of the board and to keep track of issues arising following consideration of items.

KEY ISSUES FOR CONSIDERATION

3. Attached at Appendix 1 is a draft work plan for the Health and Wellbeing Board for 2018-20. The work plan is to be driven by the priorities agreed by the Board and underpinned by the Health and Wellbeing Strategy.

4. The work plan will be submitted to each meeting to enable the board to note / consider any necessary changes as appropriate.

Policy implications

5. This report is not considered to have direct policy implications. Relevant policy implications will be set out in the individual items when considered by the board.

Community impact statement

6. Community impact will be addressed when considering the individual items.

Resource implications

7. There are no direct resource implications in this report.

SUPPLEMENTARY ADVICE FROM OTHER OFFICERS

8. None.

BACKGROUND DOCUMENTS

Background Papers	Held At	Contact
Previous health and wellbeing board agendas and minutes	Southwark Council Website	
Link: http://moderngov.southwark.gov.uk/ieListMeetings.aspx?CommitteeId=365		

APPENDICES

No.	Title
Appendix 1	Proposed work plan 2018-2020

AUDIT TRAIL

Lead Officer	Kevin Fenton, Strategic Director of Place and Wellbeing	
Report Author	Everton Roberts, Principal Constitutional Officer	
Version	Final	
Dated	21 February 2019	
Key Decision?	No	
CONSULTATION WITH OTHER OFFICERS / DIRECTORATES / CABINET MEMBER		
Officer Title	**Comments sought**	**Comments included**
Director of Law and Democracy	No	No
Strategic Director of Finance and Governance	No	No
Cabinet Member	**No**	**No**
Date final report sent to Constitutional Team		22 February 2019

APPENDIX 1

Work Programme for 2018-19 and 2019-20

Item	Meeting date							Commentary
	30 July 2018	21 Nov 2018	4 Mar 2019	Jun 2019	Oct 2019	Feb 2020	Apr 2020	
Proposed themes for future meetings								
Giving Every Child Best Start in Life	-	-						
Community Safety – Knife Crime, public health approach		-						
Health Inequalities	-	-	✓					
Dementia	-	-						
Bridges to Health and Wellbeing	-	-						
Previous Themes								• Mental Health and Inequalities (January 2018) • Place and Health (March 2018) • Health and Wellbeing Board – Past, Present and Future (July 2018) • Best Start – Young People's Mental Health and Wellbeing (November 2018)

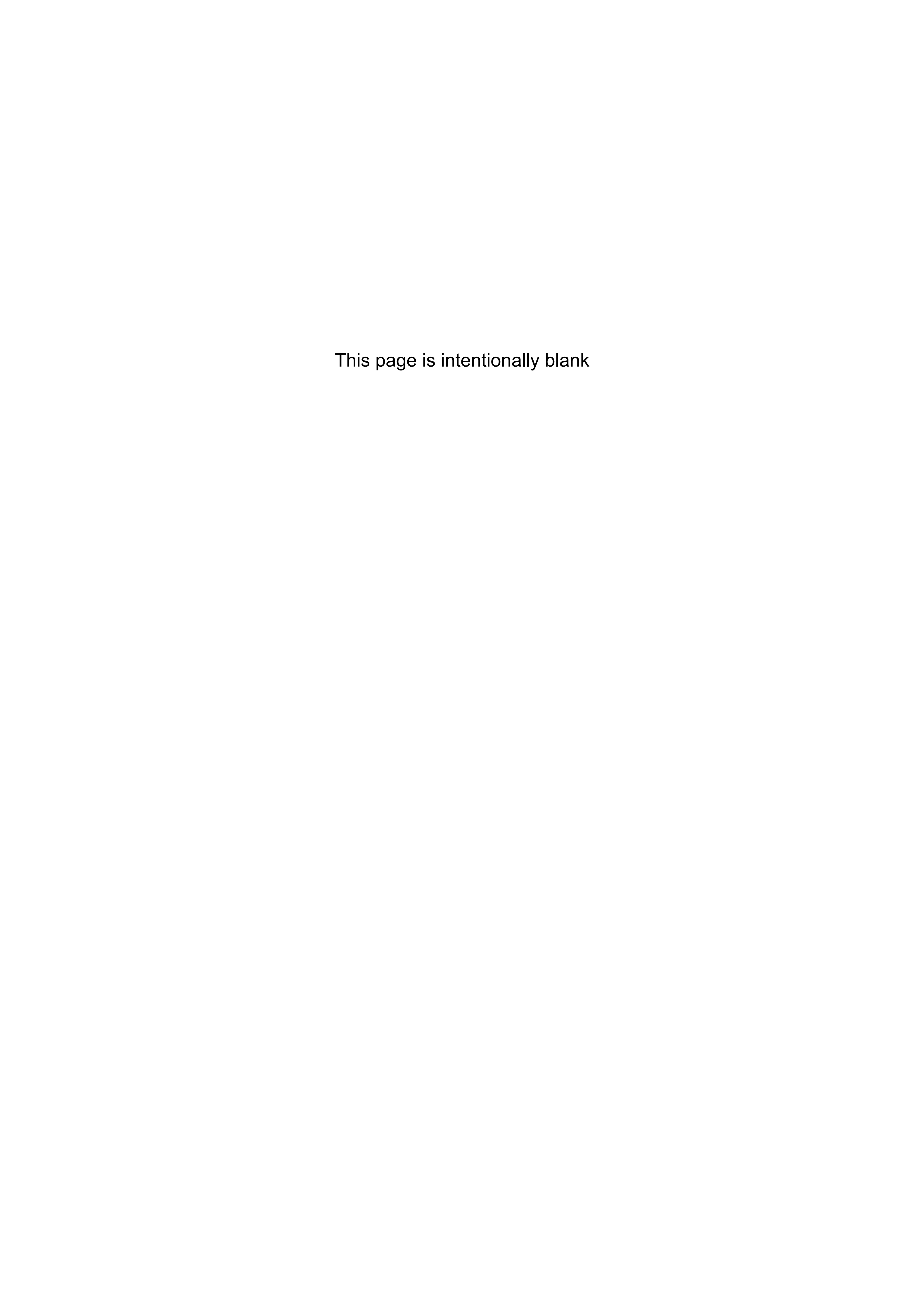
Item	Meeting date							Commentary
	30 July 2018	**21 Nov 2018**	**4 Mar 2019**	**Jun 2019**	**Oct 2019**	**Feb 2020**	**Apr 2020**	
Council Business								
Overview of Southwark Health and Wellbeing Strategy and progress to date	✓	-	-					Board to receive regular reports on the health and wellbeing of children and young people, the wider determinants of health and social regeneration and long term conditions
Council Plan 2018 – 2021-22	✓	-	-	-	-	-	-	
Sexual Health Update	✓	-						Requested at January 2018 board meeting.
Southwark Healthy Weight Strategy ‘*Everybody’s Business’*	-	-	-					Findings of Expert Challenge Panel scheduled to meet in Autumn 2018.
Annual Performance report covering obesity, smoking, HIV and sexual health	✓	-	-					
Joint Strategic Needs Assessment	-	-	-					
Local Government Declaration on the reduction of Sugar and Healthier Food	-	-	-					Declaration agreed at September Cabinet. Cabinet also agreed that a progress report be brought back to cabinet and the health and wellbeing board in six months with a more developed action plan.

Item	Meeting date							Commentary
	30 July 2018	**21 Nov 2018**	**4 Mar 2019**	**Jun 2019**	**Oct 2019**	**Feb 2020**	**Apr 2020**	
Pharmaceutical Needs Assessment	-	✓	-					Supplementary document agreed – November 2018.
Director of Public Health Annual Report	-	-	-	✓	-	-	✓	
Immunisation programmes in Southwark – Update	-	-	-					Report to be brought back once strategy is in place. Originally considered at January 2018 board meeting.
Enhancing the impact of planning policy on health outcomes and inequalities in Southwark and Lambeth (Health Innovation Fund)	-	-	-					Update on progress of the project. Originally considered at January 2016 board meeting.
Domestic Violence Strategy – Update	-	-	-					
Primary Care Commissioning Committee – Health and Wellbeing Board observer	✓	-	-	✓				Councillor Evelyn Akoto nominated July 2018.
Policy and Resources Revenue Budget 2019-20	-	-	✓	-	-	-	✓	

Item	Meeting date							Commentary
	30 July 2018	21 Nov 2018	4 Mar 2019	Jun 2019	Oct 2019	Feb 2020	Apr 2020	
Clinical Commissioning Group business								
Key Developments - CCG	✓	✓	✓	✓	✓	✓	✓	Update to be provided at each meeting on key developments in the CCG
South East London Sustainability and Transformation Plan	-	✓	-	✓	-	✓	-	Update to be provided at every other meeting.
Our Healthier South East London	-	✓	-	✓	-	✓	-	Update to be provided at every other meeting.
Joint Council and CCG Business								
BCF and iBCF	-	✓	-					Update received at November 2018 board meeting.
CAMHS – Whole System Approach	✓	✓	-					Full report including findings and recommendations to come to the Autumn 2018 (Requested at July board meeting). Review report considered at November 2018 board meeting.
Integrated Commissioning Update	✓	-	-					
Integration Policy Update: NHS 10 Year Plan and Social Green Paper	-	-	-					

Item	Meeting date							Commentary
	30 July 2018	21 Nov 2018	4 Mar 2019	Jun 2019	Oct 2019	Feb 2020	Apr 2020	
Southwark Five Year Forward View	-	-	-					
Health and Wellbeing Board Structure and Governance Review	✓	-	✓					Update on the progress of the governance review to be received at the Autumn meeting. Agreed at July 2018 board meeting.
London Mayor's Health Inequalities Strategy Pledges	-	-	-					Update arising from pledges agreed at board meeting of January 2018.
Building healthy communities – social regeneration and strategic estate planning	-	✓	-					Requested at March 2018 board meeting under the guise of Development of a Shared Estate Strategy. Further meeting to be arranged to discuss in more detail the content and shared implications to implement the strategy.
Building Health communities – Developing Superzones around schools	-	✓	-					Considered at November 2018 board meeting. Further report to be brought back setting out the proposed model for London with implications for implementation in Southwark.
Looked after Children in Southwark	-	-	-					Presentation from Sunshine House (Looked after children team)

Item	Meeting date							Commentary
	30 July 2018	**21 Nov 2018**	**4 Mar 2019**	**Jun 2019**	**Oct 2019**	**Feb 2020**	**Apr 2020**	
Other								
Voluntary & Community Sector Strategy Action Plan – Update	-	-	-					Last considered at March 2018 board meeting.
Health and Wellbeing Board Workplan 2018-2020 – Updates	✓	✓	✓	✓	✓	✓	✓	Opportunity to review at each meeting.



This page is intentionally blank

HEALTH AND WELLBEING BOARD AGENDA DISTRIBUTION LIST (OPEN)
MUNICIPAL YEAR 2018/19

NOTE: Amendments/queries to Everton Roberts, Constitutional Team, Tel: 020 7525 7221

Name	No of copies	Name	No of copies
Health and Wellbeing Board Members		**Officers**	
Councillor Evelyn Akoto	1	Sarah Feasey	1
Councillor Jasmine Ali	1		
Andrew Bland	1		
Cassie Buchanan	1	**Others**	
Sally Causer	1		
Kevin Fenton	1	Everton Roberts, Constitutional Team	8
Ross Graves	1		
Dr Jonty Heaversedge	1		
Councillor Peter John	1		
Eleanor Kelly	1		
Catherine Negus	1	**Total:**	26
Councillor David Noakes	1		
Dr Matthew Patrick	1		
Paul Rymer	1		
Ian Smith	1		
David Quirke-Thornton	1		
Dr Yvonneke Roe	1		
		Dated: February 2019	