Foreword

This needs assessment has been written to help inform the recommissioning of Human Immunodeficiency Virus (HIV) prevention, testing and support services for Luton residents.

Whilst the symptoms of HIV are now treatable and nationally the rates of new HIV infections are declining there are still new infections despite being a preventable illness, and those infected have lifelong consequences. Prevention starts with education for the whole population as well as those with HIV so that they know how to prevent passing on the infection. Testing for HIV is essential to help prevent the spread of the virus. People with HIV need supporting throughout their lives, to enable them to adhere to their medication requirements which will help to maintain a good quality of life.

Luton’s is populated with groups of people that are at high risk of becoming infected with HIV including men who have sex with men, black Africans, people who inject drugs and sex workers. We need to ensure that the services we commission to prevent transmission of HIV are efficient and effective helping to ensure that the population of Luton has a lower risk of new cases of this virus.

Kelly O’Neill
Service Director, Healthy Lives and Childrens’ Commissioning
# Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foreword</td>
<td>2</td>
</tr>
<tr>
<td>Contents</td>
<td>3</td>
</tr>
<tr>
<td>List of figures/ tables</td>
<td>5</td>
</tr>
<tr>
<td>Aim, Purpose and Scope</td>
<td>7</td>
</tr>
<tr>
<td>Executive Summary</td>
<td>8</td>
</tr>
<tr>
<td>Recommendations</td>
<td>10</td>
</tr>
<tr>
<td>Assessment</td>
<td>12</td>
</tr>
<tr>
<td>Introduction</td>
<td>12</td>
</tr>
<tr>
<td>Local demographics</td>
<td>12</td>
</tr>
<tr>
<td>Population projection</td>
<td>13</td>
</tr>
<tr>
<td>Ethnicity and Diversity</td>
<td>14</td>
</tr>
<tr>
<td>Deprivation</td>
<td>15</td>
</tr>
<tr>
<td>Life expectancy</td>
<td>16</td>
</tr>
<tr>
<td>HIV and Vulnerable Groups</td>
<td>21</td>
</tr>
<tr>
<td>National Context</td>
<td>27</td>
</tr>
<tr>
<td>NICE Guidelines</td>
<td>32</td>
</tr>
<tr>
<td>Literature Review</td>
<td>34</td>
</tr>
<tr>
<td>Local Picture</td>
<td>35</td>
</tr>
<tr>
<td>Overview</td>
<td>35</td>
</tr>
<tr>
<td>Local HIV overview</td>
<td>37</td>
</tr>
<tr>
<td>HIV Testing</td>
<td>40</td>
</tr>
<tr>
<td>Vulnerable Groups</td>
<td>44</td>
</tr>
<tr>
<td>Finances</td>
<td>46</td>
</tr>
<tr>
<td>Local service provision</td>
<td>56</td>
</tr>
<tr>
<td>Consultation</td>
<td>63</td>
</tr>
<tr>
<td>Recommendations</td>
<td>64</td>
</tr>
<tr>
<td>Strategic Recommendations</td>
<td>64</td>
</tr>
</tbody>
</table>
List of figures/ tables

Figure 1: Luton’s Population by age and gender
Figure 2: Luton population density
Table 1: Luton population projections by age from 2011 to 2031
Figure 3: Ethnic composition of Luton and England
Figure 4: Map of Luton by Index of Multiple Deprivation 2015
Figure 5: Life expectancy in Luton and England (Male)
Figure 6 Life expectancy in Luton and England (Female)
Figure 7: Life expectancy, males, Luton and comparator areas, 2012-14
Figure 8: Life expectancy, females, Luton and comparator areas, 2012-14
Figure 9: Slope Index of Inequality (Males)
Figure 10: Slope Index of Inequality (Females)
Figure 11: Life Expectancy by MSOA, Males, 2009-13
Figure 12: Life Expectancy by MSOA, Females, 2009-13
Figure 13: Healthy life expectancy, Males 2012-14
Figure 14: Healthy life expectancy, Females 2012-14
Figure 15: Percentage of people who were unaware of the HIV status
Figure 16: New cases of sexually transmitted infections (trend)
Figure 17: New cases of sexually transmitted infections (comparison)
Figure 18: New cases of sexually transmitted infections (excluding Chlamydia in the under 25s) (trend)
Figure 19: New cases of sexually transmitted infections (excluding Chlamydia in the under 25s) (comparison)
Figure 20: STI testing positively (excluding chlamydia) aged under 25 years
Figure 21: STI testing positively (excluding chlamydia) aged under 25 years (comparison)
Figure 22: New HIV diagnosis rate (15+ population)
Figure 23: New HIV diagnosis rate (15+ population) (comparison)
Figure 24: HIV prevalence per 1,000 (15-59 population)
Figure 25: HIV prevalence per 1,000 (15-59 population) (comparison)
Figure 26: Trend in Luton residents diagnosed with HIV
Figure 27: Ethnic group of people living with HIV in Luton
Figure 28: The age of HIV treatment population in Luton
Figure 29: HIV testing uptake
Figure 30: HIV testing uptake (comparison)
Figure 31: HIV testing uptake in MSM
Figure 32: HIV testing uptake in MSM (comparison)
Figure 33: HIV testing uptake in women
Figure 34: HIV testing uptake in women (comparison)
Figure 35: HIV testing uptake in men
Figure 36: HIV testing uptake in men (comparison)
Figure 37: HIV testing coverage
Figure 38: HIV testing coverage (comparison)
Figure 39: HIV testing coverage in MSM
Figure 40: HIV testing coverage in MSM (comparison)
Figure 41: HIV testing coverage in women
Figure 42: HIV testing coverage in women (comparison)
Figure 43: HIV testing coverage in women
Figure 44: HIV testing coverage in women (comparison)
Figure 45: Late diagnosis of HIV
Figure 46: Late diagnosis of HIV (comparison)
Figure 47: Proportion of TB cases offered an HIV test
Figure 48: Proportion of TB cases offered an HIV test (comparison)
Figure 49: Public Health Spend and Outcome quadrant chart by programme
Figure 50: Sexual Health Indicators (SpOT)
Figure 51: Spend per head of population for sexually transmitted infection testing and treatment (SpOT) 49
Figure 52: Spend per head of population for sexual health services, contraception (SpOT) 50
Figure 53: Spend per head of population sexual health services advice, prevention and promotion (SpOT) 50
Figure 55: HIV diagnosed prevalence rate (SpOT) 52
Figure 56: HIV late stage diagnosis (SpOT) 52
Figure 57: HIV testing coverage in men (SpOT) 53
Figure 58: HIV testing coverage MSM (SpOT) 53
Figure 59: HIV testing coverage in women (SpOT) 54
Figure 60: HIV testing uptake, men (SpOT) 54
Figure 62: HIV testing uptake, women (SpOT) 55
Figure 63: Age and gender of people accessing CAFPH services 56
Table 2: Proportion of people accessing CAFPH services by age group 57
Figure 64: Ethnic group of people accessing CAFPH services 58
Table 3: Sessions attended by CAFPH clients 58
Table 4: Embrace clients by age group, 2015/16 59
Figure 65: Embrace clients by age and gender, 2015/16 60
Figure 66: Embrace clients by ethnic group 60
Table 5: Number of service users accessing Embrace services 61
Aim, Purpose and Scope
Local authorities assumed responsibility for public health, including HIV prevention, in April 2013. This needs assessment looks at Human Immunodeficiency Virus (HIV) prevention, testing and support for the population of Luton and will inform and guide the recommissioning of health, wellbeing and social care services for people living with HIV. It also looks at the inequalities related to HIV that are known to exist.

This report does not include the treatment of people with HIV.

Data used is from the national Fingertips online reporting system, via Public Health England (PHE), PHE Sexual and Reproductive Health Activity Data (SRHAD) tool, PHE Local Authority HIV, sexual and reproductive health epidemiology report (LASER): 2015 (latest available) and local reporting of existing HIV prevention services within Luton. Luton Borough Council social care system was interrogated for clients with a record of having or being at risk of HIV. Luton Borough Council housing data was also interrogated for social care clients with a record of having or being at risk of HIV.

Data from current providers for prevention and testing are incorporated to help understand demand. Sources and definitions for data used will be described with the data.

Comparator data used throughout this report are England, East of England and Chartered Institute of Public Finance and Accountancy (CIPFA) statistical neighbours¹ for Luton (Leicester, Coventry, Peterborough, Blackburn and Darwen, Bradford, Oldham, Bolton, Rochdale, Medway, Derby, and Sandwell).

The local population of Luton, patient groups, service providers, statutory services and care commissioners will be consulted regarding this needs assessment using focus groups and questionnaires and the responses summarised in this report.

¹ CIPFA Nearest Neighbour Methodology http://www.cipfastats.net/resources/nearestneighbours/ (last accessed 5/12/2016), last updated January 2016
Executive Summary

This report contains the findings of the HIV prevention and support services needs assessment for Luton. This was undertaken between October 2016 and March 2017 for director of Public Health. It draws out key findings and their implications for the future of HIV prevention and support programmes in Luton. The aims of the needs assessment were to:

- Review and understand the changing epidemiology of HIV in Luton Borough Council
- Provide an overview of HIV prevention services and programmes currently provided in Luton Borough Council
- Review the evidence for the effectiveness
- Capture stakeholders including service user’s views on current and future HIV prevention services in Luton

It is hoped that this report and other published outputs from this needs assessment will serve as a useful resource for future commissioning of HIV prevention services to meet the need of the local population.

HIV continues to be a major public health issue for Luton with 57 people newly diagnosed HIV positive in Luton in 2015.

Luton has a very diverse population, with a higher than nationally, greater proportion of people from a black and black African population. There is a high prevalence (number of people in the community) of people with HIV in Luton. Luton has the highest rate of new HIV diagnosis compared with its comparators and is significantly higher than England. The rate is increasing.

HIV Prevention services currently provided are as follows:

- Embrace Life Luton provides opportunities for people affected by HIV/ AIDS, to enable people dealing with physical and psychological challenges brought on by HIV/ AIDS. It provides information, advice, support, services and arranges activities to enable people living with HIV/ AIDS to make positive and informed decisions on how to live well in the context of HIV infection. It represents the views, interests and experiences of people living with HIV/ AIDS and advocates for prompt and appropriate services, whether provided by the State or independent agencies. It has self-help and up to date information on HIV/ AIDS as essential and complementary to anti-HIV treatments as part of an integrated and holistic approach to successful management of HIV infection.

- Centre for All Families Positive Health (CAFPH) is a peer led organisation providing support to HIV affected people across Luton, Bedford and the East of England. With diagnosis rates in the local area sitting above national average, the need for targeted social support which is culturally sensitive, client centred and lead by those who can really understand the experience remains a priority. CAFPH have been providing such support for the last decade in Luton and Bedfordshire.
L&D HIV Care & Support group

Luton and Dunstable NHS hospital HIV treatment and care service provide one-to-one support services, providing information, support, advice and guidance to manage their condition.

The HIV treatment and care service in Luton is commissioned by NHS England and provided by Luton Sexual Health, part of Luton and Dunstable University Hospital NHS Foundation Trust. The Public health commissioned support services have developed a good working relationship with this provider and are able to offer timely support to newly diagnosed patients.

GP testing and Care services

GPs are commissioned locally to provide:

- A confidential service for routine HIV testing of existing patients. This includes pre and post-test discussions, onward referral and signposting for further support
- HIV testing for all new patient registrations aged 15-59 years
- A holistic approach to assessment of risk of STI, HIV and/or unplanned pregnancy, including consideration of other relevant health concerns such as problematic drug and/or alcohol or mental health problems for all patients

Evidence of what works in HIV prevention

Based on findings from PHE prevention programs and National Aids Trust reviews 2016 falling to the following categories:

- HIV Testing – Testing is an important part of prevention as it enables people to know their status and therefore can look after their own health as well prevent onward transmission to others. Negative results can encourage behaviour change
- Condoms – it is important for those living with HIV or at high risk of transmission should have free or low cost access to condoms. Condom distribution is an opportunity for sexual health behaviour change
- Information and awareness raising – evidence supports the use of mass media campaigns in raising awareness and increasing uptake of testing and signposting to services. The delivery of targeted HIV prevention through social media is good for reaching certain target populations
- Outreach interventions – Interventions that engage with people in target population groups in their own social, community or other settings can be effective in increasing knowledge, awareness and reduce sexual risk behaviours
- Behavioural interventions – Individual and small group behaviour change interventions have shown an impact in reducing risk behaviour among HIV positive people
- Educational, Knowledge and skilled based interventions – educational information and skills based interventions, such as Sex and relationships educations in young people’s learning environments can be effective in increasing Knowledge and awareness of the impact of HIV and risky sexual health behaviour
Harm reduction measures in people who inject drugs – substance misuse treatment and needle exchange schemes are both effective measures to reduce HIV transmissions in people who inject drugs.

**Recommendations**
The following recommendations are made to support and inform the future of HIV prevention in Luton.

**Strategic Recommendations**

1. There is considerable concern about increasing sexual risk taking behaviours in MSM associated with recreational drug use. This new trend needs to be addressed through broader interventions targeting sexual and other health-related risk-taking behaviours, and indicates the need for a more integrated approach between substance misuse and sexual health services. It is imperative that people are able to continue accessing needle exchange schemes to minimise risk associated with injecting drug use.
2. The World Health Organisation (WHO) strongly recommends men who have sex with men consider taking antiretroviral medicines as an additional method of preventing HIV infection (pre-exposure prophylaxis (PrEP)) alongside the use of condoms.
3. Work is required to increase the knowledge within African communities of prevention and treatment options and consider the sexual health needs of black African and young people born in the UK.
4. GP practices in areas with significant black African communities have an important role to play to reduce the rates of late diagnosis of HIV.
5. Local authorities need to understand the specific social care needs of black African communities and take account of them in their training of social care staff, in their support for the local voluntary and community sector, and in their planning, commissioning and service delivery.
6. Diagnosing those with HIV promptly has a significant role in reducing the spread of HIV in the local population.
7. Earlier HIV diagnosis reduces onward transmission of HIV among the population because people tend to adapt sexual behaviours to reduce risk following diagnosis and effective treatment significantly reduces transmission risk.
8. Improve the financial reporting for spend on HIV prevention, testing and support.
9. Prompt diagnosis remains a priority for heterosexuals living with HIV.
10. Undertake needs assessments around MSM drug use, injecting and sexual risk to identify the scope for joint commissioning of tailored drugs and sexual health services for MSM.

**Commissioning Recommendations**

1. Ensure there is a mandatory HIV education session delivered as part of mandatory training for all new employers in public health services to reduce Stigma.
2. Increase HIV education awareness for people who are HIV positive and their families/ carers.
3. Reviews the opening hours for HIV support services and include Saturday services; this may encourage more of our residents to use local services.
4. Provide tailored HIV awareness training for GPs and dentists that treat HIV positive patients.
5. Ensure HIV services have a confidential reception area for service users.
6. Improve the pathways for access to mental health, housing and social care advice.
7. Strengthen the counselling and therapy treatment for HIV positive people.
8. Support patients to maintain their support plans they have in place.
9. Review outreach work and increase the provision to reach more of the HIV positive clients.
10. Increase HIV testing of all patients attending specified services, presenting with an indicator condition or reporting a history of high risk behaviour.

11. Promote HIV screening and testing among patients with indicator conditions or attending termination of pregnancy services.

12. Continue to support testing in non-medical settings such as community HIV testing, self-sampling.

13. Ensure Sexual health services are provided for key groups at high risk of STIs, people with STIs, accessible sexual health services and vulnerable young people under 18 including young women who are pregnant or mothers already.

14. Provide condoms in addition to other methods of contraception and providing school and education-based contraceptive services.

15. Social media should be considered to look to support the HIV prevention and testing messages for everyone but particularly those at increased risk of HIV.

16. Ensuring optimal implementation of effective prevention interventions such as condom use is required.
Local demographics

The health of the population of Luton is poorer than the England average. The poorer health outcomes are linked primarily to the levels of socioeconomic deprivation experienced by a significant segment of the population.

This section describes the numbers and projected growth of the population; demographics (e.g. age, gender, and ethnicity); population movement in and out of the borough; deprivation and poverty; the health of the people in Luton using life expectancy as a measure; and information on causes of death in the borough.

Figure 1: Figure 1 presents a population pyramid showing age and gender of the resident population of Luton compared to England and shows Luton has a younger population for both genders below the age of 40 years.

Figure 2 shows the most densely populated areas of Luton are in the centre of the town. With an area of 4,336 hectares, the official (ONS) population figure translates into a population density of 48 people per hectare across the borough. This figure is greater than many London Boroughs.

---

Figure 2: Luton population density

Table 1 shows a summary of population projections for Luton. Key changes over the next 20 years are:

- Population of Luton is projected to increase by 50,400, an increase of 25%
- School age population (5-15 year olds) is projected to increase by 7,850, an increase of 26%
- Those aged 65-89 is projected to increase by 10,750 people, an increase of 47%
- Very elderly population (90+) is projected to increase by 1,450 people, an increase of 1 ½ times more than 2011

Population projection

Luton’s population is projected to grow significantly between 2011 and 2031, with the latest forecasts projecting growth of 25% in the next 20 years. Key drivers for this are high levels of natural growth (more births than deaths) and international in-migration. Luton also has high population churn and Mayhew Harper Associates found that 70% of the population in Luton in 2010 was either not born or not living in Luton at the time of the 2001 Census.

Table 1 shows a summary of population projections for Luton. Key changes over the next 20 years are:

- Population of Luton is projected to increase by 50,400, an increase of 25%
- School age population (5-15 year olds) is projected to increase by 7,850, an increase of 26%
- Those aged 65-89 is projected to increase by 10,750 people, an increase of 47%
- Very elderly population (90+) is projected to increase by 1,450 people, an increase of 1 ½ times more than 2011

Primary authors Patsy Richards, Jane Robinson
Table 1: Luton population projections by age from 2011 to 2031

<table>
<thead>
<tr>
<th>YEAR</th>
<th>0-4</th>
<th>5 to 15</th>
<th>16-64</th>
<th>65-89</th>
<th>90+</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>16,700</td>
<td>30,150</td>
<td>5,400</td>
<td>127,400</td>
<td>23,050</td>
<td>950</td>
</tr>
<tr>
<td>2021</td>
<td>18,050</td>
<td>36,050</td>
<td>5,650</td>
<td>142,600</td>
<td>27,150</td>
<td>1,450</td>
</tr>
<tr>
<td>2031</td>
<td>18,650</td>
<td>38,000</td>
<td>6,600</td>
<td>154,550</td>
<td>33,800</td>
<td>2,400</td>
</tr>
</tbody>
</table>

2011-21 Change  
2011-31 % Change  
2011-31 Change  
2011-31 % Change

Proportions

<table>
<thead>
<tr>
<th>YEAR</th>
<th>0-4</th>
<th>5 to 15</th>
<th>16-64</th>
<th>65-89</th>
<th>90+</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>8.2%</td>
<td>14.8%</td>
<td>2.7%</td>
<td>62.6%</td>
<td>11.3%</td>
<td>0.5%</td>
</tr>
<tr>
<td>2021</td>
<td>7.8%</td>
<td>15.6%</td>
<td>2.5%</td>
<td>61.7%</td>
<td>11.8%</td>
<td>0.6%</td>
</tr>
<tr>
<td>2031</td>
<td>7.3%</td>
<td>15.0%</td>
<td>2.6%</td>
<td>60.8%</td>
<td>13.3%</td>
<td>0.9%</td>
</tr>
</tbody>
</table>

Source: Luton Borough Council using POPGROUP software and a ten year migration average. Components may not sum to totals due to rounding

Ethnicity and Diversity

Figure 3 shows the broad ethnic groups in the Luton population. Approximately 45% of the population of Luton is of Black and Minority Ethnic Origin (BME) or non-white ethnicity. The ethnic composition of Luton fits a model known as 'super-diversity' in which there is an increasing number of BME communities within the population, each with its own needs and cultures. Luton has a long history of migration into the area both from elsewhere in the UK and overseas. There have been long-standing African-Caribbean, Bangladeshi, Indian, Irish and Pakistani communities in Luton as a result of international migration and more recently the migration patterns have become more complex. In the mid-1990s, the opening of the University of Luton (now the University of Bedfordshire) caused a rapid growth in the student population of the town and this growth has been sustained with an increase in the number of overseas students.

In the mid-2000s, the expansion of the European Union led to a significant increase in migration from eastern European countries, particularly Poland and Lithuania. 7% of Luton’s population is classed as ‘other white’ which is the group for non-British or Irish Europeans and includes people from other parts of the world including Americas and Australasia (England has 4.6% of the population in this category in comparison). There has also been in-migration from African countries such as the Congo, Ghana, Nigeria, Somalia and Zimbabwe. There is also a Turkish population in Luton. More recently, National Insurance Registration data has demonstrated further increases in international migration with Romanians moving to the town after the 2014 change in law allowing them the right to work in the UK. Analyses of translation service data also reflects the levels of diversity in the town, identifying over 120 languages or dialects being spoken by residents. This provides corroborating evidence of Luton being super-diverse.

4.5% of the total population of Luton are Black African or Black African heritage (England 2.1%) and 5.9% Black Caribbean or Black Caribbean heritage (England 1.9%). 14.4% of the population are Pakistani (England 2.1%), 6.7% Bangladeshi (England 0.8%) and 5.2% Indian (England 2.6%).

3 2011 ONS Census, Ethnic group of residents
Deprivation

There is no single generally agreed definition of deprivation. Deprivation is a concept that overlaps, but is not synonymous with, poverty. Absolute poverty can be defined as the absence of the minimum resources for physical survival, whereas relative poverty relates this to the standards of living of a particular society at a specific time.

The Index of Multiple Deprivation 2015 produced by Department of Communities & Local Government (CLG) combines a number of indicators, chosen to cover a range of economic, social and housing issues, into a single deprivation score for each small area in England. This allows each area to be ranked relative to each other according to their level of deprivation.

Luton is ranked the 59th (of 326) most deprived local authority – one being the most deprived. In 2010 Luton was ranked as the 69th most deprived local authority in 2007 as the 87th (out of 354 authorities) and in 2004 the 101st most deprived local authority. This indicates that Luton is becoming more deprived in comparison to the other local authorities of England and this trend of increasing deprivation has been occurring since 2004 (Figure 4). Luton has nine output areas in the top ten per cent most deprived areas in the country. Three of these are in Northwell, two in Farley and South wards and one in Biscot and Dallow wards.
Life expectancy

Life expectancy at birth is an estimate of how long a new born baby can expect on average, to live if they experienced the current age-specific mortality rates of an area throughout the remainder of their life. It is used as a summary indicator of health status in an area.

Life expectancy at birth in Luton for males is 78.4 years and 82.1 years for females. This is an increase for both genders on the previous year (77.9 and 81.9 years respectively). Although life expectancy in Luton has shown a steady increase (Figure 5), it is one year below that of England (79.4 years and 83.1 years respectively). Luton is ranked 276 and 275 out of 404 local areas for male and female life expectancy respectively. Trend data has shown that both male and female life expectancy in Luton has been rising and the gap in life expectancy (Figure 6) with females in England as a whole has narrowed (1.8% to 1.0%). However, the trend for males shows that the life expectancy gap between Luton and England has remained constant since the start of the 21st century.
Luton’s life expectancy is similar to CIPFA statistical neighbour comparators for both male and female life expectancy shown in figure 7 and figure 8. In the male population only 2 similar areas have life expectancy that is not significantly worse than England (Thurrock and Milton Keynes). For the female population all LAs in the statistical neighbour comparator group are significantly worse than England.

Figure 7: Life expectancy, males, Luton and comparator areas, 2012-14

<table>
<thead>
<tr>
<th>Area</th>
<th>Rank</th>
<th>Count</th>
<th>Value</th>
<th>95% Lower CI</th>
<th>95% Upper CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>-</td>
<td>-</td>
<td>79.5</td>
<td>79.5</td>
<td>79.6</td>
</tr>
<tr>
<td>Thurrock</td>
<td>15</td>
<td>-</td>
<td>79.3</td>
<td>79.0</td>
<td>79.6</td>
</tr>
<tr>
<td>Milton Keynes</td>
<td>12</td>
<td>-</td>
<td>79.1</td>
<td>79.1</td>
<td>79.6</td>
</tr>
<tr>
<td>Medway</td>
<td>9</td>
<td>-</td>
<td>79.1</td>
<td>79.1</td>
<td>79.1</td>
</tr>
<tr>
<td>Coventry</td>
<td>2</td>
<td>-</td>
<td>79.7</td>
<td>79.7</td>
<td>79.7</td>
</tr>
<tr>
<td>Peterborough</td>
<td>3</td>
<td>-</td>
<td>79.6</td>
<td>79.1</td>
<td>79.1</td>
</tr>
<tr>
<td>Luton</td>
<td>-</td>
<td>-</td>
<td>78.4</td>
<td>78.4</td>
<td>78.4</td>
</tr>
<tr>
<td>Derby</td>
<td>10</td>
<td>-</td>
<td>78.3</td>
<td>78.3</td>
<td>78.7</td>
</tr>
<tr>
<td>Bolton</td>
<td>7</td>
<td>-</td>
<td>78.3</td>
<td>78.3</td>
<td>78.2</td>
</tr>
<tr>
<td>Bradford</td>
<td>5</td>
<td>-</td>
<td>77.6</td>
<td>77.6</td>
<td>77.6</td>
</tr>
<tr>
<td>Chelmsford</td>
<td>6</td>
<td>-</td>
<td>77.4</td>
<td>77.4</td>
<td>77.4</td>
</tr>
<tr>
<td>Leicestershire</td>
<td>1</td>
<td>-</td>
<td>77.3</td>
<td>77.3</td>
<td>77.3</td>
</tr>
<tr>
<td>Rochdale</td>
<td>10</td>
<td>-</td>
<td>77.2</td>
<td>77.2</td>
<td>77.2</td>
</tr>
<tr>
<td>Nottingham</td>
<td>14</td>
<td>-</td>
<td>77.1</td>
<td>77.1</td>
<td>77.1</td>
</tr>
<tr>
<td>Sandwell</td>
<td>11</td>
<td>-</td>
<td>77.1</td>
<td>77.1</td>
<td>77.1</td>
</tr>
<tr>
<td>Salford</td>
<td>13</td>
<td>-</td>
<td>76.7</td>
<td>76.7</td>
<td>76.7</td>
</tr>
<tr>
<td>Blackburn with Darwen</td>
<td>4</td>
<td>-</td>
<td>76.7</td>
<td>76.7</td>
<td>76.7</td>
</tr>
</tbody>
</table>

Source: Figures calculated by Office for National Statistics using ONS mortality data and mid-year population estimates.
This is a high-level health inequality outcome that measures the difference in life expectancy between the most and least deprived deciles (or tenths) of the population over a three year pooled period. The overall increase in life expectancy for both genders masks the inequalities that exist between areas within Luton. The slope index of inequality highlights the gap between the most and least deprived areas. Figures for 2012-14 show a gap of 5.7 years for females and 12 years for males, which compared with 2011-13 is a reduction for females but an increase for males (Figures 9 and 10).

Variation in life expectancy by Middle Layer Super Output Area (MSOA) within Luton for 2009-13 shows the inequalities in life expectancy across Luton (Figure 11 and Figure 12). Lower life expectancy is concentrated around the more deprived areas in Luton and differs for males and females as outlined below.
Figure 11: Life Expectancy by MSOA, Males, 2009-13

Life expectancy at birth for males, 2009-2013 - source: © Crown Copyright 2015

©PHE - © Crown copyright and database rights 2014, Ordnance Survey 100018569 – ONS © Crown Copyright 2014 - Middle level SOA

Primary authors Patsy Richards, Jane Robinson
Healthy life expectancy (HLE) is an important summary measure of mortality and morbidity and is the measure of the average number of years a person would expect to live in good health based on contemporary mortality rates and prevalence of self-reported good health\(^3\).

Whereas life expectancy is an estimate of how many years a person might be expected to live, healthy life expectancy is an estimate of how many years they may live in good health (e.g. without disabilities)\(^4\). Luton

---

has a high proportion of years spent in disability compared with the national average for both males and females. Healthy Life Expectancy at birth is 60.8 years for males and 61.1 years for females - significantly lower than England (63.4 years for males and 64 years nationally for females). Data is shown for statistical neighbour comparator areas (Figure13 and 14). Most LAs in the comparator group also have HLE figures that are significantly worse than England. For males living in Luton 22.4% of their life is spent not in good health compared with 20.3% nationally. For females living in Luton 25.7% of their life is spent not in good health compared with 23.1% nationally.

Figure 13: Healthy life expectancy, Males 2012-14

<table>
<thead>
<tr>
<th>Area</th>
<th>Rank</th>
<th>Count</th>
<th>Value</th>
<th>95% Lower CI</th>
<th>95% Upper CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>15</td>
<td>-</td>
<td>63.4</td>
<td>63.3</td>
<td>63.6</td>
</tr>
<tr>
<td>Thurrock</td>
<td>12</td>
<td>-</td>
<td>64.6</td>
<td>63.6</td>
<td>64.6</td>
</tr>
<tr>
<td>Milton Keynes</td>
<td>12</td>
<td>-</td>
<td>64.0</td>
<td>62.2</td>
<td>65.8</td>
</tr>
<tr>
<td>Medway</td>
<td>9</td>
<td>-</td>
<td>62.6</td>
<td>60.9</td>
<td>64.4</td>
</tr>
<tr>
<td>Bradford</td>
<td>5</td>
<td>-</td>
<td>61.5</td>
<td>59.8</td>
<td>63.3</td>
</tr>
<tr>
<td>Bolton</td>
<td>7</td>
<td>-</td>
<td>61.5</td>
<td>59.7</td>
<td>63.2</td>
</tr>
<tr>
<td>Peterborough</td>
<td>3</td>
<td>-</td>
<td>61.2</td>
<td>59.3</td>
<td>63.2</td>
</tr>
<tr>
<td>Derby</td>
<td>10</td>
<td>-</td>
<td>61.1</td>
<td>59.3</td>
<td>62.8</td>
</tr>
<tr>
<td>Luton</td>
<td>2</td>
<td>-</td>
<td>60.9</td>
<td>59.0</td>
<td>62.6</td>
</tr>
<tr>
<td>Coventry</td>
<td>6</td>
<td>-</td>
<td>60.5</td>
<td>58.7</td>
<td>62.3</td>
</tr>
<tr>
<td>Oldham</td>
<td>4</td>
<td>-</td>
<td>59.9</td>
<td>59.3</td>
<td>60.3</td>
</tr>
<tr>
<td>Rochdale</td>
<td>1</td>
<td>-</td>
<td>58.5</td>
<td>56.7</td>
<td>60.3</td>
</tr>
<tr>
<td>Blackburn with Darwen</td>
<td>3</td>
<td>-</td>
<td>58.0</td>
<td>56.3</td>
<td>59.8</td>
</tr>
<tr>
<td>Nottingham</td>
<td>14</td>
<td>-</td>
<td>57.8</td>
<td>56.0</td>
<td>59.5</td>
</tr>
<tr>
<td>Salford</td>
<td>13</td>
<td>-</td>
<td>57.2</td>
<td>55.3</td>
<td>59.0</td>
</tr>
</tbody>
</table>

Source: http://www.ons.gov.uk/peoplepopulationandsocialchange/healthandlifeforexpectancies/datasets/healthylifeexpectanciesandlifeexpectancy HealthyLifeExpectancyMalesEngland

Figure 14: Healthy life expectancy, Females 2012-14

<table>
<thead>
<tr>
<th>Area</th>
<th>Rank</th>
<th>Count</th>
<th>Value</th>
<th>95% Lower CI</th>
<th>95% Upper CI</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>15</td>
<td>-</td>
<td>64.0</td>
<td>63.8</td>
<td>64.2</td>
</tr>
<tr>
<td>Milton Keynes</td>
<td>12</td>
<td>-</td>
<td>65.8</td>
<td>63.8</td>
<td>67.8</td>
</tr>
<tr>
<td>Thurrock</td>
<td>15</td>
<td>-</td>
<td>62.8</td>
<td>60.8</td>
<td>64.9</td>
</tr>
<tr>
<td>Coventry</td>
<td>3</td>
<td>-</td>
<td>62.7</td>
<td>60.9</td>
<td>64.5</td>
</tr>
<tr>
<td>Bolton</td>
<td>7</td>
<td>-</td>
<td>59.6</td>
<td>59.9</td>
<td>63.3</td>
</tr>
<tr>
<td>Medway</td>
<td>9</td>
<td>-</td>
<td>59.1</td>
<td>59.1</td>
<td>63.1</td>
</tr>
<tr>
<td>Luton</td>
<td>2</td>
<td>-</td>
<td>58.1</td>
<td>58.9</td>
<td>63.2</td>
</tr>
<tr>
<td>Bradford</td>
<td>5</td>
<td>-</td>
<td>51.0</td>
<td>59.2</td>
<td>62.9</td>
</tr>
<tr>
<td>Blackburn with Darwen</td>
<td>4</td>
<td>-</td>
<td>60.3</td>
<td>58.3</td>
<td>62.3</td>
</tr>
<tr>
<td>Peterborough</td>
<td>3</td>
<td>-</td>
<td>59.7</td>
<td>57.5</td>
<td>62.0</td>
</tr>
<tr>
<td>Derby</td>
<td>10</td>
<td>-</td>
<td>59.1</td>
<td>59.7</td>
<td>61.2</td>
</tr>
<tr>
<td>Oldham</td>
<td>6</td>
<td>-</td>
<td>59.9</td>
<td>57.1</td>
<td>63.0</td>
</tr>
<tr>
<td>Sandwell</td>
<td>11</td>
<td>-</td>
<td>58.4</td>
<td>56.7</td>
<td>60.2</td>
</tr>
<tr>
<td>Nottingham</td>
<td>14</td>
<td>-</td>
<td>58.4</td>
<td>56.6</td>
<td>60.2</td>
</tr>
<tr>
<td>Salford</td>
<td>13</td>
<td>-</td>
<td>58.3</td>
<td>56.3</td>
<td>60.3</td>
</tr>
<tr>
<td>Leicester</td>
<td>1</td>
<td>-</td>
<td>57.8</td>
<td>55.8</td>
<td>59.7</td>
</tr>
<tr>
<td>Rochdale</td>
<td>8</td>
<td>-</td>
<td>57.2</td>
<td>55.7</td>
<td>59.4</td>
</tr>
</tbody>
</table>

Source: http://www.ons.gov.uk/peoplepopulationandsocialchange/healthandlifeforexpectancies/datasets/healthylifeexpectanciesandlifeexpectancy HealthyLifeExpectancyFemalesEngland

HIV and Vulnerable Groups

HIV (Human Immunodeficiency Virus) is a virus which attacks the immune system—the body's defence against diseases. Once infected HIV stays in the body for life, but treatment can keep the virus under control and the immune system healthy and able to respond to infection. Without medication people with HIV can develop AIDS (Acquired Immune Deficiency Syndrome). AIDS is the most advanced stage of an
HIV infection, when the immune system can no longer fight infections. Someone with AIDS has both HIV and at least one of a specific list of 'AIDS-defining' diseases, which include tuberculosis, pneumonia and some types of cancer. AIDS is life threatening, but if HIV is caught early and is treated, it will not always progress to AIDS. If HIV is caught late, it can lead to more complications and could ultimately lead to AIDS. That is why it is so important for individuals to get tested early if at risk of HIV, as it will allow for access to treatment that will reduce the risk of developing into AIDS.

There are particular groups of the population that are at an increased risk of HIV infection.

• **MSM** - Men who have sex with men:

Men who have sex with men are a high risk group for HIV and other sexually transmitted infections. There is considerable concern about increasing sexual risk taking behaviours in MSM associated with recreational drug use. This new trend needs to be addressed through broader interventions targeting sexual and other health-harming risk-taking behaviours, and indicates the need for a more integrated approach between substance misuse and sexual health services. It is imperative that people are able to continue accessing needle exchange schemes to minimise the risk of HIV and other blood-borne infections associated with injecting drug use.

The World Health Organisation (WHO) strongly recommends men who have sex with men consider taking antiretroviral medicines as an additional method of preventing HIV infection (pre-exposure prophylaxis (PrEP)) alongside the use of condoms\(^5\). Rates of HIV infection among men who have sex with men remains high almost everywhere and new prevention options are urgently needed. Modelling estimates that, globally, 20-25% reductions in HIV incidence among men who have sex with men could be achieved through pre-exposure prophylaxis, averting up to 1 million new infections among this group over 10 years.

• **Black Africans**

People from sub-Saharan African comprise one of the largest and most recently arrived BME communities in the UK, accounting for 1.8% of the UK resident population. Black African people are also disproportionately affected by HIV and, in 2012 comprised of 34% of all those diagnosed with HIV in the UK\(^6\). There is significant HIV transmission within black African communities in the UK. This is one of the starkest examples of health inequalities in this country and something which should be addressed urgently. We need to:

- reduce HIV incidence and late HIV diagnosis
- address and eliminate HIV stigma and discrimination
- maximise the benefits not just of HIV treatment and care but the wider care and support needed to live a long, productive and fulfilling life whilst managing this long-term condition

---


\(^6\) National AIDS Trust, HIV and Black African Communities in the UK, June 2014
For HIV prevention to tackle infection in this group work is required to increase the knowledge within African communities of prevention and treatment options and consider the sexual health needs of black African and young people from that community born in the UK.

Black African men and women are the group most likely to be diagnosed late, with serious implications for health and life expectancy. The failure of the NHS to implement UK guidance on HIV testing profoundly harms black African communities in the UK and must be addressed urgently. GP practices in areas with black African communities have an important role to play to raise awareness and reduce stigma and discrimination.

The risk of HIV acquisition and black Africans’ experience of living with HIV are pervasively influenced by the high levels of poverty, unemployment and poor housing faced by many people in these communities. Immigration-related restrictions are a significant cause of such deprivation, though not the only one. We cannot meet the HIV-related needs of black African communities in the UK without addressing wider inequalities.

Local authorities need to understand the specific social care needs of black African communities and take account of them in their training of social care staff, in their support for the local voluntary and community sector, and in their planning, commissioning and service delivery. Issues include ageing with HIV, the needs of those who have lived with HIV from birth, including both young people and those who are now adults, and the specific needs of women and of families.

- **Undiagnosed HIV**

In 2012 PHE stated that one in five people with HIV in the UK did not know they were infected (18% of MSM with HIV, 27% of Black African men with HIV and 21% of Black African women with HIV were unaware of their HIV positive status). Diagnosing those with HIV promptly has a significant role in reducing the spread of HIV in the local population. Research estimates that it is the undiagnosed minority with HIV who are responsible for at least 50% of new infections (recent modelling for HIV transmission amongst men who have sex with men (MSM) in the UK suggests as high as 82% of transmissions are from the undiagnosed). There is particular value in diagnosing HIV at the early stage soon after infection, known as primary HIV infection, when in the majority of cases temporary symptoms occur. At this stage the individual is highly infectious and it is thought, especially for MSM, a significant proportion of HIV transmissions take place during this period (the same modelling study for UK MSM suggests 48% of HIV transmissions amongst MSM are from those in the primary stage of HIV infection). Earlier HIV diagnosis reduces onward transmission of HIV among the population because people tend to adapt sexual behaviours to reduce risk following

---


8 Marks G et al., 2006 ‘Estimating sexual transmission of HIV from persons aware and unaware that they are infected with the virus in the USA’ AIDS vol.20 no.10; Phillips AN, et al., 2013 ‘Increased HIV Incidence in Men Who Have Sex with Men Despite High Levels of ART-Induced Viral Suppression: Analysis of an Extensively Documented Epidemic.’ PLOS ONE 8(2):e55312

Primary authors Patsy Richards, Jane Robinson
diagnosis\textsuperscript{9} and effective treatment significantly reduces transmission risk\textsuperscript{10}. Figure 15 shows the percentage of people unaware of their HIV status\textsuperscript{11}.

\textsuperscript{9} Public Health England, 2014 ‘Addressing Late HIV Diagnosis through Screening and Testing: An Evidence Summary’

\textsuperscript{10} ‘Position statement on the use of antiretroviral therapy to reduce HIV transmission BHIVA/EAGA’ January 2013

\textsuperscript{11} NAT Commissioning of HIV Testing, 2014
**Sex Workers**

Sex workers are approximately eight times more likely to be living with HIV than other adults globally. In developing countries female sex workers are 14 times more likely to be living with HIV than other women of reproductive age\(^\text{12}\). For male and transgender sex workers, the risk of HIV is known to be even higher yet epidemiological data and research is less widely available for these groups\(^\text{13}\).

Street-based sex workers tend to experience very low standards of general and sexual health and frequently experience violence at the hands of clients. Street-based sex workers are more likely to use drugs and alcohol, share needles and have unprotected sex than parlour-based sex workers\(^\text{14}\). Sex workers face barriers to accessing sexual health services owing to the environment and the context of their work, which puts them at risk of HIV. Female and male sex workers experience discrimination because of their work and the criminalisation of prostitution. Stigmatisation, reinforced by the spread of HIV, has created further barriers to sex workers accessing social and health services.

**People who inject drugs (PWID)**

One of the most striking successes of the UK response to HIV has been the continuing low rate of HIV amongst people who inject drugs. This has not been the result of luck but of ethical, evidence-based and effective policies introduced early on during the course of the epidemic. In particular, the provision and roll-out of needle and syringe programmes (NSPs) and of Opioid Substitution Therapy (OST) have reduced unsafe injecting and means that HIV prevalence amongst people who inject drugs is one of the lowest in Europe. Transmissions of HIV and other blood borne viruses (BBVs) still occur amongst people who inject drugs and we should be aiming to reduce these rates further.

A significant proportion of people with HIV who inject drugs are also found to be co-infected with hepatitis C. HIV/hepatitis C co-infection complicates each disease, affecting both disease

---


\(^{13}\) NSWP. Briefing papers on the needs and rights of male and trans sex workers. www.nswp.org/sites/nswp.org/files/Male%20SWs.pdf and http://www.nswp.org/sites/nswp.org/files/Trans%20SWs.pdf

\(^{14}\) Royal College of Nursing, social inclusion and sex workers http://www.rcn.org.uk/development/practice/social_inclusion/sex_workers
progression and treatment options and effectiveness\textsuperscript{15}. A 2010 paper found that 83% of people who inject drugs diagnosed with HIV are co-infected with hepatitis C\textsuperscript{16}. The key risk for HIV and hepatitis transmission is the direct sharing of injecting equipment and this has declined over recent years. In the late 1990s it stood at 30% of people who inject drugs but by 2011 this had declined to 17%\textsuperscript{17}. In addition, there continues to be a significant percentage of people who inject drugs diagnosed late (after the point at which they should have started HIV treatment (CD4 count of less than 350 cell/mm\textsuperscript{3}). Overall, in the UK in 2011 52% of people who inject drugs with HIV were diagnosed late. This figure is higher than the overall proportion of people living with HIV diagnosed late (47%). 30% of people who inject drugs who have HIV were also diagnosed very late (CD4 count of under 200 cells/mm\textsuperscript{3}) compared to 26% of all new diagnoses of people living with HIV in that year\textsuperscript{6}.

There is a worrying trend in injecting newer club drugs amongst men who have sex with men (MSM), as well as injecting more widely of image and performance enhancing drugs (IPEDs) such as steroids and tanning agents. There is a clear risk of the spread of blood-borne viruses amongst populations newly injecting who have not traditionally been targeted by harm reduction interventions. One of the new injecting patterns is of new psychoactive drugs or ‘club drugs’ that have traditionally been ‘snorted’ or ingested. A report by the National Treatment Agency (NTA) (now part of PHE) suggested the proportion of club drug users reporting injecting had risen from 6% to 8% in the period 2007/2008 to 2011/2012\textsuperscript{18}.

Commissioning of drug services became a responsibility of local authorities in 2013 as part of the transfer of public health responsibilities from the National Health Service (NHS). Along with PHE, it is essential that the commissioned drug services take in to account adequate health checks, sexual health advice and clients are screened and immunised for BBV and risky behaviours are monitored. Commissioners outside London should undertake needs assessments around MSM drug use, injecting and sexual risk to identify the scope for joint commissioning of tailored drugs and sexual health services for MSM. Clinicians and health advisors in sexual health clinics should be trained to ask service users, and in particular MSM, systematically and on an ongoing basis about problematic recreational drug and alcohol use. Generic drug treatment services should be trained to respond sensitively and in a clinically appropriate way to the needs of ‘non-traditional’ drug users such as MSM, and to the use of newer drugs in addition to opiates and crack cocaine. There are risks of blood borne virus infection to people who are injecting IPEDs. Local authorities should ensure the health needs of IPED users are known and met in their local area, drawing on advice from NICE and Public Health England. Local authorities are advised to commission interventions to advise newer communities injecting drugs of the dangers of sharing injecting equipment, and the importance of sterile equipment, as well as of where to go to access NSP services. These communities include steroid users, young women injecting tanning agents, and MSM injecting crystal meth and mephedrone. Social media and newer settings should be considered (twitter, gyms, tanning salons, gay clubs etc.).

\textsuperscript{15} NAT Hepatitis C and HIV Co-infection, 2012


\textsuperscript{17} NAT, Peter Burkinshaw HIV and Injecting Drug Use Roundtable, 2011

\textsuperscript{18} National Treatment Agency, Club Drugs: Emerging Trends and Risks, 2012
• **Risky sexual behaviours**

Sexual intercourse without using a condom has risk of individuals becoming infected with HIV (and other sexually transmitted infections).

Sexual health advice and education is critical to prevent the spread of sexually transmitted infections. Testing for sexual transmitted infections, including HIV, will reduce the infection rates and will give the opportunity for some safer sexual health advice. Educational information and skills based interventions, such as sex and relationships education in community learning environments can be effective in increasing knowledge and awareness of the impact of HIV and risky sexual health behaviour.

• **Others**

Other groups that are at risk of HIV infection include people who have had sexual intercourse with someone from sub-Saharan Africa, a blood transfusion from sub-Saharan Africa, clients, children and partners of sex workers. People with tuberculosis and hepatitis can also be more likely to be infected with HIV. Babies born to mothers who are HIV positive and include any risk related to late booking

Babies born to mothers who are HIV positive may experience a difficult start to life due to poor health outcomes associated with this condition. Of particular importance are the issue of breast feeding and the risk of postnatal transmission from mother to child. There is conflicting evidence regarding breast feeding of babies born to mothers with HIV. The WHO’s current guidelines state that formula should be used only when it is accessible, feasible, affordable, sustainable, and safe; but where that’s not guaranteed, mothers should breastfeed if at all possible. The risk of transmission remains, albeit minimally. However, some evidence endorses the idea of totally avoiding breast feeding and opting for formula milk. Depending on the socio-economic status of the mother, affording formula milk may not be financially sustainable and this may lead to malnourished children. Local authorities have a responsibility to ensure that measures in are in place to support HIV positive mothers and their babies. This will consequently lead to improved health outcomes for both the mother and baby

**National Context**

Overall, the number of people living with HIV in the UK continues to increase and the number living with undiagnosed HIV remains high[^19].

**Prevalence**

In 2014, an estimated 103,700 people (95% credible interval (CrI) 97,500-112,700) were living with HIV (PLWH) in the UK, of whom 69,200 were men and 34,400 were women. This compares to an estimated 100,000 PLWH in 2013[^20]. The overall HIV prevalence in the UK in 2014 was 1.9 per 1,000 people aged 15


[^20]: Differences between estimates for PLWH in 2014 in this report and last year’s report are due to changes in the mathematical model and data sources used to calculate the estimates
and over. In 2014, an estimated 18,100 (17%) PLWH were unaware of their infection and at risk of unknowingly passing on HIV if having sex without a condom, and this is similar to revised estimates from 2013 (18,219 (18%)). The estimated number and proportion of people living with undiagnosed HIV have declined since 2010 (from 22,800 and 25% respectively), with the majority of this decline happening before 2012.

**Diagnosis and testing**

Despite a decline in undiagnosed HIV infections among men who have sex with men there is evidence that rates of ongoing HIV transmission remain high. An estimated 45,000 men living with HIV in the UK in 2014 had acquired their infection through sex with other men (MSM), up from 43,000 in 2013. Among MSM aged 15-44, one in 20 is estimated to be living with HIV. An estimated 6,500 (14%) MSM were unaware of their infection in 2014, a decline from 8,500 in 2010. HIV testing coverage among MSM attending sexual health (STI) clinics has increased over this period and is likely to be the reason for the estimated decline in undiagnosed infections and observed increases in new diagnoses. Despite this there remains a high HIV incidence in MSM, with an indication of a small sequential increase in 2013 and 2014.

HIV testing in STI clinic attendees continues to increase throughout most of England with high coverage particularly among MSM. In England, 1.43 million people attended a STI clinic in 2014, with 69% of eligible attendees having an HIV test. Testing coverage was highest among MSM and 179/223 (80%) of STI clinics across England achieved the British Association for Sexual Health and HIV (BASHH) standard\(^\text{21}\). Coverage was less comprehensive for eligible heterosexual men (77%, 382,743/497,455) and women\(^\text{19}\) (62%, 504,249/814,459), and only 33/223 (15%) STI clinics achieved 80% HIV test coverage.

Prompt diagnosis remains a priority for heterosexuals living with HIV. Among the 54,100 people (men (21,300), women (32,700)) living in the UK who had acquired HIV through heterosexual sex, more than one in five (21% (11,200)) were unaware of their HIV infection, with a higher proportion of those living outside London unaware (24% out of London undiagnosed compared to 12% in London). Among heterosexuals aged 15-44 in the UK, almost one in every 1,000 is estimated to be living with HIV (0.9 per 1,000, with higher prevalence’s among black African heterosexual men (one in 56) and women (one in 22). Late diagnosis remains a significant problem among heterosexuals with 55% (1,381/2,490) newly diagnosed at a late stage of infection in 2014, of which 51% were black African. There is a need for expanded and scale up HIV testing across the UK to reduce undiagnosed infection and late diagnosis in line with national HIV testing guidance\(^\text{22,23,24}\).

---

\(^\text{21}\) British Association for Sexual Health. BASHH Recommendations for Testing for Sexually Transmitted Infections in Men who have Sex with Men Accessed on: 16 November 2015. Available at: http://www.bashh.org/documents/BASHH%20Recommendations%20for%20testing%20for%20STIs%20in%20MSM%20-%20FINAL.pdf


Transmission

The ongoing high rates of HIV transmission and acquisition among men who have sex with men emphasise the need for high impact, appropriately tailored combination prevention strategies and programmes. Despite high and increasing rates of HIV testing by MSM coupled with high levels of effective anti-retroviral treatment (ART) coverage for those diagnosed positive, there remains evidence of ongoing HIV transmission among MSM. Ensuring optimal implementation of effective prevention interventions such as condom use is required to reduce infections, in addition to addressing the wider determinants of poor sexual health among MSM which are closely linked to HIV infection25.

Treatment

The evidence for efficacy and effectiveness of antiretroviral agents to reduce onward transmission from people who are HIV positive26,27 as well as prevent HIV acquisition in those who are HIV free (HIV – Pre Exposure Prophylaxis HIV – PrEP)28,29 continues to expand, making important additions to the prevention toolkit.

In England all anti-retroviral drugs, whether for treatment or prevention, are commissioned by NHS England. In June 2015 the use of ART by people who are HIV positive to both prevent as well as treat HIV infection (treatment as prevention or TasP) was approved by NHS England30. At present there is no publicly funded PrEP Commissioning of HIV screening and testing falls to local authorities, clinical commissioning groups and NHS England. The Public Health Outcomes Framework (PHOF) has included the proportion of persons presenting with HIV at a late stage of infection as a high level indicator of essential actions to be taken to protect the public’s health.

National HIV testing guidelines, endorsed by the National Institute of Health and Care Excellence (NICE), recommend HIV testing of all patients attending specified services, presenting with an indicator condition or reporting a history of high risk behaviour. Furthermore, they recommend that HIV screening and testing be


expanded into general medical services (e.g. hospital general medical admissions) in areas of high HIV prevalence (where the local diagnosed HIV prevalence ≥2 per 1,000 16-59 year olds).

Nationally, HIV screening and testing coverage among attendees of genitourinary medicine (GUM), antenatal services, needle exchange and other drug services is high. Low levels of HIV screening and testing among patients with indicator conditions or attending termination of pregnancy services, hospital general medical admissions, and primary care have been reported, even though screening in these services has been shown to be feasible, acceptable, effective and cost-effective.

Testing in non-medical settings such as community HIV testing, self-sampling and self-testing for HIV broadens the options available to people wishing to take an HIV test. Although testing in community settings has often exceeded cost-effectiveness thresholds, data to ascertain if testing in the community was more effective than in traditional settings were inconclusive.

NHS England will fund a major extension to the national HIV prevention programme led by Public Health England (PHE) with the aim of supporting those most at risk and reducing the incidence of HIV infection. It has also decided to routinely commission 10 new specialised treatments as part of the annual prioritisation process for specialised treatments. The new HIV initiative is joint between NHS England and PHE, and follows the recent Court of Appeal ruling that NHS England, alongside local authorities, has the power, although not the obligation, to fund the provision of anti-retroviral drugs for the prevention of HIV, known as pre-exposure prophylaxis (PrEP). The first phase of implementation will be the launch of a large scale clinical trial early in the 2017 to 2018 financial year. Although the evidence around the clinical effectiveness of PrEP is strong, advice from PHE has highlighted significant outstanding implementation questions that should be answered prior to using PrEP in a sustained way on a substantial scale in England. These questions will be answered by the clinical trial, paving the way for full roll-out.

**HIV risk reduction messages**

- Early diagnosis of HIV infection enables better treatment outcomes and reduces the risk transmitting the infection to others. Have an HIV test if you think you may have been at risk
- Always use a condom correctly and consistently, and until all partners have had a sexual health screen
- Reduce the number of sexual partners and avoid overlapping sexual relationships
- Men who have sex with men are advised to have an HIV and STI screen at least annually, and every three months if having unprotected sex with new or casual partners
- Unprotected sex with partners believed to be of the same HIV status (serosorting) is unsafe. For the HIV positive person, there is a high risk of acquiring other STIs and hepatitis. For the HIV negative person, there is a high risk of acquiring HIV infection (6,500 of MSM remain unaware of their HIV infection) as well as of acquiring STIs and hepatitis
- Black African men and women are advised to have an HIV test and a regular HIV and STI screen if having unprotected sex with new or casual partners

**HIV testing is readily available from:**

- Go to an open-access sexually transmitted infection (STI) clinic (some clinics in large cities are offering ‘fast-track’ HIV testing) or go to a community testing site (http://www.aidsmap.com/hiv-test-finder)
- Ask your GP for an HIV test – nowadays there is no need for a lengthy discussion about the test, it just involves having blood taken, or even a finger prick
- HIV testing kits are available online for a self-sampling kit ([www.freetesting.hiv](http://www.freetesting.hiv))
- Locally contact the sexual health website [www.lutonsexualhealth.org.uk](http://www.lutonsexualhealth.org.uk)
The Terrance Higgins Trust (THT) quote the prevalence of HIV in England as 101,200 people and that one in seven do not know that they have HIV because they have never had a HIV test or they acquired HIV since their last test\(^{31}\). More than half of the 6,000 people tested positive for HIV each year are gay or bisexual men. Around 47,000 gay or bisexual men and around 48,500 heterosexuals were estimated to be living with HIV in the UK by the end of 2015. In the heterosexuals of those living with HIV 56% are from black African communities. Black Africans make up 1.8% of the UK population but 47% of all heterosexual men living with HIV, and 65% of all heterosexual women. Within the African population living with HIV in the UK, around one in nine black African men and one in ten black African women do not know they have it.

The commissioning of HIV testing services is the responsibility of a number of different commissioning bodies. The role of local authorities is the commissioning of HIV prevention, testing and reducing late HIV diagnosis. All commissioners involved in HIV health and care related systems must ensure that commissioning is integrated and complementary across all commissioners at a local level, with clarity on responsibility for commissioning/payment and care pathways work together to commission to a shared vision of need and a shared strategic approach to HIV testing include as partners key stakeholders from clinical, statutory, voluntary and community sectors.

---

The following table outlines the relevant commissioning bodies that are responsible for HIV testing:

<table>
<thead>
<tr>
<th>Body</th>
<th>Level</th>
<th>Service</th>
<th>Commissioning responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local authorities</td>
<td>Local</td>
<td>Public health (including local sexual health/ GU services and health promotion)</td>
<td>Testing in sexual health/ GU clinics; testing in community settings; routine screening for public health purposes in primary and secondary care through local arrangements etc.; testing in drug treatment services</td>
</tr>
<tr>
<td>Clinical Commissioning Groups</td>
<td>Local</td>
<td>Secondary care (apart from specialised commissioning, which includes HIV treatment – this is commissioned by NHS England)</td>
<td>Testing in all relevant secondary care specialties for clinical indicator conditions/as part of patient care; testing in termination of pregnancy (TOP) services</td>
</tr>
<tr>
<td>NHS England</td>
<td>National</td>
<td>Primary care Specialised commissioning (including HIV treatment)</td>
<td>Testing in primary care as clinically indicated or when requested by patient; testing in SARCs; testing in ante-natal care; testing in other NHS England commissioned services as part of patient care</td>
</tr>
</tbody>
</table>

### NICE Guidelines

The National Institute of Care Excellence (NICE) with PHE have issued national guidance on HIV testing: increasing uptake among people who may have undiagnosed HIV, NG60\(^\text{32}\). This guideline covers how to increase the uptake of HIV testing in primary and secondary care, specialist sexual health services and the community. It describes how to plan and deliver services that are tailored to the local prevalence of HIV, promote awareness of HIV testing and increase opportunities to offer testing to people who may have undiagnosed HIV.

Its recommendations are based on different prevalence rates, settings as well as certain clinical criteria.

NICE also have a Local Government Briefing LGB21 HIV Testing\(^\text{33}\) which states “Local authorities must commission comprehensive sexual health services, including HIV testing in community and sexual health services. They are also responsible for commissioning HIV prevention. Clinical commissioning groups are responsible for funding HIV testing in primary and secondary care. NHS England is responsible for commissioning HIV treatment and care (including drug costs for post-exposure prophylaxis following sexual exposure). Key to preventing HIV transmission is HIV testing because more than 50% of new cases are estimated to have been the result of people who are undiagnosed having unprotected sex. People who do not know their HIV status are believed to be 3 times more likely to pass on the infection than those who know their status. They are also more than twice as likely to have unprotected sex. Timely diagnosis of HIV carries huge health benefits and, in addition, once people are being treated they are much less infectious. Once someone is diagnosed with HIV they are also likely to make more effort to reduce the risk

\(^{32}\) NICE NG60, HIV Testing: Increasing uptake among people who may have undiagnosed HIV [https://www.nice.org.uk/guidance/ng60](https://www.nice.org.uk/guidance/ng60)

\(^{33}\) NICE LGB21 HIV Testing [https://www.nice.org.uk/advice/lgb21/chapter/Introduction](https://www.nice.org.uk/advice/lgb21/chapter/Introduction)
of transmission. Earlier diagnosis of HIV, leading to better management of the condition, can help reduce demand on long-term care and other services.”

NICE reviewed the evidence of Pre-exposure prophylaxis of HIV in adults at high risk and published an update in October 2016. The evidence summary reviewed 4 randomised trials of Truvada (emtricitabine/tenofovir disoproxil 200 mg/245 mg) for pre-exposure prophylaxis (PrEP) of HIV in either HIV-negative men or transgender women who have sex with men, or HIV-negative individuals in a heterosexual partnership with a person already infected with HIV. In these trials, Truvada reduced the relative risk of acquiring HIV infection by between 44% and 86% compared with placebo or no prophylaxis, which is equivalent to approximate numbers needed to treat of between 13 and 68 per year. In all trials, Truvada was given in addition to a comprehensive package of prevention services including HIV testing, risk-reduction counselling, condoms and sexually transmitted infection management. In addition to efficacy, 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.

Prevention strategies for HIV include early diagnosis of HIV infection through HIV testing, antiretroviral therapy for those diagnosed positive to reduce onward transmission (treatment as prevention [TasP]), correct and consistent condom use, and addressing the wider determinants of high-risk sexual behaviour. Using antiretroviral agents to prevent HIV acquisition in those who are HIV negative (PrEP) is also an option (Public Health England, situation report 2015).

In the European AIDS Clinical Society (EACS) guidelines from 2015 the recommended PrEP regimen is 1 tablet of emtricitabine/tenofovir disoproxil 200 mg/245 mg once daily. For men who have sex with men with high-risk sexual behaviour, these guidelines recommend that 'on demand' emtricitabine/tenofovir disoproxil 200 mg/245 mg may be given. WHO guidelines from 2016 recommend oral PrEP containing tenofovir disoproxil (no particular regimen is recommended).

The cost of Truvada is £355.73 for 30 tablets (Monthly Index of Medical Specialities (MIMS), August 2016). However, it is currently purchased for treating HIV at discounted net price through the Commercial Medicines Unit (CMU) regional framework (personal communication, Gilead, June 2016). Costs of Truvada given 'on demand' (based on an average use of 15 tablets per month) or as separate tenofovir disoproxil 245 mg (Viread) and emtricitabine 200 mg (Emtriva) tablets are given in the full evidence summary. However, Truvada is the only antiretroviral product licensed for use as PrEP in the UK. The licence extension is for once-daily use: 'on demand' use of Truvada, tenofovir disoproxil (Viread) alone, or with emtricitabine (Emtriva) as separate tablets, is not licensed for PrEP.

Public Health guideline 52 Needle and syringe programmes (PH52) states that local authorities need to commission generic and targeted services to meet local needs and provide a range of services. There

34 NICE ESNM78 Pre-exposure prophylaxis of HIV in adults at high risk https://www.nice.org.uk/advice/ESNM78/chapter/Key-points-from-the-evidence
36 European Aids Clinical Society guidelines http://www.eacsociety.org/guidelines/eacs-guidelines/eacs-guidelines.html
37 WHO consolidated guidelines for antiretroviral drugs for treating and preventing HIV infection http://www.who.int/hiv/pub/arv/arv-2016/en/
38 MIMS http://www.mims.co.uk/
39 NICE PH52 Needle and syringe programmes https://www.nice.org.uk/guidance/PH52
needs to be a service for young people who inject drugs, people who inject image and performance enhancing drugs and a community based pharmacy and specialist needle and syringe programme.

Sexually transmitted infections and under-18 conceptions: prevention is a NICE guideline (PH3) which recommends services are provided for key groups at high risk of STIs, people with STIs, accessible sexual health services and vulnerable young people under 18 including young women who are pregnant or mothers already.

In NICE guideline PH51 Contraceptive services for people aged under 25 recommend providing condoms in addition to other methods of contraception and providing school and education-based contraceptive services.

PH34 is NICE guideline for Hepatitis B and C testing and indicates that local authorities should raise awareness about hepatitis B and C among the general population and people at increased risk of infection, educate and train professionals who provide services for people at increased risk of infection, test for hepatitis B and C in primary care, prisons and immigration removal centres, drugs services, and sexual health and genitourinary medicine clinics.

**Literature Review**

A literature review was performed based on search criteria shown in appendix 1.

40 NICE PH3 Sexually transmitted infections and under-18 conceptions: prevention
https://www.nice.org.uk/guidance/ph3

41 NICE Contraceptive services for under 25s
https://www.nice.org.uk/Guidance/PH51

42 NICE Hepatitis B and C testing
https://www.nice.org.uk/guidance/ph43
Local Picture Overview

The trend nationally and in Luton is reducing numbers of sexually transmitted infections (figure 16). Luton has similar rates compared with England and is similar when compared to its CIPFA statistical neighbour group of local authorities (figure 17). The super diversity of Luton and related HIV rates does not make local figures comparable to regional authorities in the East of England.

However, if we exclude chlamydia infections (the most common STI in young people) we can see that the trend is increasing slightly in England although Luton’s rate is relatively steady and it is lower than England. When compared with similar areas Luton has the fifth highest rate:

Primary authors Patsy Richards, Jane Robinson
Positive STIs in Luton in the under 25s excluding chlamydia data are shown in figure 20 and 21. Luton’s proportion of positive tests for STIs in the under 25 years is higher than England but not significantly and is in the middle of the range for the proportion of positive testing compared to its comparators.
Primary authors Patsy Richards, Jane Robinson

**Local HIV overview**

Luton has a very diverse population, with a greater proportion of people from a black and black African population compared to the national average. There is a high prevalence (number of people in the community) of people with HIV in Luton. Luton has the highest rate of new HIV diagnosis compared with its comparators and is significantly higher than England. The rate is increasing. This data is shown in figure 22 and 23.

Data from the Sexual and Reproductive Health Data (SRHAD) report shows that the Luton diagnosed prevalence of HIV is 4.3 per 1,000 population compared with 2.3 for England. The difference between Luton and each of its comparator LAs is significantly different. There were 569 people with HIV in Luton in 2015. This is higher than the estimated prevalence for Luton (approximately 500 (assuming the local prevalence is the same as nationally and based on NAT report HIV in the UK Statistics 201519)). Data are shown in figures 24 and 25. The trend in Luton is relatively stable but has increased slightly between 2014 and 2015. The trend in HIV prevalence is increasing in England and East of England. There were 37 new HIV diagnoses in Luton. The diagnosed HIV prevalence was 4.3 per 1,000 population aged 15-59 years (compared to 2.26 per 1,000 in England).
Local data for Luton provided by Public Health England\textsuperscript{43} show that in 2015 there were 622 people with HIV diagnosed who live in Luton (Figure 26). Numbers have increased slightly over time. In response to this high prevalence, there has been a programme of work with partner agencies to improve the uptake of testing with the at risk population.

Figure 26: Trend in Luton residents diagnosed with HIV

\textsuperscript{43} Public Health England Luton Local Authority HIV, sexual and reproductive health epidemiology report (LASER): 2015
PHE reported an undiagnosed proportion (of those diagnosed with HIV) of 15.4% of the number of people diagnosed with HIV in UK. This would mean there are approximately 96 people living with HIV whom are undiagnosed in Luton making the estimated prevalence (diagnosed and undiagnosed) of 718.

In Luton 56.3% of the population diagnosed with HIV are female (women=346 (male= n276)). This is in contrast to data for the whole of the UK (per 1,000 men and 1.7 per 1,000 women) where (62.2% of people diagnosed with HIV are male).

The most probable route of infection in Luton is heterosexual contact 79.4% (n494) and from men who have sex with men 15.4% (n96). Again this differs from UK where 52.1% of the probable route for HIV infection was through heterosexual contact. The national data shows that those whose probable route of infection as heterosexual sex were mainly from the black African community. Local data do not allow us to look at the ethnic group by probable route of transmission. However we can look at the data by ethnic group (figure 27). In Luton 66% of the people with HIV are black African and 21% white.

Figure 27: Ethnic group of people living with HIV in Luton

![Ethnic Group of People Living with HIV in Luton](image)

The age of existing treatment population in Luton is shown in figure 28. The largest age group are those between 35 and 49 years and nearly two thirds of this group are females, however there are more males in the under 35 age groups and 50+ age groups. Data for the UK show that there are more males than females with diagnosed with HIV in all age groups and Luton’s HIV population are younger than the UK as a whole (Luton has 31.8% of its HIV population aged 50+ and the UK have 34.7% of its diagnosed population aged 50+).

---

We know from data provided by PHE, LASER, the areas with high prevalence are similar to the areas of greatest deprivation (2015 IMD) within Luton. This data is not in the public domain due to the possibilities of individual people being identified.

**HIV Testing**

Testing for HIV is an important strategy to prevent the spread of the disease and will mean people can be treated earlier to improve their health outcomes. If people know their HIV status they can take the necessary precautions. Figure 29 shows that the trend in HIV testing uptake in Luton is improving. Figure 30 shows the HIV testing uptake compared with other similar LAs to Luton. Luton’s proportion of uptake is significantly better than England. Most LAs in the cluster are also better than England. Among specialist Sexual Health Clinic patients from Luton who were eligible to be tested for HIV, 80.9% were tested (compared to 67.3% in England).
In men who have sex with men (MSM) the uptake has been relatively consistent over the last few years. Luton’s uptake in this vulnerable group is slightly better than England but is the 4th lowest in its CIPFA cluster. Data are shown in figures 31 and 32.

Figure 31: HIV testing uptake in MSM

![HIV testing uptake in men who have sex with men (%)](image1)

Figure 32: HIV testing uptake in MSM (comparison)

![HIV testing uptake in men who have sex with men (% in 2015](image2)

HIV testing uptake in women has improved and the proportion is significantly higher than England and whilst for 2013 and 2014 followed the lowering trend in uptake seen in England in 2015 Luton’s uptake increased. The data are presented in figures 33 and 34.

Figure 33: HIV testing uptake in women

![HIV testing uptake in women (%)](image3)

Figure 34: HIV testing uptake in women (comparison)

![HIV testing uptake in women (% in 2015](image4)

The uptake of HIV testing in men in Luton is at similar levels to England and whilst England’s uptake is quite stable in Luton the uptake is improving as can be seen in figures 35 and 36.
HIV test coverage data represent the number of persons tested for HIV and not the number of tests reported. HIV testing is integral to the treatment and management of HIV. Knowledge of HIV status increases survival rates, improves quality of life and reduces the risk of HIV transmission. Data for Luton show better and improving coverage compared with England and its comparators and is shown in figures 37 and 38.

HIV testing coverage for men who have sex with men for Luton is the best in its comparator group of LAs. It has a higher proportion of coverage than England. These data are shown in figures 39 and 40.
HIV testing coverage for women for Luton is the second best in its comparator group of LAs. The data are presented in figures 41 and 42. It has a higher proportion of coverage than England and is improving.

**Figure 41: HIV testing coverage in women**

**Figure 42: HIV testing coverage in women (comparison)**

HIV testing coverage for men for Luton is the best in its comparator group of LAs. It has a higher proportion of coverage than England and is improving. These data are shown in figures 43 and 44.

**Figure 43: HIV testing coverage in women**

**Figure 44: HIV testing coverage in women (comparison)**

Late diagnosis is the most important predictor of morbidity and mortality among those with HIV infection. Those diagnosed late have a ten-fold risk of death compared to those diagnosed promptly and is essential to evaluate the success of expanded HIV testing. This indicator directly measures late diagnoses and indirectly informs our understanding of the proportion of HIV infections undiagnosed. Ideally the fewer people diagnosed late the better. Luton has a significantly greater number of people diagnosed with HIV late compared to England. All but one local authority in the comparator group have more late diagnosis than England. The data is shown in figures 45 and 46. In Luton, between 2013 and 2015, 55.1% (95% confidence interval [CI] 43.4-66.4) of HIV diagnoses were made at a late stage of infection (CD4 count <350 cells/mm³ within 3 months of diagnosis) compared to 40.3% (95% CI 39.5-41.1) in England.
Vulnerable Groups

Tuberculosis

Countries where there are high prevalence rates for HIV can also have high rates of Tuberculosis (TB). With that in mind PHE have set a target of improving the testing for HIV in TB patients. Improving treatment and care services is a key action in the Collaborative Tuberculosis Strategy for England 2015-2020. Increasing the proportion of TB cases offered an HIV test is a key indicator. Data from 2012 to 2014 are presented in figure 47 and 2014 for comparative LAs in figure 48. Luton offered less people with TB an HIV test than England but not statistically significantly. Other LAs in the cluster have a higher proportion. (There were no data reported for Medway.)

Drug users

The National Drug Treatment Monitoring System (NDTMS) with PHE report the estimated prevalence of opiate users in the population. In Luton the estimated prevalence for 2011/12 (latest available, produced in April 2014) was 1,604 opiate or crack users (rate per 1,000 population 11.84 (England 8.4)) with 199 of them injecting (rate per 1,000 population 1.47 (England 2.49)). Luton has more opiate and crack users
than England but less people injecting. The quarter 4 2015/16 proportion of opiate and/or crack users in treatment is 54.4% which is greater than England (51.7%)\textsuperscript{45}.

There were 28 people in drug and alcohol treatment who were currently injecting at quarter 4 2015/16. There were 80 people in treatment who previously injected. 28.7% (n188 of 656) of new people in drug and alcohol treatment were offered and accepted hepatitis B vaccination but of those only 15.4% (n29) completed the vaccination course\textsuperscript{46}. 41.7% of new engagements to treatment (current or previous injectors) were offered, and accepted a test for hepatitis C (n45 of 108) and of these 30, 66.7% had received a test.

A healthcare assessment is given to each new client to drug treatment and this should be reviewed during intervention reviews and treatment outcome reviews. 92.4% of care plans were started but only 70.2% were completed\textsuperscript{46}.

‘Dual diagnosis’ (clients with co-existing mental health diagnoses) data are also available and this can hinder engagement with treatment. As at quarter 4 of 2015/16 21.2% (n139 of 656) of new engagements to treatment were recorded as having a dual diagnosis\textsuperscript{46}.

In April 2016 data on the protected characteristics of clients started to be collected. This includes sexuality which would be interesting to review alongside the data relating to clients’ injecting status.

Luton drug and alcohol service has been re-commissioned with one main provider with the service start in 1\textsuperscript{st} April 2017. It will be easier to monitor this group of clients and help ensure that they get regular health checks including sexual health advice and STI testing when appropriate. The uptake of hepatitis B inoculation and hepatitis C testing should be performance managed closely with an aim to improve uptake.

**Sex workers**

In 2013 a multi-agency strategy for ‘Tackling the Street Sex Trade’\textsuperscript{47} in Luton was implemented by the Community Safety Partnership (CSP) – soLUTiONs identified that:

- Of the known forms of prostitution operating within the town it is highly visible on-street sex trade which appears to be having the most significant and detrimental impact on the town and communities
- Although reports relating to the on-street sex trade have been received from a number of (electoral) wards within the town this activity is most concentrated in a relatively small geographical area close to the town centre and train station
- Those seeking to buy sex are travelling to the affected areas both in vehicles and on foot
- All those currently identified as engaged in selling sex “on-street” in Luton were women over the age of 21

\textsuperscript{45} NDTMS, DOMES quarter 4 2015/16

\textsuperscript{46} NDTMS, Adult Activity Report – Partnership quarter 4 2015/16

\textsuperscript{47} Data from Bedfordshire Police – Operation Turtle, as quoted in ‘Tackling the Street Sex Trade’, Luton Community Safety Partnership – soLUTiONs
The vast majority of those involved in selling sex have drug and/or alcohol misuse problems and a history of abuse and/or emotional trauma.

Those purchasing sex are predominantly men. Most are residents of the town although approximately a quarter are visitors to Luton.

An action plan was drawn up as a result of this report which feeds in to the Health and Wellbeing Board for Luton. Since 2013 reports of street sex trading has been falling. Operation Turtle by Bedfordshire Police has been superseded by Operation Sentinel and is looking at reducing many crimes including prostitution. Regular reports to the CSP

Finances
Spend on HIV support services for 2016/17

- CAFPH £47,000
- Embrace Life £47,000
- HIV testing in A&E/MIU £10,000
- HIV prevention and promotion £41,000

Planned spend for 2017/18

- CAFPH £23,500 (April – September)
- Embrace Life £23,500 (April – September)
- Integrated HIV testing, prevention and support - £65 -75,000 tbc (October – March)

Planned spend 2018/19

- Integrated HIV Prevention, Testing, and support services £130-£140,000 tbc

Spend and Outcome Tool (SpOT) data

Public Health England (PHE), health economics programme, has produced a Spend and Outcome Tool (SpOT) and this report summarises the data shown within the tool for Luton Council (LC). The tool gives organisations in England an overview of spend and outcomes across key areas of business. The profile supports understanding of the overall relationship between spend and outcomes, by identifying areas of significant variance which are likely to require more in-depth analysis. The latest data shown are for 2014/15. Whilst data are relatively old (2014/15 finance data and generally 2013 or 2013/14 outcome data)

48 Luton Borough Council General Ledger 2016

49 PHE, 2015/16 Spend and Outcome Tool (SpOT)
they do provide some useful insight to services and their related outcomes. An update to the SpOT is due imminently. Data are presented in a macro driven spreadsheet and these data relating to sexual health and HIV are presented below.

Figure 49 shows the data that relate to the PH department spend by programme budget. The Health Improvement (HI) programme budget category shows higher spend but better outcomes than the average (mean). Spend on Violence and Mental Public Health (MPH) are the same and very similar to the mean respectively (MPH z-score 0.04). Health Protection (HP) and Child Public Health (Child) show low spends and worse outcomes. Tobacco (Smoke), Sexual Health (Sex) and Healthcare Public Health (HC) have higher spends with worse outcomes. All these categories have a z-score of +/- 1. Drug and Alcohol (Drug) spend has a z-score just over 1 for spend per head.

Figure 49: Public Health Spend and Outcome quadrant chart by programme

Sexual health spend in Luton is more than the average when compared with England as a whole but has 'worse' outcomes. Figure 50 shows the value for Luton, England, the ONS Cluster (comparator local authorities), the deprivation decile (other LAs that have similar levels of deprivation to Luton) and the range for the Public Health England Centre.
PHE make available box plots for each outcome indicator for sexual health. Boxplots show the chosen organisation represented as a red diamond and the upper and lower quartile boxes represent the middle 50% of authorities’ outcome measure scores. The white line through the middle of the quartile box is the median. The whiskers extend 1.5 x the interquartile range, up to the max/min values. Organisations outside the whiskers are categorised as outliers. (NB: Whiskers are not the same as confidence limits.) Boxplots are provided for a number of peer comparator sets. The data assist in determining which peer groups the organisation is similar to and not similar to for each measure. It can also suggest areas to look at when exploring variation.

Figure 51 shows spend for the sexual health programme for sexually transmitted infection testing and treatment for Luton and comparators as spend per head of population. Luton spends £7.34 per head of population for this category. This is more than England, unitary authorities combined, East of England and other local authorities with similar levels of deprivation but less than similar local authorities (ONS cluster of multicultural suburbs).
When this is broken down to contraception (figure x) and advice, prevention and promotion (figure 52) Luton spends more on contraception and advice, prevention and promotion than all comparators although not significantly so and advice, prevention and promotion shows that it is within the range of spend in other local authorities within the deprivation decile.
Data are further broken down by specific outcomes. The main outcome is new sexually transmitted infections (including chlamydia) and data are shown in figure 54.
The HIV data are shown in figures 55 to 62. Luton has a higher prevalence rate than its comparator areas (figure 24) and significantly more than other unitary authorities and ‘non-core cities’. Luton has a greater number of late diagnosis than its comparator areas. Because of the health impacts of HIV it is important that people at risk of HIV are tested and the earlier they are diagnosed with HIV the more effective their treatment and outcomes. Luton has relatively high rates of late diagnosis of HIV (figure 45) although similar to East of England, non-core cities and its ONS cluster. Testing coverage is better in men (figure 35), men who have sex with men (MSM) (figure 31) and women (figure 33). Testing uptake in men is the same as the average for East of England but lower than the other comparators. Testing uptake in MSM (figure 39) is lower than all comparators and testing uptake in women (figure 41) shows lower levels than its comparators. We know that from more recent data testing uptake has improved (see PHE Fingertips and Luton’s HIV prevention needs assessment (due to be published 2017)).
Figure 55: HIV diagnosed prevalence rate (SpOT)

Figure 56: HIV late stage diagnosis (SpOT)
Figure 57: HIV testing coverage in men (SpOT)

Figure 58: HIV testing coverage MSM (SpOT)
Figure 59: HIV testing coverage in women (SpOT)

Figure 60: HIV testing uptake, men (SpOT)
Figure 61: HIV testing uptake, MSM (SpOT)

Figure 62: HIV testing uptake, women (SpOT)
Local service provision

HIV support services in Luton are currently commissioned by Luton public health grant to provide support services for HIV positive people and their families or carers. HIV testing services is partly funded by PHEs Home sampling programme, launched in 2016.

There are commissioned services delivering work on our high risk groups to provide the required services locally:

In Luton there are two commissioned HIV support services, located in Luton town centre, providing HIV testing and support for HIV Adults, Children and LGBT communities, and Black African communities and their families. There is also HIV testing provision in GPs and in Luton and Dunstable A&E and the Minor Injuries Unit (MIU).

Embrace Life Luton provides opportunities for people affected by HIV/ AIDS, to support and enable people to deal with the physical and psychological challenges brought on by HIV/ AIDS. It provides information, advice, support services and arranges activities to enable people living with HIV/ AIDS to make positive and informed decisions on how to live well with their HIV infection. It represents the views, interests and experiences of people living with HIV/ AIDS and advocates for prompt and appropriate services, whether provided by the State or independent agencies. It has self-help and up to date information on HIV/ AIDS which is essential and complementary to anti-HIV treatments as part of an integrated and holistic approach to successful management of HIV infection.

Centre for All Families Positive Health (CAFPH) is a peer led organisation providing support to HIV affected people across Luton, Bedford and the East of England. With diagnosis rates in the local area sitting above national average, the need for targeted social support which is culturally sensitive, client centred and lead by those who can really understand the experience remains a priority. CAFPH have been providing such support for the last decade in Luton and Bedfordshire.

Luton and Dunstable NHS hospital HIV treatment and care service provide one-to-one support services, providing information, support, advice and guidance to manage their condition.

The HIV treatment and care service in Luton is commissioned by NHS England and provided by Luton Sexual Health, part of Luton and Dunstable University Hospital NHS Foundation Trust. The Public Health commissioned support services have developed a good working relationship with this provider and are able to offer timely support to newly diagnosed patients.

Figure 63 show the age and gender of people accessing CAFPH services in 2015/16 based on the performance data reported to LBC. The majority of clients are women and those aged under 30 are less likely to be people with HIV (services are offered to people living with HIV whether they have it themselves or not). Of the people accessing services table 2 shows the proportion of these people who have HIV. The majority of the people under the age of 30 do not have HIV themselves. For those aged 51 years or older 97% of the people accessing CAFPH services were HIV positive. The majority of the clients were from the Black African ethnic group. Most of CAFPHs clients are from a black African ethnic group and these data are shown in figure 64.

Figure 63: Age and gender of people accessing CAFPH services
Table 2: Proportion of people accessing CAFPH services by age group

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Under 16</th>
<th>16-25</th>
<th>26-30</th>
<th>31-40</th>
<th>41-50</th>
<th>51-65</th>
<th>66-80</th>
<th>81+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Proportion with HIV</td>
<td>10%</td>
<td>19%</td>
<td>18%</td>
<td>56%</td>
<td>78%</td>
<td>97%</td>
<td>100%</td>
<td>n/a</td>
</tr>
</tbody>
</table>

Source: CAFPH performance report, 2015/16
Table 3 show the types of sessions offered by CAFPH in 2015/16. One to one sessions were the most popular.

Table 3: Sessions attended by CAFPH clients

<table>
<thead>
<tr>
<th>Service provided by CAFPH, 2015/16</th>
<th>2015/16</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Name</td>
<td>Q1</td>
</tr>
<tr>
<td>Complimentary Therapies</td>
<td>60</td>
</tr>
<tr>
<td>One to One</td>
<td>169</td>
</tr>
<tr>
<td>Psychological Therapies</td>
<td>134</td>
</tr>
<tr>
<td>Activities</td>
<td>24</td>
</tr>
<tr>
<td>IT Sessions</td>
<td>25</td>
</tr>
<tr>
<td>Educational Sessions</td>
<td>11</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
</tr>
<tr>
<td>Total Services</td>
<td>424</td>
</tr>
</tbody>
</table>

Source: CAFPH performance report 2015/16

Outreach activities included one to ones with clients and people we met during the outreach sessions; condom information (and where possible demonstration) and HIV awareness materials were distributed.

CAFPH reported that they had 463 clients at quarter 2 2016/17. Over two thirds (67.6%) were from the black African community and 52.5% were women. 24% were aged between 41 and 50 years and 22.5% were under the age of 16 years.
CAFPH saw an increase in attendances to their drop in sessions in 2015/16. They reported issues with housing, finances, welfare and health and wellbeing. Employment continues to be reported as a problem. In a four month period (from starting post in November 2015) a clinical psychologist had 24 referrals (14 from CAFPH and 10 from GUM service). There was an 8 to 12 week waiting time for this service but this was increasing. CAFPH continued to notice that stigma and discrimination among many professionals continues to exist. People living with HIV are still reluctant to disclose their status for fear of breaches in confidentiality but also fear that they will be subject to discrimination when their cases are assessed. When we do initial assessments we frequently find that clients do not have a GP or a dentist. The food bank CAFPH run provided 120 adults and 143 children with food in the last 6 months of 2015/16. The food bank and issues with benefits and poverty continues to major issues for clients. Clients often attend CAFPH having problems with accessing disability benefit (despite having multiple health issues) and struggle with completing forms. Many of working clients are working on very low incomes and are struggling to manage and understand where they can obtain support.

In the first two quarters of 2016/17 CAFPH’s outreach service reported 93 activities with over three quarters of these (76.3%) being to women. For this same reporting period CAFPH reported that they tested 62 people (56.5% women). Most people tested were in the 41 to 50 age group and 46 were from the black African population. For the 2016/17 first 2 quarters 2,920 condoms were distributed to the barbers shops with 75% of these being given out in quarter 1.

Embrace had 107 service users who were actively engaged at the end of 2015/16. Their drop in service receives the most clients. Their lunch club continues to be popular. The number of service users accessing counselling varies between quarters. 52.3% of their clients were men. Embrace report their data differently from CAFPH and so it is not possible to provide comparative data in exactly the same as CAFPH. Table 4 and figure 65 show the proportion of clients by age group for Embrace services (data for some age groups have been aggregated due to data suppression rules for potentially individual identifiable data) (the chart shows data by age and gender).

Table 4: Embrace clients by age group, 2015/16

<table>
<thead>
<tr>
<th>Under 25</th>
<th>26-30</th>
<th>31-40</th>
<th>41-50</th>
<th>51-65</th>
<th>66-80</th>
</tr>
</thead>
<tbody>
<tr>
<td>17.8%</td>
<td>4.7%</td>
<td>23.4%</td>
<td>30.8%</td>
<td>18.7%</td>
<td>4.7%</td>
</tr>
</tbody>
</table>

Source: Embrace Q4 2015/16 performance report
71% of Embrace’s service users were heterosexual with the remaining 29% being gay, lesbian, bisexual or transgender. The majority of service users were from the LU1 postcode sector (more than LU2 to LU4 put together). Figure 66 shows the ethnic groups of Embrace’s clients (N.B. data are not comparable with CAFPH due to different volumes in different ethnic groups).

Table 5 show the sessions provided by Embrace and the count of service users that attended by quarter for 2015/16.
Table 5: Number of service users accessing Embrace services

<table>
<thead>
<tr>
<th>Service Name</th>
<th>Q1</th>
<th>Q2</th>
<th>Q3</th>
<th>Q4</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drop in</td>
<td>385</td>
<td>380</td>
<td>376</td>
<td>567</td>
<td>1,708</td>
</tr>
<tr>
<td>One to One</td>
<td>338</td>
<td>323</td>
<td>249</td>
<td>407</td>
<td>1,317</td>
</tr>
<tr>
<td>Lunch Club: Tuesday</td>
<td>177</td>
<td>126</td>
<td>164</td>
<td>192</td>
<td>659</td>
</tr>
<tr>
<td>Computer Use</td>
<td>183</td>
<td>68</td>
<td>62</td>
<td>136</td>
<td>449</td>
</tr>
<tr>
<td>Counselling</td>
<td>159</td>
<td>132</td>
<td>108</td>
<td>40</td>
<td>439</td>
</tr>
<tr>
<td>HIV Awareness Training</td>
<td>30</td>
<td>15</td>
<td>11</td>
<td>0</td>
<td>56</td>
</tr>
<tr>
<td>English lessons</td>
<td>9</td>
<td>5</td>
<td>9</td>
<td>2</td>
<td>25</td>
</tr>
<tr>
<td>LGBT Training</td>
<td>10</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Benefits Training</td>
<td>10</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>HIV Testing</td>
<td>11</td>
<td>0</td>
<td>50</td>
<td>22</td>
<td>83</td>
</tr>
<tr>
<td>Southend Trip</td>
<td>0</td>
<td>22</td>
<td>0</td>
<td>0</td>
<td>22</td>
</tr>
<tr>
<td>Team Building Event</td>
<td>10</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Stress Management Talk</td>
<td>12</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td>Healthy Eating Talk</td>
<td>9</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Advocacy Talk</td>
<td>10</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>Red Cross Services</td>
<td>0</td>
<td>11</td>
<td>0</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td>HIV and Disclosure</td>
<td>0</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Mental Health Talk</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Healthy Eating on a Budget Talk</td>
<td>0</td>
<td>0</td>
<td>9</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Transgender Memorial Day</td>
<td>0</td>
<td>0</td>
<td>10</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td>HIV Testing week: Beds Uni</td>
<td>0</td>
<td>0</td>
<td>11</td>
<td>0</td>
<td>11</td>
</tr>
<tr>
<td>HIV Fund Raiser at the Cali</td>
<td>0</td>
<td>0</td>
<td>6</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>HIV Testing: ICC Church</td>
<td>0</td>
<td>0</td>
<td>19</td>
<td>0</td>
<td>19</td>
</tr>
<tr>
<td>World Aids Day Event: Carnival Centre</td>
<td>0</td>
<td>0</td>
<td>15</td>
<td>0</td>
<td>15</td>
</tr>
<tr>
<td>Welfare Benefit Changes Talk</td>
<td>0</td>
<td>0</td>
<td>12</td>
<td>0</td>
<td>12</td>
</tr>
<tr>
<td>Sexual Health Talk</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>12</td>
<td>12</td>
</tr>
<tr>
<td>Easter Lunch for Service Users</td>
<td>0</td>
<td>0</td>
<td>20</td>
<td>0</td>
<td>20</td>
</tr>
<tr>
<td>Healthy Eating Talk</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>7</td>
<td>7</td>
</tr>
</tbody>
</table>

Source: Embrace Q4 2015/16 performance report

Embrace’s quarter 4 2015/16 performance report showed that there are ongoing issues with their service users in relation to immigration cases (n20). There were ‘significant’ mental health issues with 24 service users and 41 service users were experiencing social isolation. 18 service users were in poor physical health. Some service users admitted to not being compliant with their medication regime. 10 service users were misusing drugs and/or alcohol. There were 17 service users that had poor nutrition. There were 18 service users that were unemployed and over the year at least 7 (only quarters 3 and 4 had this statistic reported) service users were supported back in to work. Their reports also stated that there were issues with hate crimes and human trafficking as well as domestic abuse. Counselling services are currently being run by a volunteer and their case load at the end of 2015/16 was 12.

The number of people tested for HIV by Embrace was 67 for the last two quarters of 2015/16 (previous 2 quarters were not available) and 73 for the first two quarters of 2016/17.
Neither CAFPH nor Embrace reported activity for the additional protected characteristics\(^\text{50}\) of religion, disability, pregnant (or on maternity leave) and relationship status.

Luton Council does not record information in relation to health in their housing data and therefore although health inequalities in relation to HIV exist it cannot be quantified. The same is found with the homelessness data although occasionally poor health will be cited as the reason for becoming homeless. However CAFPH reported that they had seven clients that were homeless in the first quarter of 2016/17 (latest data available) (it is not certain of the definition for homelessness as used by CAFPH) and Embrace reported that they worked with 17 clients in 2015/16 who were homeless or ‘sofa surfing’. The number of people being supported for housing is increasing as well as the numbers of people needing support with social isolation and poor physical health including compliance with medication regimes.

Luton Borough Council adult and children’s social care records were reviewed for any notation in the ‘health conditions’ field for HIV and AIDS. There is currently (March 2017) less than 10 clients recorded on the system but the health condition field is not a mandatory one\(^\text{51}\) and consequently it is not required to be entered. We know from the consultation we have done that adult clients do not always declare their HIV status or only provide it if requested. It is therefore difficult to assess the potential social care needs of people living with HIV. It would help future commissioning and service planning if we can work with the social care, training and IT system teams to improve our recording of health status, in particular HIV. The HIV support provider(s) could also be required to report the number of clients receiving social care support.

“Whilst there is not a ‘right’ age for all children to be told their HIV diagnosis, it is generally agreed that most children should have this discussion during primary school years (WHO 2011). The approach in the UK and Ireland should be for the majority of younger children growing up with HIV to be told they have HIV by the age of 9 years. For those older children who do not yet know there should be a clear disclosure plan to enhance knowledge, including approaches which consider difficulties with communication or understanding\(^\text{52}\).

Evidence of what works in HIV prevention is based on findings from PHE prevention programs and National Aids Trust reviews 2016 fall in to the following categories:-

- HIV Testing – Testing is an important part of prevention as it enables people to know their status and therefore can look after their own health as well prevent onward transmission to others. Negative results can encourage behaviour change.
- Condoms – it is important for those living with HIV or at high risk of transmission should have free or low cost access to condoms. Condom distribution is an opportunity for sexual health behaviour change.

\(^{50}\) Equality and Human Rights Commission https://www.equalityhumanrights.com/en/equality-act/protected-characteristics

\(^{51}\) As per the Equalities and Classifications (EQ-CL) Framework for 16-17 (official guidance) which oversees all Adult Social Care statutory collections, the only mandatory health condition data required is:
- Autism (excluding Asperger Syndrome / High Functioning Autism)
- Asperger Syndrome / High Functioning Autism.
Therefore, other areas, including HIV and Aids is likely to be underreported.

\(^{52}\) Talking to children about HIV in health settings, Diane Melvin & Sheila Donaghy February 2014
• Information and awareness raising – evidence supports the use of mass media campaigns in raising awareness and increasing uptake of testing and signposting to services. The delivery of targeted HIV prevention through social media is good for reaching certain target populations.

• Outreach interventions – Interventions that engage with people in target population groups in their own social, community or other settings can be effective in increasing knowledge, awareness and reduce sexual risk behaviours,

• Behavioural interventions – Individual and small group behaviour change interventions have shown an impact in reducing risk behaviour among HIV positive people

• Educational, Knowledge and skilled based interventions – educational information and skills based interventions, such as Sex and relationships educations in young people’s learning environments can be effective in increasing Knowledge and awareness of the impact of HIV and risky sexual health behaviour.

• Harm reduction measures in people who inject drugs – substance misuse treatment and needle exchange schemes are both effective measures to reduce HIV transmissions in people who inject drugs.

Consultation

For consultation it was necessary to establish the re-commissioning working group which included representatives from public health, finance, procurement, communications, GPs and the Hospital trust.

It was agreed to use a combined approach; focus groups, questionnaires and 1-1 interviews

An online questionnaire was developed for residents, HIV positive service users and their carers and the other was for professionals and providers of health and social care services.

Two focus groups from the two current providers of HIV were carried out, as this was a good way to ensure we could reach the specific target group this consultation. Both of these were informative and participants were able to share their experiences in fuller detail.

Service users and carers were encouraged to complete the questionnaires either online or by hand.

Overall the questionnaire response was low, however the information of what was received has proved very helpful in shaping the service design for Luton.

Key findings were:

• 42% of the respondents were HIV positive people and residents in Luton

• 43% of respondents indicated they did not use HIV support services in Luton

• 30% of respondents indicated they are reluctant to reveal their status when accessing public services

• 82% of those responded felt it was important to have a private area to speak confidentially when accessing HIV service
- 76% of respondents indicated that opening on a Saturday would make services more accessible.
- Mental health, education and support at time of diagnosis were listed as key features to be included in a new service

The full results can be seen in Appendix 3

**Recommendations**

**Strategic Recommendations**
11. There is considerable concern about increasing sexual risk taking behaviours in MSM associated with recreational drug use. This new trend needs to be addressed through broader interventions targeting sexual and other health-related risk-taking behaviours, and indicates the need for a more integrated approach between substance misuse and sexual health services. It is imperative that people are able to continue accessing needle exchange schemes to minimise risk associated with injecting drug use.
12. The World Health Organisation (WHO) strongly recommends men who have sex with men consider taking antiretroviral medicines as an additional method of preventing HIV infection (pre-exposure prophylaxis (PrEP)) alongside the use of condoms.
13. Work is required to increase the knowledge within African communities of prevention and treatment options and consider the sexual health needs of black African and young people born in the UK.
14. GP practices in areas with significant black African communities have an important role to play to reduce the rates of late diagnosis of HIV.
15. Local authorities need to understand the specific social care needs of black African communities and take account of them in their training of social care staff, in their support for the local voluntary and community sector, and in their planning, commissioning and service delivery.
16. Diagnosing those with HIV promptly has a significant role in reducing the spread of HIV in the local population.
17. Earlier HIV diagnosis reduces onward transmission of HIV among the population because people tend to adapt sexual behaviours to reduce risk following diagnosis and effective treatment significantly reduces transmission risk.
18. Improve the financial reporting for spend on HIV prevention, testing and support.
19. Prompt diagnosis remains a priority for heterosexuals living with HIV.
20. Undertake needs assessments around MSM drug use, injecting and sexual risk to identify the scope for joint commissioning of tailored drugs and sexual health services for MSM.

**Commissioning Recommendations**
17. Ensure there is a mandatory HIV education session delivered as part of mandatory training for all new employers in public health services to reduce Stigma.
18. Increase HIV education awareness for people who are HIV positive and their families/carers.
19. Reviews the opening hours for HIV support services and include Saturday services; this may encourage more of our residents to use local services.
20. Provide tailored HIV awareness training for GPs and dentists that treat HIV positive patients.
21. Ensure HIV services have a confidential reception area for service users.
22. Improve the pathways for access to mental health, housing and social care advice.
23. Strengthen the counselling and therapy treatment for HIV positive people.
24. Support patients to maintain their support plans they have in place.
25. Review outreach work and increase the provision to reach more of the HIV positive clients.
26. Increase HIV testing of all patients attending specified services, presenting with an indicator condition or reporting a history of high risk behaviour.
27. Promote HIV screening and testing among patients with indicator conditions or attending termination of pregnancy services.
28. Continue to support testing in non-medical settings such as community HIV testing, self-sampling.
29. Ensure Sexual health services are provided for key groups at high risk of STIs, people with STIs, accessible sexual health services and vulnerable young people under 18 including young women who are pregnant or mothers already.
30. Provide condoms in addition to other methods of contraception and providing school and education-based contraceptive services.
31. Social media should be considered to look to support the HIV prevention and testing messages for everyone but particularly those at increased risk of HIV.
32. Ensuring optimal implementation of effective prevention interventions such as condom use is required.

Services provided or commissioned by Luton Council need to understand the issues relating to HIV awareness and prevention thereby making it easier for people with HIV and their families to access the support they require from services and feel able to share their HIV status. Ideally anyone with HIV should feel able to share their HIV status when appropriate. Where possible all teams working directly with Luton residents should feel confident in discussing HIV and recording it within their information systems. This will allow us to have much greater understanding of the support issues relating to people with HIV and how we can best offer support.

The chosen provider(s) for the future contract should report activity based on the same breakdown of service user characteristics to make understanding the needs of different populations known and better met. Data relating to the protected characteristics also need to be captured. This will allow us to better assess any inequalities in relation to these services.
## Document control, Acronyms and Consultation

### Document Control

<table>
<thead>
<tr>
<th>Version</th>
<th>Author/s</th>
<th>Date</th>
<th>Issued to</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.0</td>
<td>Jane Robinson</td>
<td>2 February 2017</td>
<td>Patsy Richards</td>
<td></td>
</tr>
<tr>
<td>2.0</td>
<td>Jane Robinson</td>
<td>6 February 2017</td>
<td>Patsy Richards</td>
<td>Additional data, text and some revisions to text</td>
</tr>
<tr>
<td>3.0</td>
<td>Patsy Richards</td>
<td>7 February 2017</td>
<td>Jane Robinson</td>
<td>Additional data, text and some revisions to text</td>
</tr>
<tr>
<td>3.1</td>
<td>Jane Robinson</td>
<td>13 February 2017</td>
<td>Patsy Richards</td>
<td>Foreword and current activity</td>
</tr>
<tr>
<td>3.2</td>
<td>Jane Robinson</td>
<td>15 February 2017</td>
<td>Patsy Richards</td>
<td>Literature search, acronyms and minor changes</td>
</tr>
<tr>
<td>3.3</td>
<td>Communications Team</td>
<td>2 March 2017</td>
<td>Jane Robinson/ Patsy Richards</td>
<td>Consultation work</td>
</tr>
<tr>
<td>3.4</td>
<td>Patsy Richards</td>
<td>9 March 2017</td>
<td>PH, BI</td>
<td>Final text and numbering</td>
</tr>
<tr>
<td>3.5</td>
<td>BI team and others</td>
<td>14 March 2017</td>
<td>PH</td>
<td>Proof read version</td>
</tr>
<tr>
<td>3.6</td>
<td>Patsy Richards</td>
<td>21st March 2017</td>
<td>BI</td>
<td>Proof read version</td>
</tr>
<tr>
<td>3.7</td>
<td>Patsy Richards</td>
<td>23rd March 2017</td>
<td>BI</td>
<td>Additional data and some reversion</td>
</tr>
<tr>
<td>3.8</td>
<td>BI</td>
<td>24th March 2017</td>
<td>PH</td>
<td>Final checking, re-indexing</td>
</tr>
<tr>
<td>3.9</td>
<td></td>
<td></td>
<td></td>
<td>HIV prevention recommissioning task and finish group</td>
</tr>
<tr>
<td>Final</td>
<td></td>
<td></td>
<td>Website, ITT portal</td>
<td>Publication</td>
</tr>
</tbody>
</table>
## Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E</td>
<td>Accident and Emergency department</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ART</td>
<td>Anti-retroviral therapy/ treatment</td>
</tr>
<tr>
<td>BBV</td>
<td>Blood Bourne Viruses</td>
</tr>
<tr>
<td>CAFPH</td>
<td>Centre for All Families Positive Health</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
</tr>
<tr>
<td>CD4</td>
<td>Cluster of differentiation 4, a glycoprotein found on the surface of immune cells measured by a blood test. In HIV patients the CD4 count will become depleted</td>
</tr>
<tr>
<td>CIPFA</td>
<td>Chartered Institute of Public Finance and Accountancy</td>
</tr>
<tr>
<td>Crl</td>
<td>Credibility intervals</td>
</tr>
<tr>
<td>CSP</td>
<td>Community Safety Partnership (in Luton the CSP is named soLUTiONs)</td>
</tr>
<tr>
<td>FSW</td>
<td>Female sex workers</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner (primary care doctor)</td>
</tr>
<tr>
<td>Hep</td>
<td>Hepatitis</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>HNA</td>
<td>Health Needs Assessment</td>
</tr>
<tr>
<td>IPEDs</td>
<td>Image and Performance Enhancing Drugs</td>
</tr>
<tr>
<td>L&amp;D</td>
<td>Luton and Dunstable Hospital</td>
</tr>
<tr>
<td>LBC</td>
<td>Luton Borough Council</td>
</tr>
<tr>
<td>LGBT</td>
<td>Lesbian, gay, bisexual and transgender</td>
</tr>
<tr>
<td>MIU</td>
<td>Minor Injuries Unit</td>
</tr>
<tr>
<td>MPES</td>
<td>Model-based estimates for HIV prevalence</td>
</tr>
<tr>
<td>MRE</td>
<td>Marriage and relationship education</td>
</tr>
<tr>
<td>MSM</td>
<td>Men who have sex with men</td>
</tr>
<tr>
<td>MSOA</td>
<td>Middle Super Output Area, a standard administrative geography produced by ONS of approximately 7,500 people</td>
</tr>
<tr>
<td>NAT</td>
<td>National Aids Trust</td>
</tr>
<tr>
<td>NICE</td>
<td>National Institute of Care Excellence</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
</tr>
<tr>
<td>NPS</td>
<td>New (or novel) psychoactive substance</td>
</tr>
<tr>
<td>NSP</td>
<td>Needle and Syringe Programmes</td>
</tr>
<tr>
<td>NSWP</td>
<td>Network of Sex Work Projects</td>
</tr>
<tr>
<td>NTA</td>
<td>National (Drug and Alcohol) Treatment Agency (now part of PHE)</td>
</tr>
<tr>
<td>ONS</td>
<td>Office of National Statistics</td>
</tr>
<tr>
<td>OST</td>
<td>Opioid Substitution Therapy</td>
</tr>
<tr>
<td>PHE</td>
<td>Public Health England</td>
</tr>
<tr>
<td>PLWH</td>
<td>People living with HIV</td>
</tr>
<tr>
<td>PWID</td>
<td>People who inject drugs</td>
</tr>
<tr>
<td>soLUTiONs</td>
<td>Luton’s Community Safety Partnership brand</td>
</tr>
<tr>
<td>SOPHID</td>
<td>Survey Of Prevalent HIV Infections Diagnosed (UK)</td>
</tr>
<tr>
<td>SpOT</td>
<td>Spend and Outcome Tool</td>
</tr>
<tr>
<td>SRHAD</td>
<td>Sexual and Reproductive Health Activity Dataset</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>THT</td>
<td>Terrance Higgins Trust</td>
</tr>
<tr>
<td>TOP</td>
<td>Termination of pregnancy</td>
</tr>
</tbody>
</table>
References
Please see footnotes throughout document.
Acknowledgements

Sally Cartwright, Public Health Registrar
Sam Freeman, Performance Business Partner
Alison Harbron, Client Services Co-ordinator
Usman Iftikhar, Management Information Officer
Farah Ismail, Senior Consultation Officer
Sital Kajee, Research Officer
Sophie Langston, Research & Information Officer (Crime & Safety)
Alamin Mukith, Performance Officer
Kelly O’Neill, Service Director of Public Health
Patsy Richards, Senior Public Health Manager
Jane Robinson, Public Health Analyst
Nazeema Tambe, Project Assistant
Nathan Tracey, Accountant
Joelle Turner, Consultant in Genitro Urinary Medicine
Helen Vincent, Senior Analyst
Background

HIV evidence review to inform the HIV Prevention needs assessment. The needs assessment is to look at Human Immunodeficiency Virus (HIV) prevention, testing and support for the population of Luton. The report is to inform and guide the recommissioning of health, wellbeing and social care services. It also looks at the inequalities related to HIV that are known to exist. Education is an important part of HIV prevention which will also be covered by the needs assessment.

This report does not include the treatment of those with HIV.

Objectives

To determine what preventative methods are effective in individuals from developing HIV

Search methods

A search was conducted on MEDLINE, EMBASE, PUBMED and CENTRAL databases using the following keywords: ‘HIV prevention’, ‘HIV education’, ‘HIV testing’, ‘support to HIV patients’ and ‘HIV inequalities’. Results have a date limitation of 2 years.

Findings

A total of 16,813 titles we found from the electronic search of reviews. 16,612 were excluded after screening against the projects inclusion and exclusion criteria and the extracts of the remaining 201 titles were obtained and further screened.

We found, 138 studies were carried out in the following countries:

<table>
<thead>
<tr>
<th>Country</th>
<th>Number of studies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Africa</td>
<td>42</td>
</tr>
<tr>
<td>South America</td>
<td>9</td>
</tr>
<tr>
<td>Australia</td>
<td>3</td>
</tr>
<tr>
<td>Europe (inc UK)</td>
<td>9</td>
</tr>
<tr>
<td>China</td>
<td>10</td>
</tr>
<tr>
<td>India</td>
<td>3</td>
</tr>
<tr>
<td>Far East</td>
<td>5</td>
</tr>
<tr>
<td>Middle East</td>
<td>5</td>
</tr>
<tr>
<td>Eastern Europe</td>
<td>5</td>
</tr>
<tr>
<td>South Africa</td>
<td>19</td>
</tr>
<tr>
<td>US / Canada</td>
<td>21</td>
</tr>
<tr>
<td>Worldwide</td>
<td>7</td>
</tr>
<tr>
<td>N/A</td>
<td>63</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>201</strong></td>
</tr>
</tbody>
</table>

93 studies specifically covered the following population groups:

<table>
<thead>
<tr>
<th>Population Group</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 30 years old</td>
<td>1</td>
</tr>
<tr>
<td>Adolescents</td>
<td>1</td>
</tr>
<tr>
<td>Adults</td>
<td>16</td>
</tr>
<tr>
<td>Population Group</td>
<td>Total</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Children</td>
<td>7</td>
</tr>
<tr>
<td>Couples</td>
<td>2</td>
</tr>
<tr>
<td>Drug abuser</td>
<td>2</td>
</tr>
<tr>
<td>FSW</td>
<td>3</td>
</tr>
<tr>
<td>Gender comparison</td>
<td>1</td>
</tr>
<tr>
<td>HIV infected patients</td>
<td>4</td>
</tr>
<tr>
<td>Kidney donors</td>
<td>1</td>
</tr>
<tr>
<td>Low monthly income</td>
<td>1</td>
</tr>
<tr>
<td>Men</td>
<td>7</td>
</tr>
<tr>
<td>Military</td>
<td>1</td>
</tr>
<tr>
<td>MRE</td>
<td>1</td>
</tr>
<tr>
<td>MSM</td>
<td>11</td>
</tr>
<tr>
<td>MSM, SW, PWID</td>
<td>1</td>
</tr>
<tr>
<td>Orphans</td>
<td>2</td>
</tr>
<tr>
<td>Pregnant women and postpartum</td>
<td>11</td>
</tr>
<tr>
<td>PWID</td>
<td>4</td>
</tr>
<tr>
<td>Sexually assaulted women</td>
<td>1</td>
</tr>
<tr>
<td>TB</td>
<td>2</td>
</tr>
<tr>
<td>Women</td>
<td>10</td>
</tr>
<tr>
<td>Young adults</td>
<td>3</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>93</strong></td>
</tr>
</tbody>
</table>

On completion of the extract screening, the following 15 were found to be most relevant (all titles listed below with extracts only included for the most relevant studies):

- Effect of rapid HIV testing on HIV incidence and services in populations at high risk for HIV exposure: an equity-focused systematic review (9)
- Reaching the unreached: treatment as prevention as a workable strategy to mitigate HIV and its consequences in high-risk groups (12)
- Behavioural and psychosocial interventions for HIV prevention in floating populations in China over the past decade: a systematic literature review and meta-analysis (17)
- HIV infection: epidemiology, pathogenesis, treatment, and prevention (24)
- Validation of the modes of transmission model as a tool to prioritize HIV prevention targets: a comparative modelling analysis (32)
- Cell-associated HIV mucosal transmission: the neglected pathway (44)
- Treatment as prevention--where next? (63)
- Predictors of condom use among peer social networks of men who have sex with men in Ghana, West Africa. (72)
- Southern Africa: the Highest Priority Region for HIV Prevention and Care Interventions. (77)
- Immunotherapeutic Approaches for the Control and Eradication of HIV. (104)
- A tale of two epidemics: gender differences in socio-demographic characteristics and sexual behaviors among HIV positive individuals in Mexico City. (136)
- Contraceptive methods and risk of HIV acquisition or female-to-male transmission. (141)
• Relative risk reduction is useful metric to standardize effect size for public health interventions for translational research. (147)

• Unprotected sex among men who have sex with men living with HIV in Brazil: a cross-sectional study in Rio de Janeiro. (193)

• HIV among people who inject drugs in the Middle East and North Africa: systematic review and data synthesis. (194)

**Medline results**

<table>
<thead>
<tr>
<th>#</th>
<th>Database</th>
<th>Search term</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>Medline</td>
<td>(HIV/ AND (prevention OR education OR testing OR (support AND patients) OR inequalities) [DT 2014-2016]</td>
<td>201</td>
</tr>
</tbody>
</table>

Results 201 of 201 on Medline - (HIV/ AND (prevention OR education OR testing OR (support AND patients) OR inequalities) [DT 2014-2016]

A full set of articles and their abstracts are available on request.
Appendix 2, Focus Groups summaries

HIV Tender Focus Group
11th January 2017
CAFPH

Q1. In your opinion, how accessible are HIV support services in Luton?

The bus fares into town are costly therefore it limits the amount of times you visit the centre; we are unable to get to the centre every day.

We need to plan in advance when to come into town. To get a bus pass from the council you need a lengthy letter form the GP to access it.

Some of the service uses have limited movement therefore have to get a taxi to town this is also very expensive. We need transport support from CAFPH to get to the service.

One service user expressed they felt at times uncomfortable due to the number of students on placement as they all go to the same shops/same university and decided to not to the centre as much due to this. Some of the service users expressed they only come to CAFPH if they have an appointment or if a trip is planned. There is no funding available previously 'we used to get money for travel'

Q2. What are the current ‘gaps’ in service?

If extra funding was available this could be used to support families on social events.

Training needs to be provided on how to manage your own health, e.g. consequences on not taking medication.

Young people are very dependent on parents to make choices on their behalf. There needs to be a support worker to work with young adults to encourage and be independent on making their own decisions. "Hard to get opinions against parents wishes". It would be useful to have a support network group for parents/carers.

It would be useful to have an allocated social worker to help with issues/problems and deal with any social and outreach support. This was previously in place but it has now been suspended due to shortage of staff, if CAFPH was not in place service users would struggle to access services.

Currently student social workers are only here for a short period of time, ‘you build a relationship and trust only for them to leave’. It is very stressful that you have to tell your story again to someone else, useful to have one person to know of your diagnosis.

Outreach worker would be useful to visits at home if you are unable to come to the service.

There is no support available out of hours when office is closed.

GP's need awareness/education training on HIV, some of the service users experienced negative reactions, especially from receptionist when they disclose their status.
Q3. What are your views on the proposed new integrated model for HIV prevention and support services for Luton?

Service users expressed concerns with sexual health and HIV service splitting and not available in Luton and Dunstable Hospital as it was easy to get to the hospital. Additional cost could occur with travel expenses due to the different locations.

All agreed the new model looked very good and seemed to have captured support that should be available.

Q4. What one thing do you most value about the current HIV services in Luton?

CAFPH provide awareness training on stigma/understanding needs of others to help if is very useful to “to help protect ourselves”

Good place for socialisation and meeting our needs. ‘Would be lost if the service was no longer available’
HIV Tender Focus Group
3rd January 2017 | 14.00
Embrace

Q1. In your opinion, how accessible are HIV support services in Luton?

The group stated it was ‘quite good’ and ‘good access to the service’ and open Monday to Thursday. It is an opportunity to meet friendly people for support; you meet lots of great people at embrace.

However some people only come to embrace for personal stuff like immigration issues and nothing in relation to HIV support.

Location:
The location of Embrace is good and easy to get to and help is always available. The centre is open 4 days a week; the centre is not open on a Friday which is good for staff as it gives them a rest day. The timing of the open hours is good.

Difficult to get transport into the town centre, so it can be difficult to get to some appointments. ‘

There is no point in having different locations for support and would be better to have the service in one place otherwise it can get confusing. It would be better to have centralised location in the town centre.

Q2. What are the current ‘gaps’ in service?

The process of get to Embrace from Luton and Dunstable Hospital was difficult. One service user stated that she felt ‘forgotten about ‘someone from the council helped me to get to Embrace’. ‘I was not told of the service.

Not easy to access the service. ‘There needs to be leaflets and posters put up around Luton or even an advert in the newspaper. Information regarding the service is hard to access online. One service user stated that they only knew about the service from a friend that is a volunteer at the centre.

There are a lot of people that come to the centre to help with immigration and benefit issues

Q3. What are your views on the proposed new integrated model for HIV prevention and support services for Luton?

There will be an impact if service users with mental health needs come to the centre this could impact on the other service users that already come to embrace. However staff are well equipped to deal with more service users coming in and will be best to help with any issues.

The focus group felt the service should focus more on factual education/awareness in HIV “how treated for it”. “ Some people are still ignorant and “ Stigma still attached to HIV” one service user stated he feel “ he would be beaten up if people are aware that he is HIV positive”.

The focus group felt there were no issues with the new proposed integrated service, it seems balanced and it’s about evolving the service and improving the service.
The idea of a one stop service is good so service users do not have to keep telling their story to different professionals.

The new proposed service needs to take into account support available for carers and families.

Q4. What one thing do you most value about the current HIV services in Luton?

Service user expressed they felt welcomed at Embrace and it is a valuable support network to meet people and talk about any worries or concerns they may have.

Feels like home and it meets our needs, ‘if the centre was closed we would be lost’

The centre makes me feel ‘important and that I exist’ ‘feel respected here and welcomed”

“you get one to one support tailored to you individual need”
HIV Support Services in Luton
Service Providers and Stakeholders Survey RESULTS: 10 responses

Q1  To ensure we hear from a representative group of local service providers, please enter the following details about your organisation and yourself:

- 10 responses

Q2  Which of the following HIV support services does your organisation provide and / or commission? please tick all that apply

- 7 (78%) contraception / family planning e.g. condoms, lubes, coil etc.
- 7 (78%) sexual health and relationship counselling
- 8 (89%) HIV testing and treatment
- 6 (67%) psychological support
- 7 (78%) education and awareness sessions
- 2 (22%) therapy sessions
- 2 (22%) lunch clubs - peer support
- 7 (78%) one-to-one / behaviour intervention
- 7 (78%) advice and any other concerns you may have associated with HIV
- 0 (0%) none
- 2 (22%) other

Other, please specify

- 3 responses
  - Support of dual diagnostic patients (Tuberculosis)
  - Student services at UoB signpost students to services as necessary
  - Family and children support

Q3  How would you describe current HIV support service provision in Luton? please tick one box only

- 1 (10%) very good
- 7 (70%) fairly good
- 2 (20%) neither good nor poor
- 0 (0%) fairly poor
- 0 (0%) very poor

If fairly/very poor, please tell us why

- 1 response
  - All services provide essential support for HIV positive people, partners and families. It would help to join up services and not duplicate any so all users can have access to equal opportunities to engage.

Q4  Are you aware of any barriers to service-users accessing HIV support services in Luton? please specify and explain your reasons
10 responses

- No
- Small community so some fear disclosure of status through attendance at support services
- No
- Through my general research with the local South Asian population I find that middle and older aged South Asian women have the least knowledge about HIV (and other sexual health) support services. We are currently completing a research study 'a pilot study exploring young people’s knowledge, attitudes and behaviour of contraception, contraceptive use and access to contraceptive services in Luton'. The findings from this study will be useful for planning services. STI's are discussed as part of the focus group discussions.
- opening times, travel/transport issues, fear of breach of confidentiality, services too specific and service users don’t meet criteria, seeing others from community, disabled access
- I believe that some people diagnosed with HIV may be a little worried with accessing services as they may know people form their community.
- Yes - they may want to access service out of area to keep their status private.
- Stigma (who can transmit it, social perceptions of HIV) access to services (knowing where to go) and what support does the service provide
- Advertising services to lower income people.
- Better access for in clinic support, sometimes transport, financial constraints

Q5 Who do you consider to be the most vulnerable service users? please specify and explain how specific needs could be met

10 responses

- Young people
- Asylum seekers - need more immigration application & legal support, also need more practical support with housing, food, transport etc.
- Homeless, Immigrants, IVDA, Sex Workers  Focused workforce
- Middle and older South Asian women and South Asian (especially Muslim) men who have sex with men.
- learning disabilities, mental health problems, young people, sex workers, LGBT, homeless, alcohol and drug users
- Drug and Alcohol dependent - this group doesn't tend consistently engage and leads to risky behaviour along with housing issues, benefits, mental and physical health and they do not adhere to ART medication. I also think the BME community as a whole, there is not as many outreach interventions being delivered that would impact on late diagnosis with this group.
- Children and young people
- Young service users are more vulnerable and at risk due to the nature of being young and being exposed to age inappropriate situations and circumstances. Young people are more likely to react to vulnerabilities (self harm, drug and alcohol abuse and poorer sexual health activities) and often find it harder to ask for help and access local services through fear of being judged.
- BME HIV+ service users tend to face the most stigma, and can feel ostracised as a result. Empowering people to break these stigmas and seek support services is key.
- People with mental health issues, learning disabilities, children and people who have mobility issues which limit their accessibility to support for not only HIV but other services
HIV Prevention and Support Service - Single Integrated Model

Q6  Are there any other services you feel should be included in the new integrated HIV Prevention and Support Service model? please specify and explain your reasons

5 responses
- Many of my clients have issues which are separate to their HIV diagnosis, but that have an impact on how they manage their condition - housing issues, immigration issues, financial difficulties, drug & alcohol problems etc. Linkage with other organisations that can provide input with these issues would be helpful e.g. weekly walk in 'clinics' for legal advice (e.g. organisations such as Refugee Action), financial advice (e.g. from Citizen's advice bureau), drug (esp chem sex) services etc.
- positive self-management programmes, back to work programs, sessions from external organisations to include debt management, living independently, immigration
- A high level of outreach needs to be included. In order to prevent late diagnosis and find PLWH that are unaware of their status. Most people that are HIV and regularly test have been found, I believe the new model should include a high level of community engagement. Support services - as a result of an HIV diagnosis comes hand in hand with many other issues - housing, immigration, benefits, employment, mental health, drug and alcohol dependency. Having a one stop shop will keep service users engaged and build trust throughout their HIV diagnosis journey and thereafter, hence reducing strains on other services further down the line.
- While it is important to have the single service, there should be greater differentiation between services offered toward younger people, single gender, and a more general HIV support.
- Family support, training for other agencies to promote awareness and reduce stigma/discrimination

Q7  Please rate on a scale of 1 to 5, how important or not, do you feel it is for the proposed model to achieve the following priorities: please tick one box per row

<table>
<thead>
<tr>
<th>Providing better services to vulnerable people e.g. substance mis-users, sex workers, mental health, BME etc</th>
<th>5 - very important</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1 - not at all important</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 (100%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td></td>
</tr>
<tr>
<td>Signposting to HIV services that support healthy pregnancy</td>
<td>7 (70%)</td>
<td>2 (20%)</td>
<td>1 (10%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Increasing adherence to ART (antiretroviral therapy)</td>
<td>8 (80%)</td>
<td>2 (20%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Preventing unplanned pregnancies to reduce the risk of an abortion</td>
<td>7 (70%)</td>
<td>1 (10%)</td>
<td>2 (20%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Support HIV vulnerable people that are being hurt or forced into sexual acts that they don't want to</td>
<td>9 (90%)</td>
<td>1 (10%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Advise people on ways to prevent contracting sexually transmitted infections in the future</td>
<td>9 (90%)</td>
<td>0 (0%)</td>
<td>1 (10%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Advising people to prevent sexually transmitted infections being passed from person to person through unprotected sex or contact</td>
<td>8 (80%)</td>
<td>1 (10%)</td>
<td>1 (10%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Providing better services to HIV positive over 50s</td>
<td>7 (70%)</td>
<td>3 (30%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Signposting carers, partners and families to information, advice and guidance around HIV</td>
<td>7 (70%)</td>
<td>3 (30%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Providing carers, partners and families access to testing and referral to HIV treatment and care if necessary</td>
<td>8 (80%)</td>
<td>2 (20%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
</tr>
</tbody>
</table>
Q8 **Overall, what potential impacts do you think the integrated model could have on service delivery in Luton?** Please tick one box only

- 0 (0%) no impact at all
- 0 (0%) very little impact
- 3 (33%) fairly big impact
- 3 (33%) a very big impact
- 3 (33%) don't know/not sure

If fairly big or very big impact, please explain

- 7 responses
  - IT may limit choice of where people can access services. People will become less visible.
  - The new integrated service should be evaluated (something that we can do at the UoB) to review impact.
  - It will affect a number of service users who currently access support services who struggle with change, may encourage those who do not access services or who stopped in the past to access services.
  - An integrated model from one service provider will offer more security and consistency for the service user. This will also give more accuracy with regards to what issues we face locally as there will be no duplication of services. This will give more opportunity to deliver a securely managed service and ensure no people living with HIV are lost, especially if strong links with sexual health services continue.
  - The provision will provide a service that meets the needs of the services users, without repetition.
  - Service users become very comfortable with current services they are accessing. They know the staff, the service, location and other services users. Changing service provision could disrupt the comfortableness a service user experiences. They may have to travel further for the service which could have time/cost implications which may discourage them for accessing the service. There may be new staff members that they may not feel comfortable talking too or are unable to build a positive relationship with and they may reduce or take away a service that is very valuable to the service user.
  - The impact needs to be carefully managed and supported to reassure service users they will still be supported.

Q9 **Do you have any concerns about the service model?** Please explain

- Educating and training practitioners and communities to tackle the stigma associated with HIV sexual health

| Educating and training practitioners | 9 (90%) | 1 (10%) | 0 (0%) | 0 (0%) | 0 (0%) |

Other, please specify

1 response

- Although we do not have high numbers for the above, I feel services I have marked as 5 are extremely important to the people that would fall in these categories and affected by these.
8 responses
- As explained above. Choice of where to receive services will not be an option
- Doesn't allow choice of where to access support
- Some more information or a cascaded plan
- The model limits service users’ choices on where they can go. How to safely provide all services mentioned in new service model. How to ensure that all service users feel comfortable accessing the service - LGBT/BME/homeless etc.
- No, hopefully through analytical data and previous reports the new HIV strategy is very much needed in Luton. Especially with the figures and statistics we have with late diagnosis and undiagnosed.
- Can one service meet the needs of two very different client groups - i.e. msm's and black African community?
- When services integrate there will always be positive and negative impact on service users. If the changes are too profound or have a negative impact on them, ultimately it will be service users that suffer. Integration of services also takes time and for some users it can take a long time for them to feel comfortable in a new service with new people. Users who are positive need to be accessing services, especially those using medication, and cannot miss appointments as this can impact on their health.
- It could have the same negative impact that has been seen with the integration of the sexual health services - less uptake among young people, and anecdotal evidence of more sexual risk taking due to confusion surrounding the change in sexual health service providers.

Q10 Do you have any suggestions to improve the integrated HIV prevention and support service model? please specify
7 responses
- Choice of where to receive services.
- To remember Tuberculosis risk in HIV Patients
- Avoid the use of trainee social workers instead fund paid posts and/or train volunteers. A service that is open every day Monday to Friday and possibly Saturdays. Specific peer support groups - YP/LGBT/Heterosexual. Ensure there is a robust confidentiality policy
- More emphasis on being sex positive, more work to reduce stigma, getting local positive people to talk about their experiences to the community
- Put service users at the centre of any decisions. Do not make it a money saving process.
- Keep as much consistency as possible between the existing model and the integrated one.
- To understand the model more information is required

Q11 Will this single integrated service have a positive or negative impact on people accessing the service because they are: please tick one box per row

<table>
<thead>
<tr>
<th></th>
<th>positive impact</th>
<th>negative impact</th>
<th>no impact</th>
<th>don’t know/not sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>young people (16-18 years)</td>
<td>1 (11%)</td>
<td>2 (22%)</td>
<td>0 (0%)</td>
<td>6 (67%)</td>
</tr>
<tr>
<td>older people (50 years and over)</td>
<td>2 (22%)</td>
<td>0 (0%)</td>
<td>1 (11%)</td>
<td>6 (67%)</td>
</tr>
<tr>
<td>men</td>
<td>1 (11%)</td>
<td>0 (0%)</td>
<td>1 (11%)</td>
<td>7 (78%)</td>
</tr>
<tr>
<td>women</td>
<td>2 (22%)</td>
<td>0 (0%)</td>
<td>1 (11%)</td>
<td>6 (67%)</td>
</tr>
<tr>
<td>gender reassigned, transgender, transsexual</td>
<td>0 (0%)</td>
<td>1 (13%)</td>
<td>0 (0%)</td>
<td>7 (88%)</td>
</tr>
<tr>
<td>disabled</td>
<td>0 (0%)</td>
<td>1 (13%)</td>
<td>1 (13%)</td>
<td>6 (75%)</td>
</tr>
<tr>
<td>of Black Minority Ethnic background</td>
<td>0 (0%)</td>
<td>1 (11%)</td>
<td>1 (11%)</td>
<td>7 (78%)</td>
</tr>
<tr>
<td>of religious/faith/belief background</td>
<td>1 (11%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>8 (89%)</td>
</tr>
<tr>
<td>gay man</td>
<td>1 (11%)</td>
<td>0 (0%)</td>
<td>1 (11%)</td>
<td>7 (78%)</td>
</tr>
<tr>
<td>lesbian woman</td>
<td>1 (13%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>7 (88%)</td>
</tr>
<tr>
<td>bi-sexual man / women</td>
<td>1 (11%)</td>
<td>0 (0%)</td>
<td>1 (11%)</td>
<td>7 (78%)</td>
</tr>
<tr>
<td>other</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>5 (100%)</td>
</tr>
</tbody>
</table>

If negative impact, please explain
Huge diversity locally within the community of PLWHIV, with huge disparity in circumstances and needs. A service designed to support a young gay man is unlikely to meet all the needs of a female, pregnant Black African recent immigrant to the UK who is seeking asylum or a married older Asian MSM and vice versa. It is impossible to create a one size fits all service for this diverse community. Also, a significant proportion of the community have a strong Christian faith which can impact on their needs, adherence and choices of how to deal with their diagnosis and some linkage with the religious community needs to be considered to help address this. However, religious and LGBTQ organisations for instance have historically not been the most compatible.

I am unable to answer the above questions. The single integrated service would have to be evaluated.

Young people may have issues being in the presence of older people/adults in a service and may feel uncomfortable accessing them.

Q12 Are there any service users / communities that are likely to be adversely impacted by the single integrated service model? please specify and explain

7 responses

- For all service users lack of anonymity.
- See above
- It depends on the service model and what is available within this and also who is delivering the integrated model.
- No, if the transition is managed efficiently and well, this should only benefit the service user. Having all HIV service users accessing one service will enable us to identify specific demographic and service user needs enabling us to address them speedy and accordingly. This will also help with variations of support that is needed; the service provider will be able to offer much more from one service, which should keep the service user engaged throughout their journey.
- Yes - if Luton is providing an integrated service then the specific needs of the group need to be taken into consideration. I am not sure that single men who identify as msm’s would want to access the same service with people who they don’t identify with.
- Service users that already feel marginalised because they are part of a minority community (MSM, BME, etc.) may feel that this is another instance of being singled out
- Not sure without clearer understanding of how the model will look.

Q13 Overall, do you feel this model would improve access to HIV prevention and support services for the residents of Luton? please tick one box only

2 (25%) yes
0 (0%) no
6 (75%) don’t know/not sure

5 responses

- May benefit some groups but cannot cater to all
- overall yes a place where service users can access all the support services they need in one place
- Unless the tender states a specific level of outreach and community engagement I feel we will continue to see a steady flow of people which in long-term is not making a big breakthrough with undiagnosed HIV people.
- there is a worry that some client needs may be overlooked when providing an integrated service
- Eventually, and if the transition is handled well, there should be a more streamlined access to HIV prevention and support services.

Q14 Do you have any suggestions on making HIV support services more accessible in Luton? please explain
To improve the quality of service, to lessen duplication, but offer space in satellite hubs to receive care. i.e. outreach teams
extended opening hours, a safe and confidential welcoming environment (with disabled access) with trained non-judgemental staff/volunteers
More spoke and ad-hoc clinics around Luton will make testing more accessible and normalise HIV and regular screening. In addition to this a level of faith work should be included. We need pastors and place of worship to want to make change, this will only happen by challenging and building relationships with these hard to reach communities. A structured approach is very much needed over a long period of time.
different days/times for different groups, outreach support meetings, telephone support for clients who work full time, inclusion of LGBT and mental health services, working alongside local sexual health services
Concentrate on the positives that have been achieved in recent years around HIV prevention and suppression of viral load, lessening stigma attached with accessing an HIV support service.
Closer relationships with clinicians and support services

Q15 Any other comments?
2 responses
- No
- N/A

About your service users and services

Q16 Who are your services specifically aimed at? please tick up to 5 boxes only

<table>
<thead>
<tr>
<th>Choice</th>
<th>Number of Selections</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unspecified</td>
<td>1</td>
<td>13%</td>
</tr>
<tr>
<td>Alcohol/substance misusers</td>
<td>2</td>
<td>25%</td>
</tr>
<tr>
<td>Armed services personnel</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Bereaved</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Black and Minority Ethnic (BME) communities</td>
<td>4</td>
<td>50%</td>
</tr>
<tr>
<td>Carers</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Children 0-4</td>
<td>1</td>
<td>13%</td>
</tr>
<tr>
<td>Children 5-7</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Children 8-13</td>
<td>1</td>
<td>13%</td>
</tr>
<tr>
<td>Elderly community (65 years and over)</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Faith communities</td>
<td>2</td>
<td>25%</td>
</tr>
<tr>
<td>Families</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Gay, lesbian, bisexual and transgender (LGBT) communities</td>
<td>3</td>
<td>38%</td>
</tr>
<tr>
<td>Gypsy/roamer/traveller community</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Homeless people</td>
<td>1</td>
<td>13%</td>
</tr>
<tr>
<td>Local residents</td>
<td>2</td>
<td>25%</td>
</tr>
<tr>
<td>Lone parents</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Men only</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Migrant workers</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>People with disabilities and/or health issues</td>
<td>1</td>
<td>13%</td>
</tr>
<tr>
<td>People at risk e.g. forced marriages, sale of sexual services etc</td>
<td>1</td>
<td>13%</td>
</tr>
<tr>
<td>Prisoners/ sex offenders</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Refugees and asylum seekers</td>
<td>2</td>
<td>25%</td>
</tr>
<tr>
<td>Unemployed/low income</td>
<td>2</td>
<td>25%</td>
</tr>
<tr>
<td>Urban communities</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Victims of crime</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Volunteers</td>
<td>2</td>
<td>25%</td>
</tr>
<tr>
<td>Young people 14-19</td>
<td>3</td>
<td>38%</td>
</tr>
<tr>
<td>Young people 20-25</td>
<td>2</td>
<td>25%</td>
</tr>
<tr>
<td>Young people Not in Education Employment or Training (NEET)</td>
<td>2</td>
<td>25%</td>
</tr>
<tr>
<td>Women only</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>All listed</td>
<td>2</td>
<td>25%</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Students</td>
<td>1</td>
<td>13%</td>
</tr>
</tbody>
</table>

Q17 If your organisation/group provides services/activities MOSTLY for people from the Black and minority ethnic communities - please indicate specific ethnic communities from the list below: please tick up to 5 boxes only

<table>
<thead>
<tr>
<th>Choice</th>
<th>Number of Selections</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>White - British</td>
<td>2</td>
<td>33%</td>
</tr>
<tr>
<td>White - Irish</td>
<td>1</td>
<td>17%</td>
</tr>
<tr>
<td>Other White</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Mixed - White and Black Caribbean</td>
<td>2</td>
<td>33%</td>
</tr>
<tr>
<td>Mixed - White and Black African</td>
<td>1</td>
<td>17%</td>
</tr>
<tr>
<td>Mixed White and Asian</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Other Mixed</td>
<td>2</td>
<td>33%</td>
</tr>
<tr>
<td>Asian/Asian British - Bangladeshi</td>
<td>1</td>
<td>17%</td>
</tr>
<tr>
<td>Other Asian</td>
<td>2</td>
<td>33%</td>
</tr>
<tr>
<td>Black/Black British - Caribbean</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Black/Black British - African</td>
<td>3</td>
<td>50%</td>
</tr>
<tr>
<td>Black Other</td>
<td>1</td>
<td>17%</td>
</tr>
<tr>
<td>Chinese</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>East European</td>
<td>3</td>
<td>50%</td>
</tr>
</tbody>
</table>
Q18  If your organisation/group provides services/activities MOSTLY for people with disabilities - please indicate specific disability groups from the list below: please tick up to 3 boxes only

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Disability Group</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 (0%)</td>
<td>Hearing impairment/deaf</td>
</tr>
<tr>
<td>1 (20%)</td>
<td>Long term illnesses</td>
</tr>
<tr>
<td>2 (40%)</td>
<td>Physical disabilities</td>
</tr>
<tr>
<td>2 (40%)</td>
<td>Emotional/mental health issues</td>
</tr>
<tr>
<td>1 (20%)</td>
<td>Learning difficulties</td>
</tr>
<tr>
<td>0 response</td>
<td>Other - please specify</td>
</tr>
</tbody>
</table>

Q19  If your organisation/group provides services/activities MOSTLY for people from faith communities - please indicate specific faith communities from the list below: please tick up to 3 boxes only

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Faith Community</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 (50%)</td>
<td>Christian</td>
</tr>
<tr>
<td>3 (50%)</td>
<td>Muslim</td>
</tr>
<tr>
<td>2 (33%)</td>
<td>Hindu</td>
</tr>
<tr>
<td>2 (33%)</td>
<td>None</td>
</tr>
<tr>
<td>0 (0%)</td>
<td>Buddhist</td>
</tr>
<tr>
<td>0 (0%)</td>
<td>Sikh</td>
</tr>
<tr>
<td>0 response</td>
<td>Other - please specify</td>
</tr>
</tbody>
</table>
HIV Support Services in Luton
Service Users and Residents Survey RESULTS: 38 responses

Local HIV Support and Prevention Services

Q1 Are you a resident of Luton? please tick one box only
   35 (95%) yes
   2 (5%) no

Q2 Are you mainly responding as a: please tick one box only
   16 (42%) HIV positive support service user
   2 (5%) HIV positive support resident
   0 (0%) carer to someone with HIV
   1 (3%) partner/spouse of someone HIV positive
   0 (0%) family member of someone HIV positive
   16 (42%) general resident
   3 (8%) other
Other, please specify
   4 responses
   • As a gay man who feel strongly about accessibility of services
   • Living with HIV
   • carer to someone with HIV and family member of someone with HIV positive
   • HIV related

Q3 Do you and/or have you accessed HIV support services in Luton from any of the following? please tick all that apply
   15 (41%) CAFPH (Children and Families Positive Health)
   11 (30%) Embrace Life
   10 (27%) Luton & Dunstable Hospital - Luton Sexual Health Services
   11 (30%) Luton & Dunstable Hospital - HIV treatment and care
   6 (16%) GP practice
   2 (5%) Accident & Emergency (L&D Hospital)
   3 (8%) local pharmacy
   16 (43%) none - I do not access HIV services in Luton
   0 (0%) other
Other, please specify
   1 responses
   • medical care in London
Q4 Which of the following HIV support services have you/do you use? please tick all that apply
5 (25%) contraception / family planning e.g. condoms, lubes, coil etc.
3 (15%) sexual health and relationships counselling
12 (60%) HIV testing and treatment
8 (40%) psychological support
4 (20%) education and awareness sessions
7 (35%) therapy sessions
5 (25%) lunch clubs - peer support
5 (25%) one-to-one support / behaviour intervention
10 (50%) advice and any other concerns you may have associated with HIV
2 (10%) other
Other, please specify
1 response
- Help with DWP etc.

Q5 When accessing public services, do you declare your HIV status? please select one response only
3 (15%) yes, always
11 (55%) sometimes - depending on service
6 (30%) no, not at all / never
Please explain
8 responses
- Anything to do medically doctors optician dentist
- I do not want to be discriminated
- some services respond to that
- At times I don't see the need. Unless there is a reason I tend to let it lie
- If i didn't feel I could trust the person I won't disclose
- fear of being discriminated
- Only at the GP. embrace and CAFPH. I have negative experience of discrimination in other services.
- only disclose when necessary

Access to HIV support services in Luton

Q6 In your opinion, how easy or difficult is it to access HIV support services in Luton? please tick one box only
9 (41%) very easy
5 (23%) quite easy
2 (9%) neither easy nor difficult
3 (14%) quite difficult
2 (9%) very difficult
1 (5%) don't know / not sure
If quite difficult / very difficult, please tell us why
5 responses
- Out of Hours and L & D A-E service for Pep is useless, Gum clinic is under staffed and can wait weeks to book appointment
- I wasn't aware of many of the services until they were listed in a previous question. Also, where the clinic is situated at the L & D, it's not exactly private. I'm used to using Birmingham Heartlands Hospital which has a much more open feeling to it. The first time I went to the L and D, I very nearly walked out again.
- I only got access to CAPH when my psychotherapy finish and KD phoned me up and asked if she could visit me.
- because I felt nervous and didn't really understand what was available
- Sometimes my arthritis makes it difficult. Transport makes it difficult.

Q7 What are the key barriers to you accessing HIV support services in Luton? please tick all that apply
6 (30%) appointment availability / timely access
1 (5%) no provision in my local area
2 (10%) service(s) I need are not offered locally
7 (35%) having to travel to access the service(s) I need
6 (30%) afraid I might bump into someone I know
5 (25%) concerned about discretion and confidentiality
2 (10%) I don't know how to access the services
2 (10%) I don't know which services are offered
0 (0%) I don't need to use the service
6 (30%) none - I am able to access

Other, please specify
2 responses
- Having only one entrance to GUM clinic which is next to main entrance and a-e of the hospital
- times, dates, money

Q8 Please indicate if you have any of the following needs when accessing HIV support services . . . please tick all that apply
5 (29%) disability access - wheelchair access, automatic door assistance, disabled toilet, hearing loop etc
1 (6%) large print labels / leaflets
4 (24%) staff that speak your first language - please specify spoken language in the box below
14 (82%) private area to speak confidentially
3 (18%) specific services for women / men only
2 (12%) specific to LGBT
2 (12%) child friendly for those visiting with children
1 (6%) services aimed at young people (aged 16-18)
3 (18%) none/not applicable
0 (0%) other

Please specify any other specific needs you may have (i.e. cultural, age related, faith based etc.)
2 responses
- services for under 30s
- age related and African cultural, faith based
Q9  Would any of the following make the support service more accessible to you? please tick all that apply

- 6 (29%) referral from your GP / healthcare professional
- 3 (14%) support with speaking, reading and / or writing English
- 11 (52%) services offered during the evenings and/or weekends
- 9 (43%) friendly and discreet staff at reception
- 6 (29%) services offered for men and women
- 1 (5%) services offered for young people (aged 16-18)
- 3 (14%) services for LGBT
- 1 (5%) services for BME
- 4 (19%) none/not applicable
- 0 (0%) other

Other, please specify anything else that would make the service easily accessible for you
1 responses
- sometimes staff not available

Q10  Are HIV support services currently available at times that suit you? please tick one box only

- 7 (37%) yes - they are always open when I need to go
- 4 (21%) yes - they are usually open when I need to go
- 3 (16%) not really - they are sometimes closed when I need to go
- 4 (21%) no - they are not usually open when I need to go
- 1 (5%) no - they are never open when I need to go
- 0 (0%) none/not applicable

Q11  Would any of these opening times make it easier for you to access the services? please tick all that apply

- 16 (76%) open on a Saturday
- 6 (29%) open on a Sunday
- 8 (38%) open longer hours during the week
- 4 (19%) open before 8am
- 8 (38%) open after 7pm
- 2 (10%) other

Other, please specify
3 responses
- I just prefer mornings
- 9am-5pm
- staff at CAPH always free, have out of hours service, staff at Embrace less flexible more rigid about
Q12 **What one thing do you value most about the current HIV support services in Luton?** please specify
14 responses
- professional and discreet
- the staff
- They understand me
- commitment
- CAPH gives more psychological expertise at a deep level I can connect with culturally. Embrace more grassroots. I enjoy the variety CAPH gives. Embrace appeals to a less educated individual who may not be self-motivated.
- There is a very good support network and family friends who are very helpful.
- family friendly
- I like coming to CAPH - nice and friendly
- therapies, one-to-one session with Dr
- Someone to talk to, help with future goals, people who understand me.
- The moral support, professional support - welfare matters, immigration matters and advocacy
- Help with reading, writing and understanding and CAFPH always helps with my problems.
- someone to talk to openly
- Feel supported and they always try and support me with all of my needs.

Q13 **Overall, how would you rate HIV support services in Luton?** please tick one box only
- 8 (42%) very good
- 8 (42%) fairly good
- 2 (11%) neither good nor poor
- 0 (0%) fairly poor
- 1 (5%) very poor
If fairly/very poor, please tell us why
2 responses
- I cannot fault the staff, they are great especially the pharmacists. But the location, the entrance, the feeling that there is a barrier between the patent and staff when you first enter the L & D sets a bad tone which it never really recovers from. I fully support the concept of having sexual health services available at the hospital and other needed treatments are on hand but the needs of HIV and Hep C patents are very different with a unique perspective.
- outdoor activities
HIV Support and Prevention Service - Single Integrated Model

Q14 Are there any other services you feel should be included in the new integrated HIV Prevention and Support Service model? please tell which services you feel are missing

13 responses

- Confidentiality is key and I know that if I was going for HIV treatment, I wouldn't want to spend a huge deal of time stuck in a waiting room in front of people who may recognise me
- support and advice for family / friends of those with HIV - especially around the time of diagnosis
- Something more useful concerning mental health. Especially for the poor sods who took or take Sustiva. I took it for 7 years, it does affect people’s minds in bad way, I have been off it for a long time now but it still affects me.
- A lot more education a lot of married men who date us gay guys and are not as careful and considerate as they should be, many think they are not cheating with a gay man
- signposting to other services which may also assist people with HIV e.g. benefits advice
- Support services for msm and high risk groups
- N/A
- co-ordinators
- no
- help with outreach, older activities under 30s
- outdoor activities
- a co-ordinator
- no
Q15  Please rate on a scale of 1 to 5, how important or not, do you feel it is for the proposed service model to achieve the following priorities: please tick one box per row

<table>
<thead>
<tr>
<th>Priority</th>
<th>5 - very important</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1 - not at all important</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providing better services to vulnerable people e.g. substance mis-users,</td>
<td>29 (81%)</td>
<td>3 (8%)</td>
<td>1 (3%)</td>
<td>0 (0%)</td>
<td>3 (8%)</td>
</tr>
<tr>
<td>sex workers, mental health, BME etc</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Signposting to HIV services that support healthy pregnancy</td>
<td>17 (52%)</td>
<td>11 (33%)</td>
<td>2 (6%)</td>
<td>0 (0%)</td>
<td>3 (9%)</td>
</tr>
<tr>
<td>Increasing adherence to ART (antiretroviral therapy)</td>
<td>29 (83%)</td>
<td>3 (9%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>3 (9%)</td>
</tr>
<tr>
<td>Preventing unplanned pregnancies to reduce the risk of an abortion</td>
<td>19 (58%)</td>
<td>7 (21%)</td>
<td>3 (9%)</td>
<td>1 (3%)</td>
<td>3 (9%)</td>
</tr>
<tr>
<td>Supporting HIV vulnerable people that are being hurt or forced into</td>
<td>27 (84%)</td>
<td>3 (9%)</td>
<td>0 (0%)</td>
<td>0 (0%)</td>
<td>2 (6%)</td>
</tr>
<tr>
<td>sexual acts that they don’t want to</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advising people on ways to prevent contracting sexually transmitted</td>
<td>25 (71%)</td>
<td>5 (14%)</td>
<td>3 (9%)</td>
<td>0 (0%)</td>
<td>2 (6%)</td>
</tr>
<tr>
<td>infections in the future</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advising people to prevent sexually transmitted infections being</td>
<td>27 (75%)</td>
<td>4 (11%)</td>
<td>3 (8%)</td>
<td>1 (3%)</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>passed from person to person through unprotected sex or contact</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Providing better services to HIV positive over 50’s</td>
<td>23 (66%)</td>
<td>8 (23%)</td>
<td>1 (3%)</td>
<td>0 (0%)</td>
<td>3 (9%)</td>
</tr>
<tr>
<td>Signposting carers, partners and families to information, advice,</td>
<td>20 (57%)</td>
<td>10 (29%)</td>
<td>2 (6%)</td>
<td>0 (0%)</td>
<td>3 (9%)</td>
</tr>
<tr>
<td>guidance around HIV</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Providing carers, partners and families access to testing and referral</td>
<td>26 (72%)</td>
<td>6 (17%)</td>
<td>1 (3%)</td>
<td>1 (3%)</td>
<td>2 (6%)</td>
</tr>
<tr>
<td>to HIV treatment and care if necessary</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Educating and training practitioners and communities to tackle the</td>
<td>27 (75%)</td>
<td>5 (14%)</td>
<td>1 (3%)</td>
<td>1 (3%)</td>
<td>2 (6%)</td>
</tr>
<tr>
<td>stigma associated with HIV sexual health</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other, please explain</td>
<td>1 response</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I think it’s important to reach people and over 50s as the increase in</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>that age has risen higher</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Q16 What impact do you think the new integrated single approach model will have on you? please tick one box only

11 (31%) no impact at all
5 (14%) very little impact
3 (9%) fairly big impact
8 (23%) a very big impact
8 (23%) don't know/not sure

If fairly big or very big impact, please explain

9 response

- I certainly feel that testing for sexual health is important and that the services is the town have very poor accessibility, both in terms of location (they are nearly all way out from the city centre) and times (2 hour walk-in time slots that quickly become overwhelmed).
- More money out of the council coffers
- I live near the I and D so town centre is worse
- More areas can be pooled together and each can work on each other’s strength to improve lives
- waiting for appointment might take longer
- I think this will help people to understand about other languages and begin to challenge stigma.
- I don’t think they will mix well together as they offer very different services.
- Change isn’t easy to accept and not every change is an improvement to current situation. Been affiliated to one organisation in integration they tend to lose staff change the way things are run which could be uncomfortable and may lead to people stopping accessing the services altogether.
- I like a choice and two organisations to be separate
In your opinion, will this new integrated service have a positive or negative impact on people accessing the service because they are:

<table>
<thead>
<tr>
<th>Category</th>
<th>Positive Impact</th>
<th>Negative Impact</th>
<th>No Impact</th>
<th>Don't Know/Not Sure</th>
</tr>
</thead>
<tbody>
<tr>
<td>young people (16-18 years)</td>
<td>13 (39%)</td>
<td>4 (12%)</td>
<td>6 (18%)</td>
<td>10 (30%)</td>
</tr>
<tr>
<td>older people (50 years and over)</td>
<td>13 (38%)</td>
<td>6 (18%)</td>
<td>6 (18%)</td>
<td>9 (26%)</td>
</tr>
<tr>
<td>men</td>
<td>11 (33%)</td>
<td>5 (15%)</td>
<td>7 (21%)</td>
<td>10 (30%)</td>
</tr>
<tr>
<td>women</td>
<td>13 (39%)</td>
<td>4 (12%)</td>
<td>7 (21%)</td>
<td>9 (27%)</td>
</tr>
<tr>
<td>gender reassigned, transgender, transsexual</td>
<td>14 (42%)</td>
<td>3 (9%)</td>
<td>6 (18%)</td>
<td>10 (30%)</td>
</tr>
<tr>
<td>of Black Minority Ethnic background</td>
<td>12 (34%)</td>
<td>7 (20%)</td>
<td>7 (20%)</td>
<td>9 (26%)</td>
</tr>
<tr>
<td>of religious/faith/belief background</td>
<td>12 (34%)</td>
<td>5 (14%)</td>
<td>7 (20%)</td>
<td>11 (31%)</td>
</tr>
<tr>
<td>gay men</td>
<td>13 (37%)</td>
<td>4 (11%)</td>
<td>8 (23%)</td>
<td>10 (29%)</td>
</tr>
<tr>
<td>lesbian women</td>
<td>13 (37%)</td>
<td>4 (11%)</td>
<td>8 (23%)</td>
<td>10 (29%)</td>
</tr>
<tr>
<td>bi-sexual men and/or women</td>
<td>13 (39%)</td>
<td>4 (12%)</td>
<td>7 (21%)</td>
<td>9 (27%)</td>
</tr>
<tr>
<td>disabled</td>
<td>5 (31%)</td>
<td>2 (13%)</td>
<td>4 (25%)</td>
<td>5 (31%)</td>
</tr>
<tr>
<td>other</td>
<td>7 (29%)</td>
<td>2 (8%)</td>
<td>5 (21%)</td>
<td>10 (42%)</td>
</tr>
</tbody>
</table>

If negative impact, please explain

5 responses

- I am utterly opposed to any restrictions on accessibility of service, particularly as far as testing goes. Getting an HIV test in Luton is stupidly difficult, and quite often I've been turned away from walk-in sessions because the services are overwhelmed. At least at the moment, there is more than one place to access a GUM clinic for testing, and my fear is that if it is all integrated in one place it will be even harder.
- I honestly do not know, too many variables. Depends on how the building is viewed by the public, the last thing is for it to obtain the Gloria's distinction of the local "clap clinic", it would disenfranchise the users who are more at risk
- You have to fire those corrupted professionals and employ new peoples. Friendly and vocational. With open brain and personality! People who are dedicated to this job!
- Non BAME or ethnic HIV positive people - neg.
- In integration the 50+ feel will be lost and left out as not much programmes made available for them BME will be disadvantaged - language barriers, faith - most programmes might disregard people's faith.
Q18 Are there any other people especially the vulnerable (e.g. homeless, sex workers, young people etc.) You feel may be impacted by these changes? please specify
13 responses
- Anyone who is elderly, disabled or without a car may find accessing services difficult if they have to travel further than they do already.
- Immigrants
- Homeless; sex-workers
- Hopefully they will have a place where they are understood
- No
- I think there would be a positive impact for the people who are most difficult to engage e.g. those on the margins of services such as sex workers and chaotic drug users and also people living in environments where their HIV status would be difficult to admit e.g. traditional Muslim backgrounds.
- homeless,
- It will cause new problems
- no
- Yes the older people are so vulnerable and they need a lot of help to get back to recovery
- Everybody will be impacted. Change needs to be managed very carefully, focussing on the service users.
- possibly the homeless
- There needs to be services only for HIV with no comparison in users

Q19 Overall, do you feel this model would improve access to HIV Prevention and Support Services for the residents of Luton? please tick one box only
15 (41%) yes
9 (24%) no
13 (35%) don’t know/not sure
please explain
6 responses
- Not familiar with current provision. I hope proposals are an improvement.
- I think access is good enough. The quality of the services is the issue!
- on paint
- I think it will work
- I am very sceptical about this integration model on improving the access.
- consistency with support

The new service will cover the Luton area. In an integrated single service approach, it is envisaged these services will be delivered by a single provider at a site(s) located near to or within the town centre.

Q20 Do you have any concern about the single service being located near to or within the town centre? please tick one box only
13 (37%) yes
22 (63%) no
If no, please explain
13 responses

- If it is going to be anywhere, it would have to be near the town centre
- This may make it more difficult for people to access if they live some way away from town centre.
- It's no different to having a doctors surgery close by
- The town centre is a very public space and less discreet, increasing the chance of people accessing the service being seen by friends / colleagues etc. that they may not wish to be seen by. Having a single site for delivery of the service means greater chance of overcrowding, less overall capacity and less flexibility over locations. A town centre location means parking issues
- lots of people visit the hospital you can just blend in
- I can see the need to be in the town centre but it must be balanced with the need for patents privacy. If accessing the establishment requires you to enter very a very over looked, public place, it would be counterproductive. Multiple entrances with a public entrance but another which is much more private. For newly diagnosed patents this is very important. I used to work for a HIV charity helping newly diagnosed patients and it cannot be understated how the ability to just slip in unnoticed was something of a relief to those being helped.
- This is the best location for accessibility
- always on time
- Central site is vital
- no
- Prefer to have services together.
- Its central, less bus fares though not sure about confidentiality as one can easily dump into people one knows who don’t know about their status.
- more accessible
Q21  Do you have any concerns about the new HIV Prevention and Support Service model? please explain
21 responses

- No
- I am opposed to any cutback of accessibility of the service. I certainly think testing should be accessible at multiple sites and cutting back on this could reduce the chances of people getting tested. There is also notable friction among the social groups most at risk. Certain ethnic groups are a higher risk, and some of these have cultural issues with LGBT people, of whom gay men are also a high risk group.
- Insufficient locations
- No
- It will concentrate people in one area and make them easily identifiable
- Would be against a single site for delivery as it reduces choice / flexibility of location, increases the footfall of people going in / out of the location and so makes it less discreet and increases the chances of deterring people from using the service because they may be seen by people they don’t wish to be seen by. town centre location is not convenient re parking, congestion, journey times to and from
- Cost to council tax bill
- No
- Yes. You will give away money which won’t be spent wisely. But you have no understanding what this condition is about. As long you not listen individuals but someone like Management from those charitable organisation you will never deliver what is more needed.
- no
- Worried about change and losing hard fought for services.
- no
- none
- no
- no
- 1. Worried about meeting need for very vulnerable people. 2. Worried about change 3. Worried about mixing LGBT & HIV and increasing stigma and some not accessing.
- I have a problem, i wish us as service users were consulted before this was put up together.
- yes, about change and loss of dedicated services
- no
- no
**Q22** Do you have any suggestions to improve the new HIV Prevention and Support Service model? please specify

16 responses

- The model would work well with gender segregated sessions for testing and treatment. I also feel strongly that testing should be available at multiple facilities.
- Provide more locations to provide the service.
- You can't help people who don't want to be helped. There is already nationally a disproportionate amount of government and charity money spent on an HIV minority which could be better spent elsewhere.
- Clinic times are essentially only office hours which means accessing the service means taking time off work which means informing work managers: before 8am, after 6pm, weekend appointments would make the service easier, more discreet and more flexible to use.
- No
- Make sure it's well funded and run and continued long term
- No
- I have amazing one.
- There is no service for the children for the service users kids they feel they left out
- no
- n/a
- no
- to encourage more people to be tested
- more for under 30s
- I am not sure at the moment
- no

**Q23** Any other comments?

9 responses

- None
- I've had two friends die of aids and have several young & old gay friends who no matter what is said will not change their ways
- No
- Completely wrong idea.
- CAPH is as homely as can be
- no
- Does this model work?
- no
- I feel it will mean everyone will be treated fairly
About You

The following questions are voluntary, however to ensure that we are reaching all residents we would appreciate it if you could answer the following questions about yourself.

Q24  Your postcode
33 responses
- u32ex
- LU1 1LB
- LU2 7JW
- Lu29sp
- LU3
- Lu27bd
- LU1 5ND
- LU1 3NZ
- LU2 7QH
- Lu1
- lu29jd
- LU34BA
- LU2 7QS
- LU4 9GN
- LU33LT
- lu2 7xb
- sg5 3hl
- Lu2 7qz
- LU49FR
- Lu2 7es
- LU1 5DT
- LU3 3UG
- LU3 3UG
- LU3 8JN
- LU2 0UT
- LU4
- LU3
- AL1
- SG19
- LU2
- LU1
- LU4
- LU4 2DE

Q25  Are you . . . ? please tick one box only
20 (61%)  male
13 (39%)  female

Q26  Which age group do you belong to? please tick one box only
0 (0%)  under 18
2 (6%)  18 - 24
3 (8%)  25 - 34
9 (25%)  35 - 44
10 (28%)  45 - 54
5 (14%)  55 - 64
7 (19%)  65 and over

Q27  At present, are you? please tick all that apply
13 (37%)  in full-time employment
3 (9%)  in part-time employment
1 (3%)  self-employed
4 (11%)  unemployed
0 (0%)  full-time student
0 (0%) part-time student
1 (3%) looking after home/family
6 (17%) long term sick/disabled
8 (23%) retired
0 (0%) other

Other, please specify
1 response
  • volunteer at HIV charity

Q28 Which of the following group best describes you? please tick one box only

<table>
<thead>
<tr>
<th>Group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>White - British</td>
<td>22 (63%)</td>
</tr>
<tr>
<td>White - Irish</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Other White</td>
<td>2 (6%)</td>
</tr>
<tr>
<td>Mixed - White and Black Caribbean</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Mixed - White and Black African</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Mixed - White and Asian</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Other Mixed</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Asian/Asian British - Indian</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Asian/Asian British - Kashmiri</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Asian/Asian British - Pakistani</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>Asian/Asian British - Bangladeshi</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Other Asian</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Black/Black British - Caribbean</td>
<td>8 (23%)</td>
</tr>
<tr>
<td>Black/Black British - African</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>Black Other</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>Chinese</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>East European</td>
<td>0 (0%)</td>
</tr>
</tbody>
</table>

Other, please specify
1 response
  • citizen of Luton

Q29 Do you consider yourself to have a disability? please tick one box only

<table>
<thead>
<tr>
<th>Answer</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>17 (47%)</td>
</tr>
<tr>
<td>No</td>
<td>19 (53%)</td>
</tr>
</tbody>
</table>

Q30 Please state which of the following best describes your disability. please tick all that apply

<table>
<thead>
<tr>
<th>Disability</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing impaired/deaf</td>
<td>2 (13%)</td>
</tr>
<tr>
<td>Visually impaired/blind</td>
<td>1 (7%)</td>
</tr>
<tr>
<td>Physical</td>
<td>8 (53%)</td>
</tr>
<tr>
<td>Emotional/mental health</td>
<td>2 (13%)</td>
</tr>
<tr>
<td>Learning</td>
<td>1 (7%)</td>
</tr>
<tr>
<td>Other</td>
<td>3 (20%)</td>
</tr>
</tbody>
</table>

Other, please specify
2 responses
  • irrelevant
  • HIV Positive.

Q31 Please indicate your religion/faith/belief? please tick one box only

<table>
<thead>
<tr>
<th>Religion/faith/belief</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Christian</td>
<td>19 (59%)</td>
</tr>
<tr>
<td>Buddhist</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Hindu</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Jewish</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>Muslim</td>
<td>1 (3%)</td>
</tr>
<tr>
<td>Sikh</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>None</td>
<td>12 (38%)</td>
</tr>
</tbody>
</table>

Any other religion/faith/belief - please specify
4 responses
- Non-practising Christian
- irrelevant
- Rastafarian.
- Spiritualist

Q32 Which one of the following best describes your sexuality? please tick one box only
20 (63%) Heterosexual
0 (0%) Lesbian
10 (31%) Gay man
2 (6%) Bi-sexual