Royal Borough of Kingston

Annual Public Health Report

The Final Frontier:

Sexual and Reproductive Health in Kingston

2016-17

PUBLIC HEALTH
KINGSTON
Healthier living, happier lives

THE ROYAL BOROUGH OF
KINGSTON
UPON THAMES

Contents

Foreword

I am both proud and saddened to be writing this foreword for the Annual Public Health Report for Kingston 2016-17 as Interim Director of Public Health. Proud because it is an exemplary report focusing on a subject too often left out of the limelight: sexual and reproductive health. Saddened because Dr Jonathan Hildebrand, Director of Public Health for Kingston from 2006 to 2016, an exceptional and inspirational leader, sadly died on 30th November 2016. He had spent much of what turned out to be his last days at work reviewing his tenth and final report for Kingston.

Dr Hildebrand was renowned for his Annual Public Health Reports for Kingston. He always gave huge amounts of his time, energy and intellectual rigour to reviewing and editing the content of the reports, and was a stickler for checking facts, statistical analysis and referencing. This is in part what has made the reports of such high quality, alongside his commitment to engage other stakeholders in the compilation of the reports, to ensure they reflected public health contributions across a wide partnership. He always injected a level of natural enthusiasm when presenting his report, managing to make it both interesting and informative, even when tackling the drier element of statistics.

Over the last decade leading public health in Kingston his reports have shone a spotlight on a breadth of areas which influence the public's health, reflected in the chronological list shown here. Many of his reports have been highly commended at national level, none more so than his eighth, which focused on mental health and wellbeing. NHS England's National Clinical Director for Mental Health at the time, Geraldine Strathdee, tweeted her opinion of the report in one word: "stunning".

The titles of Jonathan's reports have similarly been thoughtfully considered, with an annual competition to come up with the chosen title. Jonathan frequently won his own prize, with several not-so-subtly referencing one of his favourite interests. Those of you who enjoy space adventures will no doubt recognise the link in some of the titles and hopefully raise a smile, which I'm sure Jonathan would have approved of:

2006: Choosing Health in Kingston: health improvement in Kingston.

2007: The Road Less Travelled: the health of marginalised groups in Kingston.

2008: Health Begins at Home: housing and its role in health and wellbeing.

2009-10: Sustainability and Health.

2010-11: Live Long and Prosper: the contribution of public health in improving health.

2011-12: Live Long and Prosper, the Next Generation: a report on the health of children in Kingston.

2013: Older People in Kingston, Living Well in Later Life.

2014: Mental Health and Wellbeing in Kingston.

2015: Eat well; Exercise more; Drink sensibly.

2016-17: The Final Frontier: Sexual and Reproductive Health in Kingston.

I recommend the report to you and welcome both comments and suggestions for future report topics, which can be sent to me at iona.lidington@kingston.gov.uk.

Iona Lidington
Interim Director of Public Health

Introduction

This is my tenth report on the health and wellbeing of people in Kingston. The report focuses on sexual and reproductive health and, as far as we are aware, is the first comprehensive annual public health report in the country solely devoted to this topic.

Sexual and reproductive health is far more than just sexually transmitted infections (STIs) and contraception. The World Health Organisation (WHO) defines sexual health as "a state of physical, mental and social wellbeing 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"[1].

Sexual health is a complex issue that affects both individuals and the local communities in which we live, however it is not often discussed in an open forum. The reason why good sexual health matters is explored in more detail in the first section, which also provides the national policy context and key local principles which drive our work and which can be seen in practice in the examples of local action. It also examines the crucial role of prevention in relation to sexual health and the evidence for investment.

The report then explores sexual health across the life course, looking at how sexual wellbeing and relationships, the epidemiology of STIs and contraceptive use change as we age. The section on young people focuses on the importance of negotiating healthy, consensual relationships as a foundation for the future, as well as highlighting the disproportionate burden of STI diagnoses that occur in this age group.

The section on adults looks at how the impact of choices made at a younger age can affect individuals and their relationships in adulthood, and focuses on specific groups of the population that experience some of the poorest sexual health outcomes. In the section on older people the impact of ill health on intimacy and relationships is explored, as well as the changing picture in relation to age and STIs and the human immunodeficiency virus (HIV). The final section looks at how services in Kingston are commissioned and explains the role of the Kingston Integrated Sexual Health (KISH) network.

This report also includes a chapter on the demography of Kingston whilst the statistical annex, together with the update on progress against recommendations in last year's report which focused on diet, exercise and alcohol, can be accessed via www.kingston.gov.uk/health_and_wellbeing.

Every effort has been made to utilise the most up-to-date data, although it is worth remembering that this is constantly changing and being updated. With this in mind, we would urge you to use the online sources referenced throughout the report for further information. If you have any queries regarding specific chapters, please contact the sexual health team at kish@kingston.gov.uk.

I would like to thank all the authors and contributors and give a special mention to the team who have supported me in the compilation of the report: Amy Leftwich, Peter Taylor, Russell Styles and Christopher Rimington.

Dr Jonathan Hildebrand
Director of Public Health, Kingston Council
2006 – 2016

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5.4 The Voluntary and Community Sector	**Amy Leftwich**	Sexual Health Promotion Specialist, Public Health, Kingston Council

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6.1 Demography	**Tejal Indulkar**	Tejal Indulkar, Senior Public Health Intelligence Analyst, Public Health, Kingston Council
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1.0

Section One
Why Good Sexual Health Matters

- 1.1 Kingston's Ambitions for Sexual and Reproductive Health
- 1.2 Prevention

Kingston's ambition is to improve sexual and reproductive health outcomes by providing

high quality, consistent and accessible services and interventions

that are responsive to local need.

The national **'Framework for Sexual Health Improvement in England'** sets out key ambitions for good sexual health.

Nationally, there are rising rates of sexually transmitted infections (STIs) and

30%

of pregnancies are estimated to be unplanned.

'Prevention'

describes processes that aim to minimise the likelihood of ill health or poor health outcomes by supporting people to make informed and responsible choices regarding their health.

Nationally, preventing 4,000 new HIV diagnoses would result in overall care and treatment cost savings of

£1.9 billion

across a lifetime.

Encouraging the uptake of

Long Acting Reversible Contraception (LARC)

helps to reduce unplanned pregnancy and the associated health and social care costs.

1.1 Kingston's Ambitions for Sexual and Reproductive Health

Lead author:
Amy Leftwich
Sexual Health Promotion Specialist,
Public Health, Kingston Council

Introduction

The issue of sexual and reproductive health affects most people with over 60% of the adult population reporting sexual activity in the past year[1]. With rising rates of sexually transmitted infections (STIs)[2] and an estimated 30% of pregnancies unplanned[3], poor sexual health causes significant health and emotional issues for individuals as well as resulting in an economic cost to wider society.

In 2001, as part of their work to address these issues and promote good sexual health, the Department of Health published the first ever National Strategy for Sexual Health and HIV in England[4]. This called for improved access to information on sexual health and the equitable provision of sexual health services to the population.

Since this time the profile of sexual health has developed significantly as the public demand for high quality sexual and reproductive health services has increased. The commissioning of sexual health services has become a more complex task, requiring a high level of knowledge of the evidence base and responding to national recommendations, whilst taking into account local need and the imperative to deliver value for money.

National Ambitions

In 2013, the Government outlined its vision for sexual health in its 'Framework for Sexual Health Improvement in England'[5]. The framework sets out key ambitions for good sexual health, together with the evidence base and actions that can be taken to improve sexual health outcomes.

The framework also emphasises the important role that public health teams should play by bringing together key stakeholders to form strong networks that deliver these ambitions for the local community. The major focus is to ensure services and programmes remain responsive to local need, whilst continuing to provide high quality and accessible services to everyone who needs them.

Figure 1 outlines the key aims of the framework and how the Government intends localities to deliver these.

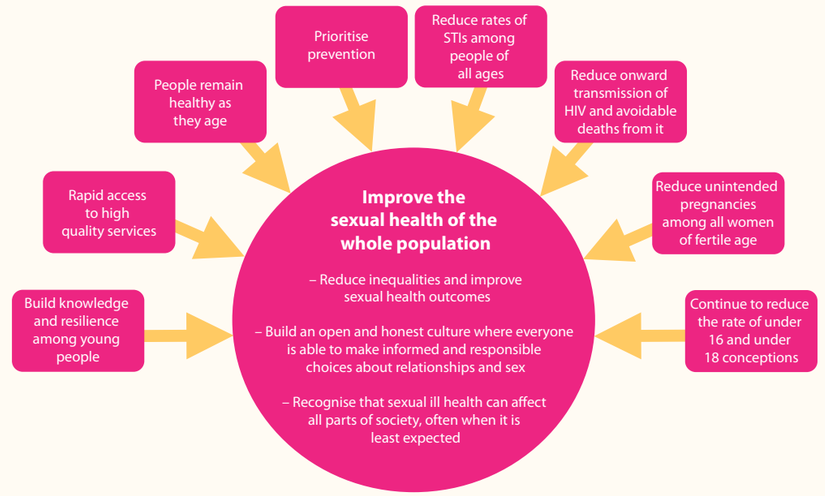
The Public Health Outcomes Framework, produced in May 2013 and refreshed in May 2016, sets out a range of outcomes and associated indicators, which provide detailed public health information not only on how long people live, but on how healthy they are through all stages of their lives[6].

There are three key indicators directly relevant to sexual health within the framework:

- under 18 conceptions
- chlamydia diagnoses (15 to 24 year olds)
- people presenting with the human immunodeficiency virus (HIV) at a late stage of infection.

Data gathered from these and other national indicators allows comparison of Kingston with other local authorities as well as London and national averages to assess performance and help inform the planning of local services.

Figure 1 A Framework for Sexual Health Improvement: key objectives.



Source: Department of Health. A Framework for Sexual Health Improvement. 2013.

Local Ambitions

At a local level, our ambition is to improve the sexual and reproductive health outcomes in Kingston by providing high quality, consistent and accessible services and interventions that are responsive to local need. At the same time, a strong network of local service providers has been built to ensure good practice is shared (see chapter 5.1).

It is also important to recognise that sexual health is not simply about STIs and unplanned pregnancy. Sexual health is a complex area, which encompasses issues of culture, religion, education and wider socio-economic factors. It is an issue relevant to most people to varying degrees throughout their lifetime.

This report aims to reflect this approach by focusing on sexual and reproductive health across the life course: young people, adults and older people.

With this in mind, the following good practice principles are highlighted in the report:

- recognise the impact of sexual ill health and unplanned pregnancy on both the individual and the wider community
- ensure anyone present within the borough has access to a range of sexual health services that provide high quality, consistent information and support (in line with statutory requirements[7])
- recognise that sexual health inequalities exist for key groups within the local population (particularly young people, men who have sex with men and people from Black and minority ethnic groups) and targeting resources appropriately to address these inequalities
- promote the safeguarding of children and vulnerable adults
- have a positive influence on the cultural and social factors that affect sexual health and eliminate discrimination where it exists
- explore new technologies, as they become available, to support a culture of self care
- involve service users in the review, design and development of sexual health services and interventions
- share learning and best practice amongst sexual health professionals.

This report aims to demonstrate how both national guidance and these principles inform commissioning decisions and local practice to ensure that local people can achieve good sexual and reproductive health outcomes.

1.2 Prevention

Lead author:
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What is Prevention?

Prevention describes processes that aim to minimise the likelihood of ill health and/or poor outcomes that may be detrimental to an individual's health and wellbeing, by supporting people to make informed and responsible choices regarding their health[1].

Whilst behavioural change in an individual is key to prevention efforts, effective prevention is best addressed within a wider determinants of health model[2]. Figure 1 illustrates how the health of an individual is determined by the complex interactions between individual lifestyle factors and the wider economic, physical and social environments.

As well as an awareness of the complex set of factors that may influence an individual's choices regarding their health, it is also important to understand how different aspects of prevention work together to reduce ill health and promote an environment in which healthy behaviour choices are supported.

There are four levels of prevention[3]:

Primary prevention aims to prevent disease or injury from occurring in the first place by preventing exposure to hazards, altering unhealthy behaviours and increasing resistance to disease.

Secondary prevention aims to minimise the impact of disease by diagnosing and treating it as quickly as possible.

Tertiary prevention aims to reduce the negative impact of established disease by restoring function and reducing disease-related complications.

Quaternary prevention describes a set of activities that mitigate or avoid the need for unnecessary, unsafe or excessive interventions.

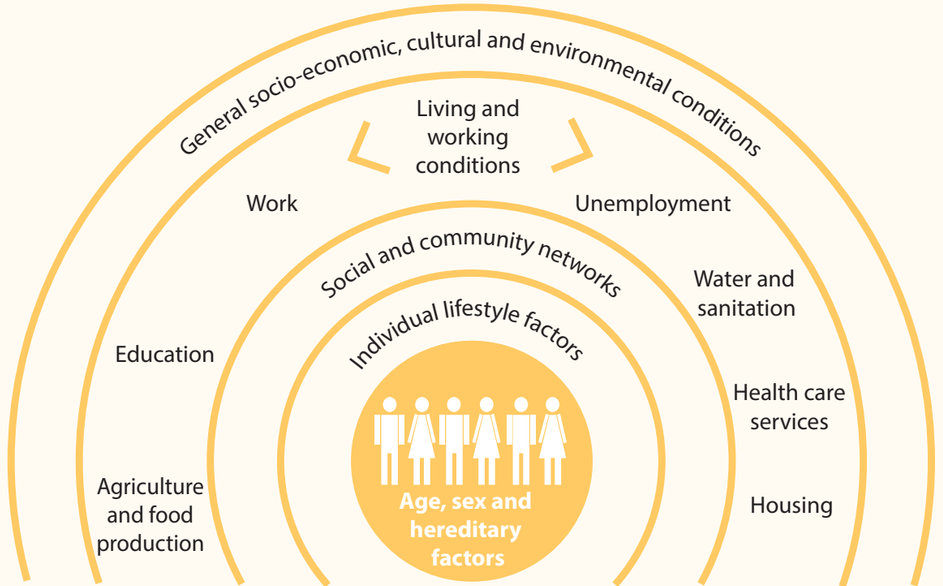
This report focuses mainly on the activities and programmes in Kingston that aim to prevent ill health at primary and secondary levels as this reflects the main focus of public health activity in the area of sexual health.

Prevention in Sexual and Reproductive Health

In the area of sexual and reproductive health, primary prevention is often described as sexual health promotion. Health promotion attempts to engage people throughout their lives in recognising factors within both their direct control, which may be affecting their health and wellbeing, as well as wider conditions that may also have an impact[4]. This early intervention and inclusive approach attempts to go further than simply preventing ill health; it aims to encourage an awareness of factors that may optimise health and wellbeing for both individuals and the wider community, leading to more sustained improvements in health and associated reductions in health inequalities[5].

The National Teenage Pregnancy Strategy, published in 1999, is a good example of successful sexual health promotion in practice[6]. This aimed to halve the rate of under 18 conceptions in England and support teenage parents to achieve better outcomes for both themselves and their children. The strategy sought to address a range of health determinants in order to effect long term change.

Figure 1 Wider determinants of health model.



Source: Dahlgren G. and Whitehead M. European strategies for tackling social inequities in health. 2007.

This included improving sex and relationships education (SRE) to build young people's knowledge, access to contraception to provide the necessary resources, and lobbying at a regional and national level for policies to support young parents and their children[6]. By 2010 the strategy had not only achieved its aims, but it was widely acknowledged that it had resulted in a cultural shift that allowed young people and their families to be more open in discussing sex and relationships; and professionals, such as teachers, to be more supportive in their approaches to sexual health and teenage pregnancy[7].

Kingston Public Health aims to work in an holistic way to influence a broad range of health determinants. This approach seeks to give local residents the best opportunity to effect positive and sustained behaviour change. The report includes examples of programmes and services in Kingston that demonstrate this way of working in relation to sexual and reproductive health.

1.0 Why Good Sexual Health Matters

Evidence Base for Investment

Measuring the cost effectiveness of prevention interventions is key to ensuring that resources are appropriately allocated. This is particularly important when spending plans face ever increasing scrutiny and therefore initiatives need a strong evidence base if they are to be sustained.

The 'Unprotected Nation 2015' report calculates how a 10% budget cut could represent a huge 'false economy' around sexual health[8]. Over the five years to 2020, each £1 cut could cost £86 further down the line in terms of the additional health, social and economic costs associated with increased unplanned pregnancy and STI burdens.

In 2016 the Evidence for Policy and Practice Information and Co-ordinating Centre (EPPI-Centre) published 'Sexual health promotion and contraceptive services in local authorities: A systematic review of economic evaluations 2010-2015'[9]. This reviewed a number of evaluations related to the cost effectiveness of different types of sexual health promotion interventions. In relation to primary prevention, amongst UK based studies, the report found evidence to support:

- promotion of long acting reversible contraception (LARC) over user dependent methods of contraception (such as the contraceptive pill) in terms of the number of unplanned pregnancies avoided and the health and social care costs associated with this
- promotion of sexually transmitted infection (STI) screening in accessible locations, using point of care tests and offered to high risk groups, such as men who have sex with men (MSM)
- promotion of regular HIV testing to high risk groups, such as MSM and people of Black African origin
- provision of contraceptive services to young people, such as condom distribution and emergency hormonal contraceptive provision

In 2005 the National Institute for Health and Care Excellence (NICE) published a cost impact report to assist local areas in calculating the cost of investing to save in the most effective LARC methods (coils and implants)[10].

An accompanying cost modelling tool helps identify the resource impact of fully implementing the LARC guidelines at a local level[11]. The model incorporated savings made by expected switches from the oral contraceptive pill to LARC methods (assuming that 8% of all women aged 15 to 49 will switch to a LARC method, so increasing LARC usage from 7% to 15% and reducing pill usage from 27% to 19% of all women) without assuming any overall increase in contraception use which stayed static in the model at 34% of all women. The model also included savings made from reduced contraceptive failures resulting in unplanned pregnancies. Using 2014 population data for Kingston, which indicates the borough has 45,900 women of reproductive age, the tool calculates a potential net saving of £389,000 in health terms.

The Advisory Group on Contraception promote a tool that allows local authorities to calculate the costs of unplanned pregnancy in terms of education, social care, welfare and housing expenditure[12]. When applied locally, and assuming a conservative estimate of 128 unplanned pregnancies per year that result in live births, this tool calculates these social and welfare related costs for Kingston as an estimated £398,850 per year.

There is also a growing body of evidence to support the cost effectiveness of interventions to reduce the incidence of HIV transmission. With a lifetime's HIV treatment costs estimated to be around £300,000, preventing four thousand new diagnoses in 2011 would have resulted in overall care and treatment cost savings of £1.9 billion across the UK[13]. Studies analysing the cost effectiveness of different settings for HIV testing found that one positive result per thousand tests carried out was considered the lowest threshold for cost-effectiveness[13,14]. These reviews helped provide evidence to support expanding testing into general practice (GP), an approach which Kingston now applies.

Recommendations

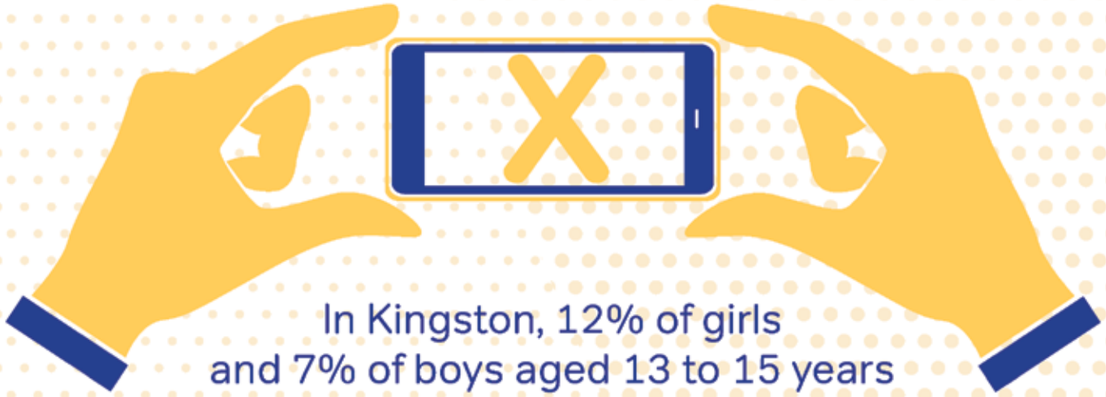
1. **Maintain a focus on primary prevention and sexual health promotion.**
2. **Target preventative activities at communities and individuals most impacted by poor sexual health.**
3. **Ensure impact evaluation is built into commissioned sexual health services from inception to assure that outcomes are assessed.**

2.0 Section Two **Young People**

- 2.1 Relationships and Sexual Wellbeing
- 2.2 Sexually Transmitted Infections and Human Immunodeficiency Virus
- 2.3 Reproductive Health and Contraception
- 2.4 Teenage Pregnancy
- 2.5 Safeguarding Children and Young People

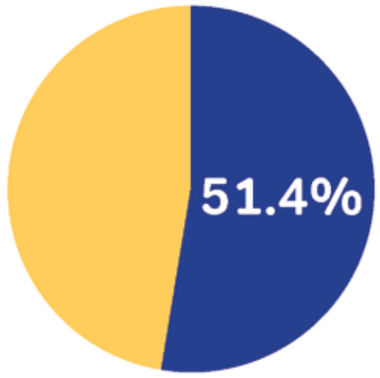
59%

Nationally, young people report that lessons in school are their main source of information about sex and relationships. In Kingston, 59% of young people at secondary school reported they had received some form of sex and relationships education (SRE) in the preceding 12 months.



In Kingston, 12% of girls and 7% of boys aged 13 to 15 years say their partners have asked them to send sexually explicit text messages or images.

In Kingston, in 2014, **51.4%** of **under 25s** using contraception were using long acting reversible contraception (LARC) methods compared to 40.4% nationally.



The most common sexually transmitted infection (STI) diagnosed in England is chlamydia.

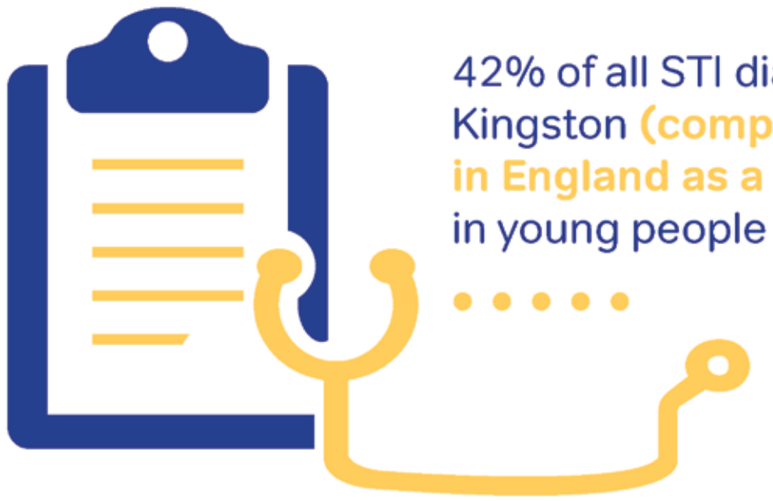
61% of diagnosed chlamydial infections in England occur in **young people** aged between **15 and 24 years**.

10%

In the UK approximately 10% of all new human immunodeficiency virus (HIV) diagnoses are in those aged under 25 years.

6% of 14 and 15 year olds in Kingston have experienced a partner pressuring them to do something they did not want to do, whilst 10% reported their partner using hurtful or threatening language and 3% had experienced physical violence.

In 2015, the conception rate for women aged 15 to 17 years in Kingston was 14.1 per 1,000 young women. This is significantly lower than both regional and national rates, which were 19.2 and 20.8 respectively.



42% of all STI diagnoses in Kingston (compared with 46% in England as a whole) occur in young people aged 15 to 24.

2.1 Relationships and Sexual Wellbeing

Lead authors:

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Jenna Nicolls
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Introduction

There are many factors that impact the choices young people (defined here as those aged under 25 years) make about their relationships and sexual wellbeing.

From peer group pressure to what type of contraception to use and when to raise the topic of sexual health screening with a new partner, young people are bombarded with dilemmas that can have a major impact on their relationships and wellbeing.

Increasing exposure to social media and pornography means there are even greater risks of a negative impact on healthy development, as well as sexual exploitation[1]. This makes it even more important to provide information and support that educates and safeguards young people[2,3].

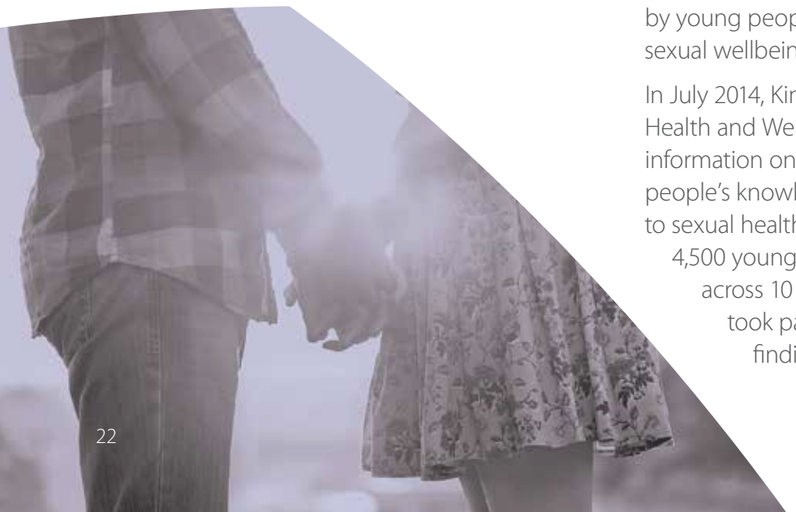
Nationally, young people report that lessons in school are their main source of information about sex and relationships[4]. The delivery of effective and well evaluated sex and relationships education (SRE) is therefore crucial to combat some of these pressures and empower young people to make safe and well-considered choices regarding their relationships and sexual health[5].

Local Picture

In 2015, there were an estimated 55,063 (31.7% of the total population) children and young people under the age of 25 resident in Kingston[6]. This is projected to rise to 63,943 by 2030.

Kingston has relatively low rates of unintended pregnancies amongst young people when compared to London and national rates (see chapter 2.4). In relation to sexually transmitted infections (STIs) amongst young people, Kingston has lower rates than London and similar rates to England (see chapter 2.2)[7]. Whilst this is good news, it gives little indication as to the issues being faced by young people in Kingston with regards to their sexual wellbeing and relationships.

In July 2014, Kingston undertook a Young People's Health and Wellbeing Survey, which gathered information on a range of topics including young people's knowledge and experience in relation to sexual health and relationships[8]. Approximately 4,500 young people from years seven to 10 across 10 secondary schools in Kingston took part in the survey and some of the findings are discussed in this chapter.



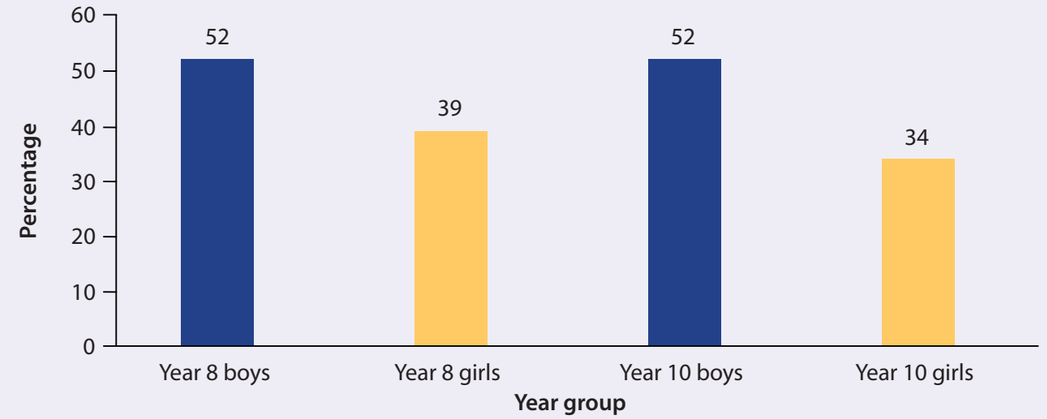
Self-Esteem

The confidence to negotiate a relationship requires a high level of self-esteem[9]. A young person with low self-esteem may make decisions that have a detrimental impact later in life; for example, they may not feel able to negotiate use of contraception, raise the issue of sexual health screening, or share what they feel is acceptable or unacceptable behaviour in a relationship. This can put their emotional and sexual health at risk.

According to the Kingston Young People's Health and Wellbeing Survey, 43% of respondents recorded high levels of self-esteem[8]. This was 6% higher than the survey recorded nationally, however it still indicates that the majority of young people responding to this survey did not record high levels of self-esteem.

Locally, girls' levels of self-esteem were much lower than boys and the level of self-esteem fell as they got older (Figure 1).

Figure 1 Pupils who recorded levels of 'high self-esteem' by year group.



Source: Kingston Young People's Health and Wellbeing Survey. Schools and Students Health Education Unit (SHEU). 2015.

Consent

Any sort of sexual activity without consent is illegal, regardless of age. However, it is becoming increasingly apparent that many young people are putting pressure on their peers to engage in sexual activity that they may not want[10].

The Young People's Health and Wellbeing Survey found that 69% of year eight (aged 12 and 13) and year 10 (aged 14 and 15) pupils in Kingston usually or always said 'no' if a friend asked them to do something they did not want to do[8]. This compared to 65% across the national reference survey sample.

However, 6% of year 10 pupils had experienced a partner pressuring them to do something they did not want to do, whilst 10% reported their partner using hurtful or threatening language and 3% had experienced physical violence[8].

Sexuality

The Personal, Social, Health and Economic (PSHE) Association recommends educating all young people of secondary school age (11 to 16 years) to recognise and respect diversity, including sexual orientation, and understand that it is everyone's responsibility to challenge discrimination, prejudice and abuse[11].

When asked whether there were good sexual health and support services in Kingston for lesbian, gay, bisexual and transgender (LGBT) young people, 67% of those responding to the Young People's Health and Wellbeing Survey indicated that they were 'not sure'[8].

An LGBT sexual health needs assessment undertaken by Public Health Kingston in 2013 highlighted a lack of awareness of specialist services for LGBT people, with most respondents travelling outside the borough to access such services[12]. Younger LGBT respondents also highlighted the lack of inclusive SRE in schools and felt most of it had been irrelevant for them.

Social Media and Sexting

Advances in, and increased access to, a wide range of technology that enables connection to the internet and contacting people instantly has brought with it challenges, particularly around how we monitor young people's activity in relation to the information they are accessing and the way they are conducting relationships.

Locally, findings from the Young People's Health and Wellbeing Survey indicated that 33% of pupils had chatted to people online they had never met, with 19% saying they had gone on to meet someone in real life who they had first met online[8].

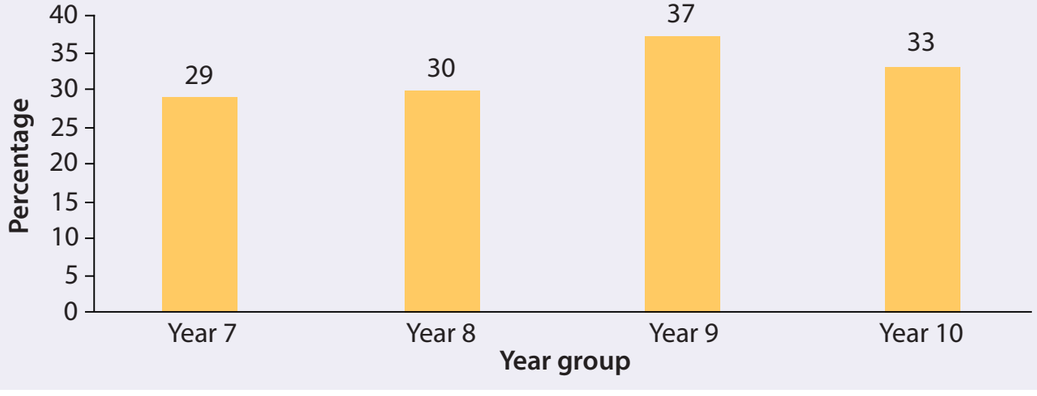
Sexting (sending sexually explicit text messages or images to others) is becoming an increasingly common practice amongst young people. In Kingston, 12% of year nine and 10 girls (13 to 15 years) and 7% of year nine and year 10 boys have reported that their partners have asked them to send such messages or images[8]. Most young people are unaware that if the person in the image is under the age of 18, sending these images to someone else is illegal, being classed as creating and distributing child pornography[13].

Sex and Relationships Education

The Kingston Young People's Health and Wellbeing survey found that 59% of young people had received some form of SRE in the preceding 12 months and 32% of these felt their lessons were at least 'quite useful' (Figure 2)[8].

Furthermore, 62% of year 10 pupils said they knew where to get free condoms in the borough compared to 59% of the wider sample[8]. However, only 33% of year 10 pupils said they were aware of specialist young people's contraceptive services locally.

Figure 2. Percentage of pupils who found their lessons on sexual health at least 'quite useful' by year group.



Source: Kingston Young People's Health and Wellbeing Survey. SHEU. 2015.

Local Action

The Council commissions a variety of SRE programmes, delivered within schools (both primary and secondary), youth centres and other settings, to target a range of young people, including those who may be more vulnerable to poor sexual health outcomes, such as young people in care or those not in education or training. SRE provision includes lessons and workshops on healthy relationships and lifestyles, internet safety, awareness of exploitation and consent. Lessons regarding contraception and sexual health are also provided for secondary school age young people and local services are always promoted at the end of talks and by providing printed resources and links to websites.

Every school should have a written policy on SRE, and schools keep parents informed about what is covered at each stage of the lessons. These lessons generally begin during Key Stage Two for children aged nine to ten years. Parents have the right to withdraw their children from these lessons, but from Key Stage Three onwards it is a compulsory part of the national curriculum[14].

To ensure there is a consistent approach to delivery of SRE in the borough, Kingston has developed a local SRE Charter (see appendix 1). The charter also aims to ensure sessions meet certain quality standards using examples of best practice to inform content and delivery.

In addition, Young People's Health Link Workers provide health and wellbeing support to young people in local secondary schools. This includes one-to-one interventions and coordination of group work through PSHE events. These events often follow a theme and incorporate education about factors which impact on relationships, whilst promoting access to other health services.

Youth specific sexual health clinics, such as KU19 and The Point, are available throughout the week, both in schools and across the borough. These clinics offer STI screening and contraception, as well as an opportunity to talk to a professional in a non-judgemental and safe space. There is also a youth bus that offers specific sexual health drop-in sessions for young people wishing to access information, advice and support, as well as resources such as free condoms.

In recognition that young people increasingly access information online, 'Getting it On' was launched in 2008. This website provides information and support for teenagers in South West London on a range of subjects including sexual health, mental health and drug and alcohol services. It also signposts to local services and offers young people the opportunity to submit questions online.

Recommendations

1. **Ensure all SRE programmes delivered to young people cover issues of consent, how to negotiate a healthy relationship and the influence of social media.**
2. **Explore the reasons why young people's levels of self-esteem fall as they get older and investigate strategies for preventing this.**
3. **Increase awareness of LGBT specific sexual health services in the borough.**
4. **Ensure SRE programmes are inclusive and relevant for LGBT young people.**
5. **Work with teachers and health professionals to enable them to respond to young people about every aspect of their sexual health and wellbeing, ensuring education about the biological elements of sex is not considered in isolation from relationships.**
6. **Increase awareness of young people specific sexual health services in the borough.**
7. **SRE programmes should be regularly reviewed to ensure they continue to meet the evolving needs of young people.**

Case Study

Young People: Relationships and Sexual Wellbeing

Written by School Nurse and 'Rachel'.

This case study demonstrates the value of good communication and integrated working between young people, parents, school staff and school nurses. It also shows the importance of early intervention, and how building supportive relationships where young people trust professionals can promote independence and guide them towards making safe decisions and give them confidence to access services.

Rachel (not her real name) is a girl who is now almost 16 and attends a local school. She is a lively and popular girl who likes football and singing. Rachel has additional needs.

When Rachel was 13 she started to become very interested in boys and curious about sex. Her school provided a really good sex and relationship education (SRE) programme supported by very individual pastoral care from student support, but the School Safeguarding and Prevention Officer (SPO) and Rachel's mum were worried that she might become sexually active and be at risk of pregnancy.

Discussions took place with Rachel, her mum, the SPO and the school nurse about how to protect Rachel, and it was agreed that having a contraceptive implant fitted (giving protection from pregnancy for three years) would be a good idea.

Rachel's mum and grandmother came with Rachel to the KU19 (Kingston Under 19) clinic nearest their home and the school nurse fitted the implant. The nurse talked to Rachel about delaying sexual activity, consent, choices about sex and staying safe. Rachel says "It was my choice to have the implant, not just my mum's".

The school, school nurse and mum continued to promote delay of sexual activity and discuss with Rachel what consent means, what makes a safe relationship and what is an abusive relationship. Rachel says "in personal, social, health and economic (PSHE) education I learned about contraception, about good relationships and what to do if you're in a bad relationship".

Staff in school and the school nurse worked hard to foster a trusting relationship where Rachel felt that she could talk openly about sex, ask questions and seek guidance and help. She describes the staff in student support at her school as "a massive inspiration….they have helped me so much. They help me through EVERYTHING. Any problems I go to…(the SPO)".

Rachel very recently felt ready to have sex, almost three years after having her implant fitted. It was her choice, fully consensual and with a boy her age she has known for a long time. Because she trusted the SPO and the school nurse, she told them both about what had happened and that although she knew all about using condoms and had some at home, on this occasion they had not used one. Rachel knew she needed to do a chlamydia and gonorrhoea test. This was done in school by the school nurse and was negative. Rachel says, "I know and trust the school nurse and can tell her anything".

2.2 Sexually Transmitted Infections and Human Immunodeficiency Virus

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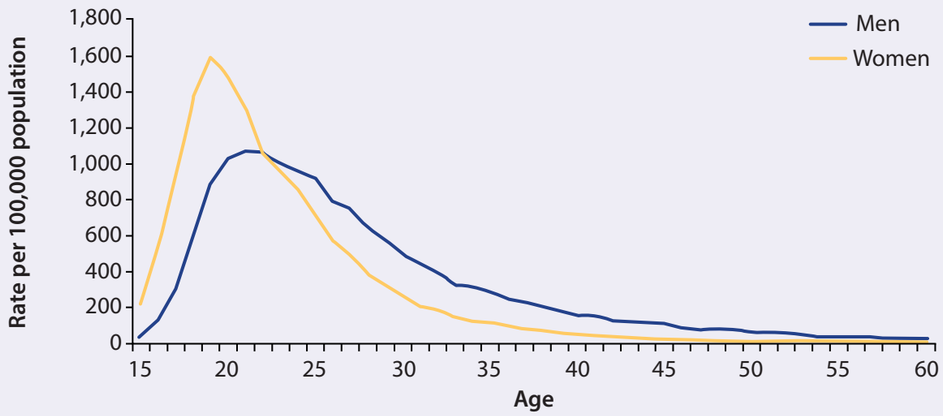
Introduction

Young people aged 16 to 24 years are at high risk of contracting sexually transmitted infections (STIs). They report the highest rates of partner change[1] and are disproportionality affected by almost all STIs. In 2015, over 50% of diagnoses of chlamydia, gonorrhoea and genital warts and 41% of genital herpes diagnoses were in young people[2].

The most common STI diagnosed in England is chlamydia[2]. The National Chlamydia Screening Programme (NCSP) aims to control chlamydia through early detection and treatment of asymptomatic infection (which makes up the majority of infections) to reduce onward transmission and the consequences of untreated infection. Across England, 61% of diagnosed chlamydial infections occur in young people aged between 15 and 24 years (Figure 1), with the peak rate occurring at a younger age in women than men[2].

Chlamydia is a major risk factor for pelvic inflammatory disease (PID), infertility and ectopic pregnancy. Nationally the Public Health Outcomes Framework provides information on how public health is being improved and protected and includes a variety of indicators to measure this[3]. Chlamydia is one of these indicators with local authorities advised to aim for a diagnosis rate of 2,300 per 100,000 young people aged 15 to 24 years.

Figure 1 Rates of chlamydia diagnoses in genitourinary medicine (GUM) services by gender and age, England, 2015.



Source: Public Health England (PHE). STI Slide Set, 2015.

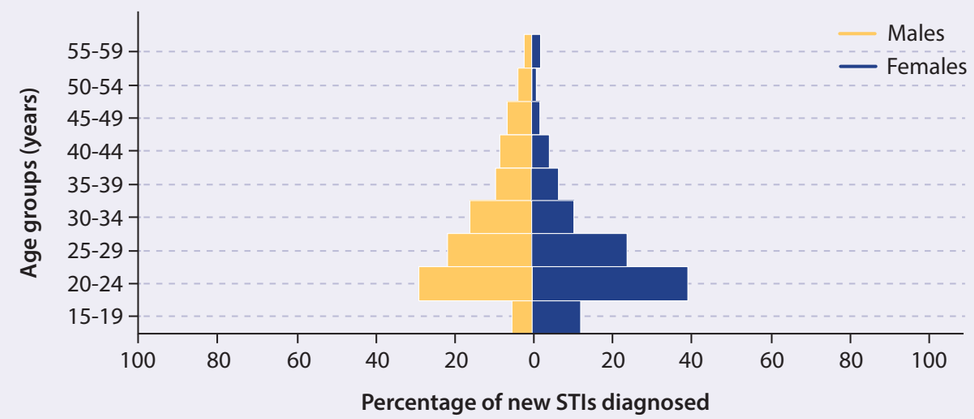
Nationally, the human papilloma virus (HPV) vaccination programme is offered to female school children in year 8 (12 and 13 year olds). Efforts to achieve improved uptake of the HPV vaccine in school-aged children aim to reduce the incidence of genital wart infection and so protect against the risk of cervical cancer given that HPV infection is the most important single risk factor for this type of cancer[4]. Around 970 women died from cervical cancer in 2011 in the UK and it is estimated that about 400 lives could be saved every year in the UK as a result of vaccinating girls before they are infected with HPV[4].

The numbers of young people being newly diagnosed with human immunodeficiency virus (HIV) are low and have remained fairly static over recent years. In the UK approximately 10% of all new HIV diagnoses are in those aged under 25 years[5]. Nationally, there are approximately 753 young people living with HIV.

Local Picture

In Kingston, 41% of all STI diagnoses (compared with 45% in England as a whole) occur in young people aged 15 to 24[6]. Figure 2 gives a breakdown of STI diagnoses by age group in Kingston and illustrates the disproportionate number of young people affected by STIs and the fact that young women are more affected than young men.

Figure 2 Percentage of new STIs by age group and gender in Kingston upon Thames, 2015.



Source: PHE. Kingston Local Authority HIV, Sexual and Reproductive Health Epidemiology Report (LASER), 2015. 2016.
Please note that to prevent deductive disclosure the number of STI diagnoses has been rounded up to the nearest five.

In 2015, 5,194 (22.7%) Kingston residents aged 15 to 24 were screened for chlamydia[7]. This represents a lower coverage rate than London (27.4%) but was slightly higher than the England average (22.5%).

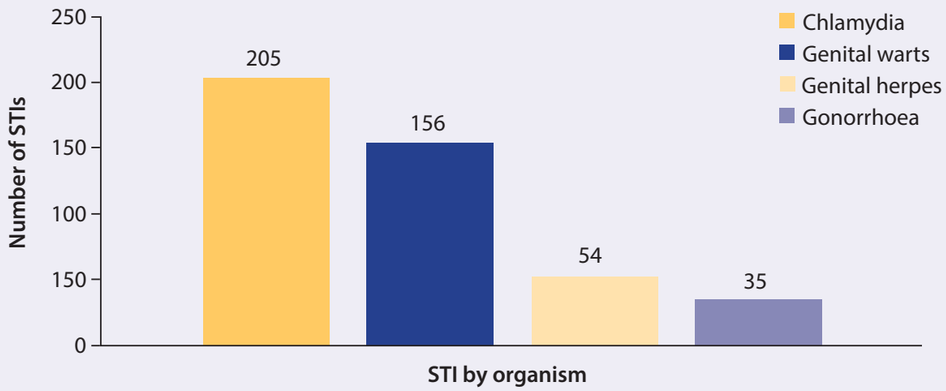
In the same period, 367 15 to 24 year olds locally were diagnosed with chlamydia, giving a detection rate of 1,601 per 100,000 which is a lower detection rate than both London (2,200 per 100,000) and England (1,887 per 100,000)[8]. Kingston males have a detection rate of 1,110 per 100,000 and females 2,062 per 100,000. These rates demonstrate additional screening is required to meet the public health outcome framework target, particularly for the male population.

Figure 3 shows a breakdown of the number of STIs diagnosed in specialist sexual health clinics in 2015 amongst those aged 15 to 24 living in Kingston[9]. It can be seen that chlamydia and genital warts together make up more than 85% of the total number of STIs being diagnosed in this age group.

Locally, 48% of all new diagnoses of genital warts were in young people under 25 years[9]. Kingston has introduced the HPV vaccination programme in all schools locally and uptake of this programme is currently 85.3%[10]. This is higher than the London average of 79.2% and compares well against all local authorities which range in uptake from 59.9% to 98%.

In 2015, there were no new HIV diagnoses amongst young people under the age of 25 in Kingston[11]. Locally, 5% of the total population of people living with HIV in Kingston are under the age of 25 years, which is half that of national figures.

Figure 3: Number of STIs in 15-24 year olds in 2015 diagnosed in specialist sexual health clinics, by organism.



Source: PHE. GumCadv2 data. 2016.
Please note data referring to chlamydia includes diagnoses from specialist sexual health clinics only and does not include diagnoses from community settings as part of NCSP.

Local Action

STI and HIV prevention in the borough is undertaken through a variety of mechanisms and services, such as sex and relationships education (see chapters 2.1 and 2.3).

Since 2008 when the NCSP was introduced for young people in Kingston, the availability and access to local screening has expanded to include:

- free online testing available from www.freetestme.co.uk
- regular outreach events
- community settings, schools and colleges, including screening availability at youth centres, a dedicated young people's health bus, and at drug and alcohol services
- all sexual and reproductive health services
- primary care settings, including all GP surgeries, and 10 out of 30 Community Pharmacies.

In Kingston, gonorrhoea, which is much less common than chlamydia (as can be seen from Figure 3) is tested for at the same time as chlamydia using the same urine sample and results are provided together. Whilst this is not officially part of the NCSP, Kingston made the decision to offer this screening option locally following data to suggest increases in this STI nationally[2].

Treatment for chlamydia can be accessed at many services cited above, but treatment for gonorrhoea is currently only available locally at the Wolverton Centre due to the need for additional testing.

Recommendations

1. **Explore options for developing a targeted programme of events to engage more young men aged 15 to 24 to increase uptake of chlamydia screening in this group.**
2. **Continue to prioritise access to screening and treatment for young people under the age of 25 years.**
3. **Continue to ensure the delivery of an effective, timely and high coverage immunisation programme for females from 12 years of age or from school year eight for the prevention of HPV (types 6, 11, 16, 18) infection.**

2.3 Reproductive Health and Contraception

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Introduction

The percentage of young people engaging in sexual intercourse before the age of 16 has increased significantly over the last 60 years[1]. Only 4% of women and 15% of men aged 65 to 74 years report engaging in sexual intercourse before they were 16, but this rises to 29% of women and 31% of men currently in the 16 to 24 age group. It is therefore essential that young people are able to obtain appropriate sexual health information and support, including contraceptive supplies.

Guidance from the National Institute of Health and Care Excellence (NICE) highlights the health, social and economic benefits of providing local, age specific contraceptive services[2]. It recommends that these services be located in areas easily accessible for young people, such as in schools and town centres; be available in all sexual health clinics to avoid the need for travel to multiple services; and provide a mixture of drop-in and appointment only clinics.

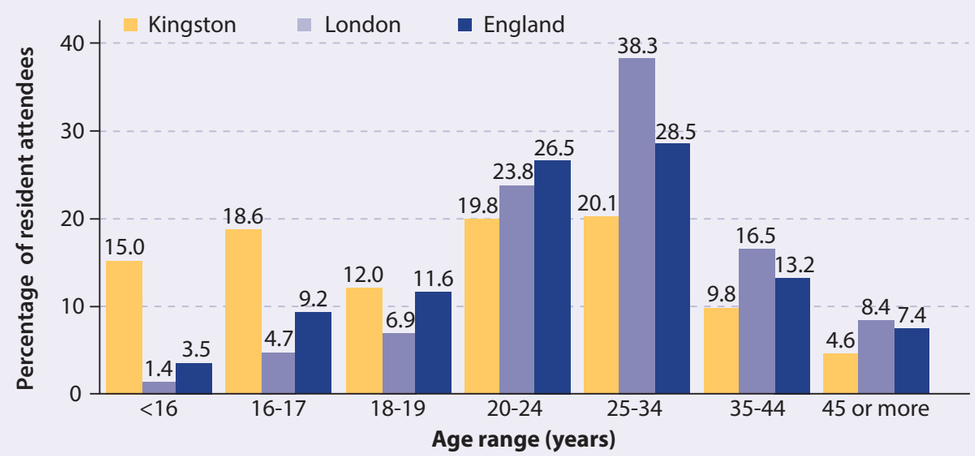
The guidance also recognises the importance of offering tailored support to young people from areas of disadvantage, teenage mothers or those for whom it would be culturally unacceptable to publicly access contraceptive services[2].

Department of Health guidance makes provision for contraceptive services to be offered to those aged under 16 years, providing these young people understand the information being given to them and there is a belief that not providing the service would have a detrimental impact on their physical or mental health[3].

Local Picture

In 2014, the majority of attendees at Sexual and Reproductive Health (SRH) services in Kingston were aged under 25 years[4]. Figure 1 shows a much higher proportion of SRH service attendees from Kingston were aged 19 or less, comprising 45.6% of all attendees, compared with 13.0% for London and 24.3% across England as a whole. This can partly be explained by the number of SRH services in Kingston that specifically target the under 19s age group.

Figure 1. Proportion of SRH services attendees by age group, in residents of Kingston, London and England: 2014.



Source: PHE. Kingston LASER, 2015. 2016.

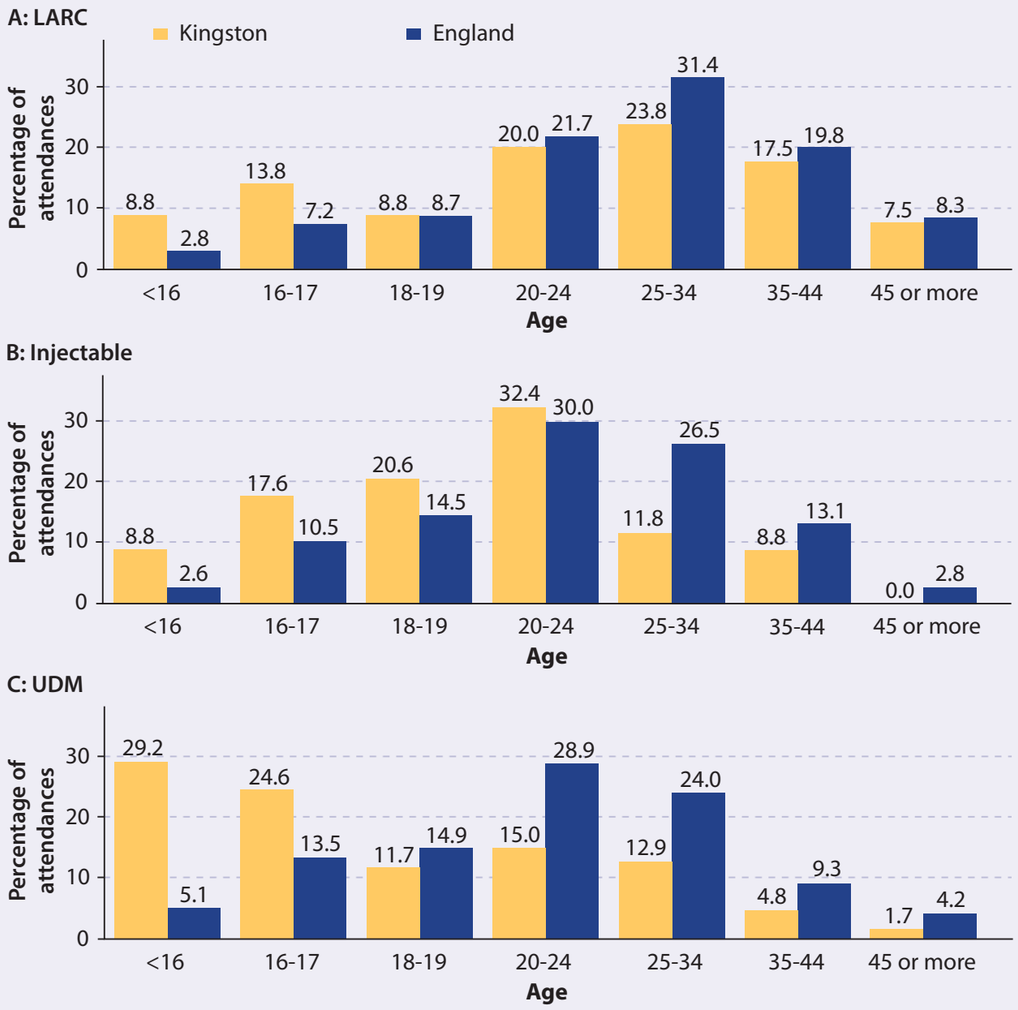
In 2014, the most popular method of contraception provided to those under 25 years in Kingston was the male condom, followed by the oral contraceptive pill[4]. This follows national trends and is perhaps unsurprising as anecdotal evidence tells us young people find these methods among the most socially acceptable and easily available.

NICE guidance on the provision of contraception to young people states that they should be offered a choice of all methods, including long acting reversible contraception (LARC)[2]. Nationally, there has been a major drive to promote LARC to women of all ages as it is recognised that increasing the uptake of LARC will reduce the numbers of unintended pregnancies (see chapters 1.2 and 3.3)[5]. In Kingston, young women aged 18 to 24 years are accessing LARC from SRH services at similar rates to the England average (28.8% and 30.4% respectively) and the under 18 age groups are accessing it at higher rates with 22.6% of under 18s accessing LARC in Kingston compared to 10% across England (Figure 2 overleaf).

Figure 2 overleaf illustrates the high proportion of residents under 18 using user dependent methods (UDMs), such as condoms and the oral contraceptive pill, compared with the England average. There are also a high number of young people locally using the contraceptive injection compared to England averages. This may be explained by the high number of SRH services in the borough that specifically target young people under 19 years.

Amongst UDMs, it is difficult to ascertain how much of this includes condom use. When used correctly, male condoms are 98% effective and female condoms are 95% effective at preventing pregnancy in the first year of use and are the most efficient means of protecting against HIV and other STIs[6]. However, it does need to be acknowledged that these methods are often less effective than the figures quoted above given that they are often not used perfectly.

Figure 2. Percentage of LARC, injectable and UDMs prescribed by age group among residents of Kingston and England: 2014.



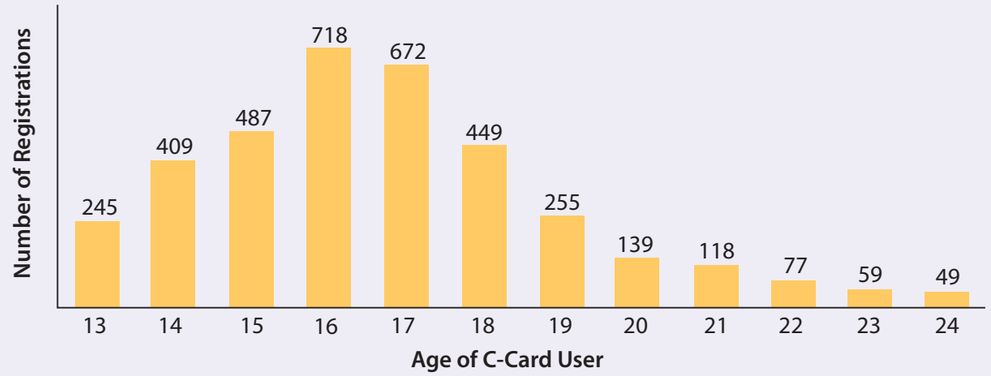
Source: PHE Kingston LASER, 2015. 2016.
Please note to prevent deductive disclosure the number of contraceptive methods prescribed has been rounded to the nearest five.

Kingston offers young people aged 13 to 24 years access to free condoms at a variety of services across the borough and much of this is done through a monitored condom distribution scheme, called the C-Card. Kingston joined the scheme in 2011 and since this time there have been 3,848 registrations[7]. In 2015-16, there were a total of 985 registrations and 952 repeat visits (these are young people returning for more condom supplies after initial registration)[8].

There was an even split in terms of the gender of those registering for a C-Card, but amongst those returning for more supplies, 56% were young men.

The largest group of users in 2015-16 were aged between 16 and 18 years old, with the next biggest group being 13 to 15 year olds (Figure 3) [8]. This is reflected at a London wide level and is explained by the types of services offering C-Card and the age groups they target.

Figure 3 Age of C-Card user at registration in Kingston (January 2011 to March 2016).



Source: Kingston C-Card Evaluation Report. 2016.

In 2015-16, 59% of C-Card users identified as White and 29% identified as being from Black and minority ethnic (BME) or 'other' groups[8]. The remaining 12% chose not to answer this question.

Emergency contraception aims to prevent a pregnancy from occurring after unprotected sexual intercourse. There are two types of emergency contraception: the intrauterine device (IUD), more commonly known as the coil and emergency hormonal contraception (EHC), which is a pill. The majority of young people opt for EHC and locally this is offered for free to young women aged under 25 at a range of services across the borough. In 2015, there were a total of 1,316 EHC pills supplied to Kingston residents (this data does not include prescriptions by GPs)[10]. Community pharmacy was the most popular venue for young women needing emergency contraception with 1,010 of the 1,316 being issued by pharmacists in 2015.

Local Action

Young people can attend any of the SRH services located in the borough, however there are also a number of age specific services offering support to young people under the age of 19. KU19 and The Point are clinics that offer young people the opportunity to access a range of contraception, sexual health screening and support from health professionals specifically trained in working with young people. A clinic is open every weekday after school and these are based in different locations across the borough.

Most of the secondary schools in Kingston have drop-in clinics running during the school day, which offer access to EHC, pregnancy testing, condoms, and chlamydia and gonorrhoea screening.

Young people can also access any GP in the borough for reproductive health services. They do not have to be registered with the GP they are visiting in order to access these services.

Additionally, there are a number of pharmacies that offer free EHC to young people under the age of 25, distribute free condoms, and have information on local sexual and reproductive health services.

See chapter 2.1 for more details of the promotional work undertaken to ensure young people are aware of services.

Recommendations

1. **Increase the number of young people using LARC by ensuring access to qualified staff able to offer all methods.**
2. **Continue to promote condoms as an effective method of preventing unplanned pregnancy and STIs.**
3. **Ensure services are well publicised, in particular to young people from disadvantaged backgrounds and teenage mothers.**
4. **Investigate ways of ensuring information is distributed to young people for whom it would be culturally unacceptable to access sexual and reproductive health services.**

2.4 Teenage Pregnancy

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Introduction

Teenage conception rates in England have more than halved since the National Teenage Pregnancy Strategy was implemented in 1999, but the national rate is still higher than similar Western European countries[1]. In 2015, the under 18 conception rate in England was 20.8 conceptions per 1,000 women[2].

The Department of Health document 'Effective Public Health Practice' outlines the importance of reducing the rate of under 16 and under 18 conceptions, as most are unplanned and many end in termination[3]. As well as the emotional impact on young women, unplanned pregnancies and the subsequent terminations or births also have a financial cost to both the families involved and the wider community.

Where teenage pregnancies result in a birth, evidence shows that having children at a young age can negatively affect young women's health and wellbeing and severely limit their education and career prospects[4]. In addition, children born to teenage girls have, on average, more health issues than those born to adult women.

Local Picture

Kingston teenage conception rates are consistently lower than London and national rates[1]. Data from 2015 reveals a conception rate of 14.1 per 1,000 young women aged 15 to 17 in Kingston. This is significantly lower than both regional and national rates, which were 19.2 and 20.8 respectively (Table 1)[1].

The number of parents aged under 18 in Kingston is also significantly lower than London and England averages[1]. In 2015, there were seven live births to women under the age of 18 locally giving a rate of 2.9 per 1,000 women. The rates for London and England are 7.0 and 10.1 respectively.

Table 1 Teenage Pregnancy related rates/1,000 15-17 year old women for Kingston, London, and England.

	England	London	Kingston
Under 18s conception rate, 2015	20.8	19.2	14.1
Under 18s conceptions leading to abortion rate, 2015	10.6	12.1	11.2
Under 18s birth rate, 2015	10.1	7.0	2.9

Source: ONS. Conception Statistics, England and Wales, 2015. 2017.

Local Action

Prevention of Teenage Pregnancy

Taking action on teenage pregnancy includes addressing relationship issues and sexual wellbeing (see detail of local provision in chapters 2.1, 2.2 and 2.3).

Support around Unplanned Pregnancy for Young People

All sexual health services in the borough are able to offer support around pregnancy options and onward referral for young people who experience an unplanned pregnancy and wish to have a termination.

Termination services, which are commissioned as part of the borough's integrated sexual health programme, are available to women of any age providing they meet the legal criteria (see chapter 3.4).

For those wishing to continue with the pregnancy, Kingston has midwives specially trained in working with pregnant women under the age of 18. Antenatal classes specifically aimed at under 18s are also available. The midwives are also able to refer into postnatal support services for young parents.

Support for Young Parents

Kingston has a number of Children's Centres across the borough, which offer support for parents with young children. These cover a range of topics including the practicalities of caring for a young child, household budgeting, and health and wellbeing for parents.

The Council commissions supported accommodation for mothers under the age of 18, this offers programmes to enable young women to build their confidence to live independently in the future.

Kingston also promotes and supports Care to Learn, a national programme which helps young parents get back into education or employment.

Recommendations

1. **Continue to prioritise preventing unwanted teenage pregnancy and improved sexual health including support to schools to deliver personal, social, health and economic (PSHE) education programmes.**
2. **Ensure young people can access the support services they need that do not judge or stigmatise them including if they want to have a child at this stage of their lives.**
3. **Ensure there are services offering support for young parents to improve outcomes for both them and their children.**

2.5 Safeguarding Children and Young People

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Introduction

Safeguarding children is defined nationally in the Department of Education's guide 'Working Together to Safeguard Children'[1] as:

- protecting children from maltreatment
- preventing impairment of children's health or development
- ensuring that children grow up in circumstances consistent with the provision of safe and effective care and
- taking action to enable all children to have the best outcomes.

The age range given in this document is children and young people who have not yet reached their 18th birthday.

In the context of this annual public health report the focus of this chapter is on Child Sexual Exploitation (CSE) and Female Genital Mutilation (FGM). It should be noted that these areas are only discussed in overview here. More local detail can be found at the Kingston Joint Strategic Needs Assessment (JSNA) website (http://data.kingston.gov.uk/Kingston_JSNA) and the Kingston and Richmond Local Safeguarding Children Board (LSCB) website (http://kingstonandrichmondlscb.org.uk/).

Child Sexual Exploitation (CSE)

CSE[2] is a sensitive and complex issue and it is not confined to any particular area, ethnicity or social background. It is widespread[3] and has a huge impact on victims and their families. All councils should assume CSE is happening in their area, and take proactive action to respond to it and prevent it happening[4].

In CSE, children aged under 18 are involved in exploitative relationships or situations where they receive something (which can include gifts, money, food, affection, legal or illegal drugs, or accommodation) in exchange for engaging in sexual activity[4]. This can include providing sexual images. Those who exploit children in this way have power over them, and violence, coercion, and intimidation are common[4]. A child's involvement in exploitative relationships is often due to their limited choices resulting from their social, economic or emotional vulnerability.

A common feature of CSE is that the child or young person does not recognise the coercive nature of the relationship and does not see themself as a victim of exploitation. There are a range of factors that increase a child's vulnerability to sexual exploitation, including a disrupted family life, domestic violence, a history of physical or sexual abuse, being a victim of child trafficking, or the child of a parent who has been trafficked, being in care of the local authority (and in the latter group particularly looked after children with instability in their placement), as well as children missing from education, home, or care[4, 5, 6, 7, 8].

These references also highlight that there are population groups amongst young people who are commonly 'hidden' from being identified as vulnerable to CSE, such as children who are:

- experiencing sexual exploitation from a peer
- particularly young
- sexually abused online
- male
- affected by a learning disability
- lesbian, gay, bisexual and transgender (LGBT)
- from Black and minority ethnic (BME) groups.

A significant proportion of children who have experienced CSE have issues with drugs and alcohol, mental health problems (including post-traumatic stress disorder, depression, self-harming, thoughts of suicide, severe low self-esteem, self-neglect); and sexual health issues (including teenage pregnancies)[9].

Female Genital Mutilation (FGM)

Female genital mutilation (FGM) comprises all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons[10]. FGM is illegal and is a form of child abuse.

There are four major types of FGM :

- **Type 1:** Often referred to as clitoridectomy, is the partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals), and in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).
- **Type 2:** Often referred to as excision, involves the partial or total removal of the clitoris and the labia minora (the inner folds of the vulva), with or without excision of the labia majora (the outer folds of skin of the vulva).
- **Type 3:** Often referred to as infibulation, is the narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the labia minora, or labia majora, sometimes through stitching, with or without removal of the clitoris (clitoridectomy).
- **Type 4:** Includes all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping, pulling and cauterizing the genital area.

FGM has no health benefits whatsoever and carries serious short and long term health consequences[11]. Long term consequences include vaginal and urinary tract infections, sexual health problems, an increased risk of childbirth complications, the need for later surgery and mental health problems[11].

The reasons underlying why FGM is carried out are complex and vary between different regions, and include a number of socio-cultural factors. It is a complex form of control of women's sexual and reproductive rights[13]. FGM is practised in a range of countries in Africa, the Middle East and Asia. Whilst girls whose families come from an FGM practising community are at increased risk of FGM, the most significant factor is whether the girl's family has a history of practising FGM[13].

Registered professionals in health, social care, and teaching have a statutory duty to report to the police cases where the professional observes physical signs of FGM in a girl aged under 18, or when a girl under 18 discloses that she has had FGM carried out on her[11]. Multi-agency statutory guidance on FGM was published in April 2016 (see reference for link to guidance)[14] and guidance for professionals on FGM risk and safeguarding was published the following month (see reference for link to guidance)[15]. This guidance recommends nominating lead professionals to undertake additional training on FGM and be responsible for ensuring that this remains a high priority for local areas.

Local Picture

CSE

Looked After Children (LAC):

As noted previously in this chapter, LAC are at higher risk of CSE. On 31 March 2015, there were 115 children in the care of Kingston Council. The rate of LAC in Kingston is lower than London and England rates, at 32 per 10,000 children aged under 18 compared with London and England averages of 52 and 60 respectively[16].

Boys are over represented amongst LAC, and this is even more pronounced in Kingston compared with London and England with boys comprising 64%, 58% and 55% of all LAC respectively[16].

Of the 115 LAC who were the responsibility of Kingston Council, approximately 70% were placed in care outside the borough. Conversely, approximately 40 children who were not Kingston residents were placed in care within the borough.

Age, gender and ethnicity information

The monthly Multi Agency Sexual Exploitation Meeting (MASE) figures for 2015-16 are described below.

In line with the national trends, 14 and 15 year olds account for 58% of all 'new' cases discussed at the Kingston MASE in 2015-16. The number of 16 and 17 year olds may be under represented due to not being identified. Five or fewer children (exact number withheld due to data protection requirements) aged 12 were referred into the MASE and all were closed within a month due to the lack of evidence of CSE concerns.

Of the total of 52 cases, 42 (80%) were female whilst only 10 were male. This is similar to the national data picture. However, it may be that the number of males may be under represented due to not being identified.

Of the cases referred, 81% had an ethnic background of White and the remaining 19% were from Black and minority ethnic (BME) backgrounds. The percentage of the Kingston 11 to 18 population of BME origin is 34%[17] and experience from other areas would suggest that the proportion of cases from people from BME backgrounds is likely to be under reported due to them not being identified.

FGM

Prevalence estimates are compiled in three categories[18]:

Children who may be at risk of FGM 2005-13

It is estimated that between 2005 and 2013, in Kingston, approximately 83 girls were born to mothers that had themselves undergone FGM. This is an average of nine births per year. This estimation method takes into account ethnicity, the mother's country of birth, and adjusts for the prevalence of FGM in different countries. This is less than 1% of all girls born in Kingston and is amongst the lowest borough prevalence rates in London.

Women who may have undergone FGM

In Kingston, 323 women are estimated to have been subjected to FGM. This method takes into account ethnicity and the countries of birth of local borough residents.

Women that have been identified as having undergone FGM in 2015-16

Between 1 April 2015 and 31 March 2016 some 2,940 women in London were newly recorded as having had FGM[19], of which five or less (exact number withheld due to data protection requirements) were Kingston women.

Local Action

CSE Primary Prevention Activities

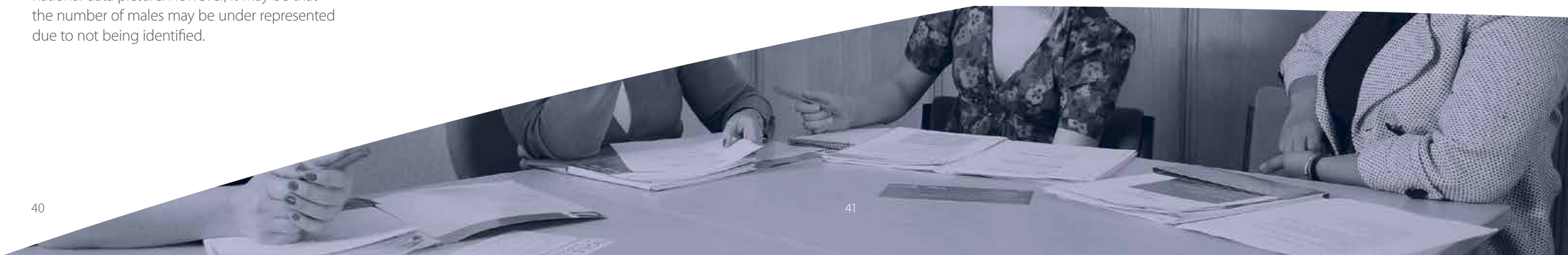
- A local community awareness strategy is in development, and the Metropolitan Police campaign Operation Makesafe[20] highlights CSE to the business community. This has been promoted by borough police during national and local events.
- In 2015-16, the Kingston and Richmond Local Safeguarding Children Board (LSCB) offered 21 CSE training events across Kingston. Attendees included 113 Kingston staff from business support services, early years and childcare, education services, health services, justice and crime prevention, social, family and voluntary support services and youth services.
- CSE is discussed during Sex and Relationships Education (SRE) in schools (see Chapter 2.1).

The following activities have also been undertaken in Kingston schools:

- Health Link Workers have been delivering CSE prevention activities in five secondary schools and St Philip's School for Special Educational Needs (SEN).
- Specific early CSE intervention activities in one school in 2014-15 addressed the low levels of CSE and were delivered through joint working between the Health Link Workers and the Achieving for Children (AfC) Family Support First Contact (FSFC) team. Work included healthy relationships, gender equality, and respect.
- Between 2014 and 2016, the Family Planning Association (FPA) were commissioned to deliver an SRE training programme for young people with learning disabilities, their primary carers, and health, social care and education staff. The training for professionals included information on different aspects of CSE, assessing capacity to consent and responding to disclosure. There was some difficulty engaging a small number of schools in taking up this training. This may have been due to difficulty getting time off for staff training, particularly for an issue relating to a small cohort of students and the particularly high turnover of support staff.

The following has occurred as a result from the FPA work:

- a sub-group to the Personal, Social, Health and Economic (PSHE) Strategic Working Group has been established, which aims to maintain the competency and identify opportunities for sharing this learning by those members of social care, health, and education staff who have received enhanced SRE training for people with learning disabilities. A Health Link Worker, a school nurse, a member of staff from Kingston's specialist SRH service and a person with learning disabilities, who helped co-deliver the training, are members of this sub-group
- a leaflet, 'Relationships, the Internet, and You' for 11 to 16 year olds and one for adults with learning disabilities has been developed
- St Philips School, which provides for young people with moderate learning disabilities, has lesson plans that the FPA developed incorporated into the PSHE programme and delivered by in-house staff.



2.0 Young People

CSE Strategy Development

The Kingston and Richmond LSCB has developed a CSE strategy[21], which sets out multi-agency working arrangements and promotes a co-ordinated approach. This document includes the British Association of Sexual Health and HIV (BASHH) and Brook Spotting the Signs Proforma[22], which can be used by health professionals to aid in the identification of possible CSE. In addition, a Children Missing from Education Policy and Procedure Protocol (2015)[23] and a Joint Handbook for Safeguarding Missing Children[23] have been developed, which will assist in identifying, assessing and referring children appropriately.

Children who are 'Missing' from Home, Care and Education

The Kingston Missing Persons (MISPER) meeting reviews and takes action with respect to children who normally live in Kingston, Kingston children placed in other boroughs and other areas' children placed in Kingston who are missing.

It is expected that return home interviews (RHIs) are routinely offered by Achieving for Children's (AfC) Family Support First Contact (FSFC) team. This information is shared with Police and other appropriate agencies so that any CSE concerns can be actioned. From April to September 2016, a total of 59 children were reported missing from home accounting for 88 incidents. Of these children, 48 were offered a RHI.

FGM

Actions taken from 2014 to 2016 have included:

- the Kingston and Richmond LSCB has ensured that FGM is incorporated into its multi-agency training programme
- the LSCB produced FGM prevention guidelines in February 2016[25] and these are now being implemented by agencies in Kingston, including sexual health services
- FGM awareness is raised within mainstream safeguarding training to staff in GP practices and pharmacies providing sexual health services (mandatory reporting requirements) and via Kingston Integrated Sexual Health (KISH) quality assurance self-assessments
- a family lawyer for victims of FGM advised sexual health providers from community and acute settings on new FGM legislation during 2015
- since 2014-15 there have been two FGM awareness raising events held before the summer holidays (when girls may be at higher risk) in local secondary schools across Kingston and Richmond.
- raising awareness of the 'Single Point of Access' (SPA) team. SPA is the team responsible for child protection in Kingston and any FGM concerns should be referred straight to them without forewarning parents.

Recommendations

CSE Recommendations

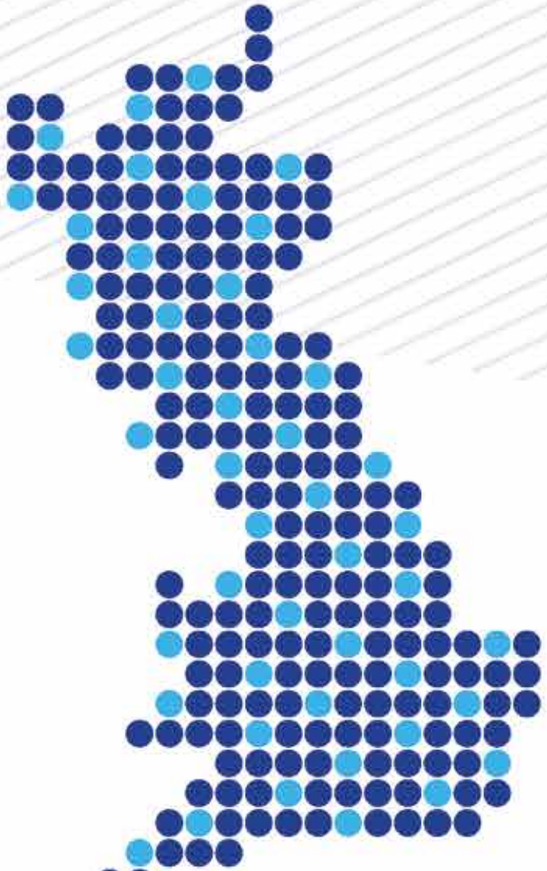
1. **Improve identification, recording, and reporting of CSE including in those population groups that are under reported.**
2. **Improve multi-agency working and information sharing to intervene early and increase prosecutions.**
3. **Prioritise the needs of Looked After Children, Missing Children, and the quality and safety of placements.**
4. **Improve primary prevention through appropriate SRE work with schools (including primary and independent schools) to raise awareness of CSE and FGM.**

FGM Recommendations

1. **Ensure all agencies are following the multi agency statutory guidance on FGM[14].**
2. **Ensure schools update their safeguarding policy, making explicit that FGM concerns should be referred to the 'Single Point of Access' (SPA) team.**
3. **Consider a FGM Safeguarding champion model in relevant local communities.**

3.0 Section Three **Adults**

- 3.1 Relationships and Sexual Wellbeing
- 3.2 Sexually Transmitted Infections and Human Immunodeficiency Virus
- 3.3 Reproductive Health and Contraception
- 3.4 Termination of Pregancy
- 3.5 Men who have Sex with Men
- 3.6 Black and Minority Ethnic Communities
- 3.7 People Living with Human Immunodeficiency Virus
- 3.8 People with Learning Disabilities

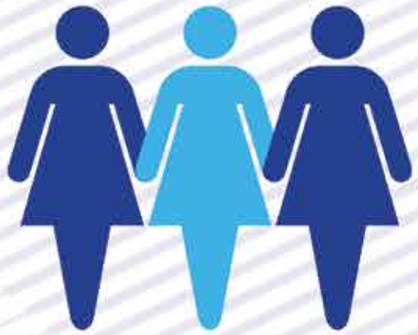


In 2015, there were
1,532
sexually transmitted infections (STIs)
diagnosed in Kingston residents.

In 2015, there were
271 people living with diagnosed HIV
in Kingston.

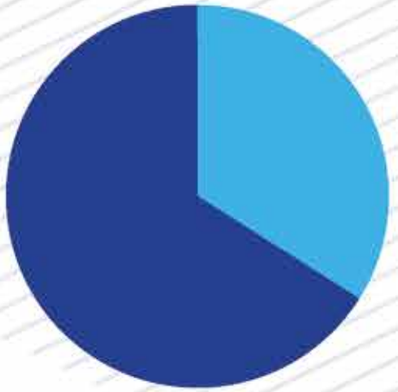
There are between
10 and 20 new HIV infections
diagnosed in Kingston residents each year.

Nationally, more than
one in five people
are unaware of their HIV status.



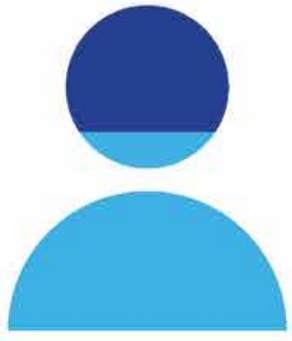
Nationally, one in three women
will undergo a termination of pregnancy during their lifetime.

Men who have sex with men (MSM) accounted for
31% of all STI diagnoses
in 2015 in Kingston.



In 2015, Kingston residents of **Black African origin represented 1.9%** of the borough's total population and **34% of people living with diagnosed HIV** in Kingston.

In 2014-15, user dependent methods of contraception, such as the contraceptive pill, were the most commonly used method in
Kingston (73%),
London (68%)
and England (63%).



Nationally, **63% of people with learning disabilities want to know more about sex and relationships.** Yet many are prevented from accessing this information due to outdated attitudes from carers and professionals.

3.1 Relationships and Sexual Wellbeing

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Introduction

Relationships, including platonic ones, aid our health and wellbeing[1]. Research shows that people who experience healthy and meaningful relationships not only report better levels of emotional wellbeing, but also have lower rates of morbidity and mortality. This has led some researchers to recommend public health campaigns focus on helping people to develop strong and sustainable relationships as part of wider health improvement strategies[2].

Alongside this, there is growing evidence of the physical and psychological benefits of sexual intimacy and having an active and pleasurable sex life[3,4]. It has been found that sex itself, and the frequency of sexual intercourse, can have benefits for a range of health conditions, such as high blood pressure[5].

Conversely, sexual dysfunction, defined as a problem someone may have reacting physically and/or emotionally to sexual stimulation, can have a significant detrimental impact on individuals and their relationships[6]. Symptoms may include an inability to achieve or maintain an erection or relax the vaginal muscles, a lack of desire for sex, and/or pain during sexual intercourse. The causes of these problems can stem from physical issues such as diabetes, heart disease, or lifestyle factors (for example smoking or obesity), or psychological issues such as stress and anxiety, bereavement, or issues associated with sexual assault, sexual abuse and rape[6]. The National Survey of Sexual Attitudes and Lifestyles (Natsal-3) found that 42% of men and 51% of women had experienced one or more sexual difficulties in the past year and 10% of men and 11% of women reported feeling worried or distressed about their sex life[7]. Those reporting sexual functioning problems had higher rates of relationship breakdown, STI diagnoses and a higher chance of having experienced sex against their will; in addition to which, men affected were more likely to have paid for sex and women to have a higher rate of partner change.

Local Picture

Data about healthy relationships as a key component of mental wellbeing is covered under mental health promotion strategies within Kingston[8]. However, local data focusing specifically on the benefits of sexually intimate relationships amongst adults is difficult to identify.

There is some local data relating to sexual dysfunction, however this is also limited. In 2015, 266 Kingston residents attended a sexual health clinic in London for a psychosexual service[9]. Of those, just over 60% were women. The age range most commonly seen amongst female patients was 24 to 33 years and amongst male patients was 34 to 43 years. Just over 91% of patients identified as heterosexual[9]. However, this does not include those who may have attended a clinic outside London or who received support via General Practice (GP). The actual figure is therefore likely to be far higher, especially when taking into consideration the numbers of people attending their GP for other conditions that may also be having an impact on sexual functioning such as depression, menopause or postnatal complications[10].

It is well documented that victims of intimate partner violence (defined as physical, sexual, and emotional abuse and controlling behaviours by an intimate partner) are at much higher risk of sexual dysfunction and poor sexual health outcomes[11]. Between April 2014 and March 2015 the national rate of domestic abuse incidents (a form of intimate partner violence) per 1,000 population was 20.4 and across London was slightly higher at 21.6[12]. In 2016 the Kingston rate was much lower at 13 per 1,000 population[13]. In relation to sexual violence, between April 2015 and March 2016 the national rate of sexual offences per 1,000 population was 1.7[12]. This was the same in London and was slightly higher than the Kingston rate of 1.2.

Lesbian, gay, bisexual and transgender (LGBT) people also experience higher rates of sexual dysfunction and poorer sexual health outcomes[14]. Whilst there is some data on the needs of gay and bisexual men (see chapter 3.5), there is very little available regarding lesbian and bisexual women and those who identify as transgender. National estimates suggest that approximately 5% to 7% of the population are gay or bisexual[15] and a Home Office study estimated that there were between 300,000 and 500,000 people in UK with some form of gender variance[16]. Locally, a study looking at the sexual health needs of LGBT people in Kingston found high levels of mental health problems amongst this population group, with stress, anxiety and depression cited most commonly[17]. There were also issues around loneliness, isolation and problems with relationships that were linked to experiences of rejection related to disclosure of sexual orientation and levels of discrimination. Furthermore, 57% of transgender respondents said they felt their needs were not at all understood by their GP[17].

Local Action

Kingston Council commissions a range of sexual health services which seek to address not only the medical aspects of the population's sexual and reproductive health (see chapters 3.2 and 3.3), but also to educate and support people to develop and maintain positive choices regarding their relationships and sexual wellbeing.

The Wolverton Centre offers a psychosexual support service for clients experiencing psychological difficulties in relation to their sexual wellbeing. This is available via referral from within the clinic. Despite high demand for this service, it is an area of sexual health that has traditionally been missing from the national agenda and subsequently has been poorly funded[18]. In response to this, from 2017, a new payment system will be introduced in Kingston that will recognise a wider range of service provision and interventions such as psychosexual services.

There is also work within the borough to support the needs of groups who may be more vulnerable to poor sexual health outcomes. As well as those groups outlined in chapters 3.5 to 3.8, there is support available for people working in the sex and adult entertainment industry via the Delta Service at the Wolverton Centre which offers a fast track screening and treatment system. Strong links have been developed with the Kingston Domestic and Sexual Violence Partnership (DSVP) to ensure sexual health support is available to victims in a way that meets individual need and provides a coordinated approach with other services. In 2014, Kingston also published its first strategy 'Ending Domestic and Sexual Violence in Kingston, Enabling All to be Free from Fear'[19]. Kingston Public Health have also worked with homeless projects and substance misuse services to deliver sexual health information sessions to both workers and service users.

In addition, the Council supports and runs a number of campaigns that seek to address people's sexual and reproductive health needs (see chapters 3.2 and 3.3) in order to support the development and maintenance of healthy sexual lives.

3.0 Adults

Recommendations

1. **Undertake an assessment of need for psychosexual services in Kingston.**
2. **Work with local stakeholders, including GPs, to raise awareness of local psychosexual services and when and how to refer to these.**
3. **Ensure all Kingston residents have access to accurate, high quality sexual health information, education and services, including the focus that sexual behaviour should never result in exploitation, oppression, physical, emotional or psychological harm.**
4. **Continue work with professionals and the public to challenge discrimination of minority groups.**

3.2 Sexually Transmitted Infections and Human Immunodeficiency Virus

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Introduction

Sexually transmitted infections (STIs) are an important national and local health priority having a significant physical and psychological impact on those affected, as well as a financial cost.

STIs are passed from one person to another via unprotected sexual contact[1]. The most commonly diagnosed STIs in the United Kingdom (UK) include:

- **Genital warts** which can cause small painless fleshy growths, bumps or skin changes[2]
- **Genital herpes** which can cause flu like symptoms, followed by stinging or itching in the affected area, followed by blisters which burst leaving painful sores[2]
- **Chlamydia** and **gonorrhoea:** early symptoms are often quite similar and include pain when passing urine or during sexual intercourse, an abnormal discharge, bleeding between periods and swelling and/or pain in the testicle[2].

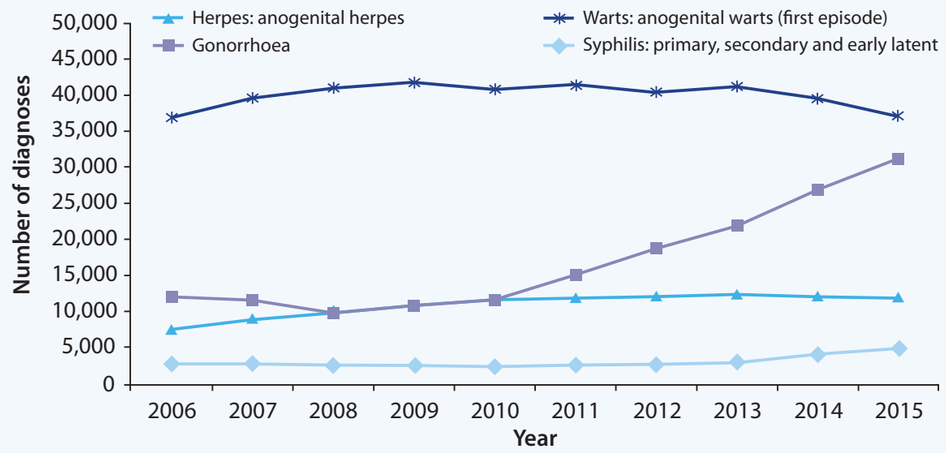
However, many infections are asymptomatic, meaning that those infected have no symptoms at all, and this is often the reason why STIs are not diagnosed sooner[2]. If left untreated chlamydia and gonorrhoea can cause long term complications such as pelvic inflammatory disease (PID), ectopic pregnancy and infertility in women, and possibly reduced fertility in men.

Syphilis is a much rarer STI. The first sign of this STI is one or more usually painless sores lasting two to six weeks. If syphilis is not treated then next stage signs can include a painless rash, flat growths in the ano-genital area, flu-like illness, white patches in the mouth and patchy hair loss. If there is still no treatment, the next stage is a latent stage where diagnosis has to be made by a blood test[2].

In addition, there is some evidence to suggest that STIs can increase the risk of acquiring and transmitting the human immunodeficiency virus (HIV)[3].

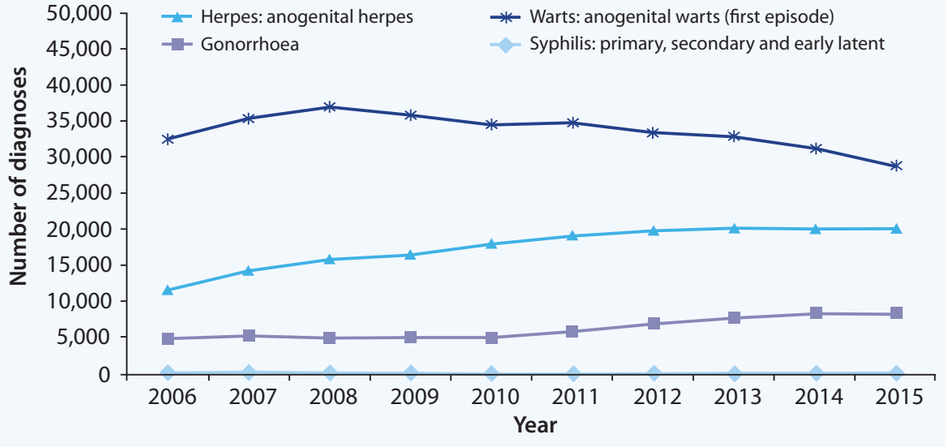
In 2015, there were 435,000 STIs diagnosed in England, which is a 3% reduction on 2014[4]. Part of this fall is thought to be due to a reduction in chlamydia testing in community settings and a drop in genital wart diagnoses following the introduction of the human papilloma virus (HPV) vaccination programme in England (see chapter 2.2). There have been marked increases in other infections including a 20% increase in syphilis, and an 11% increase in gonorrhoea[4]. The latter is of particular concern due to the occurrence of an increasing number of cases of antibiotic resistant gonorrhoea in the UK[5]. Some of these increases are undoubtedly due to improved testing rates and more sensitive diagnostic tests, however it is widely acknowledged that ongoing unsafe sexual practices are also contributing to this picture[6].

Figure 1 Number of STIs amongst men: England, 2006-2015.



Source: Public Health England (PHE). Sexually Transmitted Infections in England, 2015. 2016.
Please note chlamydia data is excluded due to high numbers.

Figure 2 Number of STIs amongst women: England, 2006-2015.



Source: PHE. Sexually Transmitted Infections in England, 2015. 2016.
Please note chlamydia data is excluded due to high numbers.

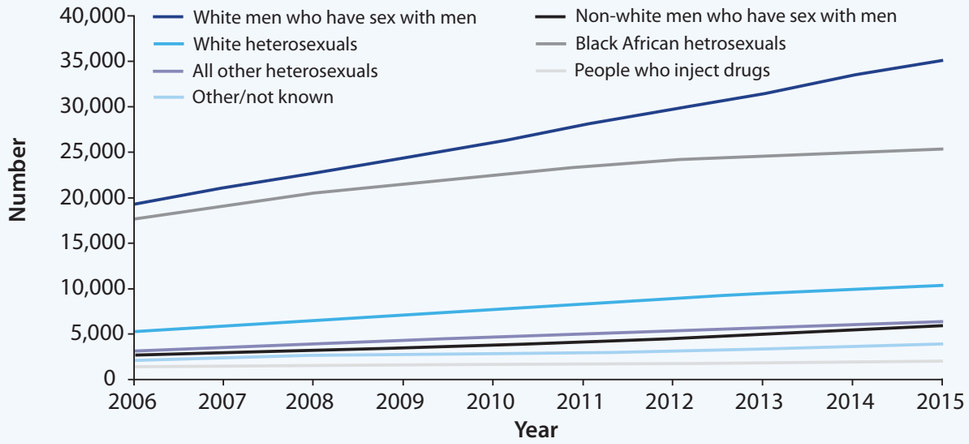
Figures 1 and 2 show the rates of some of the most common STIs diagnosed in men and women between 2006 and 2015 (chlamydia is excluded due to very high numbers, further information is available in chapter 2.2). Some of the differences between the genders, such as the sudden rise in gonorrhoea in men from 2010, may be explained by the epidemiology of STIs in men who have sex with men (MSM) (see chapter 3.5)[7].

Nationally the burden of STIs continues to be greatest in young people, MSM and the Black and minority ethnic (BME) communities (see chapter 3.6)[8]. The highest STI diagnosis rates by age group in England are in young people aged 15 to 24 years of age (see chapter 2.2).

Human Immunodeficiency Virus (HIV)

HIV is a virus that attacks and weakens the immune system making it harder for a person to fight infections and disease[9]. In the UK, HIV is most commonly transmitted through unprotected sexual intercourse with someone who is HIV positive, although it can also be transmitted through sharing infected needles and other injecting equipment and from an HIV positive mother to her baby (this can be during pregnancy, birth, or through breastfeeding). There is currently no cure for HIV, however there are very effective treatments available that can suppress the virus to significantly slow, and in some cases stop, its attack of the body's immune system[9]. Acquired immune deficiency syndrome (AIDS) describes a stage when a person's immune system is no longer able to fight off illnesses due to the damage done by HIV. In the UK, this is a term rarely used now due to the effective treatments that prevent most people from getting to this stage and the stigma attached to the term 'AIDS'.

Figure 3 The number of people seen for HIV care by exposure group and ethnicity: UK 2006-2015.



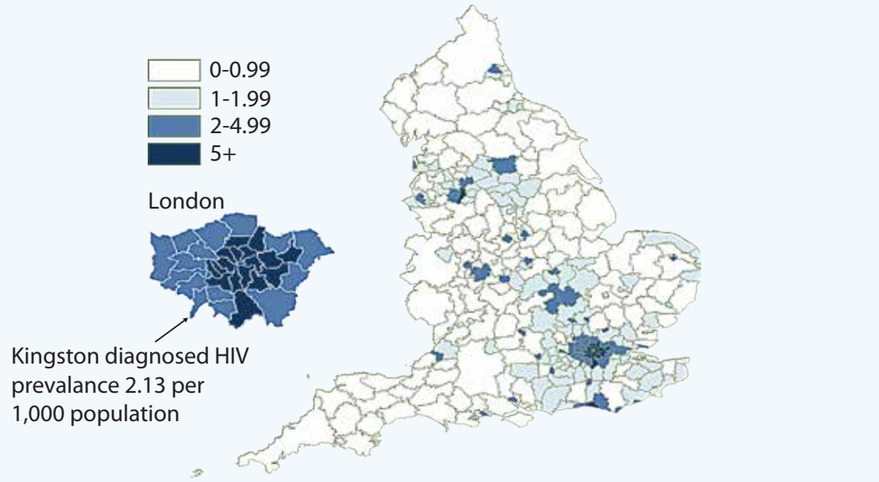
Source: Public Health England. HIV in the UK Slide Set, 2015. 2016.

The number of people living with HIV in the UK continues to rise and, in 2015, an estimated 88,769 people were living with diagnosed HIV[10]. This reflects the longer life expectancy achieved by the introduction of effective antiretroviral therapy (ART), as well as ongoing HIV transmission. In recent years, the number of new HIV diagnoses has remained stable at around 6,000 per year[10].

HIV infection remains largely concentrated among white MSM and Black-African heterosexuals (Figure 3)[9]. In the UK, very few people acquire their HIV infection through sharing injecting drug equipment and, although not represented in Figure 3, the number of cases of mother to child transmission has fallen so significantly that less than 1% of babies born to women with HIV will be HIV positive themselves[11].

Today, the majority of individuals receiving a new HIV diagnosis in the UK will have acquired it in this country[10]. Looking at regions within the UK, the prevalence of HIV is highest in London with 41% of those accessing HIV treatment and care services living in the capital (Figure 4)[7]. National guidelines recommend considering offering routine HIV testing for all new primary care registrations and general medical admissions where the local HIV prevalence exceeds 2 per 1,000 population[12]. This applies to Kingston, and all but one other London borough (Figure 4 overleaf).

Figure 4 Prevalence of diagnosed HIV infection by area of residence among population aged 15 to 59: UK 2015.



Source: Public Health England, HIV in the UK Slide Set, 2015. 2016.

The issues of both undiagnosed and late diagnosis of HIV remain a cause for concern in the UK. Nationally, more than one in five people are unaware of their HIV status[10] and, in 2015, 40% newly diagnosed with HIV were diagnosed at a late stage (late diagnosis is defined as being when a person's CD4 count falls below 350 cells/mm^3. CD4 is a measure of how the immune system is functioning)[13]. Late diagnosis is associated with a tenfold increased risk of death in the first year following diagnosis and living with undiagnosed HIV increases the chance of unknowingly infecting others.

Local Picture

Sexually Transmitted Infections

In 2015, there were 1,532 new STI diagnoses to residents of Kingston[14]. The table below summarises the local rates of STIs compared to the regional values in London and also nationally.

Table 1 Rates of STI diagnosis per 100,000 total population in Kingston, London and England, 2015.

	Kingston	London	England
New STI diagnoses	901	1,391	768
New STI diagnoses excluding Chlamydia in under 25s	997	1,606	815
Chlamydia (all ages)	564	544	361
Chlamydia (15 to 24 years of age)	1,601	2,200	1,887
Gonorrhoea	68.3	221.9	70.7
Syphilis	7.6	32.9	9.3
Human Papilloma Virus (Genital Warts)	190.6	159.3	118.9
Herpes Simples Virus (Genital Herpes)	78.3	93.8	57.6

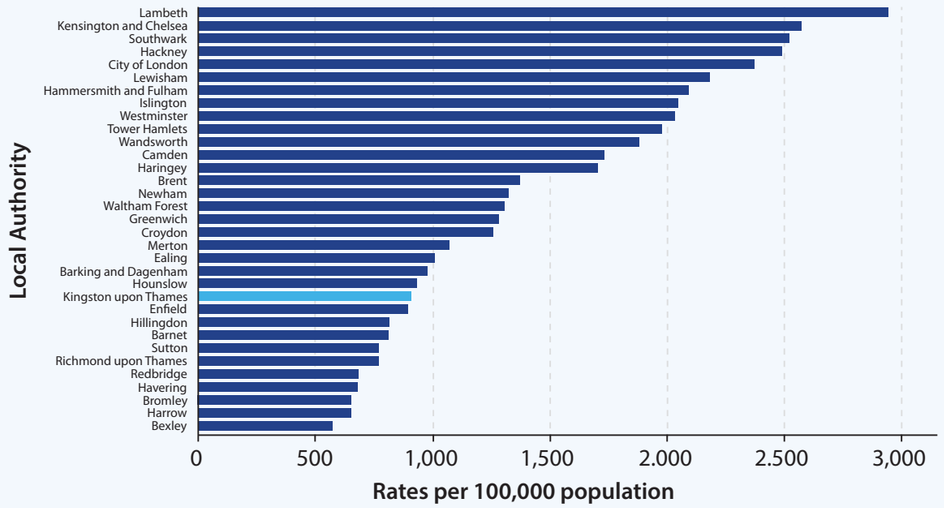
Source: PHE. Sexual and Reproductive Health Profiles. 2016.

Table 1 shows that Kingston has a lower overall STI diagnosis rate than the London average, with gonorrhoea and syphilis rates being lower than both the London and England averages[14].

All age chlamydia rates in Kingston are just above the London average. Genital warts is the only STI to have a higher rate in Kingston than both London and England averages.

Looking at the picture across London, Kingston's rates of STIs compare favourably against most other London boroughs, being the twelfth lowest rates in the region (Figure 5)[6].

Figure 5 Rates of new STIs in each local authority in London: 2015.



Source: PHE. Kingston LASER Report, 2015. 2016.

It is generally acknowledged that STI reinfection is an indication of repeated risky behaviour[6]. In Kingston, between 2011 and 2015, an estimated 9% of women and 11% of men who had presented with a new STI at a genitourinary medicine (GUM) clinic, subsequently returned with either a further new STI or reinfection within twelve months. These are slightly higher than the national figures of 7% and 9% respectively[6].

HIV

In 2015, there were 271 adults living with HIV in Kingston[15] giving a local prevalence of 2.13 per 1,000[13]. This reflects the national average rate of 2.26, but is significantly lower than the London average which is 5.83 per 1,000. More data on the demographics of the HIV positive population in Kingston can be found in chapter 3.7.

There are between 10 and 20 new HIV infections diagnosed in Kingston residents each year[6]. In 2015, there were 13 adults newly diagnosed with HIV. The numbers are small and fluctuate from year to year, but are in line with national trends, and the overall incidence has not changed significantly over the last five years. Due to such small numbers it is not possible to provide local information regarding routes of transmission.

Early diagnosis of HIV is of paramount importance both in relation to best care of the person living with HIV, as clinical trial data shows people with HIV will maintain their health and live longer with early HIV treatment[16], and also in preventing onward infection. Each area's late HIV diagnosis rate, as a percentage of all new diagnoses, is one of the three national Public Health Quality Outcome Framework measures. Measured as a three year rolling average, the proportion of HIV infections in Kingston diagnosed late is currently stated as 23.3% of new diagnoses[13]. This rate has more than halved in recent years and compares favourably to both London and England averages at 33.5% and 40.3% respectively.

There have been no cases of mother to child (perinatal) transmission of HIV to Kingston mothers in the last 20 years[14]. Nationally in 2014, five or fewer (exact number withheld due to data protection requirements) children were reported to have acquired HIV perinatally. This reflects the success of the national antenatal HIV screening programme in detecting HIV positive mothers, and starting them on ART to prevent infection in the baby. In 2014, antenatal screening in Kingston tested 99.7%[17] of all pregnant women, which is above the national average of 97%[18].

Local Action

Kingston provides sexual and reproductive health care through a range of services and settings including pharmacies, general practices, contraceptive and sexual health (CaSH) clinics in the community, and a specialist centre at Kingston Hospital (the Wolverton Centre). Across these services a mixture of drop-in and appointment only services are available throughout the whole week, including a Saturday CaSH clinic, to facilitate easy and rapid access.

Kingston was an early adopter of the Department of Health (DH) promoted integrated model of care, with sexual health services in all settings working towards offering a mix of both STI and contraceptive provision (see chapter 5.1).

To achieve earlier diagnosis of HIV, testing is promoted in a range of settings locally, including the specialist sexual health service at the Wolverton Centre and community sexual health services run by Your Healthcare CIC.

In Kingston, HIV testing is also offered to all new registrants in general practices in line with HIV testing guidance from the National Institute for Health and Care Excellence (NICE)[12].

Patients admitted to Kingston Hospital are tested for HIV if they present with an HIV indicator condition such as pneumonia or oral thrush. Routine HIV testing of all patients admitted has not been implemented.

Kingston is also investing in innovative ways of increasing access to STI testing. Since November 2015, free online HIV self-sampling (www.freetesting.HIV) has been available to Kingston residents at high risk of HIV infection. A free sampling pack is available online with a result provided by a trained clinician within 48 hours. Positive HIV results in Kingston are coordinated via the Wolverton Centre for confirmatory testing and follow-up care.

More recently, a London wide e-service has been devised, for which a procurement process is underway at the time of writing this report, which will allow people to be assessed and triaged, and to request as appropriate, a suite of STI tests online.

Kingston Public Health also supports national campaigns throughout the year, such as National HIV Testing Week, offering information, advice and HIV testing from mobile health units.

Partner Notification

This is an important way of detecting undiagnosed STIs and HIV infections. The British Association of Sexual Health and HIV (BASHH) recommends that everyone newly diagnosed with HIV at a sexual health clinic should have a discussion about partner notification[19]. In England in 2014, 2,225 people attended a sexual health clinic as a contact of someone diagnosed with HIV and 102 (5.6%) were found to be HIV positive[6].

Recommendations

1. **Continue to prioritise access to STI and HIV screening and treatment for high risk groups in the local population, such as MSM and BME groups.**
2. **Investigate the reasons why rates of genital warts in Kingston are higher than both London and England rates and explore ways to tackle this.**
3. **Develop an improved partner notification process.**
4. **Prioritise health education and health promotion for high risk groups.**
5. **Increase access to testing by providing more STI screening in the community.**
6. **Improve the coverage of routine HIV testing in general practice, sexual and reproductive health services and specialist services to reduce undiagnosed HIV infection and late diagnosis.**

3.3 Reproductive Health and Contraception

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Kingston Hospital Foundation Trust

Introduction

With the average age of menopause now 51 years there is a need for contraception in women to cover a longer period of the life course[1]. Guidance on contraception published in September 2016 by the National Institute for Health and Care Excellence (NICE) states that sexual and reproductive health (SRH) services should offer access to the full range of contraceptive methods with robust, timely referral pathways, and accurate reproductive health information from appropriately trained staff, allowing the patient to make an informed choice and so take control of their fertility[2].

Evidence demonstrates that increasing access to contraception will yield returns now and in the future, by avoiding economic costs and the personal difficulties that can result from an unplanned pregnancy (see chapter 1.2[3]).

An interval between pregnancies of less than six months is associated with an increased risk of extremely preterm delivery and neonatal death[4]. Easy access to contraception post-pregnancy minimises this risk. Easy access post-termination of a pregnancy also reduces the incidence of women having more than one abortion[2].

User Dependent Methods (UDMs) of Contraception

UDMs are those methods of contraception that rely on someone remembering to take them every day; apply them at daily or weekly intervals; or use them each time they have sexual intercourse[5]. Examples are oral contraception (the pill), diaphragm/cap, contraceptive patch and condoms. Oral contraception and condoms are currently the most common methods of contraception used in the UK[2].

When adhered to 100% of the time, UDMs are 99% effective at preventing pregnancy, however typical use (taking into account human error) puts effectiveness of these methods at between 71% and 91% depending on the individual method[6]. This means there is a greater risk of pregnancy amongst women using these methods than those using long acting reversible contraception (LARC), which does not rely on women remembering to take or use them. LARC methods are 99% effective at preventing pregnancy[6]. The only exception to this is the contraceptive injection as it relies on a woman returning for injections every 12 weeks; and so the typical effectiveness of this method is 94%[6].

Long Acting Reversible Contraception (LARC)

Guidance from NICE on LARC demonstrates that after one year of use, all LARC methods are more cost effective than the combined pill (the most commonly prescribed contraceptive method in the UK)[7].

The contraceptive injection has already been discussed. The subdermal implant, the hormonal intrauterine system, and the copper intrauterine device are implanted or inserted by a trained professional and remain in situ leaving no margin for human error and very low failure rate. If contraception is no longer required, all can be removed and their contraceptive effect is then quickly reversed.

Picture 1 Subdermal implant.

Source: MSD.

The Subdermal Implant

The hormonal subdermal implant is a small 4cm by 2mm rod, which is inserted under the skin over the biceps muscle of the non-dominant arm using a simple procedure (see Picture 1). It releases progestogen, which temporarily stops ovulation, and is effective for 3 years before needing to be replaced or removed.

Hormonal Intrauterine System (IUS)

The hormonal intrauterine system (known as a coil) is inserted into the womb. It contains progestogen hormone, which is released inside the womb and thins the lining of the womb making periods lighter or stop altogether. It is effective for between three and five years, depending on the type, before needing to be replaced or removed. Picture 2 shows one of these devices.

Picture 2 Hormonal intrauterine system.

Source: Bayer Plc.

Copper Intrauterine device (IUD)

The copper intrauterine device (also known as the coil) is inserted into the womb. It stops sperm reaching an egg by preventing sperm from surviving in the cervix, womb or fallopian tube. It may also prevent a fertilised egg from implanting in the womb.

The IUD contains no hormones and lasts for between five and 10 years, depending on the type, before needing to be replaced or removed. It may also be used as emergency contraception. Picture 3 shows this device.

Picture 3 Copper intrauterine device.

Source: Bayer Plc.

Local Picture

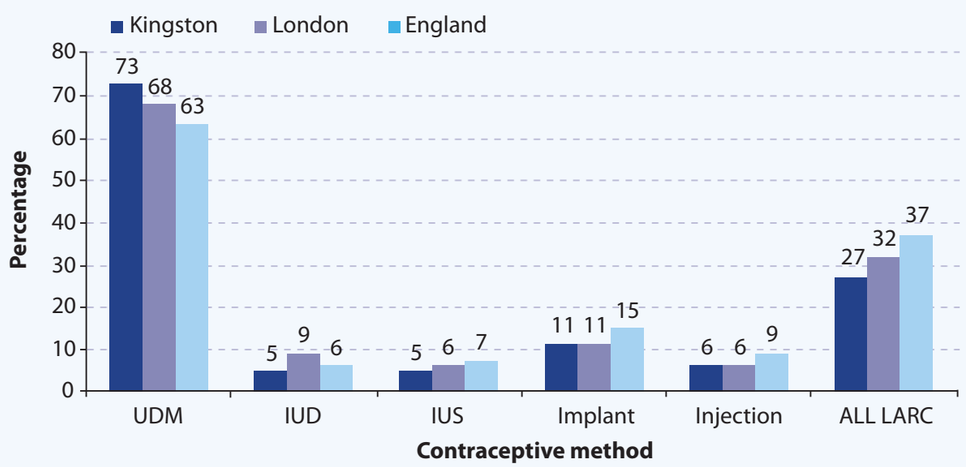
Data on contraceptive use in Kingston is compared to London and national data in the figures below.

Figure 1 shows that between April 2014 and March 2015, UDMs were the most commonly used method of contraception in Kingston (73%), London (68%) and England (63%). Locally, there was less take up of LARC in Kingston (27%) compared to both London (32%) and England (37%).

All SRH services in Kingston actively promote the use of LARCs, however many patients appear to find UDMs like pills, patches and rings more acceptable, despite their higher failure rates.

In Kingston, in 2014, 49% of LARC was prescribed to women over the age of 25[8]. This differs from the national rate, which show the percentage of LARC prescribed to women over 25 was 60% in 2014.

Figure 1 Percentage of total contraception used 2014-2015 for Kingston, London and England.



Source: PHE. Sexual and Reproductive Health Activity Data Set, 2015. 2016.

Contraception in Primary Care

Table 1 shows that proportionally in 2014, general practices (GPs) in Kingston fitted more LARCs than the average for GPs across England[8]. They also prescribed less injectable contraceptives (6.6% of total contraceptive prescribing as opposed to 11.4% for GPs across England)[8]. Locally, oral contraception accounted for a greater percentage of all contraceptive prescribing (88.1%) than the England average of 83.7%.

Table 1 Number of types of contraception and percentage of total contraception prescribed within primary care settings: 2014.

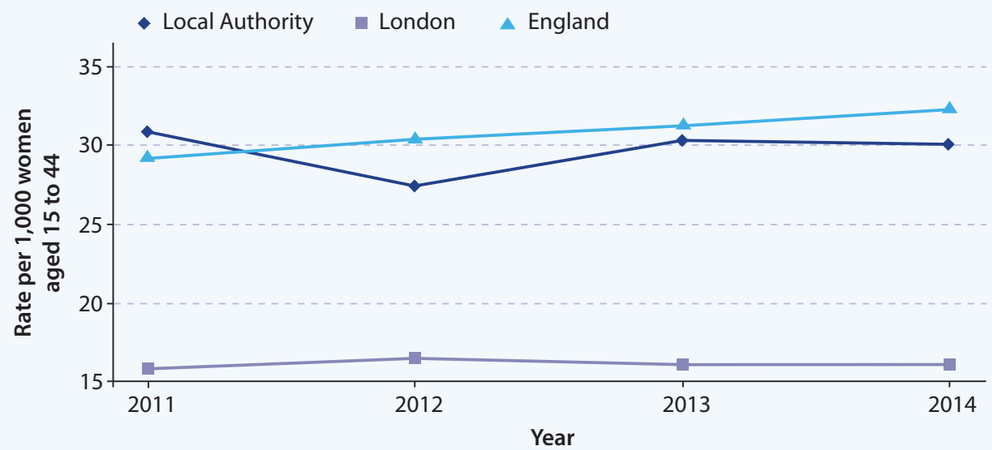
Choice	Method	Kingston (n)	Kingston (%)	England (%)
LARCs	IUD	237	0.9	0.4
	IUS	456	1.7	1.5
	Implant	483	1.8	1.8
Injectable	Injectable	1742	6.6	11.4
UDM	Oral pill *	23,313	88.1	83.7
	Patch	115	0.4	0.9
	Other UDM**	130	0.5	0.3

Source: PHE. Kingston LASER Report, 2015. 2016.
*Includes combined pill and progestogen only pill. ** Includes vaginal ring and diaphragm.

Figure 2 shows the rate of LARC prescribed in primary care nationally between 2011 and 2014. In 2014, Kingston ranked 217 out of 326 local authorities in England for the rate of GP prescribed LARC (with the local authority ranking one having the highest rate)[8].

However, it should be noted that LARC prescribing rates are much higher in Kingston than in London as a whole with 2014 rates being 30.0 per 1,000 women aged 15 to 44 in Kingston compared with 16.1 per 1,000 in London. The England rate was 32.3 per 1,000[8].

Figure 2 LARC prescribed in primary care per 1,000 women aged 15 to 44, 2011-2014.



Source: PHE. Kingston LASER Report, 2015. 2016.

Local Action

There are a number of SRH services across the borough that offer free information, advice and contraception to women of all ages, including:

- general practice
- contraception and sexual health (CaSH) services at Hawks Road, Hollyfield House and other community venues
- The Wolverton Centre for Sexual Health (which also offers a complex contraceptive clinic).

All of these services offer a mixture of drop-in and appointment only clinics throughout the week (daytime and evenings) and on Saturdays.

There are a number of vulnerable groups for whom general clinics are not ideal settings to receive contraceptive care. These include young people (see chapter 2.2 and 2.3), sex workers, homeless people (see chapter 3.1), and people with learning disabilities (see chapter 3.8).

The Wolverton Centre has a service for sex workers that ensures all their specific needs can be met in one visit and onward referral to specialist services is available. SRH services do not require people to be registered with a GP or to supply a fixed address in order to access services, removing a potential barrier to access for homeless people.

Locally, termination of pregnancy services are expected to offer and provide contraceptives to all women as part of their post abortion care and refer to local providers for their ongoing contraceptive needs.

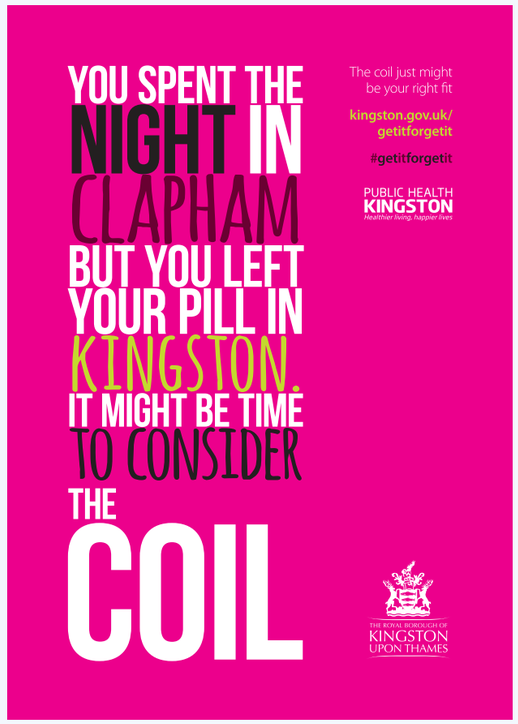
Commissioners make available local training of the borough's clinical workforce, facilitated by the Wolverton Centre, which includes training for the Diploma of the Faculty of Sexual and Reproductive Healthcare (DFSRH). Open to nurses and doctors, this ensures practitioners gain greater expertise in the field of sexual health and also improves their knowledge about all current contraceptive methods. It also provides accredited training in intrauterine device insertion and subdermal implant insertion and removal.

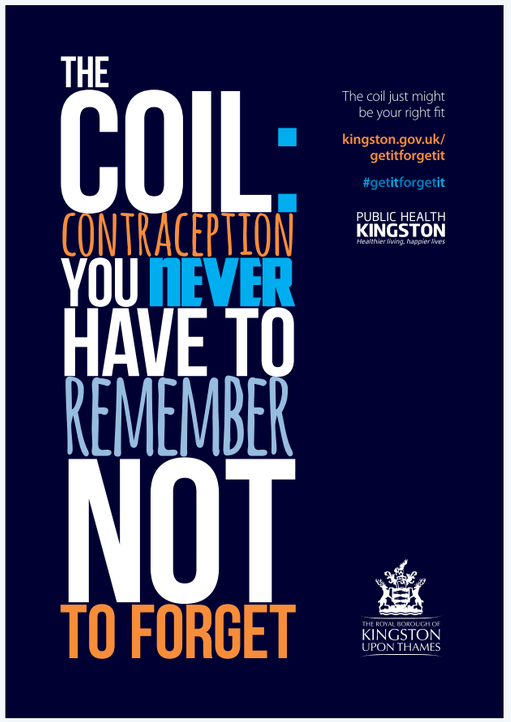
To raise awareness about the advantages of using LARC, Kingston public health commissioners have run public education campaigns about the benefits of these methods of contraception. Most recently a campaign entitled "coil – get it and forget it" was launched in August 2016[9]. The campaign consisted of posters (see Picture 4) and the use of social media to raise awareness of LARC and the benefits of switching to these methods.

Local health services were asked to:

- display the posters
- ensure that staff were confident with discussions relating to LARC methods of contraception
- be aware of the referral pathways for individuals needing complex care and for vulnerable women.

Picture 4 Posters from the "coil – get it and forget it" campaign, 2016.





Recommendations

1. **Ensure all sexual health services provide comprehensive information about all methods of contraception.**
2. **Women requesting contraception from sexual and reproductive health clinics, including termination of pregnancy services, should be given information about and offered a choice of all methods including LARC.**
3. **Commissioners and service providers should continue to promote the use of LARC to women, including the provision of accurate information and advice to dispel misconceptions about this method of contraception.**
4. **Continue to promote the Diploma of the Faculty of Sexual and Reproductive Healthcare to the primary care workforce in order to ensure high quality service provision and improved access to LARC in primary care.**
5. **Ensure all women requiring emergency contraception are made aware that an intrauterine device is more effective than an oral method.**
6. **Work with maternity services to ensure women who give birth are given information about, and offered a choice of, all contraceptive methods by their midwife within seven days of delivery.**
7. **Further monitor access to contraceptive services to ensure women do not fail to gain their method of choice due to the unavailability of appropriately trained staff.**

3.4 Termination of Pregnancy

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Introduction

With one in three women undergoing a termination of pregnancy during their lifetime, this is an issue that affects many people[1]. Examining data collected from termination services can provide us with important information regarding unplanned pregnancy and help inform decisions around contraceptive provision.

In 2015, the total number of terminations to residents of England and Wales was 185,824[2]. This has remained fairly constant in recent years and is 0.7% higher than in 2014. The NHS funded 98% of these terminations, with over two thirds taking place in the independent sector under NHS contracts[2].

Age

In 2015, the termination rate in England and Wales amongst women aged 15 to 44 years was 16.0 per 1,000 women[2]. The rate was highest in those aged 20 to 24 years at 27.5 per 1,000 women and lowest in the over 35 age group at 7.8 per 1,000 women[2]. The termination rate in young women aged under 18 fell from 11.1 per 1,000 in 2014 to 9.9 in 2015.

Gestation Period

Access to termination services earlier in gestation is important in order to maximise the choice of method and reduce the risk of complications[2]. Since 2005, when the percentage of terminations carried out at under 10 weeks gestation was 65%, there has been an increase in the percentage of terminations undertaken before 10 weeks gestation[2]. In 2015, across England and Wales, 80% of terminations were undertaken at under 10 weeks and 92% under 13 weeks.

Previous Termination

Recurring unplanned pregnancy can pose increased health risks to women and is an indicator of potential exposure to sexually transmitted infections (STIs)[2]. In 2015, 38% of terminations undertaken in England and Wales were to women who had previously had one or more terminations[2]. This is a higher percentage than in 2005 when it was 32%.

Type of Termination

There are a variety of methods used to terminate a pregnancy. Nationally the most commonly used method is a medical abortion, which involves giving a drug that induces termination[2]. This method is clinically preferable as it does not require any surgical intervention and therefore no use of anaesthetics. There are two main surgical methods of termination: vacuum aspiration and dilation and evacuation[2].

The number of medical terminations has more than doubled since 2005 and, in 2015, 55% of terminations in England and Wales were performed medically[2]. This is partly due to an increase in terminations happening at an earlier gestation, giving women more options in terms of the method of termination.

Local Picture

Locally, the Kingston Clinical Commissioning Group (CCG) commissions the British Pregnancy Advisory Service (BPAS) to provide termination services. There are a small number of women who choose not to use this service and therefore the data presented below does not include all women from Kingston who have had a termination.

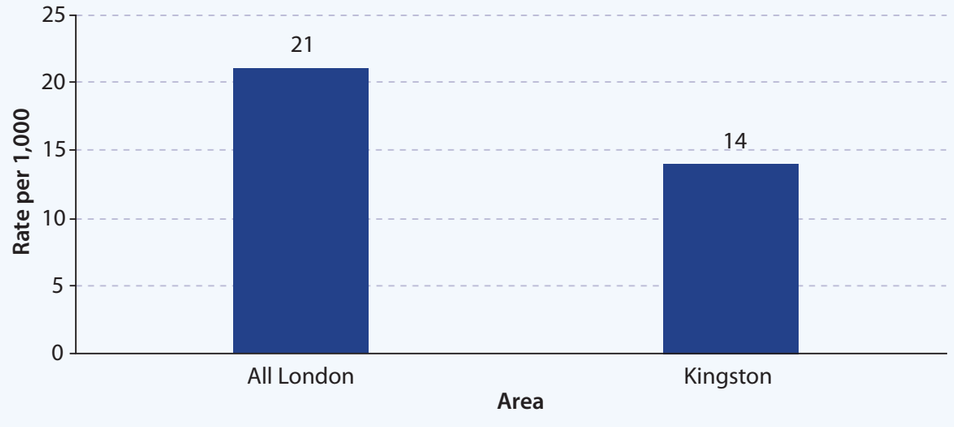
Between 1 April 2015 and 31 March 2016, BPAS treated 569 clients resident in Kingston[3]. This is a slight reduction from 587 in the previous year. In recent years the way in which women access termination services has changed and referral from a medical professional is no longer required. In Kingston, any woman who is registered with a general practice (GP) within the CCG area can self-refer to BPAS and, in 2015-2016, 58% of clients did this[3]. Others were referred through their GP or via sexual health clinics.

Age

Figure 1 shows that the age standardised termination rate in Kingston is lower than the London rate (and this is statistically significant). Although it is also lower than the England and Wales rate of 16.0 per 1,000 women this is not a statistically significant difference[2].

In Kingston, the highest rate of termination was amongst women aged 18 to 19 years old at 29 per 1,000 women[2]. This is a younger age peak than both national and regional figures (where women aged 20 to 24 had the highest rates) and may, in part, be explained by the presence of a large number of students in the borough.

Figure 1 Average age standardised rate of termination per 1,000 women aged 15 to 44 years in London and Kingston, 2015.



Source: Department of Health. Abortion Statistics, England and Wales: 2015-2016.

Gestation Period

In 2015, the percentage of Kingston clients treated at under 10 weeks gestation was 86%[2]. This is slightly higher than the London percentage of 84% and the England and Wales percentage of 80%.

Previous Termination

The rate of termination amongst women who have previously had one or more terminations is considerably lower in Kingston than across London[2]. In Kingston in 2015, 34% of terminations were for those who had previously had a termination[2]. This figure is 42% for London[2].

Type of Termination

In Kingston, in 2015, the most common method of termination was a surgical termination[3], with 61% of women choosing this method over a medical termination. This compares to 52% across London and 45% in England[2].

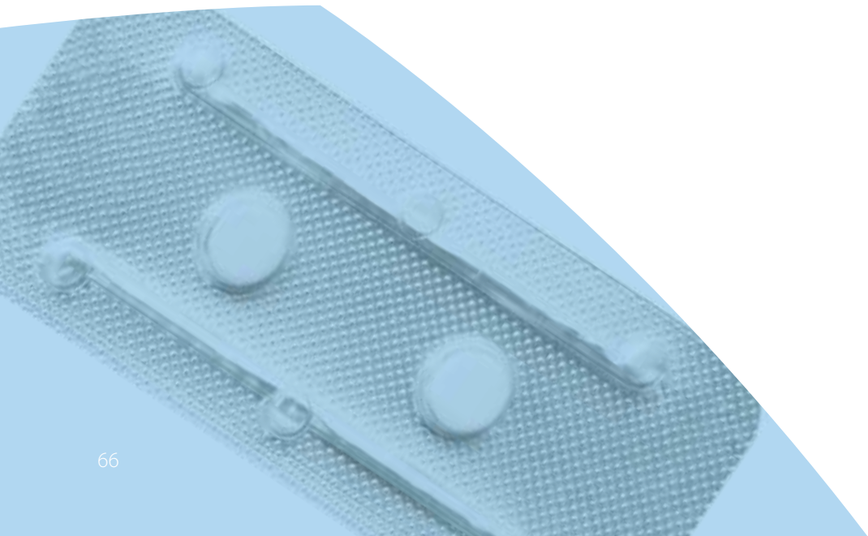
Local Action

Work is currently underway to improve access to termination services within Kingston. At present, women needing to access termination services have to travel outside the borough for this service. This is not ideal as it may make accessing services more difficult, particularly for more vulnerable groups such as young women. Given the increasing numbers of women choosing a medical termination, and coming forwards earlier than 10 weeks gestation, a 'closer to home' service may be more viable than previously. Kingston CCG is therefore exploring options to address this issue.

In recent years, work has been undertaken to improve access to contraception for women who have had a termination. Contraceptive services are offered from within the termination service and better pathways into local contraceptive services are now available.

Recommendations

1. **Increase options and access for women requiring a termination through a greater number of commissioned providers and consideration of locating an early termination service within the borough.**
2. **Explore the reasons why more women in Kingston are choosing a surgical termination over a medical termination.**
3. **Further promotion of the ability to self-refer to ensure women are not deterred from accessing termination services due to fears over confidentiality.**



3.5 Men who have Sex with Men

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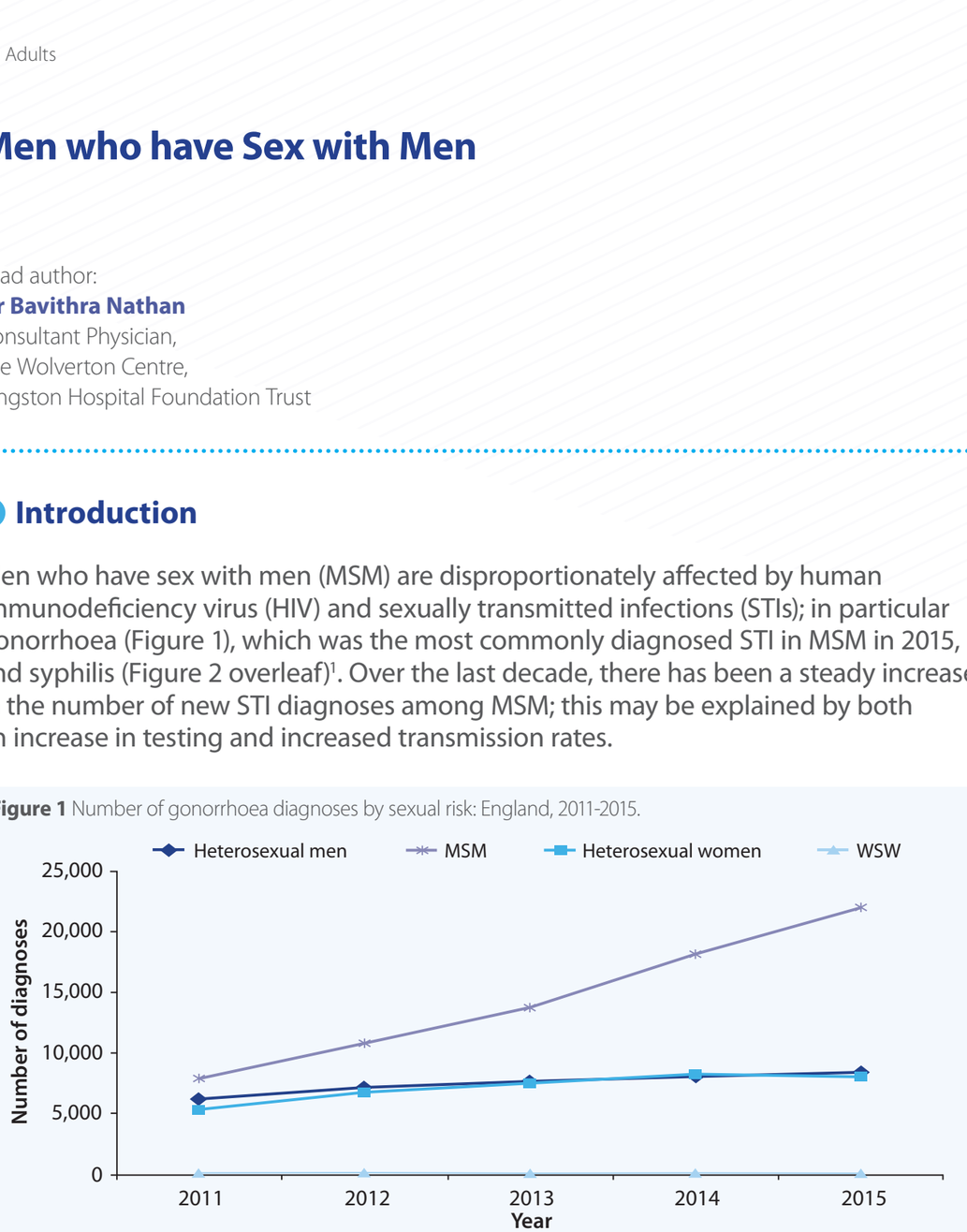
Introduction

Men who have sex with men (MSM) are disproportionately affected by human immunodeficiency virus (HIV) and sexually transmitted infections (STIs); in particular gonorrhoea (Figure 1), which was the most commonly diagnosed STI in MSM in 2015, and syphilis (Figure 2 overleaf)[1]. Over the last decade, there has been a steady increase in the number of new STI diagnoses among MSM; this may be explained by both an increase in testing and increased transmission rates.

Figure 1 Number of gonorrhoea diagnoses by sexual risk: England, 2011-2015.

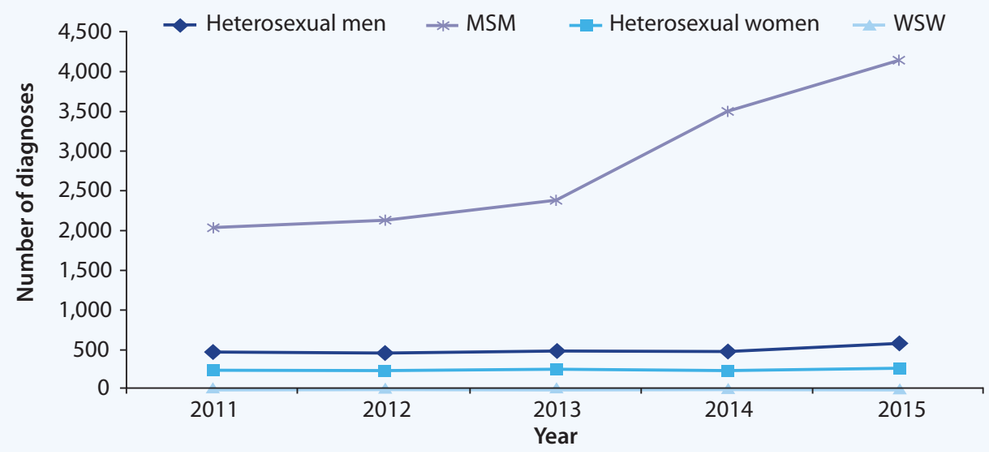


Source: Public Health England. 2015 STI Slide Set. 2016.
WSW = women who have sex with women.

In 2014 there were 6,095 new HIV diagnoses in the UK and 54% of these were in MSM[2]. It is estimated that 14% of MSM in the UK are unaware of their HIV infection, and therefore not accessing treatment, and at higher risk of unknowingly transmitting the virus to sexual partners[3].

Recently, strong evidence has been put forward for the use of Pre-Exposure Prophylaxis (PrEP) as an HIV prevention strategy. It has been shown in the PROUD[4] and IPERGAY[5] studies that a daily tablet of emtricitabine and tenofovir disoproxil fumarate (also known by the brand name Truvada), a drug currently used in the treatment of people living with HIV, can reduce transmission of the disease.

Figure 2 Number of syphilis (primary, secondary and early latent) diagnoses by sexual risk: England 2011-2015.



Source: Public Health England. 2015 Slide Set. 2016.
WSW = women who have sex with women.

More recently the National Institute for Health and Care Excellence (NICE) has completed an evidence review of four randomised trials[6]. Three considered the use of Truvada; two of those trials are outlined above and the third was the iPrEx study conducted in Peru, Ecuador, Brazil, US, Thailand and South Africa. A fourth trial (Partners PrEP), which also evaluated Truvada, looked at PrEP in HIV negative heterosexual men and women and was conducted in Africa only.

In summary, the NICE evidence review found that there was 'little doubt that Truvada is effective in reducing HIV acquisition in high risk people who are HIV negative'[6]. However, issues relating to uptake, adherence, sexual behaviour, drug resistance, safety, prioritisation for prophylaxis and cost effectiveness are also important to consider, especially at a population level.

At the time of writing the use of Truvada as PrEP is not yet available on the NHS, but there has been a surge of interest from the MSM population on social media and many men have sought to purchase the medication online or by way of a private prescription.

'Chemsex' is a recognised term for the use of certain drugs (commonly crystal methamphetamine, gammahydroxybutrate/gammabutyrolactone (GHB/GBL) and mephedrone) before or during planned sexual activity to sustain, enhance, disinhibit or facilitate the experience[7]. These drugs can be administered in a variety of ways and, when injected, it is often referred to as 'slamming'. It is most commonly associated with MSM and, although the numbers of men involved in Chemsex are small, this practice can have a serious adverse impact on health and wellbeing. For example, there is an increased risk of HIV and hepatitis from sharing needles and the reported high levels of unprotected sex means the risk of STI and HIV transmission is high.

MSM engaged in Chemsex may feel that sexual health services are more likely to be empathetic and knowledgeable compared to standard drug treatment services. Some MSM who present to sexual health services and require support may not consider that they have a drug problem. Sexual health services, substance misuse services and commissioners will need to work closely together to address emerging Chemsex issues[7].

Local Picture

For STI cases in men where route of sexual transmission was known, MSM made up 31% of all cases in 2015 in Kingston, with the most commonly diagnosed STIs amongst MSM being gonorrhoea and chlamydia[8].

In 2015, 74% of all male gonorrhoea diagnoses in Kingston were in MSM[8], compared to 70% nationally[1]. Similarly, 85% of all new cases of syphilis diagnosed in men in Kingston were in MSM[8], compared to 84% nationally[1].

In the same year, 47% of those diagnosed with and accessing HIV care were believed to have acquired their HIV through sex between men[9]. This is slightly higher than the national rate of 45%, but is marginally lower than the regional rate of around 50%[3].

Rates of recreational drug use in MSM in Kingston have been found to reflect average rates for London. A local survey undertaken in 2014-15 of 150 MSM indicated a high level of drug use with 60% reporting some form of drug use and 21% using drugs commonly associated with Chemsex (see above for details of these) in the last six months[10].

A holistic approach in all aspects of health is paramount. In 2014, a local needs assessment found high levels of mental health problems in lesbian, gay, bisexual and transgender (LGBT) people in Kingston[11]. This was further highlighted in 2015 when Public Health England (PHE) launched the action plan 'Promoting the health and wellbeing of gay, bisexual and other men who have sex with men'[12].

Local Action

The Wolverton Centre at Kingston Hospital provides specialist STI and HIV care, including a dedicated evening clinic for MSM.

The clinic offers:

- specialist sexual health screening, rapid testing and treatment
- in-house referral to a clinical psychologist, psychosexual services and specialist health promotion nurse
- Chemsex assessment, brief intervention and sign posting
- needle packs to ensure that men who choose to inject drugs do so as safely as possible
- alcohol screening and brief intervention
- vaccination for hepatitis B
- post exposure HIV prophylaxis for sexual exposure (PEPSE).

Local commissioning and practice reflects national guidelines that MSM having unprotected sex with casual or new partners should have an HIV/STI screen at least annually, and every three months if changing partners regularly[1].

For men who are HIV positive, education, prevention and campaigns concentrate on a message that MSM should avoid having unprotected sex with partners believed to be of the same HIV status (a practice known as serosorting) as there is a high risk of STI and hepatitis infection.

Kingston is part of a consortium of four boroughs in South West London that commission HIV and STI prevention services for MSM. This contract was awarded to Spectra in 2016 and includes group and one-to-one behaviour change work, outreach and condom distribution. Spectra work in a variety of venues across the four boroughs to ensure they engage with MSM of all ages and backgrounds.

Kingston is also part of the 'Do It London' HIV prevention programme that provides condom distribution and outreach to MSM in social venues across London[13].

Recommendations

1. **Develop further STI health promotion in the local community, including outreach work in local bars and clubs.**
2. **Increase HIV testing of MSM in the local community.**
3. **Increase awareness of Chemsex issues with healthcare professionals in Kingston.**
4. **Support the implementation of PrEP when an agreed and appropriately funded commissioning mechanism is in place.**
5. **Establish stronger working relationships with local services, including substance misuse and mental health, to ensure a holistic approach to working with this population group.**

3.6 Black and Minority Ethnic Communities

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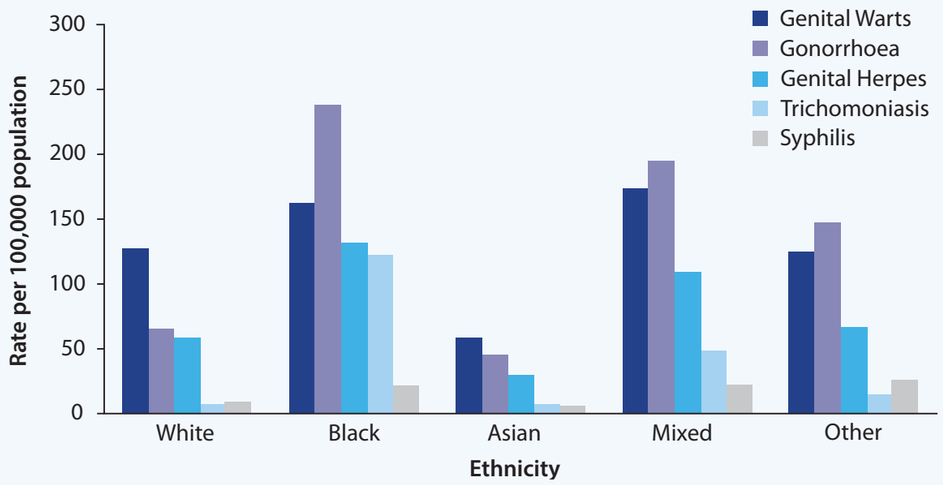
Introduction

It is widely acknowledged that Black and minority ethnic (BME) groups experience poorer sexual health outcomes than the general population[1]. Diagnostic rates of gonorrhoea and chlamydia amongst BME groups are three times the rate of the general population[2].

The reasons for this are complex with large variations in the sexually transmitted infection (STI) epidemiology of different ethnic groups (Figure 1)[3]. Black African and Black Caribbean communities are most at risk with disproportionately high rates of STIs, human immunodeficiency virus (HIV) (particularly in the Black African community) and unplanned pregnancies.

Figure 1 Rates of selected STI diagnoses by ethnicity and STI: England, 2015.



Source: Public Health England (PHE). Health Protection Report. Sexually transmitted infections and chlamydia screening in England, 2015. 2016.

In 2015 there were 88,769 people living with diagnosed HIV and accessing care in the UK[4]. Figures suggest that, of those, 31% are of Black African origin[5].

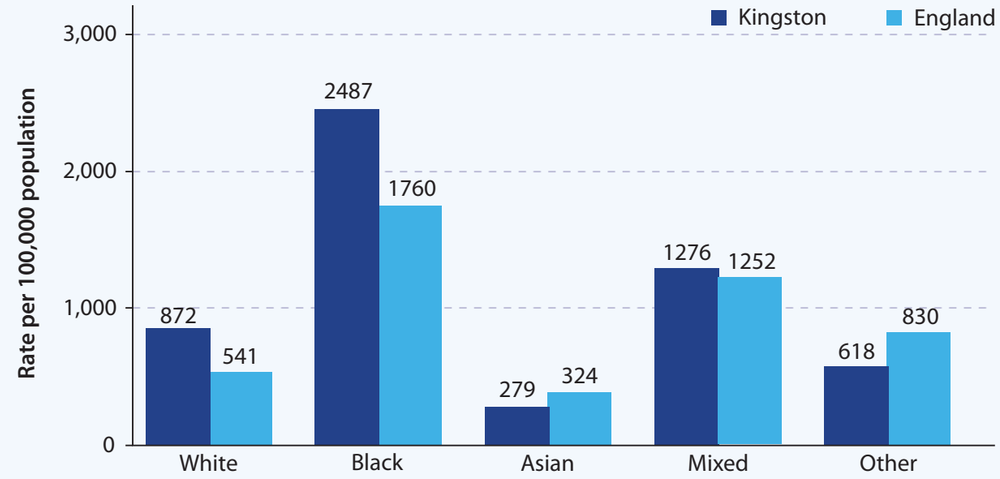
The Government highlighted the needs of BME groups in its 'Framework for Sexual Health Improvement in England'[1]. It recommends the needs of BME communities to be addressed at national and local level using robust evidence to plan interventions that can be tailored to the needs of diverse populations.

Local Picture

Sexually Transmitted Infections

Figure 2 shows variations between STI rates in ethnic groups and illustrates how Kingston broadly mirrors the national picture[6]. The rate of STIs amongst the Black ethnic group living in Kingston is higher than the national average at 2,487 per 100,000 of the population compared to 1,760 nationally.

Figure 2 Rates per 100,000 population of new STIs by ethnic group in Kingston and England (GUM diagnoses only): 2015.



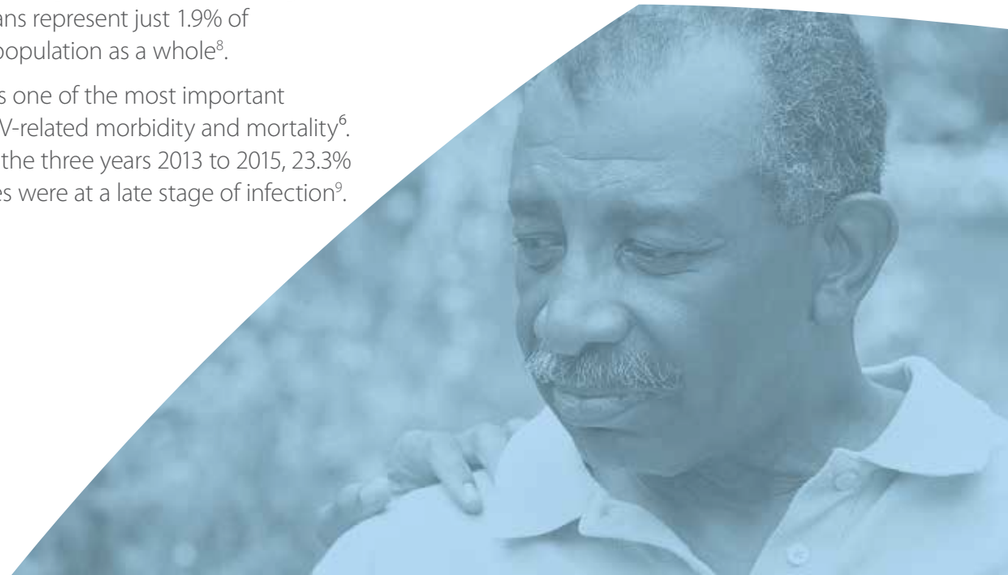
Source: PHE. Kingston Local Authority Sexual and Reproductive Health Reports (LASER), 2015. 2016.

Human Immunodeficiency Virus

In 2015, 271 Kingston residents received HIV-related care[7]. Among these, 34% were Black African. This follows national trends and confirms the disproportionately high number of people of Black African origin living with HIV in Kingston when considering that Black Africans represent just 1.9% of the borough's population as a whole[8].

Late diagnosis is one of the most important predictors of HIV-related morbidity and mortality[6]. In Kingston, for the three years 2013 to 2015, 23.3% of HIV diagnoses were at a late stage of infection[9].

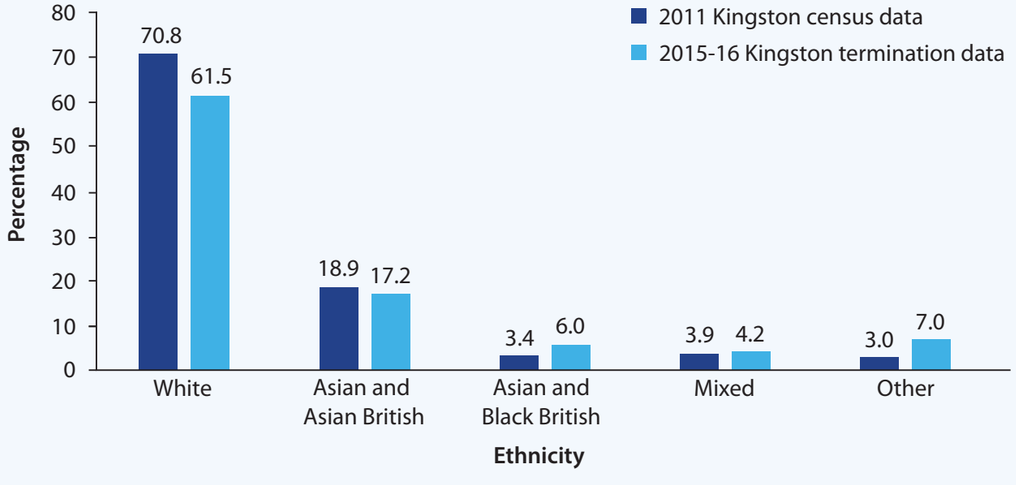
Whilst the rate has fallen by more than half in the three years since 2012, this is an issue because we know that Black Africans are at greater risk of being diagnosed late[10] and so it is likely that a considerable proportion of the late diagnoses in Kingston will be in those of Black African origin.



Unplanned Pregnancy and Termination

Nationally, BME women are over represented in the numbers of women having terminations[11]. In England and Wales in 2015, 77% of women undergoing a termination of pregnancy were reported as White, 9% as Asian or Asian British, 8% as Black or Black British, 4% as mixed, and 2% as of other ethnic origin. This differs from national ethnicity population estimates based on the 2011 census where the figures were 86%, 7%, 3%, 2% and 1% respectively[12]. Figure 3 illustrates how this over representation is mirrored locally amongst some BME groups[13].

Figure 3 Ethnic breakdown of Kingston residents having a termination in 2015-16 compared to ethnic breakdown of females aged 16-44 years in Kingston.



Source: BPAS Contract Reporting Data, 2016 and Kingston Census Data, 2011.

Needs Assessment

In 2013 Kingston commissioned a needs assessment to review the sexual health needs of the local BME community[14]. This highlighted that:

- worries about confidentiality, privacy and embarrassment are the biggest barriers to accessing services
- cultural differences and language are barriers to accessing services and these barriers are more prevalent for older age groups
- those that had used a sexual health service described having a positive experience.

Local Action

Local Level

In response to findings from the needs assessment, Kingston Public Health have worked with a variety of services to raise awareness of sexual and reproductive health within BME groups. These include sessions on sexual and reproductive health delivered to women via Learn English at Home and the Korean Women's Group, as well as articles in local media, such as the Tamil Newspaper.

Additionally, the Kingston Integrated Sexual Health (KISH) Service Guide, which provides information and advice on local services, has been produced in a variety of languages and made available to all local service providers.

Regional Level

In 2016 Kingston became part of a four borough consortium with Merton, Richmond and Sutton in order to commission STI and HIV prevention and support services for people living with HIV, with a focus on key risk groups. The BME service is primarily delivered by KwaAfrica, a charitable organisation specialising in sexual health work with BME communities. As part of their role, KwaAfrica work with commercial venues, such as barbers, faith based groups, and community organisations to make links with the BME community in order to raise awareness of, and challenge the stigma and discrimination around, sexual health and HIV.

Kingston is also part of 'Do It London', a London wide HIV prevention programme, which targets Black African communities and men who have sex with men (MSM) to increase awareness of HIV and encourage regular testing. The programme runs regular campaigns throughout the year that appear in a range of print, radio and digital media in a variety of languages. This aims to complement work being undertaken at local authority level which can be more targeted at specific communities.

National Level

Kingston is one of the founding local authorities of the Public Health England (PHE) commissioned National HIV Self-Sampling service, which aims to make HIV testing more accessible to higher risk groups, including the BME population. Between November 2015 (when Kingston joined the scheme) and August 2016, 6.5% of kits returned from Kingston residents were from the Black African community[15]. This is considerably higher than the estimated Black African population of Kingston (1.9%)[8].

Kingston also utilises resources from HIV Prevention England, the national HIV prevention programme for Black Africans and MSM. This has three goals:

- to increase HIV testing to reduce undiagnosed and late diagnosed HIV across BME and MSM communities
- to support sustained condom use, and other behaviours that prevent HIV
- to tackle stigma within these communities and more widely.

HIV Prevention England leads an annual campaign, National HIV Testing Week, which encourages people to test for HIV and highlights the importance of knowing your HIV status. Kingston has been involved in this campaign for a number of years, commissioning local sexual health services to deliver 'pop-up' HIV testing clinics in prominent locations during the campaign period and deliver outreach sessions to raise awareness of HIV.

Recommendations

1. **Undertake research in order to better understand the needs of the large Asian population in Kingston with regards to sexual and reproductive health.**
2. **In line with national recommendations, sexual health promotion should continue to ensure Black African and Caribbean men and women have a regular HIV and STI screen, if having unprotected sex with new or casual partners.**
3. **In line with national recommendations for the general population, and particularly for those at greatest risk of acquiring STIs and HIV, work should continue to promote correct and consistent condom use when having sex with casual or new partners, until all partners have had a sexual health screen.**
4. **Further investigate the local epidemiology regarding the ethnicity of women having terminations in Kingston to identify specific needs in relation to the promotion of reproductive health services.**

3.7 People Living with Human Immunodeficiency Virus

Lead authors:
Karen Skipper
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Spectra

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Metro

Introduction

In 2015 there were an estimated 88,769 people living with diagnosed human immunodeficiency virus (HIV) in the UK[1]. With treatment advances, HIV has transformed from an acute, often fatal disease, to a chronic illness.

If diagnosed early, most people living with HIV (PLWHIV) can now expect to live a near normal lifespan. These medical advances also mean that the prevalence of HIV is rising year on year, and that people living with the virus now face a new set of challenges in relation to their condition, such as its effects in combination with conditions associated with ageing. Nationally, in 2015, 34% of PLWHIV were aged over 50 compared to just 14% in 2006[2].

Whilst treatments have transformed the physical prognosis for PLWHIV, this group continue to experience significantly higher rates of poor mental health than the general population; PLWHIV are twice as likely to be diagnosed with depression and experience much higher levels of discrimination[3]. The burden of stigma attached to the disease only compounds these associated vulnerabilities and complex needs.

These factors undoubtedly have an impact on quality of life for PLWHIV. In turn, this can affect their ability to adhere to treatment regimes, attend clinic appointments, and ultimately have a major impact on physical health outcomes and risk of premature death. It also increases the risk of onward HIV transmission, as risky sexual behaviour is often linked to depression[3].

Local Picture

In 2015, 271 Kingston residents accessed HIV care and related services[4]. The HIV diagnosed prevalence rate was 2.13 per 1,000 people (aged 15 to 59), compared to 5.83 in London and 2.26 in England[5].

In 2015, 47% of people living with diagnosed HIV in Kingston were men who have sex with men (MSM) and 34% were people of Black African origin[4]. There is also an ageing HIV population in Kingston, with almost 35% people accessing HIV care being over 50 years of age in 2015[4].

Locally, 94% of PLWHIV were receiving HIV treatments in 2015, which compares favorably with national figures (91%)[4]. This is important not only for the health of PLWHIV, but also because treatment can suppress the virus to such low levels that it makes it much more difficult to transmit.

Local Action

Kingston has an HIV outpatient service based at The Wolverton Centre. The majority of people living with HIV in Kingston access this service for their treatment and care which is commissioned by NHS England. The clinic treats in line with national guidelines which recommend that people with HIV commence treatment as soon as possible after diagnosis, and certainly before their CD4 count drops below 500 cells/mm^3.

In addition Kingston Council, in line with national guidance, commissions the specialist sexual health provider to offer an annual sexual health check for PLWHIV.

Support services for people living with HIV aim to improve collaborative work and referral processes between the specialist HIV and generic service providers. This helps to reduce health inequalities for both individuals living with HIV and their families, and improves the support available for people on their treatment journeys. Kingston is part of a consortium with three other boroughs in South West London that has commissioned a range of support services for PLWHIV, including counselling, self-management courses, advice and advocacy services and peer support groups. The aim of these services is to support those living with HIV, whilst enabling them to live as independently as possible.
A family support service is also available, offering both practical and emotional support to families affected by HIV. The support service also provides training for health and social care staff to raise awareness of HIV, and support them to work more effectively with PLWHIV.

Recommendations

1. **Work with providers across health and social care to ensure a joined up approach to working with people living with HIV and seamless service provision.**
2. **Develop and provide HIV awareness training for non-HIV service providers working with older people in Kingston.**
3. **Develop self-care courses on how to manage aging with HIV.**
4. **Facilitate the development of an over 50s HIV peer support group.**

Case Study

People Living with HIV

Written by Spectra CIC

Patient A is a heterosexual Black African woman from Sub-Saharan Africa. She was admitted to hospital presenting with tuberculosis and pneumonia. She was tested on admission and found to be HIV positive, with a CD4 count below 200 cells/mm^3. After further investigation, Patient A disclosed she tested positive three months prior, but felt unable to disclose her diagnosis to her GP or seek medical assistance. She was 41 years old at the time of her diagnosis.

Patient A is now in her late-50s and is adhering to her treatment regime, however she has suffered from severe arthritis and a slow degeneration of her right knee. In the last five years she has slowly become isolated, has had to give up full time work and feels much less independent, which has had a negative impact on her financial situation and mental health.

Patient A was keen to source local support services but was unaware of what was available. She was also worried about disclosing her HIV status which prevented her from exploring her options for more than three years.

Her HIV Consultant referred her to Metro who deliver a bespoke HIV support service in Kingston. Metro assessed her needs and a package of care was arranged to support her needs regarding her mobility and isolation.

Patient A was assisted through advice and advocacy and counselling, which helped her mental health. The Support Worker alleviated Patient A's concerns about disclosing her HIV status and acted as a vital referral pathway to peer support and other services in Kingston.

As part of a partnership with Spectra and KwaAfrica, Metro offers a multi-disciplinary and client centred approach in the following areas for people with HIV: advice and advocacy, counselling, self-management courses and family support.

3.8 People with Learning Disabilities

Lead author:
Amy Leftwich
Health Promotion Specialist,
Public Health, Kingston Council

Introduction

People with learning disabilities (PLD) experience poorer health outcomes than the general population and it is widely acknowledged that much of this is due to the difficulties in accessing appropriate and timely healthcare[1].

The added sensitivities surrounding sexual health only add to these difficulties and make it a particularly challenging subject area for both health and social care professionals[2]. A national survey undertaken by the Family Planning Association (FPA) found that 63% of PLD wanted to know more about sex and relationships and yet many are prevented from accessing this information due to inappropriate attitudes and barriers that are often avoidable[3]. There is also evidence to suggest that PLD may face barriers in accessing sexual information through the informal channels by which many young people first learn about sex and sexuality[4].

This is an issue recognised internationally. A population-based study in the Netherlands found that men with learning disabilities reported higher rates of unsafe sexual practices and were eight times more likely to have sexually transmitted infections (STIs) than the general population[5].

Local Picture

In 2014-15, there were 535 people living in Kingston with a learning disability known to their GP; this equates to 0.28% of the population[2]. This is lower than both the London and England figures of 0.34% and 0.44% respectively.

No data is routinely collected by sexual and reproductive health services regarding whether patients have learning disabilities and therefore it is difficult to gather information regarding the prevalence of STIs, contraceptive use and any other sexual health need amongst PLD[6].

At a local level, Kingston has been able to collect some information regarding sexual health need through its specialist sexual health clinic for PLD (the Connect Clinic). Since the numbers attending the clinic are very small, little statistical significance can be attributed to it, but it does provide a starting point for further investigation.

Between April 2014 and March 2016, there were 62 attendances at the service with an age range of 16 to 40 years[7].

Seven STIs were diagnosed during this time, with chlamydia being the most common[7]. Six different methods of contraception were prescribed including three forms of long acting reversible contraception (LARC).

Half of clients attending the clinic disclosed information that raised safeguarding concerns, with many of these being historical in nature[7]. These were followed up as appropriate by clinicians working within the clinic in line with local safeguarding policies and procedures.

Local Action

In 2013, Public Health Kingston commissioned a sexual health needs assessment for young people with learning disabilities (YPLD) in Kingston[8]. This highlighted a variety of issues: staff reported a lack of confidence to deliver sexual health services and education programmes to YPLD, as well as the lack of inclusive sexual health resources for YPLD; and, perhaps most importantly, an unmet need for sexual health services that YPLD would be confident to access. The young people felt they needed a service that would allow them time to be understood and understand the information they were being given. They also wanted to go somewhere other PLD used, in a confidential space and with the option to bring a parent or carer.

In response to this Public Health Kingston commissioned:

- a specialist sexual health service for PLD
- a two-year training and development programme to support the establishment of the sexual health service, provide outreach support to YPLD and train staff and other stakeholders.

The specialist sexual health service (data from which is referred to earlier in this chapter) is called Connect Kingston. Clients attending this clinic receive longer appointment times and see staff who are trained to deal with any additional issues that may arise.

The clinic offers a full range of STI screening and contraception, as well as the opportunity for clients to discuss any concerns or ask questions regarding sex, relationships and sexual health. The staff also work on a longer term basis with those clients who raise issues around safeguarding at the clinic.

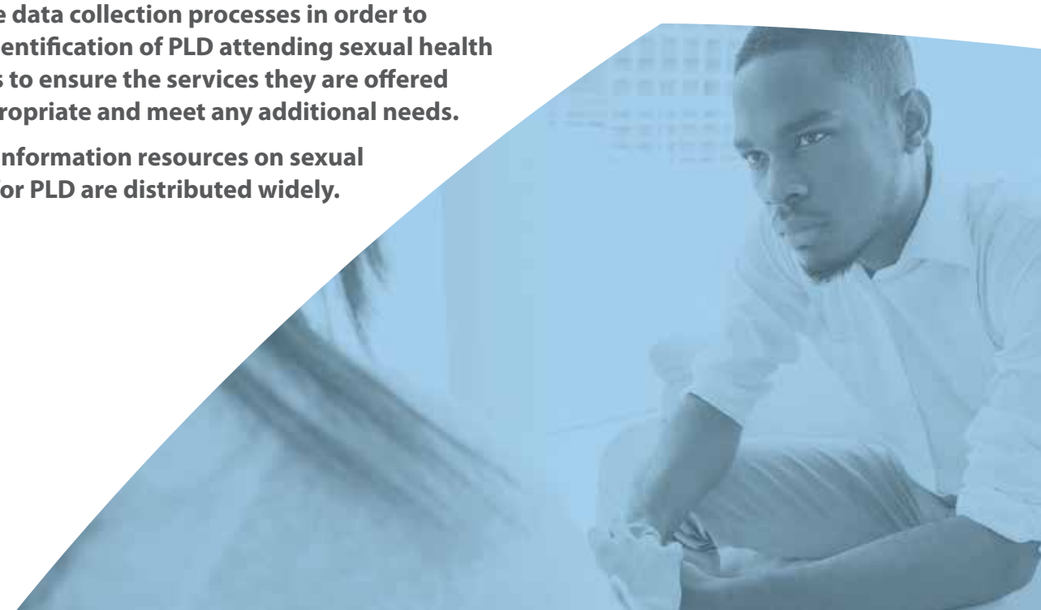
Following the success of this clinic, the London Borough of Hackney worked with the local provider of this service and Public Health Kingston to establish a similar service. Local clinical staff were able to provide further information and share good practice with colleagues, and 'The Right Choice Connect Hackney' was launched in September 2016.

Running in conjunction with the first two years of the launch of Connect Kingston, a training programme was developed to deliver sex and relationships education (SRE) programmes for YPLD in both mainstream and specialist schools across Kingston. To ensure the sustainability of the training programme, approximately 15 staff from within these organisations and other stakeholders have been trained to be able to deliver such programmes themselves.

Information resources on sexual health for PLD have been developed locally. These were designed with PLD to ensure they are helpful to this population group.

Recommendations

1. **Improve data collection processes in order to allow identification of PLD attending sexual health services to ensure the services they are offered are appropriate and meet any additional needs.**
2. **Ensure information resources on sexual health for PLD are distributed widely.**

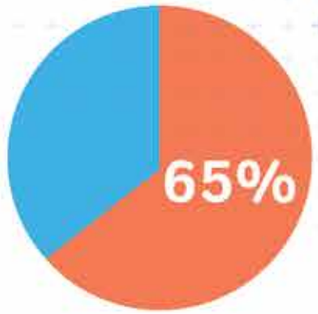


4.0

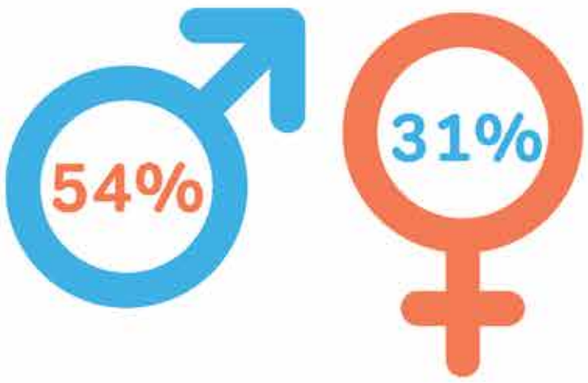
Section Four
Older People

- 4.1 Relationships and Sexual Wellbeing
- 4.2 Sexually Transmitted Infections and Human Immunodeficiency Virus

65% of over 50's are sexually active, with 46% stating they have sex once a week.



69% of people aged over 65 said that they have never sought any type of sexual health advice.



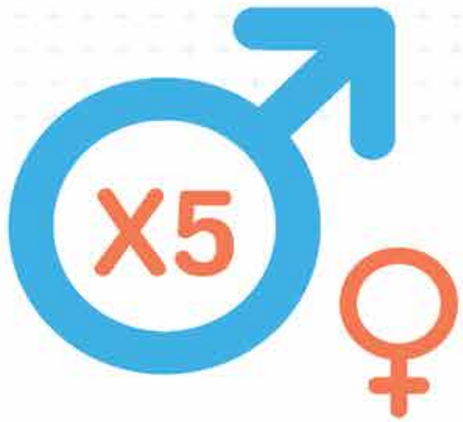
Although levels of sexual activity decline with increasing age, **more than half (54%) of men and almost a third (31%) of women aged over 70** report they are still sexually active.

78%

of people aged **65 to 74 years** are aware of sexual health services locally.

Only 55% of those aged 75 years and over are aware of such services.

Between 2010 and 2015 **the rate of diagnoses of sexually transmitted infections (STIs) in Kingston in men aged over 65 years was five times higher than the rate in women of the same age.**



65

The number of people aged over 65 living with diagnosed human immunodeficiency virus (HIV) in Kingston is currently very low.

However, the significant advances in treatment meant that this number is expected to rise significantly in future years.

4.1 Relationships and Sexual Wellbeing

Lead author:
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Health Improvement Lead: Older People,
Public Health, Kingston Council

Introduction

Sexuality and a need for intimacy and closeness are important to older people (defined here as those aged 65 years and over) and are an important part of their overall wellbeing. For most people, this lasts until the end of their life, and evidence suggests it can enhance wellbeing[1,2].

The Framework for Sexual Health Improvement in England[3] emphasises the importance of sexual health across the life course. The need to promote good sexual health therefore does not end as individuals age, yet sexual health and intimacy are rarely discussed with the older population by those involved in their health and social care, such as general practitioners (GPs), nurses and care home employees[4,5].

Understanding sexual behaviour is important when evaluating the health needs of older adults. As people age there is an increased risk of ill health. Illness can impact on sexual functioning (see chapter 3.1) and relationships. Intimacy can be lost due to the loss of partners, health disorders, medication, negative stereotyping, or lack of privacy.

Despite this increased risk of ill health, Saga reports that 65% of over 50's are sexually active, with 46% stating they have sex once a week[6]. Although levels of sexual activity decline with increasing age[7], more than half (54%) of men and almost a third (31%) of women over the age of 70 reported they were still sexually active[8]. Problems with sexual functioning are relatively common, but overall levels of sexual health concerns were much lower when compared with younger people[7]. Some research suggests that future generations of older people will be more sexually active when compared with previous generations due to things such as changes in societal attitudes around older people and sex, increasing rates of new relationships in older age and improvements in the physical health of older people, including an increase in the use of medications designed to overcome sexual dysfunction[9].

Care Homes

Within health care settings and senior living communities, sexuality can be regarded as a delicate topic, and discussions of patient and resident sexuality can create hesitance and discomfort in employees. Additionally, sexual intimacy and privacy provision are absent from many care home policies and processes. Although there are legal and ethical dilemmas when it comes to residents and intimacy, enabling rather than restricting residents is important to health and wellbeing. Care home staff should strive to achieve a balance between an individual's right to privacy and control with the need for care.

Key Drivers for Change

The Royal College of Nursing (RCN) has published a guide to intimacy in care homes[10], this states that care systems and care delivery should:

- be person-centred
- focus on the perspectives of individuals within the context of their unique lives and experiences
- be open to learning about the person's significant experiences and relationships
- promote and support human rights, dignity, privacy, choice and control
- promote clear boundaries which protect and support residents and staff.

The Alzheimer's Society also advocates greater training and awareness among care home staff when it comes to sex and relationships[11].

The Care Quality Commission (CQC), the independent regulator of health and social care in England, is assessing how care homes are tackling intimacy and relationships as part of its inspection routine from 2016.

Dementia and Sexuality

The prevalence of dementia is rising as more people live for longer and consideration needs to be given to sexuality in this population group. Dementia can create confusion in relation to people and place, and can contribute to poor judgment and loss of inhibitions. However, an individual's ability to engage in an intimate relationship does not necessarily directly diminish with a dementia diagnosis, and many people with dementia are still able to engage in healthy intimate and sexual relationships[12]. Having mental capacity is considered essential to give assurance that sexual activity is consensual[13]. Autonomy, preservation of dignity, competence in relation to informed consent, privacy and protection from harm should be considered in both existing and new relationships within care homes, in order to preserve intimacy, healthy relationships, and wellbeing[14].

Local Picture

Little is known about sexuality and intimacy with older people in the UK, and even less is known about the local picture in Kingston. However, it is clear that the number of older people is increasing in Kingston.

In 2015 there were 22,984 people aged 65 and over in Kingston making up 13.2% of the total population[15]; the number of older people is projected to rise to 28,698 by 2025 which will represent 14.6% of the total population[16]. The Projecting Older People Population Information System (POPPI) in Kingston projected that there were 776 people aged 65 or more living in care homes with or without nursing input in 2015[17]. This is projected to rise by 54.6% to 1,200 by 2030. Currently it is estimated that there are between 1,418 and 1,585 residents over the age of 65 who have dementia[18,19].

The 2015 Kingston Lifestyle survey asked whether local people were aware of local sexual and reproductive health services (Table 1). Levels of awareness were maintained in people aged up to 74 but dropped sharply in people aged 75 and over.

As societal attitudes towards sex change it is important that these changes are reflected in how services respond to the sexual preferences and practices of individuals from all age ranges. Services working with older people will need to ensure that they are not only equipped to support older people in establishing and maintaining intimate and sexual relationships, but are also inclusive to the full range of what those relationships look like. Care homes, for example, will need to ensure they are able to support older residents who are lesbian, gay, bisexual, or transgender (LGBT) as well as men who have sex with men (MSM).

Table 1 Awareness of sexual health and reproductive health services by age, Kingston.

Number								
	18-24	25-34	35-44	45-54	55-64	65-74	75+	Age not specified
No	34	104	99	89	51	30	60	10
Yes	132	197	221	205	151	104	73	5
Total	166	301	320	294	202	134	133	15
Percentage								
	18-24	25-34	35-44	45-54	55-64	65-74	75+	Age not specified
No	20.5%	34.6%	30.9%	30.3%	25.2%	22.4%	45.1%	66.7%
Yes	79.5%	65.4%	69.1%	69.7%	74.8%	77.6%	54.9%	33.3%
Total	100%	100%	100%	100%	100%	100%	100%	100%

Source: Kingston Lifestyle Survey, 2015.

Local Action

The 2015-20 Kingston Dementia Strategy identifies the need for training for a broad range of people who care for and work with people who have dementia[20]. Sexuality and intimacy is not currently mentioned in this strategy, it is recommended that when the strategy is reviewed issues of sexuality and intimacy should be included.

Given the relatively high level of contact by older people with primary care services, GPs and other primary care professionals are particularly well placed to enable access to sexual health services for older people, either through services appropriately delivered in a primary care setting, or by advice and referral to appropriate specialist sexual health services. These are open access services for people of any age.

Recommendations

1. **Improve data collection in relation to older people and sexual health to inform the design of age appropriate interventions and services, and promote local services through an appropriately devised information booklet.**
2. **Further promote access to sexual health services to older people, including raising awareness with GP surgeries, older people services and local residents.**
3. **Work should be undertaken to promote a culture of acceptance, dignity, and privacy for all users of care services, including residents of care homes; and to ensure clear staff policies are in place to respond to the intimacy and sexual needs of service users. This work, and developing policies and protocols should focus on key areas such as autonomy, dignity, consent, privacy and protection from harm.**
4. **Ensure sexuality and intimacy is included within the Kingston Dementia Strategy; and support dementia care homes to adopt policies and practices that respond appropriately to the intimate and sexual needs of the people they serve.**

4.2 Sexually Transmitted Infections and Human Immunodeficiency Virus

Lead author:
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Public Health Registrar,
Public Health, Kingston Council

Introduction

People aged 65 and over living in Kingston are, on average, projected to live for a further 20 to 22 years. This is higher than the national average and is likely to continue rising[1].

The previous chapter has highlighted that many older people are sexually active. Despite this however, a recent survey by Age UK found that many older people do not seek sexual health advice[2]:

- over two thirds of people aged over 65 (69%) said that they have never sought any type of sexual health advice
- three quarters (76%) of over 65s do not currently seek sexual health advice
- almost half (46%) of those aged over 65 feel they don't need any sexual health advice, this percentage increases to 54% in women.

As the rights of older people to establish and continue intimate and sexual relationships are promoted, it is important that sexual health messaging is accessible and relevant to this group.

The number of people aged over 65 living with human immunodeficiency virus (HIV) has remained largely static over recent years, however projections suggest that this number will steadily increase over the next ten years[3]. This is largely due to the developments in antiretroviral therapy (ART), which mean that those living with HIV can now expect a similar length of life to the general population[4]. This means services working with older people will need to become increasingly familiar with HIV and how it affects those living with the condition.

Local Picture

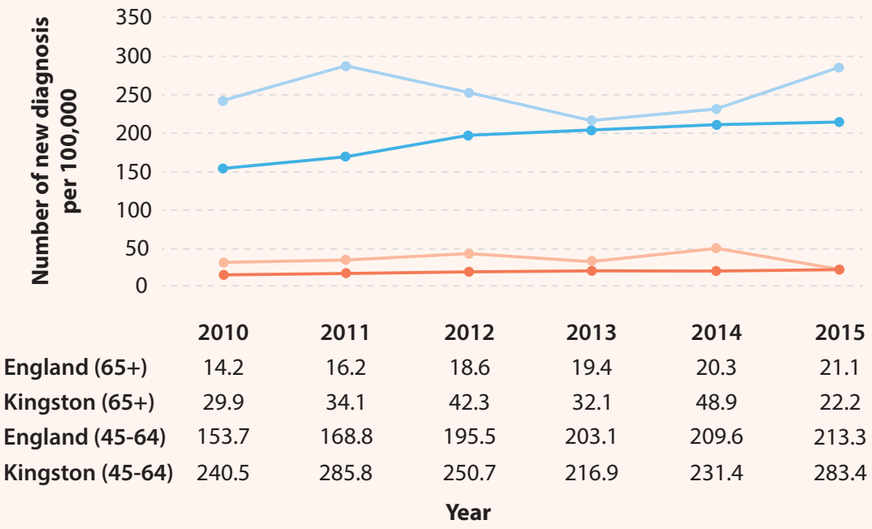
Sexually Transmitted Infections

People aged 65 and over have the lowest rate of new sexually transmitted infection (STI) diagnoses compared to other sexually active age groups in Kingston, however this rate was higher than the England average for this age group from 2010 to 2015[5] (Figure 1). Similarly the STI diagnoses rates for those aged 45 to 64 has been consistently higher in Kingston compared to the England average for this age group for the years 2010 to 2015.

Locally (and nationally) the rate of STI diagnoses in those aged 65 and over is higher for men than women. For the years 2010 to 2015 in Kingston the rate in men was five times higher than the rate in women[5].

With many older people reporting they are sexually active, it is important that this group is not forgotten about in sexual health promotion and treatment. The need for effective sexual health promotion has an increasing importance given current divorce rates and people then entering new relationships[6,7]. The use of barrier methods of contraception to protect against STIs should be highlighted.

Figure 1 Rate of new STI diagnoses per 100,000 amongst the over 45s in England and Kingston, 2010-2015.



	2010	2011	2012	2013	2014	2015
England (65+)	14.2	16.2	18.6	19.4	20.3	21.1
Kingston (65+)	29.9	34.1	42.3	32.1	48.9	22.2
England (45-64)	153.7	168.8	195.5	203.1	209.6	213.3
Kingston (45-64)	240.5	285.8	250.7	216.9	231.4	283.4

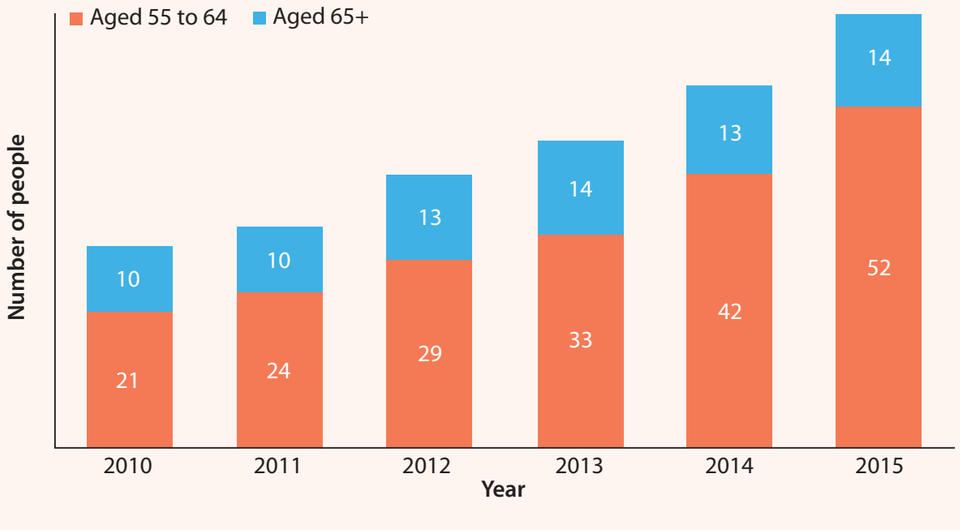
Source: Genitourinary Medicine Clinic Activity Dataset v2. 2016.

Human Immunodeficiency Virus

The number of people aged over 65 newly diagnosed with HIV in Kingston over the last five years is very low[8]. However, with the significant advances that have been made in the efficacy of treatment, the number of older people living with HIV is increasing and is forecast to continue to do so in coming years.

While the number of people living locally with HIV aged 65 and over has only increased marginally over the past five years, the number of those aged 55 to 64 has more than doubled (Figure 2)[8].

Figure 2 Number of people aged over 55 years living with HIV in Kingston, 2010-15.



Source: HIV and AIDS Reporting System (HARS), 2015. 2016.

Life expectancy for those with HIV who respond well to treatment is approaching parity with the general population and therefore many of these individuals are expected to live well beyond the age of 65[3].

This will begin to pose new challenges; as the general health of these individuals deteriorate with age, clinicians will be faced with increasingly complex co-morbidities to manage. A decrease in cognitive ability could have serious consequences for individuals managing their condition. Effective treatment for HIV requires a high level of compliance with medication and as age related memory loss occurs in some of this cohort, compliance may become inconsistent, impacting on the efficacy of their treatment.

Local Action

Sexual health services are available for all Kingston residents. However, as shown in the previous chapter there is reduced awareness of these services amongst those aged over 75. In 2015 there were a total of 12,171 attendances to the Wolverton Centre by Kingston residents, 742 of those were by people aged 50 to 64, and 98 by people aged 65 and over[9]. This accounted for 6.1% and 0.8% of all attendances respectively. For those aged 50 to 64, 171 of these appointments were for HIV related care and 571 for non HIV related care; for those aged 65 and over, 34 of these appointments were for HIV related care and 64 for non HIV related care[9].

There are no local specific sexual and reproductive health services aimed at older people, however those aged over 65 often have regular contact with primary care services and it is important that sexual health conversations are not omitted from these contacts on the basis of age. These conversations should include the need to practice safer sex and the role of barrier contraceptives in preventing STIs.

Similarly, there are no specific services for older people living with HIV in Kingston. However, as the number of people over 65 living with HIV increases in the coming years, services will have to be able to respond to the needs of this cohort.

This may present a new challenge and demand on services not already aware of the needs of individuals with HIV, such as older people's mental health services and residential care homes. Therefore, with the ongoing rise of older people living with HIV, it may become necessary to implement specific support services or initiatives for this group within Kingston.

Recommendations

1. **Ensure that primary care services continue discussing sexual health with people throughout their lifespan, including the need to practice safer sex.**
2. **Ensure that health and social care services are equipped to support older people with HIV.**
3. **Ensure that specialist sexual health services are visible to and accessible by older people.**

5.0

Section Five

Improving Outcomes Through Effective Commissioning

- 5.1 Commissioning in Kingston
- 5.2 KISH Accreditation
- 5.3 Primary Care Development
- 5.4 The Voluntary and Community Sector

Sexual and reproductive health services in Kingston are seeing **a year on year increase in attendances of over 6%.**

14.5%

By 2020 the public health grant **will be cut by 14.5% across England from the 2014-15 level of funding.**

KISH accreditation is a quality assurance process that **ensures local sexual health services strive towards best practice** both for individual service users, and to meet wider population needs.

In Kingston, GPs provide the majority of long acting reversible contraception (LARC) – **in 2015-16 GPs fitted 1,097 coils and implants compared to 749 fittings by all other local sexual and reproductive health services.**

Since commissioning more testing services for human immunodeficiency virus (HIV), Kingston's late HIV diagnosis has more than halved.

22 GP practices

30 Community Pharmacies

Primary care is easy to access. There are **22 GP practices and 30 Community Pharmacies outlets in Kingston.** All offer basic sexual health advice and information, as well as sign-posting to other appropriate services.

10

Currently **10 local Community Pharmacies provide enhanced sexual health services** to young people across the borough.

There is an increasing acceptance that voluntary and community sector organisations **(VCSOs) are often in the best position to be delivering public services** due to their ability to work at a grassroots level within communities who are often hard to reach and mistrusting of statutory services.

VCSOs

5.1 Commissioning in Kingston

Lead author:
Peter Taylor
Lead Commissioner – Sexual and Reproductive Health,
Public Health, Kingston Council

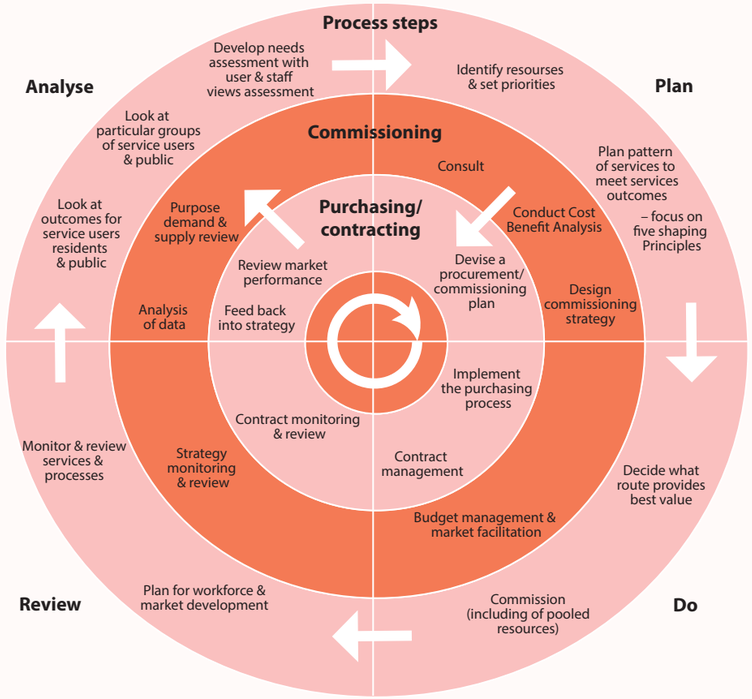
Introduction

The process of healthcare commissioning requires the responsible commissioner to:

- determine the health needs of the population
- ascertain available budgets and evidence of effectiveness of interventions
- source the best placed provider to meet need within the available budget
- oversee the quality of services, and the way in which services are delivered to ensure the need identified is met[1].

In order to carry out this task, public sector organisations in England observe a broadly standardised 'commissioning cycle' (Figure 1).

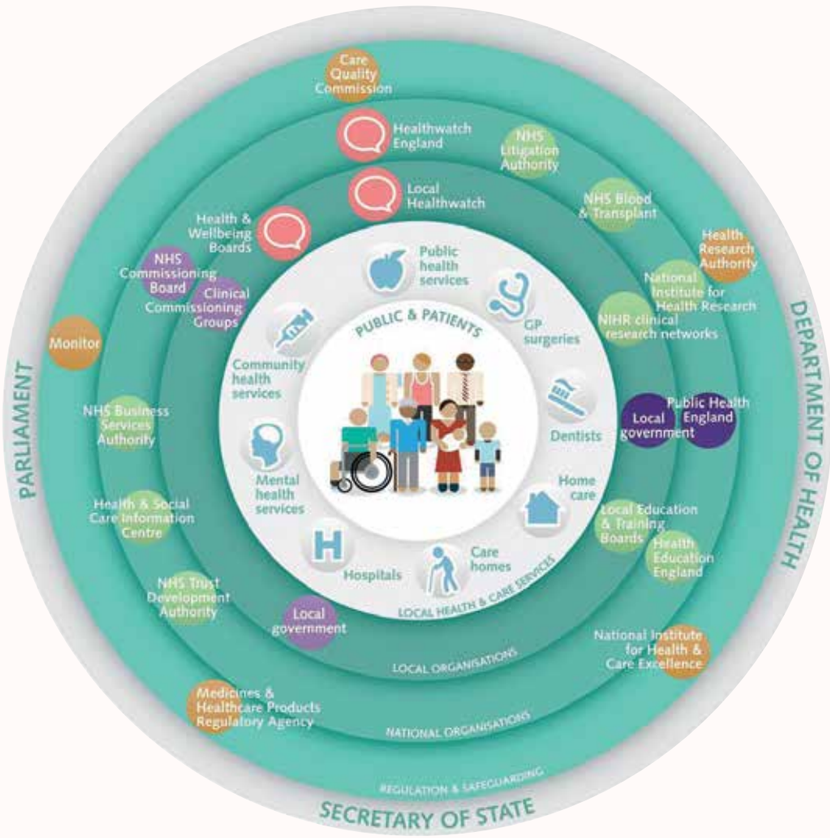
Figure 1 Commissioning Cycle.



Source: Royal Borough of Kingston upon Thames. 2015..

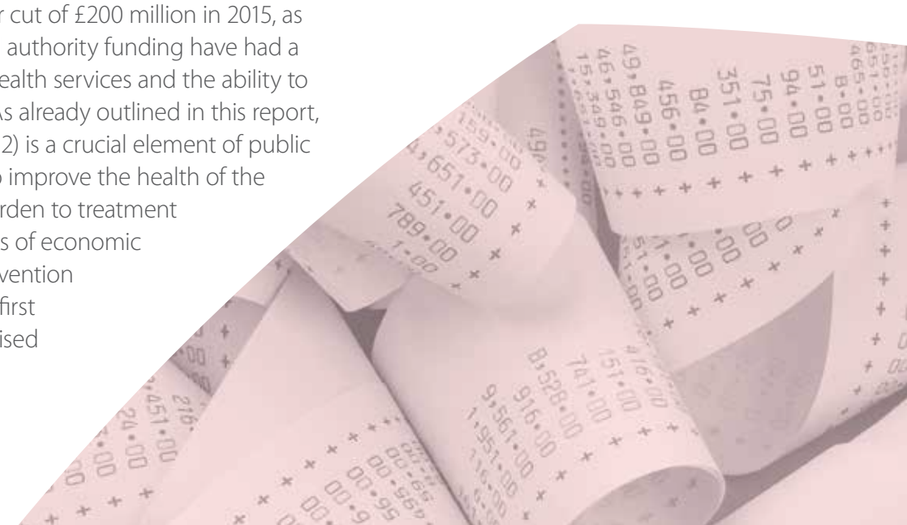
In England, a variety of local and national organisations provide a range of health services (Figure 2)[2]. Public health, including sexual and reproductive health, have been the commissioning responsibility of local authorities since April 2013 with funding coming from the Department of Health via a ring-fenced public health grant[3].

Figure 2 Health and Care System.



Source: Department of Health. 2013.

Successive cuts in recent years to the national public health grant, including an in-year cut of £200 million in 2015, as well as reductions to local authority funding have had a major impact on public health services and the ability to commission effectively[4]. As already outlined in this report, prevention (see chapter 1.2) is a crucial element of public health strategy in order to improve the health of the nation and reduce the burden to treatment services. However, in times of economic uncertainty, it is often prevention programmes that are cut first despite this being recognised as a false economy[4].



Commissioning in Sexual and Reproductive Healthcare

The Framework for Sexual Health Improvement in England places responsibility for commissioning sexual and reproductive healthcare with local authorities[5]. However, it also highlights the importance of commissioners working together alongside service providers from all sectors to ensure high quality service provision and good outcomes for the population. This approach is echoed in other sexual health commissioning guidance as it is recognised commissioning can only have maximum impact where the various organisations and individuals responsible for the sexual health of a population work in a collegiate and patient focused way[6].

This joined up way of working has been well established in Kingston for many years and pre-dates national policies such as those mentioned above. A joint Director of Public Health was in place from 2006 to 2013 working across both NHS and local government, and Kingston has a single lead commissioner for sexual and reproductive health who holds budgets on behalf of both the NHS Clinical Commissioning Group (CCG) and local authority. Furthermore, Kingston has well established links with both primary care (see chapter 5.3) and the voluntary and community sector (see chapter 5.4), which strengthen the reach into communities who may not otherwise access sexual health services.

KISH: Kingston Integrated Sexual Health

Kingston's integrated approach to commissioning of sexual and reproductive healthcare can also be seen in its long established integrated sexual health network (KISH)[7]. KISH is a commissioner facilitated network of providers from across sexual and reproductive health services (see appendix 2) which aims to improve sexual health outcomes for local residents. As part of this, the network also delivers an accreditation scheme to ensure continued delivery of high quality services (see chapter 5.2).

In partnership with its local providers Kingston has been able to constrain spending whilst managing the growth in the number of attendances at KISH services, and in 2017 is introducing the London Integrated Sexual Health Tariff which is a new payment system for these services.

Whilst published research on the matter is scarce, this model of commissioning harnessed in Kingston is recognised nationally as best practice[6] and, as seen in this report, delivers some of the best outcomes in London with above England average results for many of the monitored areas of sexual healthcare[8].

Collaborative Commissioning

The challenge posed by the rising demand for services alongside budget cuts is significant. Kingston has recognised that in order to tackle this issue, partnership working must go beyond the borough boundary.

Kingston is involved in a number of local, regional, and national initiatives that seek benefit from procuring at scale. This includes discovering innovative ways to meet population need whilst continuing to drive efficiencies in service delivery. Many of these are referenced in this report (see chapters 2.1, 3.5 and 3.7) and some are outlined below.

Regionally, Kingston is a partner of the London Sexual Health Transformation Programme[9]. As part of this, the programme is commissioning an online clinic facility that will allow people to have their sexual health needs assessed online, test kits delivered to home for self-sampling, and receive treatments or signposting for treatments. Commissioning at a regional level has given individual boroughs more negotiating power to demand higher standards from providers, whilst also delivering better value for the money being contributed to the overall budget.

Nationally, Kingston is a founding council of the National HIV Self-Sampling Service[10], which provides free blood sampling kits for those at high risk of contracting HIV. Commissioning this on a national level ensures Kingston achieves good value for money despite being a small London borough with relatively low levels of HIV prevalence.

Recommendations

1. **Continue to ensure prevention programmes, including public campaigns, remain a high priority within local public health strategies.**
2. **Opportunities for partnership working should continue to be explored and harnessed, particularly where the benefits of further innovation and cost savings can be realised.**
3. **Commissioners and providers need to plan for tackling future growth in demand for services, whilst considering the further cuts that are to be applied to the public health grant.**

5.2 KISH Accreditation

Lead author:
Sarah French
Sexual Health Promotion Specialist,
Public Health, Kingston Council

Introduction

Sexual health services in Kingston are rigorously commissioned by Kingston Council staff and this process is supported by contract monitoring mechanisms. An additional process known as Kingston Integrated Sexual Health (KISH) accreditation was initiated in 2016.

This is a quality assurance mechanism for all local providers of clinical sexual health services in Kingston. The accreditation process captures evidence systematically, makes clear to providers the expectations around service delivery and contributes to current contract monitoring and commissioning. It also helps in gathering evidence for future commissioning decisions, and creates a benchmark of quality across the whole service network.

KISH accreditation has adapted and built upon the You're Welcome (YW) young people friendly quality criteria. This Department of Health initiative was first launched in Kingston in 2013 and assesses the quality of services against a range of key criteria such as confidentiality, sexual health promotion, and the extent to which staff are empathic to and non-judgemental about young people[1]. Such factors are key in influencing young people to access sexual health services[2], and so lead to improved sexual health outcomes[3].

KISH Accreditation

The local KISH accreditation criteria have been adapted with clinical service leads to reflect an all-age service user approach. Key criteria include access, service user focused provision, confidentiality, and both user and public involvement. Clinical skills, the protection of patient identifiable and sensitive information, and a verified record of sexual health related training (which includes child and adult safeguarding) are also assessed. This key criteria evidence is gathered at the first site visit through the completion of a self-assessment template, which is then written up by the KISH accreditation lead. This identifies good practice and any actions which need addressing, such as:

- the need for a displayed confidentiality notice or sexual health service signposting leaflets in reception
- up-to-date competency certificates for long acting reversible contraceptive (LARC) provision
- training for reception staff so they have the confidence to support patients to access the information they require.

A repeat visit and further communication with the site are usually necessary until the outstanding actions are met.

After the completion of the initial self-assessment, a small team of young assessors is utilised to 'mystery shop' services. This integral part of KISH accreditation, which is well recognised in sexual health service improvement, enables current and potential service users to assess their own user experience[4]. Access to sexual health services for young people can be particularly difficult and by ensuring services meet the needs of this age group it is expected they will also be able to meet the needs of the general population.

The current group of assessors are trained to identify and test some of the key criteria. The assessors' qualitative feedback, gathered at meetings held every two weeks, can have a powerful impact when shared with providers. It may give the opportunity to address any elements requiring improvement, or to encourage staff by commending the positive experience of the visit.

An additional benefit is the self-development and learning reported by the young assessors themselves. Individuals report increased knowledge from attending the training and visiting the services, and more confidence in undertaking peer educator roles in sex and relationship education.

Service accreditation is concluded by tasking an assurance panel to verify the submitted KISH assessment portfolios. These consist of a summary accreditation report with the completed self-assessment, mystery shopping reports, and relevant training logs. Accredited services can display their KISH certificate, helping to identify to service users their KISH quality assured status. KISH accreditation is reviewed on a rolling three yearly basis, though mystery shop visits can be arranged to respond to any issues identified through contract monitoring.

Recommendations

1. **KISH accreditation should be used as evidence of quality within a commissioning process, particularly for general practice and pharmacy settings.**
2. **Identified good practice should be shared and showcased to encourage other relevant providers.**

Case Study

KISH Accreditation

Written by Sarah French

Mystery shopping visits to a local pharmacy indicated that clinical and counter staff needed additional training input to ensure they were all confident in providing condoms via the C-Card scheme (Kingston's free condom distribution scheme for young people), as part of their service's sexual health contract.

Following training, the pharmacists were able to cascade this learning quickly to their staff team. C-Card data and a further mystery shopper assessment have shown that this service is now delivering consistently well, and alongside other actions addressed through the self-assessment, the service evidence was able to be submitted to the Moderation Panel for accreditation. The service was subsequently awarded KISH accreditation.

5.0 Improving Outcomes Through Effective Commissioning

5.3 Primary Care Development

Lead author:
Karen Titterington
Sexual Health Improvement Specialist,
Public Health, Kingston Council

Introduction

Primary care is easy to access. Most people are registered with a general practice (GP), and around 1.6 million people visit community pharmacies every day[1].

There are a range of sexual health services provided in primary care settings, including contraception, testing for HIV and other sexually transmitted infections (STIs), and chlamydia screening. Primary care is well positioned to support national policy objectives such as reducing repeat abortions and teenage conceptions, reducing the late diagnosis of HIV, and increasing chlamydia screening rates in young people.

The vision of the National Chlamydia Screening Programme (NCSP) is that all sexually active young people should be offered chlamydia screening as a routine part of primary health care[2]. Some of the benefits of integrating chlamydia screening into primary care services include:

- normalising of an opportunistic offer to screen, and the discussion of sexual health issues, enabling easier access to other sexual health services such as contraception
- the combination of chlamydia screening with other sexual health packages, such as STI prevention work or condom distribution, which is cost effective
- the service user has an opportunity to address sexual health needs in a wider health context (for example, combined with travel consultations or new patient registrations).

Local Picture

Currently, there are 22 GP practices and 30 community pharmacies in Kingston. All offer basic sexual health advice and information, and will sign post to other appropriate services where necessary.

All Kingston GP practices also provide basic contraception, emergency hormonal contraception (EHC), and some STI screening as part of their national core service offer as general practitioners.

In Kingston, primary care sites are commissioned to provide enhanced sexual health services; these are services that the local authority commissions to enhance the core sexual health services described above.

All GP practices in Kingston are commissioned to provide enhanced services. This includes chlamydia and gonorrhoea screening for young people (including giving results); free condom distribution, regardless of age; HIV testing for new patients registering with the practice who are over the age of 16 years and the provision of long acting reversible contraception (LARC). In Kingston, GPs provide the majority of LARC; in 2015-16 they fitted 1,097 coils and implants compared to 749 fittings by all other local sexual and reproductive health services[3]. Seven GP practices providing enhanced sexual health services have nominated sexual health champions who have been involved in innovative work to further develop sexual health services for patients.

Currently 10 local community pharmacies provide enhanced sexual health services to young people across the borough. These services include free condom distribution, chlamydia and gonorrhoea screening, chlamydia treatment and partner notification, and EHC. Local data shows that community pharmacies are the venue of choice for most individuals receiving chlamydia treatment, regardless of which community service they received their diagnosis from[4]. Plans are in place locally to introduce a national quality assurance programme for community pharmacies during 2017 called the Healthy Living Pharmacy. It is hoped all those pharmacies providing enhanced sexual health services will take part and gain this additional quality assurance award.

Local Action

Primary care training is facilitated and delivered by public health staff by offering support for clinicians to obtain the required professional qualifications or accreditation, and delivering sessions for front line staff (such as GP receptionists and pharmacy assistants). This includes sessions such as how to fit and remove LARC for clinical staff, how to talk to young people about sex and relationships and general sexual health training to ensure staff knowledge is up to date.

Public health will continue to work with GPs and community pharmacists, providing data on activity undertaken, highlighting progress, and ensuring that development opportunities are made available to secure consistent high quality service provision. The aim is to be able to offer patients a wide range of sexual and reproductive health services from an increasing number of primary care sites.

Recommendations

1. **Maintain a comprehensive register of clinician training and accreditation and, where development is required, ensure that primary care providers have an action plan that addresses any gaps.**
2. **Continue to monitor activity in primary care and report back to providers on their performance.**
3. **Increase primary care sexual and reproductive health provision year on year.**
4. **Work with GPs to ensure every site delivering enhanced sexual health services has a sexual health champion.**

Case Study

Primary Care Development

Written by Karen Titterington

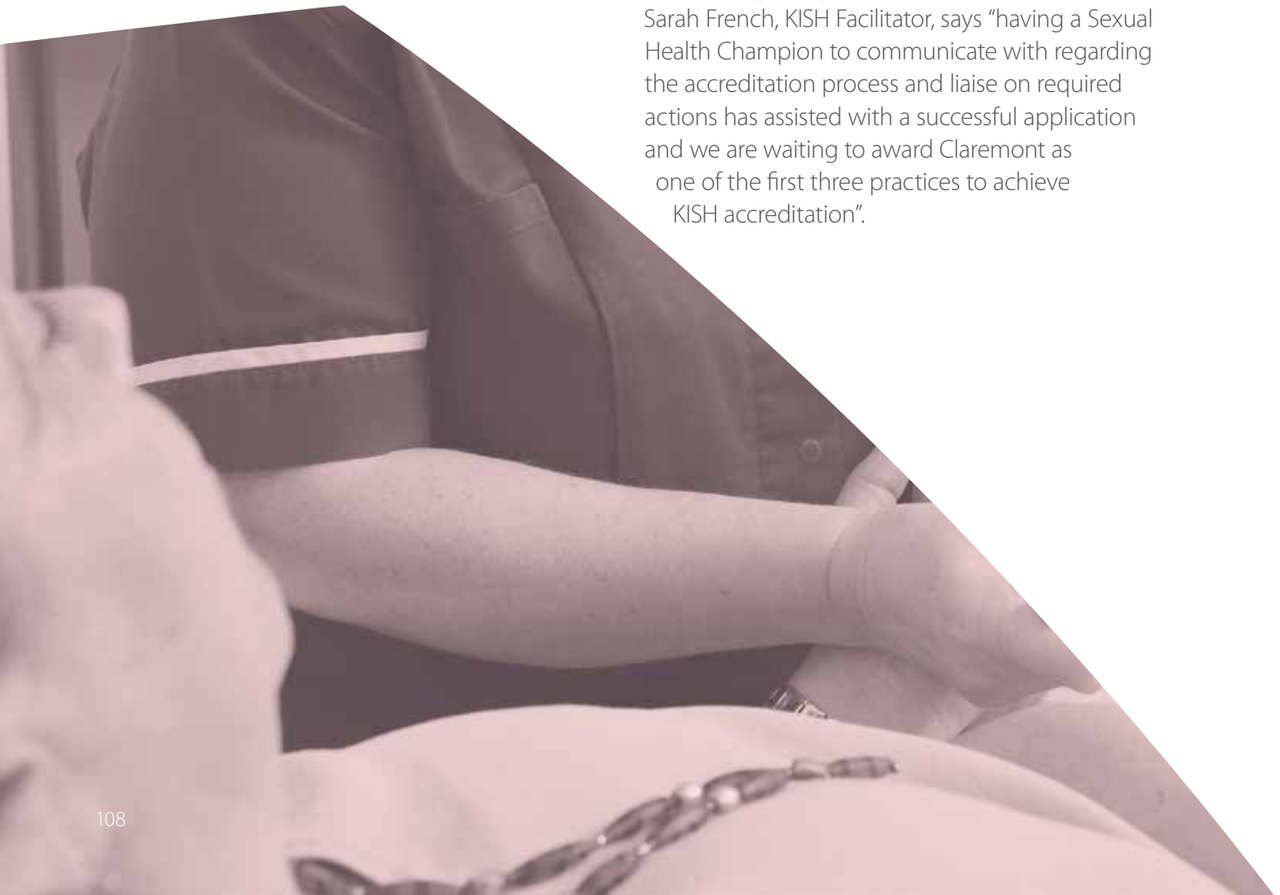
Claremont Surgery

Following sexual health training at the practice, a Health Care Assistant (HCA) was nominated as the Sexual Health Champion.

Having a nominated champion in the practice has helped to ensure:

- all front line staff are trained in basic sexual health knowledge and are able to offer services to patients or signpost to other local services if required
- the training needs of new staff are identified quickly
- regular communication occurs between the practice and the commissioner, and any issues regarding sexual health services are addressed and resolved swiftly
- new practice systems are created to enable staff to offer fast, efficient sexual health promotion advice and support. One example of this is the sexual health resource packs that are made up in advance of clinics to ensure there is always information and condoms for staff to easily distribute.

The Health Care Assistant continues to have this sexual health champion role in the practice, and has been the primary point of contact for the process of gaining the KISH accreditation award. Sarah French, KISH Facilitator, says "having a Sexual Health Champion to communicate with regarding the accreditation process and liaise on required actions has assisted with a successful application and we are waiting to award Claremont as one of the first three practices to achieve KISH accreditation".



Kingston Health Centre

In 2013 staff at Kingston Health Centre supported Kingston Public Health to run a National HIV Testing Week event. During the week-long campaign practice staff worked extra hours to ensure the surgery was open from 7am to 7pm for members of the public to have an HIV test without the need to book an appointment. Health Care Assistants were trained to carry out testing with the support of the GPs on site. The campaign was a great success with a total of 36 people accessed the walk in service to have an HIV test.

The campaign has continued to run in the borough at other venues each year. One of the HCAs has now taken the lead within the practice to coordinate and offer HIV testing for all new patient registrations aged 16 and over. The practice is currently the fourth highest performing practice out of 22 in Kingston for testing newly registered patients for HIV. During 2015-16 a total of 92 patients who registered with the practice had a HIV test.

5.4 The Voluntary and Community Sector

Lead author:
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Sexual Health Promotion Specialist,
Public Health, Kingston Council

Why Commission the Voluntary and Community Sector?

Voluntary and community sector organisations (VCSOs) have a long history of delivering public services. Nationally, in recent years, many small and medium sized charities have had to close due to reductions in funding and changes to the way many local authorities are now procuring services[1].

However, there is an increasing understanding that VCSOs are often in the best position to be delivering public services due to their ability to work at a grassroots level within communities who are often hard to reach and mistrusting of statutory services[2]. In addition, they are often able to deliver services in a more cost effective way than either the statutory or private sectors. This is due to lower overheads, less complex governance structures and an ability to draw on a volunteer workforce[2].

Across the country, VCSOs deliver a wide range of sexual health services. They have been at the forefront of many sexual health campaigns and, in many cases, are the service of choice for people seeking sexual health advice and those living with human immunodeficiency virus (HIV)[3].

Sexual Health and the Voluntary and Community Sector in Kingston

Kingston has strong links with the voluntary and community sector. The borough's commitment to working with the sector to deliver local services is outlined in its Voluntary and Community Sector Strategy 2014[4], and highlighted in planning documents such as Destination Kingston 2016-20[5].

There are a number of VCSOs delivering sexual health services in Kingston. At a local level, Kingston commissions Terrence Higgins Trust (THT), an HIV and sexual health charity, to deliver sex and relationships education to some of the more vulnerable young people in the borough (such as young people not in education or employment, those known to youth offending services and those from more socially deprived areas of the borough) and manage a free condom distribution scheme for young people.

THT's expertise in working with young people, and the opportunity to use workers who can genuinely identify with a younger age group, allows them to build strong relationships with young people that allows honest and meaningful discussion about very sensitive issues. THT consistently achieves excellent feedback from both staff in the services they visit and the young people that they work with[6].

At a sub regional level, the Council has led on a piece of work on behalf of four boroughs in South West London to commission STI and HIV prevention services and support services for people living with HIV. In February 2016, the contract for this work was awarded to Spectra – a health and wellbeing VCSO. Some elements of the service have been sub contracted to smaller VCSOs specialising in work with some of the groups that mainstream services may find hard to reach, such as Black and minority ethnic (BME) communities. This way of working has benefitted the local authorities in two ways. Firstly, value for money is achieved through a joint commissioning approach. Secondly, managing one provider is simpler and more cost effective than multiple contracts, but commissioners still receive the added benefit of having the involvement of smaller VCSOs since they are based within the communities they serve and are highly aware of local need. This awareness can be communicated to council commissioners so increasing the level of understanding of the needs of particular communities.

On a regional level, Kingston is part of a London wide initiative called 'Do It London'; an element of this is the commissioning of VCSOs to deliver outreach and media campaigns across London in order to raise awareness of HIV with some of the most at risk population groups. Much of this work is peer led and delivered by volunteers from the VCSOs, which means commissioners achieve additional value for money. A further benefit in the use of VCSOs is that using peer led interventions means outreach can take place in venues that traditionally may have been resistant to health promotion activities, such as sex on premises venues.

Recommendations

1. **Continue to work with the voluntary and community sector, through commissioning, to further strengthen our links with some of the most hard to reach communities in Kingston and ensure their needs are represented in service planning.**
2. **Engage with local networks of VCSOs to improve communication channels in order that we are kept informed of local community feeling and feedback on local issues.**

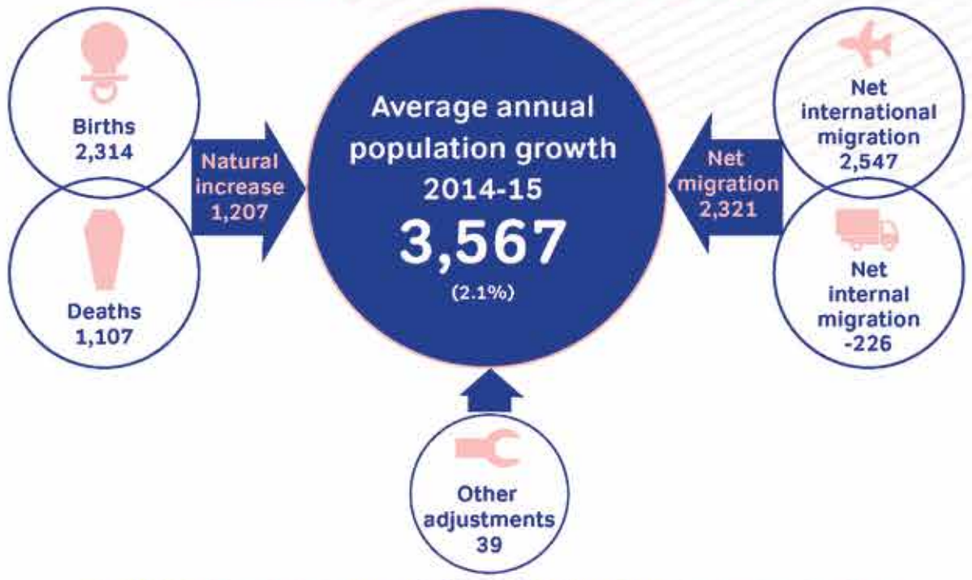
6.0 Section Six
Demography

- 6.1 Demography

Total population of Kingston in 2015, 173,525

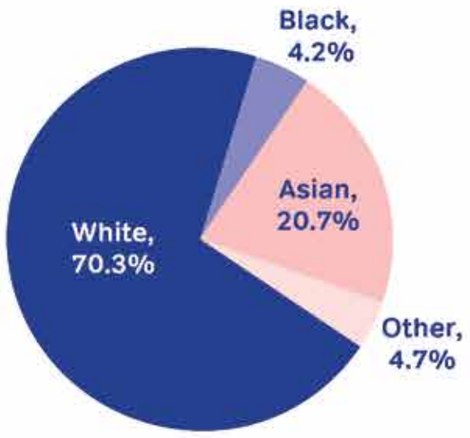
Age Profile	0-17	18-64	65+
Kingston	21.6%	65.1%	13.3%
London	22.5%	65.9%	11.5%
England	21.3%	61.0%	17.7%

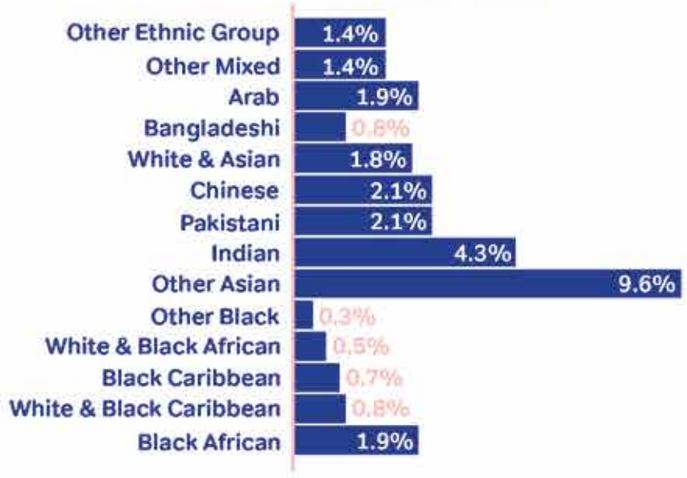
Components of Population Change



By 2030, the total population of Kingston is projected to increase by between 12% and 19% depending on the migration patterns

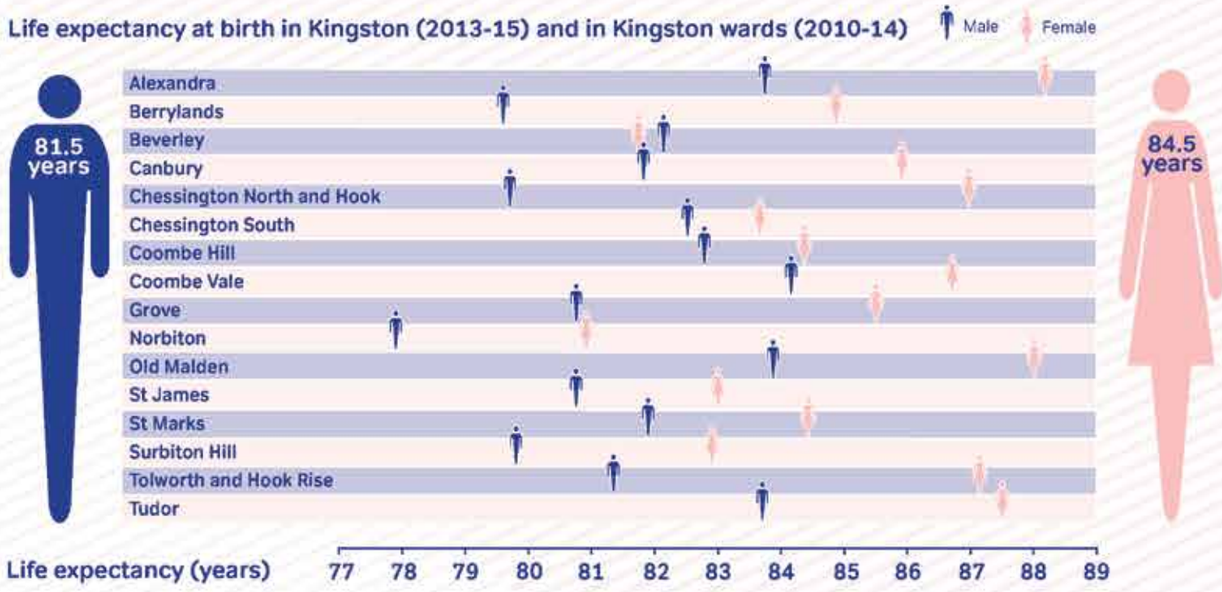
30% of Kingston's population is Black, Asian and minority ethnic (BAME) and is projected to increase to **37%** by 2030





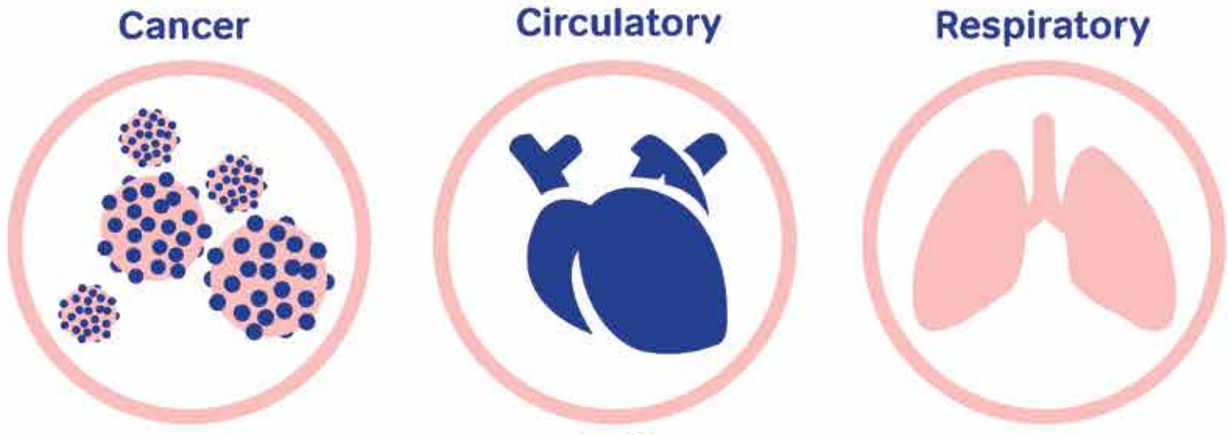
Note: Figures may not add due to rounding.

Life expectancy at birth in Kingston (2013-15) and in Kingston wards (2010-14)



The gap in life expectancy between the most and least deprived tenths of the local population is **4.8 years for men** and **4.6 years for women**

The three leading causes of death from disease in Kingston, 2014



972 total deaths registered in 2014

33% deaths were in people under 75 years of age

6.1 Demography

Lead authors:
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Introduction

The health of a population and its need for healthcare cannot be met without knowledge of its size and characteristics. This chapter gives a snapshot of the demography of Kingston and presents information on some of the main health and economic indicators together with the prevalence of different health conditions.

The Population of Kingston

The 2015 mid-year estimate of the population of Kingston indicates that the number of residents increased to 173,525 from 169,958 in mid-2014. This represented a total increase of 3,567 people (2.1%), and is a greater proportional increase than either London (1.6%) or England (0.9%) over the same time period.

Children and young people (0 to 17 years old) made up 21.6% of the Kingston population whilst people of working age (18 to 64 years old) accounted for 65.1% of the population. Older persons (aged 65 or over) accounted for 13.3% of the population. This means that in Kingston there were 1.9 adults of working age for every person over the age of 65 years and under the age of 18 years. This dependency ratio has decreased in Kingston by 0.1 since the 2011 Census meaning that there are less people of working age to support the non-working age population.

The median age of the population of Kingston was 36.1 years in mid-2015. During the same period the median ages of the population of London and England were 34.6 years and 39.8 years respectively. The median age of Kingston's population was 35.0 years at the 2011 Census, showing the median age is rising.

There were 37,555 children and young people aged 0 to 17 years in Kingston in mid-2015. The proportion of 0 to 17 year-olds in Kingston (21.6%) was a little lower than in London (22.5%) and marginally higher than England (21.3%). The absolute number is estimated to have increased by approximately 11% since the 2011 Census but the proportion of the population made up by 0 to 17 year olds has only increased slightly from 21.1% to 21.6% during this period.

According to mid-2015 estimates there were 112,986 adults of working age (aged 18 to 64 years) in Kingston; representing an increase of approximately 7% since 2011. The proportion of the population made up by 18 to 64 year olds fell slightly from 66.2% in 2011 to 65.1% in 2015. The proportion of adults of working age were higher in London (65.9%) and England (61.0%) than in Kingston during the same period.

The population of older people in Kingston continues to grow, with over 22,984 (13.3% of the population) aged 65 and over and of these 3,493 (2.0% of the population of Kingston) aged 85 and over in 2015. The proportion of the population of older people (aged 65 and over) in Kingston was higher than in London (11.5%) and England (17.7%). Since the 2011 Census, the older people population (65 and over) has increased in Kingston by approximately 13% whilst the population of those aged 85 and over has increased by only 5% (see Table 1 below and Figure 1 overleaf).

The change in the size of the population results from the combination of births, deaths and migration. The increase in the population of Kingston from mid-2014 to mid-2015 was due to a natural increase of 1,207 people (2,314 births and 1,107 deaths), a net internal and international migration flow into Kingston of 2,321 people and a very small increase (39 people) due to other adjustments, including changes to the size of armed forces stationed in the UK and other special population adjustments.

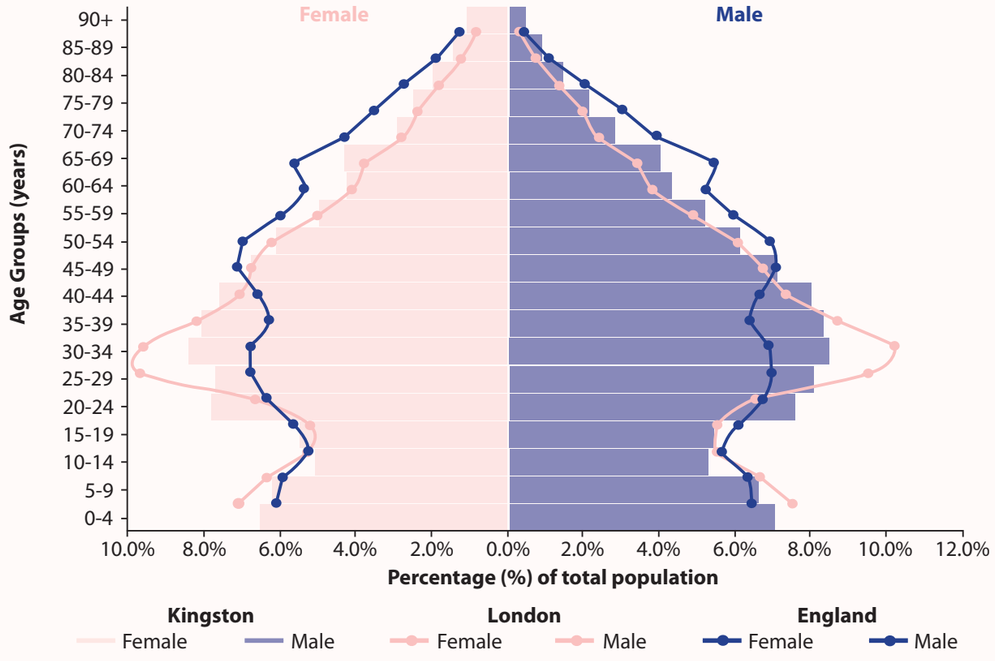
Please see Table 2 and Figure 2 overleaf.
To access the 2011 Census data, please visit the Office for National Statistics (ONS) website.

Table 1 The age and gender structure of the population of Kingston in 2015.

	Age group (years)	Female	Male	Total	% of the total population
Five year age group	0 - 4	5,803	6,047	11,850	6.8%
	5 - 9	5,528	5,710	11,238	6.5%
	10 - 14	4,532	4,535	9,067	5.2%
	15 - 19	4,831	4,648	9,479	5.5%
	20 - 24	6,901	6,528	13,429	7.7%
	25 - 29	6,835	6,902	13,737	7.9%
	30 - 34	7,442	7,260	14,702	8.5%
	35 - 39	7,136	7,125	14,261	8.2%
	40 - 44	6,714	6,876	13,590	7.8%
	45 - 49	5,997	6,084	12,081	7.0%
	50 - 54	5,433	5,295	10,728	6.2%
	55 - 59	4,389	4,480	8,869	5.1%
	60 - 64	3,782	3,728	7,510	4.3%
	65 - 69	3,836	3,464	7,300	4.2%
	70 - 74	2,624	2,452	5,076	2.9%
	75 - 79	2,219	1,829	4,048	2.3%
	80 - 84	1,781	1,286	3,067	1.8%
	85 - 89	1,295	799	2,094	1.2%
	90+	989	410	1,399	0.8%
	All Ages	**88,067**	**85,458**	**173,525**	**100.0%**
Primary school age*	5 - 11	7,448	7,666	15,114	8.7%
Secondary school age*	11 -18	7,328	7,103	14,431	8.3%
16 and Under	0 - 16	17,704	18,066	35,770	20.6%
17 and Under	0 - 17	18,625	18,930	37,555	21.6%
18 and Under	0 - 18	19,599	19,869	39,468	22.7%
Working age adults	18 - 64	56,698	56,288	112,986	65.1%
Older people	65 and over	12,744	10,240	22,984	13.2%
Reproductive age females$	15 - 49	45,856	-	45,856	52.1%$

Source: 2015 Annual Mid-Year Population Estimates for the UK, Office for National Statistics © Crown Copyright 2016.
Note: *Please note that 11 year olds are counted in both rows. $Please note that the percentage is calculated as the percentage of total female population only.

Figure 1 The age and gender structure of the mid-year resident population of Kingston in comparison with London and England, 2015.



Source: 2015 Annual Mid-Year Population Estimates for the UK, Office for National Statistics © Crown Copyright 2016.

Table 2 The components of population change in Kingston, London and England between 2014 and 2015.

Components of Change	Kingston	London	England
Estimated Population 2014	**169,958**	**8,538,689**	**54,316,618**
Births	2,314	128,520	662,014
Deaths	1,107	50,150	496,913
Births minus Deaths	1,207	78,370	165,101
Internal Migration Inflow	12,616	587,762	2,782,902
Internal Migration Outflow	12,842	665,297	2,791,338
Internal Migration Net	-226	-77,535	-8,436
International Migration Inflow	3,698	221,106	568,685
International Migration Outflow	1,151	87,205	261,367
International Migration Net	2,547	133,901	307,318
Other	39	288	5,726
Estimated Population 2015	**173,525**	**8,673,713**	**54,786,327**
Population Change between 2014 and 2015	**3,567**	**135,024**	**469,709**
% Population Change	2.10%	1.58%	0.86%
% Population Change due to Births and Deaths	0.71%	0.92%	0.30%
% Population Change due to Internal Migration	-0.13%	-0.91%	-0.02%
% Population Change due to International Migration	1.50%	1.57%	0.57%
% Population Change due to Other Adjustments	0.02%	0.00%	0.01%

Source: Annual Mid-Year Population Estimates for the UK, Office for National Statistics © Crown Copyright 2016.

Population Projections

The Greater London Authority (GLA) has released two sets of trend-based population projections at borough level based on short-term and longer-term migration trends. The volume and characteristics of migration flows vary between these projections, but the mortality and fertility methodologies are the same. The short term projection assumes that recent migration patterns will persist for the duration of the projection period whilst the long term projection uses assumptions based on longer historical trends, spanning multiple economic cycles and therefore will yield more stable projections. These projections do not take account of any political changes, such as Britain leaving the European Union.

The short and long term projections for 2015 are calculated as follows:

- Short-term migration scenario: This bases the rate of migration on estimates for the five-year period mid-2010 to mid-2014. These projections are intended to be used where accuracy in the near term is most important
- Long-term migration scenario: This bases the rate of migration on estimates for the 12-year period mid-2003 to mid-2014. These projections are intended to be used for longer-term strategic planning purposes.

Based on the short-term migration scenario, the total population of Kingston is projected to rise by 32,517 (18.8 %) between 2015 and 2030 to reach 205,134. The age composition of the population is also projected to change, with the proportion of people of working age (aged 18 to 64) decreasing from 65.1% in 2015 to 62.9% by 2030, and the proportion of older people aged 65 and over increasing from 13.3% in 2015 to 15.9% by 2030.

Table 3a overleaf shows the projected rise over shorter time periods to the years 2020 and 2025, when the short term migration scenario is considered more accurate.

The long-term scenario projects less growth, with a rise of 21,039 (12.3 %) people over the same period reaching 192,492 in 2030. The proportion of people of working age (aged 18 to 64) is projected to decrease from 65.1% in 2015 to 63.7% by 2030, and the proportion of older people aged 65 and over is projected to increase from 13.4% in 2015 to 15.9% by 2030.

Projected increases in the population of older people will increase the demand for health and social care services and the decrease in the proportion of people of working age may have an impact on the local economy due to the change in the dependency ratio. Tables 3a and 3b give the projected population figures for Kingston based on the short-term and long-term migration scenario. Figure 2 compares the projections in short-term and long-term migration scenarios by age group.

Table 3a The projected population of Kingston, Short-term migration scenario, 2015 to 2030.

	Age Group (years)	2011	2015	2020	2025	2030
Five year age group	0 - 4	11,127	11,747	11,567	11,696	11,705
	5 - 9	9,055	11,249	12,203	12,022	12,127
	10 - 14	8,515	9,063	11,356	12,254	12,077
	15 - 19	9,541	9,552	9,959	12,087	12,891
	20 - 24	13,562	13,421	13,475	13,410	15,143
	25 - 29	12,430	13,474	13,639	13,497	13,308
	30 - 34	13,355	14,332	14,640	14,804	14,624
	35 - 39	13,446	14,144	15,067	15,239	15,391
	40 - 44	12,200	13,494	14,181	15,030	15,163
	45 - 49	11,247	12,043	13,132	13,745	14,532
	50 - 54	9,541	10,727	11,674	12,558	13,100
	55 - 59	7,968	8,848	10,320	11,150	11,878
	60 - 64	7,977	7,512	8,357	9,725	10,459
	65 - 69	5,836	7,280	6,975	7,760	9,020
	70 - 74	4,498	5,081	6,743	6,492	7,229
	75 - 79	3,774	4,074	4,627	6,140	5,949
	80 - 84	3,037	3,062	3,381	3,901	5,205
	85 - 89	2,130	2,099	2,152	2,476	2,928
	90+	1,230	1,416	1,633	1,929	2,404
	All Ages	**160,469**	**172,617**	**185,082**	**195,915**	**205,134**
Primary school age	5 - 11	12,413	15,127	16,973	16,792	16,983
Secondary school age	11 -18	13,946	14,434	16,716	19,438	19,661
16 and Under	0 - 16	32,187	35,674	39,109	40,792	40,735
17 and Under	0 - 17	33,895	37,468	40,954	43,197	43,244
18 and Under	0 - 18	35,774	39,382	42,857	45,536	45,917
Working age adults	18 - 64	106,069	112,137	118,616	124,020	129,155
Older people	65 and over	20,505	23,012	25,512	28,698	32,736
Reproductive age females	15 - 49	85,781	90,460	94,093	97,812	101,052

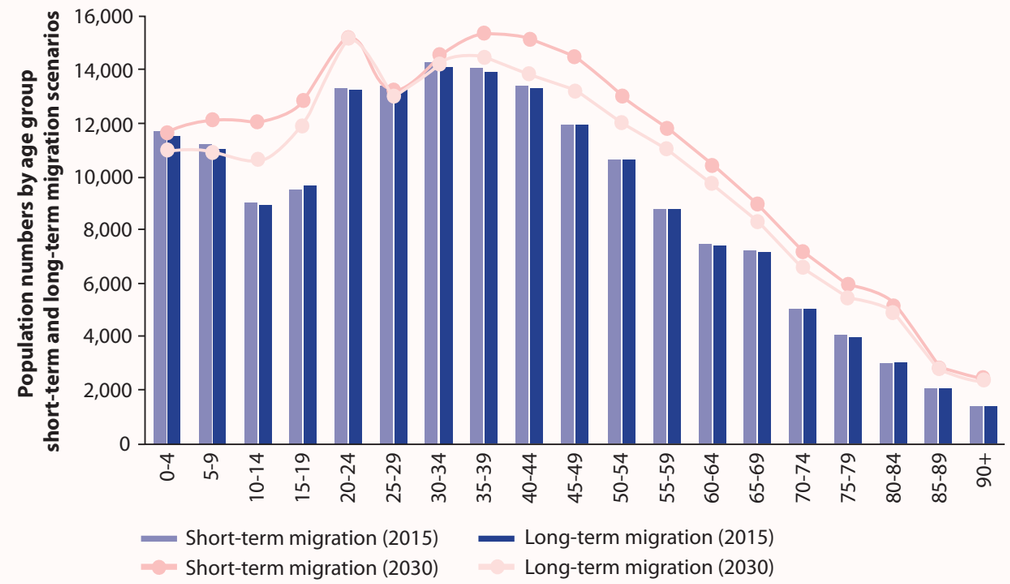
Source: 2015 Round of Demographic Projections, Local authority population projections – Trend projections, short-term migration scenario, © GLA 2016.
Note: Figures may not add due to rounding.

Table 3b The projected population of Kingston, Long-term migration scenario, 2015 to 2030.

	Age Group (years)	2011	2015	2020	2025	2030
Five year age group	0 - 4	11,127	11,587	10,939	10,991	11,052
	5 - 9	9,055	11,146	11,424	10,884	10,952
	10 - 14	8,515	8,990	10,854	11,145	10,674
	15 - 19	9,541	9,709	9,891	11,642	11,944
	20 - 24	13,562	13,298	13,802	13,648	15,238
	25 - 29	12,430	13,339	13,220	13,297	13,069
	30 - 34	13,355	14,170	14,146	14,325	14,321
	35 - 39	13,446	13,978	14,223	14,276	14,508
	40 - 44	12,200	13,379	13,477	13,827	13,902
	45 - 49	11,247	11,983	12,680	12,828	13,213
	50 - 54	9,541	10,677	11,369	11,915	12,078
	55 - 59	7,968	8,806	10,048	10,648	11,087
	60 - 64	7,977	7,468	8,106	9,252	9,776
	65 - 69	5,836	7,238	6,737	7,331	8,374
	70 - 74	4,498	5,052	6,534	6,118	6,674
	75 - 79	3,774	4,059	4,508	5,848	5,518
	80 - 84	3,037	3,057	3,322	3,756	4,909
	85 - 89	2,130	2,099	2,146	2,432	2,822
	90+	1,230	1,416	1,634	1,926	2,380
	All Ages	**160,469**	**171,453**	**179,059**	**186,089**	**192,492**
Primary school age	5 - 11	12,413	14,989	15,979	15,185	15,266
Secondary school age	11 -18	13,946	14,374	16,090	17,993	17,510
16 and Under	0 - 16	32,187	35,320	37,042	37,502	36,941
17 and Under	0 - 17	33,895	37,111	38,832	39,768	39,198
18 and Under	0 - 18	35,774	39,045	40,715	42,015	41,675
Working age adults	18 - 64	106,069	111,420	115,346	118,911	122,617
Older people	65 and over	20,505	22,921	24,881	27,411	30,678
Reproductive age females	15 - 49	85,781	89,857	91,438	93,844	96,195

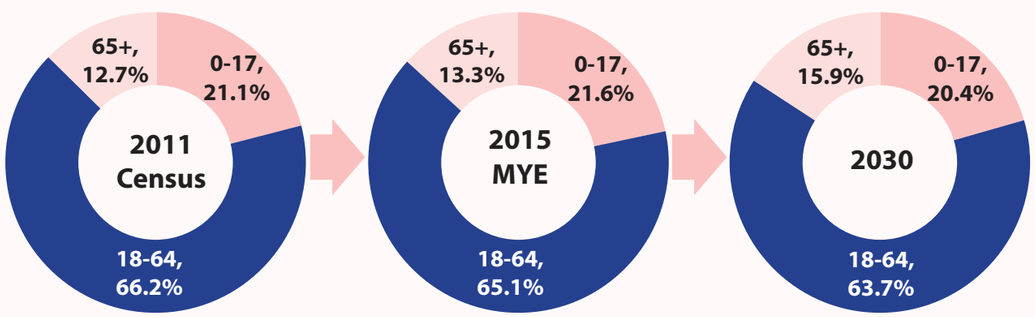
Source: 2015 Round of Demographic Projections, Local authority population projections – Trend projections, long-term migration scenario, © GLA 2016.
Note: Figures may not add due to rounding.

Figure 2 Projected population of Kingston in 2015 and 2030 according to the short-term and long-term migration scenarios.



Source: 2015 Round Demographic Projections. Local Authority Population Projections – Trend Projections, long-term migration and short-term migration scenario. © GLA 2016.

Figure 3 Change in the population structure of Kingston since 2011 Census.



Source: 1) 2011 Census, office for National Statistics 2) 2015 Mid-year estimates, Office for National Statistics 3) 2030 projections, 2015 Round of Demographic Projections, Local authority population projections – Trend projections, long-term migration scenario. © GLA 2016.
Note: 1) Figures may not add due to rounding. 2) 0-17, 18-64 and 65+ are age groups. 3) MYE is mid-year estimate.

Projections of the Electoral Ward Populations of Kingston

The GLA produces annual projections of the electoral ward populations. Table 4 presents a summary of the electoral ward population estimates for Kingston over the next 15 years.

Table 4 Projections of the electoral ward populations of Kingston, 2015 to 2030.

Ward	2015	2020	2025	2030
Alexandra	9,896	10,337	10,806	10,976
Berrylands	10,199	10,447	10,755	10,908
Beverley	11,070	11,710	12,146	12,280
Canbury	14,296	15,577	15,846	16,191
Chessington North and Hook	9,120	9,153	9,213	9,243
Chessington South	10,866	11,168	11,707	12,159
Coombe Hill	10,960	11,290	12,026	12,397
Coombe Vale	10,232	10,417	10,486	10,560
Grove	12,109	13,409	15,005	15,547
Norbiton	10,892	11,229	11,759	12,823
Old Malden	9,915	10,057	10,334	10,533
St James	9,415	9,501	9,573	9,659
St Mark's	11,612	11,826	12,213	12,458
Surbiton Hill	11,192	11,573	12,033	12,099
Tolworth and Hook Rise	10,510	11,913	12,935	13,302
Tudor	10,067	10,293	10,225	10,192
Kingston	**172,351**	**179,900**	**187,062**	**191,327**
% Growth from 2015	**-**	**4.4%**	**8.5%**	**11.0%**

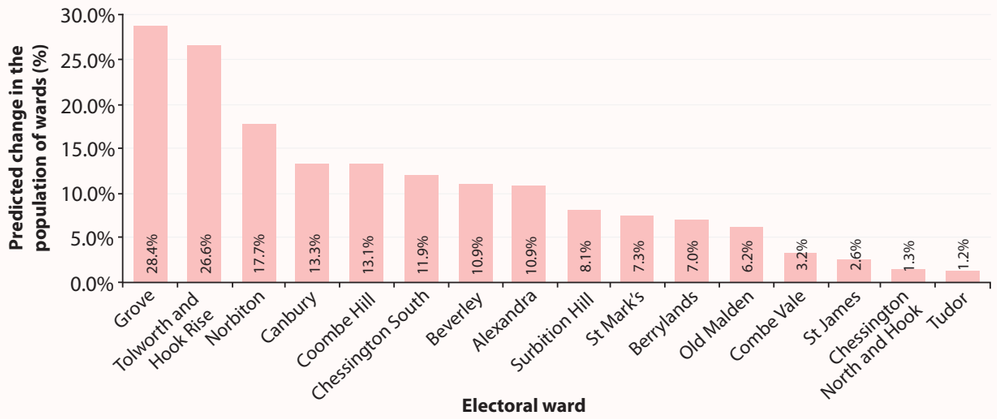
Source: 2015 Round of Demographic Projections – Ward projections, SHLAA-based; Capped Household Size model. © GLA 2016.
Note: 1) Figures may not add due to rounding. 2) The total for Kingston does not match with the total shown in Tables 3a and 3b because of the different projection methodologies used. The methodology used in Tables 3a and 3b is "Trend-based" which projects forward based on recent trends in fertility, migration and death and applies assumptions about how these factors may change in the future i.e., birth rate will decrease, life expectancy will improve. Further sub-variants of this model are the Short-term and Long-term migration scenarios. Ward projections in the above table are "Housing-linked" which project growth based on anticipated new development from the Strategic Housing Land Availability Assessment (SHLAA).

The projected ward population changes during the period 2015 to 2030 are illustrated in Figure 4. The population of the different Kingston wards are predicted to grow at varying rates and the highest population increases are likely to be seen in Grove (28.4%), Tolworth and Hook Rise (26.6%) and Norbiton (17.7%) wards.

Table 5 shows the population distribution (from ONS and GLA) in Kingston wards by age group. This table also shows the classification of wards into Kingston Neighbourhoods (the administrative boundaries used by the Royal Borough of Kingston upon Thames).

Small area population estimates are used by both central government departments and local authorities for a range of purposes including planning and monitoring of services and as denominators for the calculation of various rates and indicators. However, it is important to note here that the population of electoral wards are small and therefore minor changes in some of the factors used in these predictions may disproportionately affect their size. This renders long term predictions highly imprecise.

Figure 4 The predicted change in the electoral ward populations of Kingston, 2015 to 2030.



Source: 2015 Round of Demographic Projections - Ward projections, SHLAA-based; Capped Household Size model. © GLA 2016.

Table 5 Projected population by age group (using GLA and ONS models) of the electoral wards in Kingston. 2015.

Neighbourhoods	Electoral wards	2015 GLA Population Projections	Age groups (years)			
			0 to 17	18 to 64	65 to 84	85 and over
Kingston Town	Canbury	14,296	3,422	9,795	919	160
	Grove	12,109	1,654	9,400	899	156
	Norbiton	10,892	2,227	7,746	832	87
	Tudor	10,067	2,546	6,112	1,201	208
Malden and Coombe	Beverley	11,070	2,569	6,970	1,275	256
	Coombe Hill	10,960	2,305	6,999	1,360	296
	Coombe Vale	10,232	2,364	6,423	1,261	184
	Old Malden	9,915	2,212	5,997	1,502	204
	St James	9,415	2,089	5,573	1,433	320
South of Borough	Chessington North and Hook	9,120	2,038	5,613	1,281	188
	Chessington South	10,866	2,487	6,821	1,369	189
	Tolworth and Hook Rise	10,510	2,352	6,841	1,155	162
Surbiton	Alexandra	9,896	2,318	6,008	1,377	193
	Berrylands	10,199	1,954	6,735	1,269	241
	St Mark's	11,612	1,513	9,221	733	145
	Surbiton Hill	11,192	1,993	7,746	1,161	292
Total		**172,351**	**36,043**	**114,000**	**19,027**	**3,281**

Neighbourhoods	Electoral wards	2015 ONS Population Projections	Age groups (years)			
			0 to 17	18 to 64	65 to 84	85 and over
Kingston Town	Canbury	14,740	3,666	9,887	1049	138
	Grove	11,740	1,957	8,622	988	173
	Norbiton	10,674	2,351	7,322	869	132
	Tudor	9,995	2,647	5,908	1,222	218
Malden and Coombe	Beverley	10,844	2,552	6,815	1,232	245
	Coombe Hill	11,640	2,538	7,372	1,355	375
	Coombe Vale	10,299	2,511	6,313	1,285	190
	Old Malden	9,802	2,149	5,849	1,585	219
	St James	9,297	2,032	5,531	1,453	281
South of Borough	Chessington North and Hook	9,177	2,133	5,639	1,198	207
	Chessington South	10,567	2,443	6,577	1,345	202
	Tolworth and Hook Rise	10,383	2,392	6,586	1,227	178
Surbiton	Alexandra	9,710	2,302	5,826	1,355	227
	Berrylands	9,872	1,882	6,469	1,307	214
	St Mark's	13,567	1,779	10,804	830	154
	Surbiton Hill	11,218	2,221	7,466	1,191	340
Total		**173,525**	**37,555**	**112,986**	**19,491**	**3,493**

Source: 1) 2015 Round of Demographic Projections – Ward projections, SHLAA-based; Capped Household Size model. © GLA 2016. 2) Ward Level Mid-Year Population Estimates (Experimental Statistics), Office of National Statistics (ONS), 2016.
Note: Figures may not add due to rounding.

Practice Population

A total of 204,510 people were registered with Kingston CCG general practices in January 2017; an increase of 1,802 people over the previous year (January 2016). The total number of registered men (101,709) was slightly lower than the number of women (102,801).

Comparison of the registered GP population with the resident population indicates that the number of registered patients with local general practices is greater than the number of resident people in all age groups. Overall there were 30,985 more people registered with local GP practices than live in Kingston (see Tables 6a and 6b).

Table 6a Kingston CCG GP registered population by age group, showing difference between registered and resident populations January 2017.

Age group (years)	Male	Female	Total	Difference (Practice – Resident population)
0-4	6,425	6,212	12,637	787
5-9	6,486	6,388	12,874	1,636
10-14	5,637	5,563	11,200	2,133
15-19	5,075	5,616	10,691	1,212
20-24	6,998	9,159	16,157	2,728
25-29	7,617	8,025	15,642	1,905
30-34	8,117	8,293	16,410	1,708
35-39	9,136	8,565	17,701	3,440
40-44	8,768	7,864	16,632	3,042
45-49	8,204	7,020	15,224	3,143
50-54	7,253	6,360	13,613	2,885
55-59	5,682	5,246	10,928	2,059
60-64	4,339	4,332	8,671	1,161
65-69	4,009	4,102	8,111	811
70-74	3,107	3,280	6,387	1,311
75-79	2,034	2,446	4,480	432
80-84	1,508	1,882	3,390	323
85-89	871	1,419	2,290	196
90+	443	1,029	1,472	73
Total	**101,709**	**102,801**	**204,510**	**30,985**

Source: NHS Digital, 2017.

Table 6b Kingston CCG GP registered population by practice, January 2017.

Practice code	Practice name	Male	Female	Total
H84010	Canbury Medical Centre	4,887	5,049	9,936
H84015	Brunswick Surgery	3,719	3,861	7,580
H84016	The Groves Medical Centre	7,594	7,932	15,526
H84020	Fairhill Medical Practice	10,147	11,981	22,128
H84025	Hook Surgery	3,440	3,585	7,025
H84027	The Churchill Medical Centre	9,466	9,127	18,593
H84030	Central Surgery	6,214	6,351	12,565
H84033	St Albans Medical Centre	3,564	3,617	7,181
H84034	The Orchard Practice	4,195	4,166	8,361
H84042	Holmwood Corner Surgery	6,131	6,446	12,577
H84049	Maypole Surgery	282	113	395
H84050	Chessington Park Surgery	3,437	3,521	6,958
H84051	Roselawn Surgery	3,020	2,896	5,916
H84053	Berrylands Surgery	2,018	2,127	4,145
H84054	Red Lion Road Surgery	1,605	1,335	2,940
H84058	Kingsdowne Surgery	2,067	1,817	3,884
H84061	Kingston Health Centre	4,940	5,185	10,125
H84062	Langley Medical Practice	3,743	3,820	7,563
H84618	Sunray Surgery	2,054	1,952	4,006
H84619	Claremont Medical Centre	5,496	5,418	10,914
H84629	Village Surgery	2,686	2,254	4,940
H84635	Manor Drive Medical Centre	6,662	6,439	13,101
H84637	The Grays Medical Practice	249	119	368
H85055	West Barnes Surgery	3,850	3,539	7,389
Y03054	Gosbury Hill GP Clinic	243	151	394
Total		**101,709**	**102,801**	**204,510**

Source: NHS Digital, 2017.

Note: Maypole surgery, The Grays Medical Practice and Gosbury Hill Practice were closed in financial year 2016-17 and the patients were repatriated to other General Practices.

Ethnicity in Kingston

The Greater London Authority (GLA) produces annual ethnic population projections for London boroughs to support their planning and resource allocations. The need to close the health gap for ethnic minorities is a recognised objective and understanding the ethnic mix of a population can improve the delivery of health and social care by helping to target activities such as screening programmes, education and resource allocation.

The 2015 Round of Ethnic Population Projections released by the GLA is the first time there has been projection for 17 ethnic groups, which is an important step forward in understanding London's evolving population. They have been produced using ethnic migration patterns based on data collected in the 2011 Census with an aim to gain more insight into the variations in the characteristics, and the resulting needs, of diverse ethnic groups.

Two sets of projections based on short-term and longer-term migration trends were released by the GLA to reflect the uncertainty about the number of people who will be migrating into and out of London boroughs in the future. Please refer to the "Population Projections" section (page 119) for more information on migration scenarios.

The proportion of the White (includes White British, White Irish and Other Whites) population is seen to have decreased over the inter-censal decade, from 84.5% in 2001 to 74.5% in 2011, and is projected by the short-term migration scenario to decrease further to 62.5% by 2030. However, White still remains the single largest ethnic group in Kingston for the entire projection period.

The short-term migration scenario projects the Other White population to be one of the fastest growing groups, increasing from 19,829 in 2015 to 28,663 in 2030 (4.3%). This could be possibly attributed to a significant arrival of European Union Accession citizens as well as other White people from other countries.

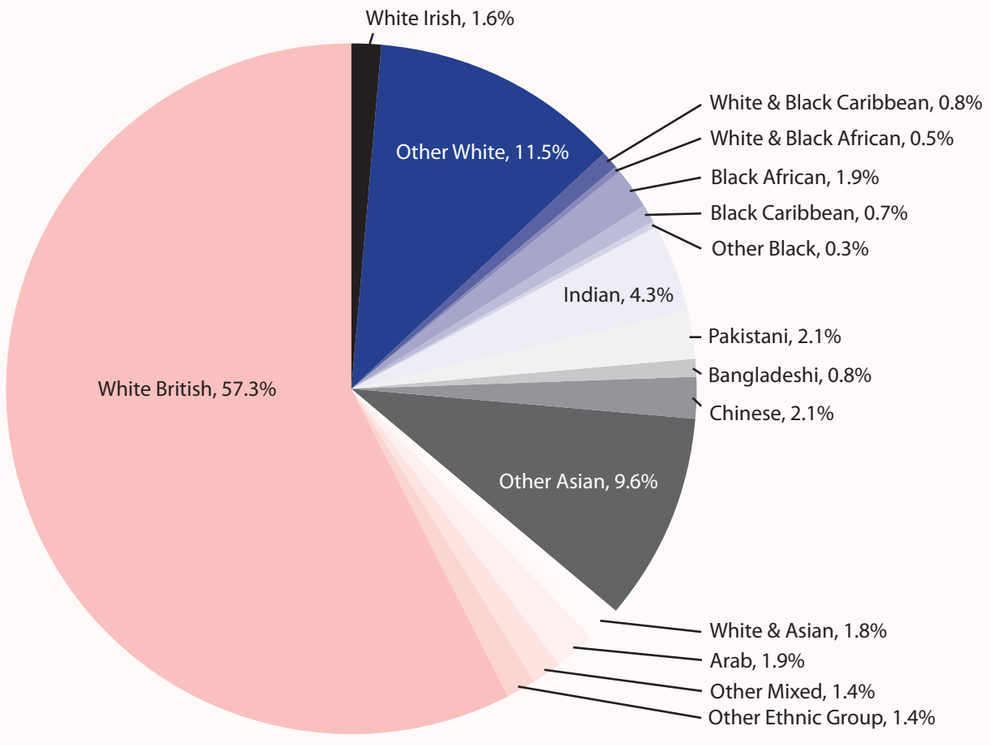
The proportion of the Black, Asian and minority ethnic (BAME) population is seen to have increased over the inter-censal decade, from 15.5% in 2001 to 25.5% in 2011, and is projected by the short term migration scenario to increase further to 37.5% by 2030. Over the projection period to 2030, the proportions of most individual BAME groups are projected to increase by a greater or lesser extent, the majority of increases will occur between 2015 and 2020. The Other Asian population is projected to be one of the fastest growing groups increasing from 16,539 in 2015 to 25,715 by 2030 (4.4%). During the past ten years, the Indian population was the largest BAME group in Kingston but by 2015 the Other Asian group became the largest, with a population of 16,539 compared to 7,404 of the Indian group.

The long-term migration scenario predicts the proportion of White population in Kingston to decrease to 62.9% by 2030 and a corresponding increase in the BAME population to 37.1%. The relative ethnic differences between the two variants are small over the projection period (see Figure 5 and Tables 7, 8 and 9).

The 2011 Census reported that 3,408 (2.1%) people identified themselves as Korean and 4,012 (2.5%) as Sri Lankan in Kingston.

Tables 7, 8 and 9 illustrate the projected change in the ethnic composition of the population of Kingston between 2015 and 2030.

Figure 5 Key ethnic groups, short-term migration scenario. 2015.



Source: 2015 Round of demographic projections, local authority population projections – trend based ethnic group projections, short-term migration scenario. © GLA 2016.

Table 7 Ethnic groups in Kingston, Short-term migration scenario, 2015.

Ethnic Groups	Age group (years)			
	0 to 17	18 to 64	65 and over	All Ages
White British	19,396	61,749	17,693	98,842
White Irish	178	1,794	784	2,756
Other White	3,619	14,885	1,323	19,829
Black African	858	2,324	99	3,288
Black Caribbean	202	929	115	1,244
Other Black	194	265	26	485
White & Black Caribbean	698	707	33	1,440
White & Black African	438	365	11	817
Indian	1,345	5,233	830	7,404
Pakistani	1,156	2,302	236	3,692
Bangladeshi	367	1,011	48	1,424
Chinese	476	2,914	237	3,625
Other Asian	4,409	11,181	949	16,539
White & Asian	1,562	1,453	89	3,102
Arab	899	2,149	290	3,337
Other Mixed	1,144	1,221	69	2,433
Other Ethnic Group	529	1,666	166	2,360
BAME	14,274	33,701	3,213	51,191
White	23,193	78,428	19,800	121,427
All persons	37,468	112,137	23,013	172,617
BAME age distribution (%)	27.9%	65.8%	6.3%	100.0%
White age distribution (%)	19.1%	64.6%	16.3%	100.0%
All persons age distribution (%)	21.7%	65.0%	13.3%	100.0%

Source: 2015 Round of demographic projections, local authority population projections – trend based ethnic group projections, short-term migration scenario. © GLA 2016.
Note: Figures may not add due to rounding.

Table 8 Ethnic group population projections, Short-term migration scenario, 2011 to 2030.

Ethnic Groups		Age group (years)					% of total population		
		2011	2015	2020	2025	2030	2011	2015	2030
	All persons	160,469	172,617	185,082	195,915	205,134	-	-	-
White	White British	101,299	98,842	97,013	96,512	96,706	63.1%	57.3%	47.1%
	White Irish	2,729	2,756	2,742	2,744	2,752	1.7%	1.6%	1.3%
	Other White	15,523	19,829	23,725	26,550	28,663	9.7%	11.5%	14.0%
	Total	119,551	121,427	123,480	125,806	128,121	74.5%	70.3%	62.5%
Black	White & Black Caribbean	1,239	1,440	1,639	1,797	1,921	0.8%	0.8%	0.9%
	White & Black African	702	817	916	983	1,031	0.4%	0.5%	0.5%
	Black African	2,615	3,288	4,014	4,588	5,036	1.6%	1.9%	2.5%
	Black Caribbean	1,027	1,244	1,463	1,635	1,778	0.6%	0.7%	0.9%
	Other Black	378	485	585	658	710	0.2%	0.3%	0.3%
	Total	5,961	7,274	8,617	9,661	10,476	3.7%	4.2%	5.1%
Asian	Indian	6,338	7,404	8,479	9,362	10,097	3.9%	4.3%	4.9%
	Pakistani	3,015	3,692	4,338	4,854	5,280	1.9%	2.1%	2.6%
	Bangladeshi	893	1,424	2,007	2,528	3,001	0.6%	0.8%	1.5%
	Chinese	2,889	3,625	4,306	4,842	5,286	1.8%	2.1%	2.6%
	Other Asian	13,071	16,539	20,173	23,217	25,715	8.1%	9.6%	12.5%
	White & Asian	2,507	3,102	3,612	3,965	4,196	1.6%	1.8%	2.0%
	Total	28,713	35,786	42,915	48,768	53,575	17.9%	20.7%	26.1%
Other	Arab	2,444	3,337	4,302	5,116	5,789	1.5%	1.9%	2.8%
	Other Mixed	1,834	2,433	2,991	3,435	3,758	1.1%	1.4%	1.8%
	Other Ethnic Group	1,968	2,360	2,776	3,129	3,414	1.2%	1.4%	1.7%
	Total	6,246	8,130	10,069	11,680	12,961	3.9%	4.7%	6.3%
	White	119,551	121,427	123,480	125,806	128,121	74.5%	70.3%	62.5%
	BAME	40,918	51,191	61,601	70,109	77,013	25.5%	29.7%	37.5%

Source: 2015 Round of demographic projections, local authority population projections – trend based ethnic group projections, short-term migration scenario. © GLA 2016.
Note: Figures may not add due to rounding.

Table 9 Ethnic group population projections, Long-term migration scenario, 2011 to 2030.

Ethnic Groups		Numbers					% of total population		
		2011	2015	2020	2025	2030	2011	2015	2030
	All persons	**160,469**	**171,453**	**179,059**	**186,089**	**192,492**	-	-	-
White	**White British**	101,299	98,459	94,986	93,169	92,473	63.1%	57.4%	48.0%
	White Irish	2,729	2,731	2,637	2,588	2,559	1.7%	1.6%	1.3%
	Other White	15,523	19,523	22,301	24,381	25,962	9.7%	11.4%	13.5%
	Total	119,551	120,713	119,924	120,138	120,994	74.5%	70.4%	62.9%
Black	**White & Black Caribbean**	1,239	1,433	1,600	1,732	1,836	0.8%	0.8%	1.0%
	White & Black African	702	812	887	934	971	0.4%	0.5%	0.5%
	Black African	2,615	3,263	3,881	4,367	4,746	1.6%	1.9%	2.5%
	Black Caribbean	1,027	1,239	1,439	1,592	1,719	0.6%	0.7%	0.9%
	Other Black	378	481	562	621	663	0.2%	0.3%	0.3%
	Total	5,961	7,228	8,369	9,246	9,935	3.7%	4.2%	5.2%
Asian	**Indian**	6,338	7,346	8,183	8,882	9,476	3.9%	4.3%	4.9%
	Pakistani	3,015	3,669	4,212	4,642	4,999	1.9%	2.1%	2.6%
	Bangladeshi	893	1,422	1,998	2,510	2,971	0.6%	0.8%	1.5%
	Chinese	2,889	3,591	4,145	4,583	4,946	1.8%	2.1%	2.6%
	Other Asian	13,071	16,363	19,174	21,514	23,434	8.1%	9.5%	12.2%
	White & Asian	2,507	3,075	3,460	3,706	3,861	1.6%	1.8%	2.0%
	Total	28,713	35,466	41,172	45,837	49,687	17.9%	20.7%	25.8%
Other	**Arab**	2,444	3,297	4,077	4,729	5,264	1.5%	1.9%	2.7%
	Other Mixed	1,834	2,413	2,870	3,223	3,474	1.1%	1.4%	1.8%
	Other Ethnic Group	1,968	2,336	2,648	2,918	3,138	1.2%	1.4%	1.6%
	Total	6,246	8,046	9,595	10,870	11,876	3.9%	4.7%	6.2%
	White	**119,551**	**120,713**	**119,924**	**120,138**	**120,994**	**74.5%**	**70.4%**	**62.9%**
	BAME	**40,918**	**50,740**	**59,136**	**65,952**	**71,498**	**25.5%**	**29.6%**	**37.1%**

Source: 2015 Round of demographic projections, local authority population projections – trend based ethnic group projections, short-term migration scenario © GLA 2016.
Note: Figures may not add due to rounding.

Main Health Indicators

The main health indicators described below are useful tools for monitoring the health of the population. These indicators can be used to support planning, and to track progress toward identified objectives such as reducing the prevalence of certain conditions.

Live Births

There were 2,350 live births in Kingston in 2015, a small increase of 103 live births (4.6%) when compared with 2,247 in 2014. The increase in the number of live births in 2015 followed a 9.3% decrease between 2012 and 2013.

In 2015, London had the largest number of live births when compared to the other English regions and within London; Newham (6,226) had the largest number of live births whilst Kensington and Chelsea (1,805), Hammersmith and Fulham (2,345) and Kingston upon Thames (2,350) had the fewest number of births.

The Total Period Fertility Rate (TPFR) tells us more about the rate of births in the population than total numbers alone does. The TPFR is the average number of live births that would occur per women resident in an area if women experienced the area's current age-specific fertility rates throughout their childbearing lifespan. The TPFR for Kingston increased slightly in 2015 to an average of 1.66 children per woman from 1.63 in 2014 (see Table 10); however, it remained lower than the London (1.73) and national (1.82) rates.

In 2015, around 38 live births in Kingston (1.6%) were to mothers aged under 20 years and of these 0.3% of the live births were to mothers under 18 years of age. The birth rate in Kingston amongst women aged under 20 (6.4 per 1,000 women) was lower than both the London rate (10.5 per 1,000 women) and the England rate (14.3 per 1,000 women).

The highest birth rate of 120.4 per 1,000 women occurred in women aged 30 to 34 years in Kingston and it was higher than London (106.5 per 1,000 women) and England (111.3 per 1,000 women) rates for the age group. The birth rate for women in Kingston aged 40 and over has been increasing consistently for some time and in 2015 the rates in Kingston (27.3 per 1,000 women) was higher than London and England rates. Among women aged 45 and over the birth rate for Kingston (2.7 per 1,000 women) was slightly lower than London (2.8 per 1,000 women) but higher than England (1.1 per 1,000 women).

Key birth statistics for 2015 show that 7.7% of births in Kingston were to mothers aged 40 years and above and the percentage in Kingston was higher than London (6.1%) and England (4.2%). In most developed countries, including the UK, women have been increasingly delaying childbearing to later in life, which has resulted in rising fertility rates among older women. This may be due to a number of socioeconomic factors such as increased female participation in higher education and the labour force, the increasing importance to woman of having a career, the rising costs of childbearing, labour market uncertainty and housing factors[1]. Higher birth rates at older ages are associated with a higher level of risk for both the mother and the baby. The birth rates for women of different ages in Kingston are shown in the Table 11.

Low birth weight, defined as an infant being born with a weight less than 2,500 grams, is a leading cause of infant mortality and is also associated with chronic diseases later in life. The percentage of live births with low birth weight was higher in Kingston (7.6%) in 2015 than the London (7.2%) and England (7.0%) averages. Please see Table 10.

Table 10 Live birth (number, rates and percentages) trends in Kingston, 2010 to 2015.

Year	Total Births	Crude Live Birth Rate[1]	General Fertility Rate (GFR)[2]	Total Period Fertility Rate (TPFR)[3]	Percentage of live births under 2500 grams
2015	2,350	13.5	59.0	1.66	7.6
2014	2,247	13.2	57.4	1.63	5.9
2013	2,112	12.7	54.4	1.55	7.1
2012	2,328	14.2	60.6	1.74	6.9
2011	2,289	14.3	60.7	1.75	6.1
2010	2,312	13.7	58.8	1.66	7.1

Source: Office for National Statistics licensed under the Open Government Licence, 2016.
Note:1) Live births per 1,000 population (all persons and all ages). This was calculated using the mid-year population estimates. 2) The General Fertility Rate (GFR) is the number of live births per 1,000 women aged 15 to 44. The GFRs have been calculated using the mid-2015 population estimates. 3) The national TPFRs have been calculated using the number of live births by single year of age and the mid-year population estimates.

Table 11 Live births by maternal age in Kingston (numbers and rate), London and England, 2015.

Age group (years)	Number	Rate per 1,000 women in age group*		
	Kingston	Kingston	London	England
Under 18	7	2.5	4.4	6.3
Under 20	31	6.4	10.5	14.3
20 to 24	169	24.5	46.5	57.7
25 to 29	419	61.3	75.2	100.5
30 to 34	896	120.4	106.5	111.3
35 to 39	654	91.6	81.8	66.7
40 to 44	165	24.6	22.9	14.2
45 and over	16	2.7	2.8	1.1
All ages	**2,350**	**59.0**	**63.9**	**62.5**

Source: Office for National Statistics, 2016.
Note: *The rates for women of all ages, under 18, under 20 and 45 and over have been calculated using mid-2015 population estimates for the female population aged 15 to 44, 15 to 17, 15 to 19 and 45 to 49 respectively.

Infant Mortality

The infant mortality rate (IMR) is defined as the number of deaths under the age of one year, per 1,000 live births.

Infant mortality is seen as a key measure of the population's health, with a long-established link with social and health inequalities.

Reducing infant mortality overall and the gap between the richest and poorest groups are part of the Government's strategy for public health[2]. The number of infant deaths is generally small, however, its impact is huge for the individuals, their families as well as the population they are part of. There is therefore a need to maximise the opportunities for reducing the risk of infant death where it is possible.

Table 12 Infant Mortality and Still Births (3 year average) in Kingston, London and England, 2012-14.

Indicator	Definition	Number	Mortality rate per 1,000 live births		
		Kingston	Kingston	London	England
Still birth	Death at or before delivery	27	4.0 (2.8 to 5.9)	5.2 (5.0 to 5.5)	4.7 (4.6 to 4.8)
Early Neonatal mortality	Deaths under 7 days	19	2.8 (1.8 to 4.5)	1.9 (1.8 to 2.1)	2.1 (2.1 to 2.2)
Peri-natal mortality	Still births and deaths under 7 days	46	6.9 (5.1 to 9.1)	7.2 (6.9 to 7.4)	6.8 (6.7 to 6.9)
Neonatal mortality	Deaths under 28 days	23	3.4 (2.3 to 5.2)	2.5 (2.3 to 2.6)	2.8 (2.7 to 2.8)
Post-neonatal mortality	Deaths between 28 days and 1 year	6	0.9 (0.4 to 2.0)	1.1 (1.0 to 1.2)	1.2 (1.2 to 1.3)
Infant mortality	Deaths under 1 year	29	4.3 (3.0 to 6.2)	3.6 (3.4 to 3.8)	4.0 (3.9 to 4.1)

Source: The NHS Indicator Portal, 2016.

Notes: Values in brackets denote 95% confidence intervals. Some deaths are included in more than one indicator category (see Glossary for definitions).

In Kingston, there were 29 infant deaths and 27 still births during the three year period 2012-14. Most infant deaths occurred under 28 days old (23 deaths), but there were 6 deaths between 28 days and 1 year old.

The IMR for Kingston during this period (4.3 per 1,000 live births) was not significantly different from the national (4.0 per 1,000 live births) and London (3.6 per 1,000 live births) average. There was a wide variation in infant mortality rates within London, with Hackney's IMR rate about three times higher than the rate for Bromley[3]. Explanations for the variations in the IMR between different populations are complex. Variation in IMR due to ethnic differences involves the interplay of a large number of environmental factors including; deprivation, physiological, behavioural and cultural factors[4]. The IMR may also be affected by healthcare and other care at birth and during the first year of life.See Table 12.

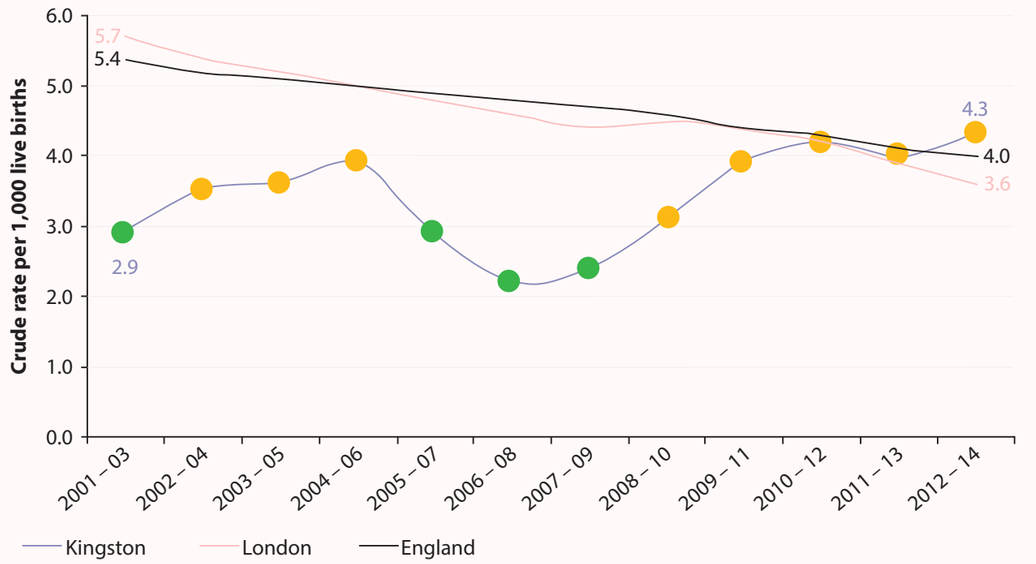
Figure 6 shows the three year average trends (2001-03 to 2012-14) of infant mortality in Kingston, London and England. The IMR for Kingston has fluctuated over the last decade due to the small number of deaths involved, but overall it was lower than the regional and national averages between 2001-03 and 2009-11.

Although the Kingston rate began to increase from 2008-10 onward, it was not significantly different from the England average.

The rates of still births in Kingston (4.0 per 1,000 live births) were lower than the London (5.2 per 1,000 live births) and England (4.7 per 1,000 live births) averages in 2012-14. The number of still births in Kingston has decreased from 13 in 2014 to six in 2015.

Reducing infant mortality requires a combination of health interventions together with actions on the wider social determinants of health and partnership between local authorities, health and the voluntary and community sector is important. These interventions must start before birth as emphasized by the Marmot Report (2015), which stated that the key to reducing infant mortality is to give priority to the early years, including infant and maternal health. Please see Table 12 and Figure 6.

Figure 6 Infant mortality trends (three year average) in Kingston, London and England, 2001–03 to 2012-14.



Source: Public Health England, 2016.

Life Expectancy

Life expectancy (LE) is a common measure of the populations' health and is often used as a summary measure when comparing groups of people living in different geographical areas. Life expectancy at birth indicates how long a person can expect to live on average given the prevailing mortality rates in that area. People in Kingston continue to have better health than the national average and this is reflected in their life expectancy.

Life expectancy at birth for the three year period 2013-15 in Kingston was 81.5 for men and 84.5 years for women. These were above the London life expectancies of 80.2 years for men and 84.1 years for women and also above the England averages (79.5 years for men, 83.1 years for women). During the same period, life expectancy at 65 years in Kingston was 19.7 years for men and 21.9 years for women. These were higher than the life expectancies in London (19.1 years for men and 21.7 years for women) and England 18.7 years for men and 21.1 years for women).

Healthy life expectancy (HLE), also called disability adjusted life expectancy, represents the average number of years that a person can expect to live in full health. This measure of full health is based on contemporary mortality rates and the prevalence of self-reported good health. The prevalence of good health is derived from the responses to a survey question from the Annual Population Survey on general health. The HLE at birth for both males (67.9 years) and females (68.6 years) living in Kingston was above the averages for London (male 64.1 years and female 64.1 years) and England (male 63.4 years and female 64.1 years). The healthy life expectancy (HLE) at 65 years for men (13.7 years) and women (12.4 years) living in Kingston was higher than the London (male 10.6 years and female 10.3 years) and national (male 10.5 years and female 11.2 years) average.

Disability-Free Life Expectancy (DFLE) estimates lifetime free from a limiting persistent illness or disability. This is based upon a self-rated assessment of how health limits an individual's ability to carry out day-to-day activities. DFLE generates information on the geographical distribution of disability and provides an evidence that both the government and private sector can use to make decisions.

The data can be used as evidence for funding health and social care and to determine the feasibility of increases to the state pension age. It also has use in private sector pensions and provides the general public with information on how their local area's health compares with neighbouring areas and with England as a whole. The DFLE at birth for both males (69.3 years) and females (67.6 years) living in Kingston was above the London (male 64.1 years and female 63.1 years) and England (male 63.0 years and female 62.6 years) averages. The DFLE at 65 years for men (13.8 years) and women (12.5 years) living in Kingston was higher than the regional (male 13.8 years and female 9.9 years) and national (male 10.0 years and female 10.2 years) average. Please note that both HLE and DFLE are calculated for upper tier local authorities only (Kingston is an upper tier local authority) and both are summary measures of population health and key indicators of the wellbeing of society.

Life expectancy has shown a noticeable increase for those in more affluent social groups whilst for those in the more deprived social groups there has been less progress. The slope index of inequality in life expectancy at birth is a measure of the socioeconomic inequalities in health between different areas that gives more detail on the deprivation that exists at small area level. Table 13 shows that for the three year period 2012-14, the gap in the life expectancy in Kingston between those living in the most and least deprived deciles was 4.8 years for men and 4.6 years for women.

Table 14 shows the average life expectancy for people living in Kingston by ward. Males living in Alexandra and Tudor wards had the highest life expectancy at birth (83.7 years) whilst those living in Coombe Hill and Old Malden had the highest life expectancy at 65 years; 21.5 and 22.2 years respectively. Similarly, females living in Alexandra (LE at birth: 88.1 years, LE at 65: 25.1 years) and Tudor (LE at birth: 87.5 years, LE at 65: 24.8 years) wards also had the highest life expectancy at birth and at 65 years of age.

Males living in Norbiton ward showed the lowest life expectancy at birth (77.9 years) and at 65 years of age (16.7 years). A similar pattern was observed with the female life expectancy at birth and 65 years in Norbiton ward (80.9 years and 19.2 years respectively), thus emphasizing the relationship between life expectancy and deprivation.

Please see Table 13 and 14 for life expectancy statistics.

Table 13 Life expectancy (three year average) in Kingston, London and England.

Period	Indicator		Kingston	London	England
2013-15	Life expectancy at birth	Female	84.5 (83.9 to 85.0)	84.1 (84.0 to 84.1)	83.1 (83.1 to 83.1)
		Male	81.5 (81.0 to 82.1)	80.2 (80.1 to 80.3)	79.5 (79.4 to 79.5)
	Life expectancy at 65	Female	21.9 (21.5 to 22.4)	21.7 (21.7 to 21.8)	21.1 (21.1 to 21.1)
		Male	19.7 (19.2 to 20.2)	19.1 (19.0 to 19.2)	18.7 (18.7 to 18.7)
	Healthy life expectancy at birth	Female	68.6 (65.7 to 71.4)	64.1 (63.6 to 64.6)	64.1 (63.9 to 64.3)
		Male	67.9 (64.8 to 71.0)	64.1 (63.6 to 64.6)	63.4 (63.2 to 63.5)
	Healthy life expectancy at 65	Female	12.4 (9.9 to 14.8)	10.6 (10.2 to 11.0)	11.2 (11.1 to 11.3)
		Male	13.7 (11.1 to 16.5)	10.3 (9.9 to 10.7)	10.5 (10.3 to 10.6)
	Disability free life expectancy at birth	Female	67.6 (64.7 to 70.5)	63.1 (62.6 to 63.6)	62.6 (62.5 to 62.8)
		Male	69.3 (66.7 to 71.9)	64.1 (63.7 to 64.6)	63.0 (62.9 to 63.2)
	Disability free life expectancy at 65	Female	12.5 (10.0 to 14.9)	9.9 (9.5 to 10.3)	10.2 (10.1 to 10.4)
		Male	13.8 (11.6 to 15.9)	10.1 (9.7 to 10.5)	10.0 (9.9 to 10.1)
	Gap in life expectancy at birth between each local authority and England as a whole	Female	1.4 (0.8 to 1.9)	1.0 (0.9 to 1.0)	-
		Male	2.1 (1.5 to 2.6)	0.8 (0.7 to 0.8)	-
2012-14	Slope index of inequality in life expectancy at birth within English local authorities, based on local deprivation deciles: the range in years of life expectancy across the social gradient within each local authority, from most to least deprived	Female	4.6 (2.0 to 7.2)	-	-
		Male	4.8 (0.6 to 9.0)	-	-

Source: Public Health England, 2017.
Note: "-"denotes values not available.

Table 14 Life expectancy (five year average) in Kingston ward, 2010-14.

	Life expectancy at birth		Life expectancy at 65	
	Male	Female	Male	Female
Alexandra	83.7 (81.5 to 85.8)	88.1 (85.4 to 90.8)	21.4 (19.5 to 23.3)	25.1 (22.6 to 27.7)
Berrylands	79.6 (77.7 to 81.6)	84.9 (83.1 to 86.7)	19.1 (17.5 to 20.7)	22.5 (21.0 to 24.0)
Beverley	82.2 (80.6 to 83.9)	81.7 (80.1 to 83.3)	19.2 (17.7 to 20.8)	20.1 (19.0 to 21.2)
Canbury	81.8 (79.7 to 83.8)	85.9 (84.2 to 87.7)	19.8 (17.9 to 21.7)	22.9 (21.3 to 24.5)
Chessington North and Hook	79.7 (77.8 to 81.7)	87.0 (84.7 to 89.2)	19.0 (17.5 to 20.5)	23.7 (21.5 to 25.9)
Chessington South	82.5 (80.3 to 84.8)	83.6 (81.9 to 85.4)	20.9 (18.8 to 22.9)	21.2 (19.9 to 22.5)
Coombe Hill	82.8 (80.8 to 84.8)	84.4 (82.6 to 86.2)	21.5 (19.9 to 23.1)	22.4 (21.2 to 23.7)
Coombe Vale	84.2 (82.2 to 86.1)	86.7 (84.9 to 88.5)	20.8 (19.0 to 22.7)	23.2 (21.4 to 24.9)
Grove	80.7 (78.8 to 82.6)	85.5 (82.8 to 88.1)	19.1 (17.4 to 20.8)	23.9 (21.5 to 26.3)
Norbiton	77.9 (76.0 to 79.8)	80.9 (79.3 to 82.5)	16.7 (15.0 to 18.4)	19.2 (18.0 to 20.4)
Old Malden	83.9 (81.7 to 86.2)	88.0 (85.9 to 90.1)	22.2 (20.3 to 24.0)	24.9 (23.0 to 26.9)
St James	80.7 (79.2 to 82.3)	83.0 (81.4 to 84.7)	18.4 (17.1 to 19.7)	20.8 (19.7 to 22.0)
St Marks	81.9 (79.9 to 84.0)	84.4 (82.2 to 86.7)	19.5 (17.6 to 21.4)	22.1 (20.1 to 24.1)
Surbiton Hill	79.8 (78.1 to 81.6)	82.9 (81.5 to 84.2)	18.5 (17.0 to 19.9)	19.5 (18.3 to 20.7)
Tolworth and Hook Rise	81.4 (79.4 to 83.3)	87.2 (84.8 to 89.7)	19.7 (18.0 to 21.4)	24.5 (22.2 to 26.8)
Tudor	83.7 (81.7 to 85.7)	87.5 (85.3 to 89.7)	20.9 (19.1 to 22.7)	24.8 (22.7 to 26.9)

Source: Greater London Authority (GLA), 2016.
Created using ONS mortality data (vital stats) and ONS mid-year population estimates.

Morbidity

Recorded illness in general practice can help to present a picture of the burden of ill health within the population. For many conditions, individuals receiving healthcare in the community provide particularly useful information since they give an indication of the local need.

It should be noted that estimates of the prevalence of a condition in the community can be affected by a range of factors including diagnostic practice and data recording. This is because it is impossible to completely standardise the methods used by clinicians to confirm a diagnosis, and there may also be variations in the completeness and accuracy of the practice records. Moreover, symptoms of a certain condition may be difficult to recognise and even if recognised the patient may not wish to seek medical attention.

Table 15 compares the prevalence of the main conditions encountered by the people attending local general practices with the estimated national prevalence from surveys and other studies, and with the modelled estimated prevalence for Kingston that takes into account the demography of the local population. This table shows that the identified prevalence of some of the conditions, such as Hypertension, Chronic Obstructive Pulmonary Disorder and Coronary Heart Disease in general practices, are lower than the estimated prevalence of these conditions in the community. This is sometimes referred to as the 'diagnostic gap', where not everyone with a condition has been identified.

Table 15 Prevalence of main conditions in primary care, March 2016.

	Number on disease register	Practice Prevalence (%)	National Population Prevalence	Modelled prevalence of the condition in Kingston
Hypertension	20,759	10.1%	32.0%	20.0%
Obesity (19 years and above)	8,151	4.0%	27.0%	14.8%
Depression (19 years and above)	9,985	4.9%	4 - 10%	-
Asthma	9,587	4.7%	12.0%	-
Diabetes	8,094	4.0%	7.3%	6.9%
Coronary Heart Disease (CHD)	4,250	2.1%	6.5%	3.8%
Chronic Kidney Disease (CKD)	3,560	1.7%	8.8%	7.1%
Cancer	3,837	1.9%	356,860 new cases	-
Chronic Obstructive Pulmonary Disease (COPD)	2,334	1.1%	2.0%	3.5%
Atrial Fibrillation	2328	1.1%	2.4%	1.9%
Stroke or Transient Ischaemic Attacks (TIA)	2,059	1.0%	2.3%	1.8%
Mental Health[$$]	1,703	0.8%	16.2%	-
Dementia	1,012	0.5%	7.1%[$]	-
Epilepsy	929	0.5%	2 - 5%	-
Heart Failure	918	0.4%	0.8%	-
Rheumatoid Arthritis	830	0.4%	-	-
Peripheral Arterial Disease	648	0.3%	-	-
Peripheral Arterial Disease (54 to 74 years)	308	0.2%	20.0% of 55 to 75 year olds*	-
Learning Disabilities	557	0.3%	2.5%	-
Palliative Care	298	0.1%	n/a	-
Osteoporosis (49 years and over)	156	0.1%	2.0% of people aged 50 years and over	-
Osteoporosis (79 years and over)	106	0.1%	25.0% at aged 80 years and over	-

Source: Number on disease registers and practice prevalence are taken from the Practice Focus Report, March 2016 and see Box 1 for modelled estimates and national population prevalence sources. Note: 1) n/a denotes not applicable. 2) Number of people on disease register: The number of people identified with a particular condition or a certain lifestyle. 3) Practice Prevalence (%): The percentage of people identified with a particular condition or a certain lifestyle of all people registered with local practices. 4) National Prevalence: The estimated prevalence of a condition in the country. 5) Modelled Prevalence: The estimated prevalence of a condition in a certain community taking into account factors such as the ethnicity, deprivation, gender and age structure of that community. 6)* denotes that around 20% of the UK population aged 55-75 years have evidence of lower extremity peripheral arterial disease, one in 20 of whom have symptoms. 7) [$]denotes the total population prevalence of dementia among over 65s is 7.1% (based on 2013 population data). 8) [$$]denotes count related to the QOF Severe Mental Illness which is schizophrenia, bipolar affective disorder and other psychoses, and other patients on lithium therapy.

Box 1 Modelled estimates and national population prevalence sources.

Condition	Source
Hypertension	British Heart Foundation and Easing the pressure: tackling hypertension, Hypertension: the public health burden, Faculty of Public Health and National Heart Forum.
Obesity	British Heart Foundation and Kingston Lifestyle Survey, 2014
Depression	Adult Psychiatric Morbidity Survey, 2007
Asthma	Asthma Statistics, British Lung Foundation, accessed 2016
Diabetes	APHO Prevalence Model, 2012
Coronary Heart Disease	British Heart Foundation
Chronic Kidney Disease	APHO modelled prevalence
Cancer	Cancer Research UK, 2014
Stroke or TIA	British Heart Foundation
Atrial Fibrillation (AF)	National Cardiovascular Intelligence Network, 2015
Chronic Obstructive Pulmonary Disease (COPD)	COPD Statistics, British Lung Foundation, accessed 2016
Mental Health	Adult Psychiatric Morbidity Survey, 2007
Heart Failure	British Heart Foundation
Epilepsy	The incidence and prevalence of epilepsy, UCL Institute of Neurology, Queen Square, London, Epilepsy Society.
Dementia	Dementia UK: Update (Second edition), Nov 2014
Learning Disability	British Institute of Learning Disabilities (BILD)
Osteoporosis	Osteoporosis in UK at Breaking Point Report, 2010

Mortality

There were 972 (451 males and 521 females) deaths of Kingston residents in 2014, a decrease of 150 deaths (13.4%) since 2013. Of these 315 deaths (32.4%) were amongst people less than 75 years of age.

Table 16 summarises the main cause of deaths in Kingston residents by age and gender.

Ischaemic heart disease was the leading cause of death for males in 2014, which accounted for 14.6% of all male deaths. The leading cause of death for females during the same period was vascular and unspecified dementia, which accounted for 10.4% of all female deaths. The second leading cause of death in 2014 was malignant neoplasm of digestive organs (8.9%) for males and pneumonia (8.4%) for females.

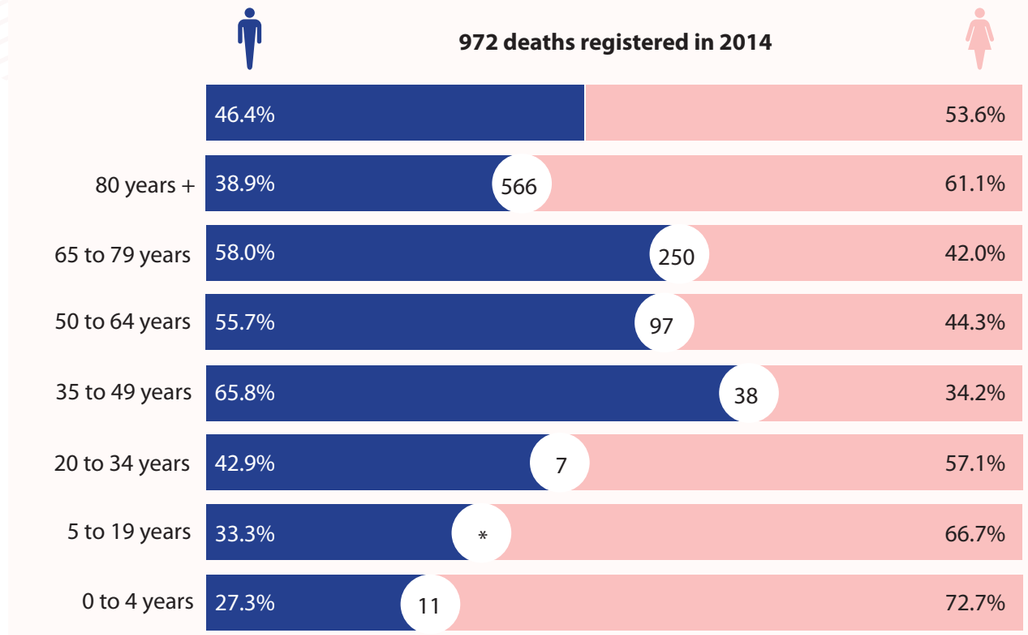
Figure 7 shows number of deaths by age group and gender. 9.9% of the total deaths in Kingston were amongst people aged 50 to 64 years, 25.7% were amongst people aged 65 to 79 years and 58.2% were amongst those aged 80 years and above.

Table 16 Main causes of deaths (number and percentage) at all ages and under 75 years of age in Kingston, 2014.

	All Ages				Under 75			
	Male	Female	Total	%	Male	Female	Total	%
Malignant neoplasm	137	144	281	28.9%	70	63	133	42.2%
Diseases of the circulatory system	140	136	276	28.4%	57	17	74	23.5%
Diseases of the respiratory system	59	92	151	15.5%	16	16	32	10.2%
Other causes of death	115	149	264	27.2%	47	29	76	24.1%
Total	**451**	**521**	**972**	**100.0%**	**190**	**125**	**315**	**100.0%**

Source: 2014 Vital Statistics (VS3), Office of National Statistics, 2016.

Figure 7 Deaths in Kingston by age and gender, 2014.



Source: 2014 Vital Statistics (VS3), Office of National Statistics.
Note: * denotes numbers less than 5.

Economic Indicators

Evidence of the existence of social inequalities in health in England has been demonstrated for over 150 years. In the past it was easy to see the contributing links from low income, through poor housing and sanitation, inadequate diets and hazardous jobs, to poor health due to infectious diseases, injuries and accidents. In our increasingly complex world however, the relationship between income and health is more nuanced and it is clear that there are complex chains of exposures, pathways, and other influencing factors between income and health across an individual's life course. Reducing inequalities in health is a key government policy across the UK, and reducing poverty and improving family incomes are key components of such policies[5].

The Office of National Statistics (ONS) undertakes annual surveys to identify the levels of economic activity in the country. Table 17 shows the key out-of-work benefit claimants' data released by the ONS on a monthly basis. It enables a comparison of the number of benefit claimants and job seekers allowance claims between Kingston, London and England, showing that there was a smaller proportion of claimants in Kingston than the London and national averages, for every group except those bereaved.

Table 18 shows the claimant data for Kingston wards by gender and highlights that Grove and Norbiton ward had the highest proportion of people claiming the jobseekers allowance in Kingston.

Table 17 Key out-of-work benefit statistics for Kingston, London and England, May 2016.

Statistical Group	Kingston		London		England	
	Number	Rate (%)	Number	Rate (%)	Number	Rate (%)
Total	7,200	6.2	582,310	9.9	3,856,070	11.1
Job seeker	950	0.8	87,780	1.5	447,920	1.3
ESA and incapacity benefits	3,610	3.1	293,280	5.0	2,031,350	5.9
Lone parent	720	0.6	62,450	1.1	359,940	1.0
Carer	900	0.8	73,250	1.2	565,030	1.6
Others on income related benefit	120	0.1	12,120	0.2	73,320	0.2
Disabled	730	0.6	45,530	0.8	316,700	0.9
Bereaved	180	0.2	7,910	0.1	61,800	0.2
Main out-of-work benefits	5,400	4.6	455,630	7.7	2,912,540	8.4

Source: Nomisweb, 2017.
Note: 1) Main out-of-work benefits include the groups: jobseekers, ESA and incapacity benefits, lone parents and others on income related benefits. 2) % is the proportion of the 16 to 64 years of age resident population of an area 3) Rates for local authorities, region and countries from 2015 onwards are calculated using the mid-2015 resident population aged 16-64. 4). Percentages of population receiving state benefits have been calculated using populations aged 16 to64 for both men and women. The age at which women reach State Pension age is gradually increasing from 60 to 65 between April 2010 and April 2020. Hence, until April 2020, some women included in the population Figure are not eligible to be part of the count of working age benefit claimants. There will be some time series discontinuity over this period, with trends partly reflecting the changing eligibility criteria.

Table 18 Out-of-work claimant count* and rates by gender in Kingston wards, December 2016.

Area	Total		Male		Female	
	Number	Rate (%)	Number	Rate (%)	Number	Rate (%)
Alexandra	75	1.2	50	1.6	25	0.8
Berrylands	85	1.3	55	1.6	30	0.9
Beverley	95	1.4	60	1.7	35	1.0
Canbury	85	0.8	55	1.1	30	0.6
Chessington North and Hook	60	1.0	35	1.2	25	0.8
Chessington South	55	0.8	30	0.8	30	0.8
Coombe Hill	65	0.8	35	0.9	30	0.8
Coombe Vale	45	0.7	25	0.7	20	0.7
Grove	120	1.3	65	1.5	50	1.2
Norbiton	115	1.5	65	1.6	50	1.4
Old Malden	70	1.1	35	1.2	30	1.0
St James	55	0.9	30	1.0	25	0.9
St Mark's	95	0.9	55	1.0	40	0.7
Surbiton Hill	80	1.0	50	1.3	30	0.8
Tolworth and Hook Rise	70	1.0	45	1.3	25	0.7
Tudor	45	0.8	30	1.0	15	0.5
Kingston upon Thames	**1,205**	**1.0**	**715**	**1.2**	**490**	**0.8**

Source: Nomisweb, 2017.
Note: 1)* Claimant count is defined as the number of people claiming Jobseeker's Allowance plus those who claim Universal Credit who are out of work. 2) Rates are calculated for proportion of resident population (ONS 2015 mid-year estimates) aged 16-64. 3) All data are rounded to the nearest 5 and may not precisely add to the sum of the number of people claiming JSA, published on Nomis, and the number of people claiming Universal Credit required to seek work, published by DWP, due to independent rounding. 4) Figures may not add due to rounding.

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Abbreviations

AfC	Achieving for Children
AIDS	Aquired Immunodeficiency Syndrome
ART	Antiretroviral therapy
BAME	Black, Asian and Minority Ethnic
BASHH	British Association for Sexual Health and HIV
BME	Black and Minority Ethnic
BPAS	British Pregnancy Advisory Service
CaSH	Contraception and Sexual Health
CCG	Clinical Commissioning Group
CQC	Care Quality Commission
CSE	Child Sexual Exploitation
DFLE	Disability-Free Life Expectancy
DH	Department of Health
EC	Emergency Contraception
EHC	Emergency Hormonal Contraception
ELSA	English Longitudinal Study of Ageing
EPPI Centre	Evidence for Policy and Practice Information and Co-ordinating Centre
FGM	Female Genital Mutilation
FPA	Family Planning Association
FSFC	Family Support First Contact Team
FSRH	Faculty of Sexual and Reproductive Healthcare
GBL	Gammabutyrolactone
GFR	General Fertility Rate
GHB	Gammahydroxybutrate
GLA	Greater London Authority
GP	General Practice/General Practitioner
GUM	Genitourinary Medicine
HAART	Highly Active Antiretroviral Therapy
HARS	HIV and AIDS Reporting System
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
HSV	Herpes Simplex Virus
IMR	Infant Mortality Rate
IUD	Intrauterine Device
IUS	Intrauterine System
KISH	Kingston Integrated Sexual Health
KU19	Kingston Under 19
LAC	Looked After Children
LARC	Long Acting Reversible Contraception
LASER	Local Authority Sexual and Reproductive Health Epidemiology Report
LE	Life Expectancy
LGBT	Lesbian, Gay, Bisexual and Transgender
LGV	Lymphogranuloma Venereum
LSCB	Local Safeguarding Children Board
MASE	Multi Agency Sexual Exploitation Group
MISPER	The Kingston Missing Persons (MISPER) Group
MSM	Men who have Sex with Men
NCSP	National Chlamydia Screening Programme
NICE	National Institute for Health and Care Excellence
ONS	Office for National Statistics
PACT	Prescribing Analysis and Cost Data
PEPSE	Post Exposure Prophylaxis for Sexual Exposure
PHE	Public Health England
PID	Pelvic Inflammatory Disease
PLD	People with a Learning Disability
PLWHIV	People Living with HIV
POPPI	Projecting Older People Population Information
PrEP	Pre-Exposure Prophylaxis
PSHE	Personal, Social, Health & Economic
RBK	Royal Borough of Kingston upon Thames
RCN	Royal College of Nursing
SCR	Serious Case Review
SHEU	School Health Education Unit
SHRAD	Sexual and Reproductive Health Activity Data Set
SPA	Single Point of Access
SRE	Sex and Relationship Education
SRH	Sexual and Reproductive Healthcare
STI	Sexually Transmitted Infection
STI(s)	Sexually Transmitted Infection (s)
THT	Terrence Higgins Trust
TPFR	Total Period Fertility Rate
UDM	User Dependant Methods
UK	United Kingdom
VCSO	Voluntary and Community Sector Organisation
WSW	Women who have Sex with Women
YHC	Your Healthcare
YPLD	Young People with Learning Disabilities
YW	You're Welcome

Glossary

Acquired Immune Deficiency Syndrome (AIDS)
AIDS is the final stage of HIV infection, when the body can no longer fight life-threatening infections. With early diagnosis and effective treatment, most people with HIV will not go on to develop AIDS.

Antiretroviral Therapy (ART)
Medicines used in the management of HIV.

Asymptomatic
A person is considered asymptomatic when they are a carrier of a disease or infection, but experience no symptoms.

CD4 Count
A CD4 count is a test that measures the number of CD4 T lymphocytes (CD4 cells) in a sample of blood. In people with HIV, it is the most important laboratory indicator of how well the immune system is working.

Chlamydia
Chlamydia is one of the most common sexually transmitted infections (STIs) in the UK. It is passed on from one person to another through unprotected sex and is particularly common in sexually active teenagers and young adults.

Deciles
Deciles are calculated by ranking the 32,844 small areas in England from most deprived to least deprived and dividing them into 10 equal groups.

Deprivation
The lack or denial of something considered to be a necessity.

Ectopic Pregnancy
An ectopic pregnancy is when a fertilised egg implants itself outside of the womb, usually in one of the fallopian tubes. The fallopian tubes connect the ovaries to the womb. If an egg becomes stuck in them, it will not develop into a baby and a woman's health may be at risk if the pregnancy continues.

Emergency Contraception (EC)
This can be used after sexual intercourse to avoid pregnancy. It works by delaying ovulation and/or preventing a fertilised egg from implanting in the womb.

European Union (EU) Accession Citizens
The European Union (EU) is an economic and political union of 28 countries. It operates an internal (or single) market which allows free movement of goods, capital, services and people between member states. One of the four freedoms enjoyed by EU citizens is the free movement of workers. This includes the rights of movement and residence for workers, the rights of entry and residence for family members, and the right to work in another Member State and be treated on an equal footing with nationals of that Member State.

Family Support First Contact Team (formerly the Family Support Team)
This service provides support to children from birth to 11 years in families where concerns have been raised. It covers Kingston and Richmond.

Genital Herpes
Genital herpes is a common infection cause by the Herpes Simplex Virus (HSV). It causes painful blisters to appear on and around the genital area. There is no cure for genital herpes, however antiviral medications can alleviate the symptoms.

Genital Warts
Genital warts are the result of a viral skin infection caused by the Human Papilloma Virus.

Gonorrhoea
Gonorrhoea is an STI caused by bacteria called Neisseria gonorrhoeae or gonococcus. The bacteria are mainly found in discharge from the penis and in vaginal fluid. Gonorrhoea is easily passed between people through unprotected vaginal, oral or anal sex and sharing sex toys that have not been washed or covered with a new condom each time they are used.

Health Inequalities
Health inequalities are where different population groups experience different health status due to social (e.g. level of education or income), geographical (e.g. area of residence) or other factors (e.g. lifestyle).

Human Immunodeficiency Virus (HIV)
HIV is a virus that attacks the immune system, and weakens the body's ability to fight infections and disease. It is most commonly caught by having sex without a condom, but can also be passed on by sharing infected needles and other injecting equipment, and from an HIV-positive mother to her child during pregnancy, birth and breastfeeding. There is no cure for HIV, but there are treatments to enable most people with the virus to live a long and healthy life.

Human Papilloma Virus (HPV)
Human papilloma virus (HPV) is the name for a group of viruses that affect your skin and the moist membrane lining of your body, for example the cervix, anus and mouth and throat. There are more than 100 types of HPV and around 30 of these affect the genital area. Genital HPV is common and easily passed on through sexual intercourse and skin-to-skin contact of the genital areas.

Infant Mortality Rate
The number of infants dying before their first birthday per 1,000 live births.

Integrated Sexual Health Service
A service which provides both contraception and STI /HIV testing and treatment.

Inter-censal
Occurring between official censuses.

Internal Migration
This is defined by the Office of National Statistics (ONS) as residential moves between local authorities and regions in England and Wales, as well as moves to or from the rest of the UK (Scotland and Northern Ireland). Internal migration statistics exclude some moves into and out of the armed forces and prisoners, which are predominantly men.

International Migration
This is a territorial relocation of people between nation-states. There are a number of ways to define an international migrant. The Office of National Statistics publishes statistics on both Long-Term International Migration (LTIM) to and from the UK and Short-Term International Migration (STIM) to and from England and Wales.

Kingston Integrated Sexual Health (KISH)
Kingston Integrated Sexual Health (KISH) is a network of services that aims to provide residents with a choice of high quality and integrated sexual health services throughout Kingston.

Kingston Young People's Health and Wellbeing Survey
This is a national health related behaviour survey for young people of primary and secondary school age. Locally, it is commissioned by Kingston Council and carried out every few years by the Schools and Students Health and Education Unit (SHEU) in secondary schools across Kingston. It covers a range of health topics including physical activity, diet, mental health, sexual health, drugs and alcohol and relationships.

The Kingston Missing Persons Group (MISPER)
This is a subgroup of the LSCB, chaired by the Associate Director of Safeguarding Services and Looked After Children that meets monthly to review children/young people who reside in Kingston, Kingston children living in other boroughs and other borough/counties' children living in Kingston who are missing. Children who live in or are looked after by another local authority are referred back to the child's residing authority.

Local Safeguarding Children's Board (LSCB)
Established by the Children Act 2004 which gives statutory responsibility to each locality to have this mechanism in place. LSCBs are now the key system in every locality of the country for organisations to come together to agree on how they will cooperate with one another to safeguard and promote the welfare of children. The purpose of this partnership working is to hold each other to account and to ensure safeguarding children remains high on the agenda across their region.

Long Acting Reversible Contraception (LARC)
These are methods of contraception that can be used for an extended period without requiring the user to do anything. They include intrauterine devices and subdermal implants.

Low Birth Weight
An infant being born with a weight less than 2,500 grams.

Multi Agency Sexual Exploitation Group (MASE)
This is a subgroup of the LSCB, chaired by a Detective Inspector of Kingston Police that meets monthly to maintain an overview of all children for whom there are CSE concerns. The Kingston MASE panel monitors and discusses children who reside in Kingston or are looked after by Kingston Children's Social Care and are placed outside of the borough. Kingston MASE are not responsible for discussing/monitoring children who have been placed in the borough, by another local authority area. These children will be discussed by MASE panels from the local authority that the child is from.

National Institute for Health and Care Excellence (NICE)
This organisation provides evidence-based guidance, advice and information services to health, public health and social care professionals.

Neonatal Mortality Rate
The number of infants dying in the first 27 postnatal days per 1,000 live births.

Perinatal
The perinatal period commences at 22 completed weeks (154 days) of gestation and ends seven completed days after birth.

Perinatal Mortality Rate
The number of stillbirths and deaths in the first six postnatal days per 1,000 total births.

Post Exposure Prophylaxis following Sexual Exposure (PEPSE)
This is a short course of HIV treatment, given to people who may have been exposed to HIV, in order to reduce the risk of them becoming HIV positive.

Postnatal
This is the period after birth.

Post Neonatal Mortality Rate
The number of infants dying at 28 days and over but under one year per 1,000 live births.

Pre Exposure Prophylaxis (PrEP)
This is HIV medication given to individuals in advance of any exposure to HIV in order to prevent them becoming infected with the virus. It is not currently available from the NHS, however a large pilot study is due to begin shortly.

Sexually Transmitted Infection (STI)
These are infections that are passed on from one person to another via sexual contact.

Serious Case Review (SCR)
A serious case review (SCR) takes place after a child dies or is seriously injured and abuse or neglect is thought to be involved, and there are concerns for how agencies worked together. Normally reviews are published. They look at lessons that can help prevent similar incidents from happening in the future. Serious Case Reviews are coordinated by the LSCB.

Single Point of Access Team (SPA)
SPA is the team responsible for child protection in Kingston.

Still birth
The birth of an infant that has died in the womb after 28 weeks of pregnancy.

Still birth Rate
The number of stillbirths per 1,000 total births.

Syphilis
Syphilis is a bacterial sexually transmitted infection that is usually caught by having sex with someone who is infected with this bacteria.

If left untreated it can cause serious problems, however if caught early it can be treated with a course of antibiotics.

User Dependent Methods of Contraception (UDMs)
These are methods of contraception that rely on the user to remember to take or use them at regular intervals (such as daily or weekly) or each time they have sex in order for them to be effective. Examples include the contraceptive pill, condoms, contraceptive patch.

Appendices

Appendix 1

Relationships and Sex Education (SRE) Charter 2016

Kingston's SRE Charter is based on the Key principles of effective prevention education produced by the PSHE Association, and is endorsed locally by the Boroughs Director of Public Health. SRE resources, including structured learning programmes provided by organisations commissioned through Kingston Public Health, are delivered in line with this Charter.

1. SRE is given the priority it deserves as an integral part of a school's overall curriculum, and uses a whole-school approach, including different types of interventions. This will ensure that the curriculum, school policies, pastoral support and the school ethos complement each other to create an environment that helps to prevent negative behaviours.

2. A developmental programme, appropriate to pupils' age and maturity will aid resilience and support during periods of transition in a student's educational life. In catering to such needs, the school will avoid interventions that induce fear, shock, or guilt.

3. Varied teaching styles, including active skills-based learning, will best secure student engagement. Aspects of learning will include:
   - Psychosocial aspects and normative education – developing confidence, resilience, self-esteem and self-efficacy.
   - Attitudes, values and perceived norms. Risk perception surrounding healthy or abusive relationships, child sexual exploitation (CSE), consent, sexting, on-line and off-line abuse, influence of the media, sexual behaviour and expression of sexuality, and gender. From whom and where to seek help if they have concerns or are being abused.

4. Learning that is inclusive of difference and relevant to the social and cultural background of pupils will play a direct role in reducing the likelihood of sexist, sexual, homophobic and transphobic bullying occurring in part through addressing some of the underlying attitudes and values that underpin it. Consideration should be given to the specific needs of vulnerable groups (although this list is not exhaustive):
   - Looked after children (LAC) and care leavers
   - Young people with physical or learning disabilities
   - Young offenders
   - Minority ethnic groups, including young refugees and travellers
   - Lesbian, gay, bisexual or transgender (LGBT) young people
   - Young people with mental health issues
   - Young people who have been or are at risk of being abused or abusing others
   - Young parents.

5. Well-trained teachers or external providers will deliver SRE that is evidence based, for example as promoted through the national PSHE CPD programme, and be part of ongoing evaluation of pupil's and teacher's views of the programme.

6. Building links between home and school, and supporting positive parenting practices, will aid in a community led design and development of the programme, and will ensure that the intervention takes place in multiple areas of a child's life.

Appendices

Appendix 2

KISH Services

The following services are all part of the Kingston Integrated Sexual Health (KISH) Network.

Further information can be found at www.kingston.gov.uk/sexualhealth

The Wolverton Centre for Sexual Health
This service offers a full range of contraception and STI testing and treatment regardless of age and gender. The clinic is open Monday to Friday and there are a mixture of appointment only and drop-in clinics (see www.sexualhealthkingston.co.uk for more information on specific clinic times).

The clinic also offers specific services for:

- young people
- men who have sex with men
- people with learning disabilities.

Your Healthcare Community Contraception and Sexual Health Clinics
These drop-in clinics are located around the borough and offer a range of contraception and STI testing and treatment regardless of age and gender. Clinics run across Kingston throughout the week and weekend, during the daytime and evening (see www.yourhealthcare.org for more information).

For young people under the age of 19 there are specialist drop-in clinics called KU19 that run at different locations across the borough throughout the week. These offer young people confidential advice on sexual health and relationships, contraception, pregnancy testing and some STI screening (see www.yourhealthcare.org for more information).

General Practice (GP)
GPs in Kingston offer a range of sexual health services, including chlamydia and gonorrhoea screening, contraception, emergency contraception, cervical smear testing, HIV testing (newly registered patients), pregnancy testing and free condoms (see www.nhs.uk for more information).

Community Pharmacy
All pharmacies should be able to provide basic information and signposting to sexual health services. 10 community pharmacies also offer specialist services for under 25s, including emergency contraception, free condoms, chlamydia and gonorrhoea screening and chlamydia treatment (see www.gettingiton.org.uk for more information).

British Pregnancy Advisory Service (BPAS)
BPAS provide Kingston's free and confidential termination of pregnancy service. You can self-refer to this service (see www.bpas.org for more information).

Achieving for Children
This social enterprise company offers youth support services across Kingston and Richmond with a focus on the most vulnerable young people (see www.acheivingforchildren.org.uk for more information).

Spectra C.I.C
This voluntary sector organisation offers health and wellbeing peer support services across London. In Kingston, Spectra delivers targeted HIV prevention programmes and an HIV support service (see www.spectra-london.org.uk for more information).

Terrence Higgins Trust
This is a national HIV and sexual health charity. In Kingston, Terrence Higgins Trust delivers sexual health services to young people including sex and relationships education and managing the local condom distribution scheme (see www.tht.org.uk for more information).

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کروائے۔ سے کسی یا کیجئے

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''ਜੇਕਰ ਤੁਸੀਂ ਅਪਾਹਜਤਾ ਜਾਂ ਭਾਸ਼ਾ ਦੇ ਕਾਰਣ ਇਸ ਦਸਤਾਵੇਜ਼ ਨੂੰ ਪੜ੍ਹਨ ਵਿੱਚ ਅਸਮਰਥ ਹੋ, ਤਾਂ ਅਸੀਂ ਤੁਹਾਡੀ ਸਹਾਇਤਾ ਕਰ ਸਕਦੇ ਹਾਂ। ਕਿਰਪਾ ਕਰਕੇ 020 8547 5000 'ਤੇ ਕਿੰਗਸਟਨ ਕੌਂਸਲ ਦੀ ਹੈਲਪਲਾਇਨ 'ਤੇ ਕਾੱਲ ਕਰੋ ਜਾਂ ਆਪਣੇ ਵੱਲੋਂ ਕਿਸੇ ਨੂੰ ਕਾੱਲ ਕਰਨ ਲਈ ਕਹੋ।''

Haddii aadan awoodin akhrinta dokumentigan sabab naafada ama luqadda ah, waan ku caawin karnaa. Fadlan soo wac Khadka caawimada ee Kawnsalka Kingston 020 8547 5000 ama qof ku matalaya ka codso inuu na soo waco

我们可以协助您，如果您因语言障碍或残疾不能阅读此文件。请拨打金斯敦市议会热线服务电话 020 8547 5000 或请求他人来代表您通话。

ئەگەر توانای خوێندنەوەی ئەم نوسراوەت نیە لەبەر پەککەوتەی/ بێ توانای یاخود لەبەر زمان تێنە گەیشتن ، ئەوا نیمە ئەتوانین یارمەتیت بدەین . تکایە پەیوەندی بکە بە هێلی یارمەتی شارەوانی کینگستۆنەوە (Kingston Council) بەژمارە تەلەفۆنی 020 8547 5000 یان بەکەسێ بڵێ کەبەناوی تۆوە پەیوەندی بکات .

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