Chief Executive's Directorate
**Office of Public Health**
8th Floor, Falcon House, The Minories, Dudley, West Midlands DY2 8PG
Tel: (01384) 814050
www.dudley.gov.uk

Dudley
Metropolitan Borough Council

# HIV Prevention Needs Assessment

# 2014

**Authors:**

**Dr Vinod Kumar, CSRH STY6 doctor**

**Dr. Mayada Abu Affan, Consultant in Public Health**

**Office of Public health, DMBC**

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## 1. Executive Summary

- The prevalence of HIV is increasing in Dudley. The prevention strategies should be targeted at the high risk groups including Black Minority Ethnic (BME) and Men who have Sex with Men (MSM).

- HIV prevalence has exceeded the threshold of >2/1000 population in four wards in central Dudley. The increasing number of infections is through heterosexual sex exposure.

- There is an urgent need for innovative and diverse ways of increasing HIV testing and awareness amongst those at high risk of infection.

- Reducing the rate of late diagnosis must be a key priority in Dudley. NICE guidelines have suggested that Point of care testing (POCT) may increase the rate of HIV testing and reduce the levels of late HIV diagnosis. Routine HIV POCT testing should be commissioned as a priority for all primary care services in high prevalence areas in Dudley.

- There is a need to invest in training health professionals including pharmacists, GPs and those who have an important role in educating local population about HIV and delivering HIV prevention programmes and services across Dudley.

- There is a need for improved communication and collaborative work between HIV specialists and local primary care health services or third-sector agencies that provide HIV prevention and support services to promote HIV testing, early diagnosis, safe sex and continuity of care. This can be achieved through the development and implementation of a multi agency HIV prevention and management pathway across the Dudley Borough.

- There are gaps in local public's knowledge about HIV. There is a need for a targeted public campaign using print or digital media sources including individual, group and community level engagement to increase awareness of HIV, promote HIV testing and improve signposting to HIV services.

- People with HIV in Dudley and their careers value the social and psychological support they currently receive from third sector organisations.

- There is a need to continue to develop models of commissioning that support the continuation, development and long term viability of the third sector organisations that provide support services for people with HIV or behavioural interventions to reduce risk taking behaviours in people who are at high risk of HIV infection.

- There is a need to continue to develop models of commissioning that support the provision of free condoms to at risk populations, including MSM, BME, sex workers and people living with HIV.

- There is a need for robust governance arrangements of commissioned HIV prevention services to demonstrate the impact and value of HIV prevention programmes in reducing prevalence of HIV.

## 2. Introduction

This report presents the findings of an HIV prevention needs assessment for Dudley residents undertaken between January and May 2014, by the Dudley Office of Public Health (OPH). It is designed to understand the epidemiology of HIV in Dudley, provides an overview of current HIV prevention services, and captures views of local population as well as stakeholder on current and future HIV prevention services in Dudley.

A range of public health responsibilities, including the commissioning of HIV prevention services, have been transferred from the NHS to local authorities on 1st April 2013. The Dudley metropolitan borough council is keen to establish whether the current services it commission are adequate enough to meet local needs to establish spending priorities.

HIV continues to be a major public health issue in the UK. An estimated 98,400 people were living with HIV in the UK in 2012. Approximately one in four (21,900) of these individuals were undiagnosed and unaware of their infection[1].

The availability of highly active antiretroviral therapy (HAART) has transformed the outcomes for individuals with HIV infection. However, high levels of morbidity and mortality continue to be associated with HIV infection in the UK. This is mostly related to the HIV being diagnosed too late in the infected person [2]. HIV infected individuals with CD4 cell counts less than 350 cells per $mm^3$ are considered to be diagnosed late. It is estimated that one in four deaths occurring in HIV-positive individuals is directly related to the diagnosis being made too late for effectual treatment.[2]

People who are unaware that they are infected with HIV are at a higher risk of transmitting HIV and those who are diagnosed late are more costly to treat. Therefore reducing the proportion of individuals with late HIV diagnoses offers significant health economic benefits. The Public Health Outcomes Framework, which sets the national & local strategic direction for public health, has included reduction in the proportion of people with HIV whose infection is diagnosed late as an indicator of essential actions to be taken to protect the health of general public. [3]

There may be several reasons of late diagnosis of HIV infection including fear of stigma surrounding HIV diagnosis, general misinformation about the infection, lack of perceived individual risk [4] and hindrance to testing within the healthcare setting.[5]

HIV can be prevented by expanding and generalising HIV testing. [6,7] British HIV Association (BHIVA) has published guidelines to promote and “generalise” HIV testing in all healthcare settings to reduce the levels of late or undiagnosed HIV infection.[6]

National Institute of Health and Care Excellence (NICE) [7,8] guidelines recommended the expansion of HIV testing in high prevalence areas for HIV (over two per 1,000 adults) to reduce levels of undiagnosed infection. The guidelines recommended for the introduction of a routine universal offer of HIV testing in hospitals for general medical admissions and new registrants in general practices, as well as the expansion of targeted outreach testing in community settings in high prevalence areas.

A report, published by the former Health Protection Agency (HPA) in 2011, assessing the feasibility and acceptability of HIV testing in community based settings demonstrated that the routine offer of an HIV test in primary care settings was feasible and acceptable to both staff and patients.[9]

[1]Public Health England. HIV in the United Kingdom: 2013 Report.
[2]British HIV Association (BHIVA). 2005–6 mortality audit. http://www.bhiva.org/files/file1001379.ppt
[3] Department of Health (2012). Improving Outcomes & Supporting Transparency. Part 1: A Public Health Outcomes Framework for England, 2013–2016.
[4]Sigma Research (2008) BASS line 2007 survey: assessing the sexual HIV prevention needs of African people in England. London: Sigma Research
[5] Sullivan AK, Curtis H, Sabin CA et al. Newly diagnosed HIV infections: review in UK and Ireland. BMJ, 2005, 330,1301–2. http://www.bmj.com/cgi/content/full/330/7503/1301
[6] British HIV Association, British Association of Sexual Health and HIV, British Infection Society. UK national guidelines for HIV testing 2008. London
[7]NICE, Increasing the uptake of HIV testing among black Africans in England, 2011
[8] NICE, Increasing the uptake of HIV testing among men who have sex with men, 2011
[9] Health Protection Agency. Time to test for HIV: Expanding HIV testing in healthcare and community services in England. 2011.

## 3. Aims

The remit of this needs assessment was to focus on HIV prevention interventions including HIV testing and health promotion in order to inform the future commissioning of HIV prevention services and interventions in Dudley. HIV treatment and HIV-related care were outside the scope of the needs assessment, as commissioning responsibility for these services sits with NHS England.

The aims of this needs assessment were to:

1. Describe the epidemiology of HIV in Dudley
2. Review the literature evidence for the effectiveness of HIV prevention interventions
3. Map HIV prevention services and programmes currently provided in Dudley and identify gaps to make recommendations for future commissioning
4. Capture a wide range of stakeholder as well as local population views on current and future HIV prevention services in Dudley
5. Gain insight into the barriers for HIV testing, both from a clinician and user point of view
6. Make recommendations on what future health care interventions are required to meet current needs

## 4. Methods

This was an epidemiological, corporate and comparative needs assessment[1]. The assessment was undertaken over a period of five months, from 1st January to 31st May 2014. The target population was residents of Dudley. The assessment included:

- A description of Dudley population by age, gender and ethnicity
- A thorough analysis of available epidemiological Public Health England (PHE) data to identify prevalence and incidence of HIV in Dudley
- Literature review on the effectiveness and cost effectiveness of HIV prevention interventions
- Mapping of current HIV prevention services and interventions in Dudley
- Qualitative data collection using questionnaire surveys, and interviews with service providers in Dudley to identify gaps, issues, challenges and opportunities in HIV testing and prevention
- Qualitative data collection from service users and key at-risk populations for HIV (MSM and black African groups) to identify the fundamental issues around barriers to HIV testing; to identify the services that are currently being used or not used and reasons for this in order to understand the most needed services and where improvements need to be focused on

Participation in this needs assessment, whether a service provider, a service user, or a healthcare professional, was voluntary. The qualitative data were collected from individuals from local population, service users and healthcare professionals via questionnaires or one-to-one/telephone interviews.

The questionnaire was sent out to all service providers via email, post or delivered by hand. All service providers were also asked to give the questionnaire to their clients using their services. Due to time restraints, the questionnaire was not piloted and the questionnaires were completed between January and March 2014.

Information from PHE Centre for Infectious Disease Surveillance and Control (CIDSC) was sourced to estimate recent HIV infection, late diagnosis of HIV, undiagnosed HIV and HIV testing in Dudley.

The new HIV diagnoses data presented in this needs assessment refer to patients diagnosed at health services in Dudley. However, not all of these patients are resident in Dudley and some Dudley residents will have been diagnosed elsewhere in the West Midlands or UK. The year of HIV diagnosis is frequently later than the year of actual infection. Where data were not available at a local level, regional or national data were used. The following data sources were used to collect data in this health needs analysis:

1. **Office of National Statistic:** This surveillance system collects data related to local population demographics [2]

2. **Survey of Prevalent HIV Infections Diagnosed (SOPHID):** This surveillance system collects annual epidemiological data of individuals seen for HIV-related care including place of residence, clinical stage and antiretroviral (ART) regime.[3]

3. **The Genitourinary Medicine Clinic Activity Dataset (GUMCAD) or quarterly KC60 returns:** This surveillance system collects disaggregated data from GUM clinics on the number of episodes of STIs and sexual health services provided including HIV testing. [4]

4. **The HIV and AIDS Reporting System (HARS):** This surveillance system collects data on demography and epidemiology of new diagnoses of HIV/AIDS via the clinicians' and microbiologists' voluntary reports to the Centre for Infectious Disease Surveillance and Control (CIDSC). Geographical analyses are not based on the patient's place of residence but based on the clinic of diagnosis.

5. **Antenatal Infection Screening Surveillance (AISS):** This surveillance system collects data to estimate offer and uptake of screening for HIV, Hepatitis B, Syphilis and Rubella susceptibility in antenatal clinics

[1] Design Option (2007). Sexual Health Needs Assessment (SHNA) A 'How To Guide'. www.apho.org.uk/resource/view.aspx?RID=74982
[2] Office for National Statistics. 2011 Census: Ethnic group, local authorities in England and Wales.
[3] Health Protection Agency (2010) GUMCAD and SOPHID data sets
http://www.hpa.org.uk/Topics/InfectiousDiseases/InfectionsAZ/HIVAndSTIs
[4] Health Protection Agency (2008) GUMCAD and HIV data sharing policies 2008
www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1247816526850

## 5. Evidence based measures to prevent HIV

This section provides evidence based guidance on interventions that may be useful to prevent HIV infection, with the aim of benefiting both individual as well as public health. The evidence provided in this section is based on guidance provided by British Association for Sexual Health and HIV (BASHH), the British HIV Association (BHIVA)[1,2], National Institute for Health and Care Excellence (NICE)[3,4] and a report published by the Matrix for the Future Commissioning of London HIV Prevention Services (FCLHPS) project steering group[5] to facilitate an increase in HIV testing in all healthcare settings to reduce the number of individuals with undiagnosed or late HIV infection.

The authors of this need assessment emphasise that HIV testing remains voluntary and confidential in the UK.

### I. Recommendations for HIV testing

A. Universal HIV testing is recommended in all of the following services:
   1. GUM or sexual health services
   2. Antenatal services
   3. Abortion services
   4. Drug dependency programmes
   5. Services providing care to patients diagnosed with tuberculosis, hepatitis B and C, and lymphoma

B. An HIV test should be offered in the following settings where diagnosed HIV prevalence in the local population exceeds 2 in 1000 population:
   1. All men and women registering in general practice
   2. All general medical admissions

C. HIV testing should be routinely offered to the following patients:
   1. Where HIV enters the list of differential diagnosis
   2. With a diagnosed sexually transmitted infection
   3. All sexual partners of an individual known to be HIV positive
   4. Men who have sex with men (MSM)
   5. All female sexual contacts of MSM
   6. IV drug users
   7. Individuals known to be from a country of high HIV prevalence (>1%)
   8. Individuals who report sexual contact abroad or in the UK with individuals from countries of high HIV prevalence
   9. Blood donors
   10. Dialysis patients
   11. Organ transplant donors and recipients

D. Repeat testing should be offered to the following groups:
   1. HIV test negative but exposure has occurred within the window period
   2. MSM – annually or more frequently if clinically indicated or ongoing high risk exposure

3. Injecting drug users – annually or more frequently if clinically indicated or ongoing high risk exposure
4. Antenatal care – women who refuse an HIV test at booking. Women presenting to services for the first time in labour should be offered a finger prick point of care test (POCT).

The UK National Guidelines for HIV Testing (2008) also clearly sets out clinical indicator diseases for adult HIV infection, where an HIV test should be offered:

A. Dermatology:
    a. Kaposi's sarcoma
    b. Multidermatomal or recurrent herpes zoster
    c. Severe or recalcitrant psoriasis or dermatitis
B. ENT
    a. Chronic parotitis
C. Gastroenterology
    a. Chronic diarrhoea of unknown cause
    b. Hepatitis B/C infection
    c. Oral candidiasis
    d. Oral hairy leukoplakia
    e. Persistent cryptosporidiosis
    f. Salmonella, shigella or campylobacter
    g. Weight loss of unknown cause
D. Gynaecology
    a. Cervical cancer
    b. Cervical intraepithelial neoplasia (CIN) Grade 2 or above
    c. Vaginal intraepithelial neoplasia (VIN)
E. Haematology
    a. Hodgkin's lymphoma
    b. Non-Hodgkin's lymphoma
    c. Any unexplained blood dyscrasia including:
        • Lymphopenia
        • Neutropenia
        • Thrombocytopenia
F. Neurology:
    a. Aseptic meningitis /encephalitis
    b. Cerebral abscess
    c. Cerebral toxoplasmosis
    d. Cryptococcal meningitis
    e. Guillain–Barré syndrome
    f. Leucoencephalopathy
    g. Peripheral neuropathy
    h. Primary cerebral lymphoma
    i. Space occupying lesion of unknown cause
    j. Transverse myelitis
G. Oncology
    a. Anal cancer or anal intraepithelial dysplasia

b. Castleman's disease
c. Head and neck cancer
d. Lung cancer
e. Seminoma

H. Ophthalmology
a. Any unexplained retinopathy
b. Cytomegalovirus retinitis
c. Infective retinal diseases including herpes viruses and toxoplasma

I. Respiratory:
a. Aspergillosis
b. Bacterial pneumonia
c. Pneumocystis
d. Tuberculosis

J. Other
a. Any lymphadenopathy of unknown cause
b. Any sexually transmitted infection
c. Mononucleosis-like syndrome
d. Pyrexia of unknown origin

## II. Condom efficacy

Consistent use of the male condoms for vaginal, anal and oral sex has been shown to reduce the transmission of HIV in heterosexual couples, including those who have anal sex[6], and in MSM[7]. The easy availability of low or free condoms is an important way to reduce transmission of all STIs including HIV in a population, including MSM, Black African individuals, young people, people living with HIV and sex workers. Condom distribution also provides an opportunity to communicate key HIV promotion and prevention messages to individuals in a population.

## III. Point of care testing (POCT)

Routine HIV serological tests results are often not available for hours or days. Consequently, conventional serological testing does not always provide information on HIV status quickly enough to be clinically useful in the same consultation.

Early diagnosis of HIV remains a key strategy in the control of HIV. POCTs allow rapid detection of HIV allowing for rapid initiation of therapy. Rapid POCT for HIV using finger-prick blood samples are seen as a way to expand the reach and accessibility to HIV testing. These tests have been shown to have a high level of acceptability since they allow results to be delivered in the same consultation as the test is taken[1]. These tests can be used for testing pregnant women in labour whose HIV status is unknown, testing source individuals after occupational exposures in addition to screening high-risk or hard to reach populations and individuals.

Pilot projects[14] assessing the feasibility of routine rapid HIV POCT testing in primary care reported that the proportion of patients who accepted an offer of testing varied from 59-75%. In one of these pilot projects, 85% of new registering patients reported that they were happy to have a rapid HIV test in this setting.

A study evaluating ways to increase HIV testing uptake in targeted marginalized groups concluded that community and GUM clinic-based POCT for HIV was feasible and acceptable to both clients as well as service providers in a low prevalence setting.[15]

A study at two London GUM clinics assessing measures to increase the HIV testing among high risk patients reported that more than half of high risk patients, who initially declined conventional HIV testing, accepted a rapid HIV POCT. [16]

A recent cluster randomised controlled trial in UK general practices to determine whether POCT testing improved early HIV detection concluded that offering rapid HIV testing at general practice registration led to earlier detection of HIV including identifying cases from non-MSM risk groups.[17]

NICE guidelines recommended that specialist sexual, primary and secondary care health services should ideally offer both fourth generation serology testing as well as POCT to increase the uptake of HIV testing. [3,4]

The POCT for HIV detects both HIV antibodies and the p24 antigen however all reactive tests require confirmation by a diagnostic laboratory test because of their lower specificity meaning that they are more likely to give false positive results. It also means that only a minority of reactive test results may be true positives in low prevalence settings where the undiagnosed prevalence of HIV is ≤1 per 1,000. Therefore, when using POCT, it is important to report the result as reactive rather than positive, emphasising the likelihood of a false reactive result and ensuring clear clinical pathways for confirmatory laboratory testing before a definitive HIV diagnosis is made.

## IV. Effectiveness of HIV prevention in key population groups

The Matrix for the FCLHPS project steering group [5] reviewed the published literature on the effectiveness and cost effectiveness of HIV prevention interventions (see appendix for details of interventions) and reported following conclusions:

a. **Behavioural interventions:** There is limited evidence that individual and small-group behaviour change interventions (including cognitive behavioural therapy) can reduce risk taking behaviours among individuals who are at higher risk of HIV infection or living with HIV.
b. **Educational and knowledge based interventions:** There is limited evidence that sex and relationships education in schools as well as educational and knowledge-based interventions in other community settings can increase awareness of HIV, risks to sexual health and ways to reduce risks of infection.
c. **Outreach interventions:** There is limited evidence that specifically targeted and tailored outreach interventions that engage with target population groups in their own social, community or other settings/environments can be effective in increasing HIV knowledge and awareness, reducing sexual risk behaviours and increasing HIV testing.
d. **Measures to reduce harm in people who inject drugs (IVDU):** Opioid substance therapy and needle exchange programmes are both reported to be effective measures for reducing HIV transmission in IVDUs.
e. **Providing HIV information and raising awareness through various communication channels and media:** There is limited evidence that the use of mass media campaigns results in raising HIV awareness, increasing uptake of HIV testing and signposting to related services. There is

also emerging evidence that the use of communication channels such as the internet, social media and sport-based intervention can deliver HIV prevention messages better in certain group of populations such as adolescents.

## V. Cost benefit of HIV prevention

A recent budgeting reprot from the NHS England suggested that approximately £630m was spent in 2012/13 on HIV treatment and care. A study conducted by the former HPA and the National AIDS Trust, on the economic implications of a newly diagnosed HIV infection, demonstrated that investing in ways to prevent HIV infection, such as increased HIV testing to reduce the levels of undiagnosed HIV infection and diagnose HIV earlier, have the potential for long term cost savings. The prevention of one new HIV infection can save up to £360,000 in direct lifetime healthcare costs.[8]

There are significantly higher costs of care for patients diagnosed late with HIV[13]. A study assessing the immediate- and longer-term direct medical costs of care for individuals diagnosed late with HIV at CD4 counts <350/mm$^3$ demonstrated a tripling of healthcare costs in the first year with increased costs persisting even after five years into care. [9] Implementing the NICE guidance on increasing uptake of HIV testing among BME and MSM in England can save up to £18m in treatment costs per year [3,4].

A study comparing the cost-effectiveness of HIV testing in out-patients settings such as in A&E or GUM clinics with hospital inpatient testing based on clinical manifestations demonstrated that screening for HIV in out-patient settings was more cost effective, where individuals were more likely to be tested early in the course of disease and have higher CD4 counts at the time of diagnosis.[10]

## VII. Policy context

The expansion of HIV testing has been recommended in various recent policy documents and guidelines:

**The Public Health Outcomes Framework**, which sets the national & local strategic direction for public health, has included reduction in the proportion of people with HIV whose infection is diagnosed late as an indicator of essential actions to be taken to protect the public's health. [11]

**The House of Lords Select Committee on HIV and AIDS** report endorsed both BHIVA and NICE testing guidelines and recommended that increasing HIV testing should be part of local HIV prevention testing strategies, especially in areas of high HIV prevalence[12].

**The National Institute for Health and Clinical Excellence** has recently published guidance for increasing the uptake of HIV testing in MSM and Black African communities recommending widespread testing in primary, secondary and emergency care health services and development of local strategies to reduce barriers to more wide-scale testing [3,4].

**The British HIV Association (BHIVA)** and **the British Association for Sexual Health and HIV (BASHH)** has developed **National HIV testing guidelines** recommending the routine offer of an HIV test to all general medical admissions and to adults registering in general surgeries in areas of high HIV prevalence [1,2].

[1]UK National Guidelines for HIV Testing 2008. British HIV Association; British Association of Sexual Health and HIV; British Infection Society. 2008
[2]UK National Guidelines on safer sex advice. The Clinical Effectiveness Group of the British Association for Sexual Health and HIV (BASHH) and the British HIV Association (BHIVA). July 2012
[3]NICE, Increasing the uptake of HIV testing among black Africans in England, 2011
[4] NICE, Increasing the uptake of HIV testing among men who have sex with men, 2011
[5]Taken directly from: Evidence Review Update (2010-2013): HIV Prevention Interventions. Final Report. Future Commissioning of London HIV Prevention Services (FCLHPS) Steering Group. Version 3. November 2013
[6] Weller S, Davis K. Condom effectiveness in reducing heterosexual HIV transmission. Cochrane Database Syst Rev 2002(1):CD003255.
[7] Golden M. HIV serosorting among men who have sex with men: implications for prevention. Thirteenth Conference on Retroviruses and Opportunistic Infections. Denver, 2006.
[8] Health Protection Agency. HIV in the United Kingdom: 2012 Report. 2012.
[9] Krentz HB; Gill J. Despite CD4 cell count rebound the higher initial costs of medical care for HIV-infected patients persist 5 years after presentation with CD4 cell counts less than 350 µl. AIDS. 2010;24(17):2750-3.
[10]Prabhu VS, Farnham PG, Hutchinson AB, Soorapanth S, Heffelfinger JD, et al. (2011) Cost-Effectiveness of HIV Screening in STD Clinics, Emergency Departments, and Inpatient Units: A Model-Based Analysis. PLoS ONE 6(5): e19
[11] Department of Health (2012). Improving Outcomes & Supporting Transparency. Part 1: A Public Health Outcomes Framework for England, 2013–2016.
[12]House of Lords Select Committee. 2011. No vaccine, no cure: HIV and AIDS in the United Kingdom.
[13]Beck, E.J. et al. 2011. The cost-effectiveness of early access to HIV services and starting cART in the UK 1996-2008. PloS one, 6(12), p.e27830.
[14]Health Protection Agency. 2011. Time to test for HIV: expanded healthcare and community HIV testing in England.
[15] Macpherson P et al. Feasibility and acceptability of point of care HIV testing in community outreach and GUM drop-in services in the North West of England: A programmatic evaluation. BMC Public Health, 2011, vol. /is. 11/ (419), 1471-2458; 1471-2458 (2011).
[16]Forsyth SF et al. Would offering rapid point-of-care testing or non-invasive methods improve uptake of HIV testing among high-risk genitourinary medicine clinic attendees? A patient perspective. International Journal of STD & AIDS, Aug 2008, vol./is. 19/8(550-2), 0956-4624;0956-4624 (2008 Aug)
[17]Lever W et al. Point-of-care HIV testing in primary care and early detection of HIV (RHIVA2): a cluster randomised controlled trial. The Lancet, Volume 382, Issue , Page S7, 3 November 2013 doi:10.1016/S0140-6736(13)62255-2

**Summary points**

- Early diagnosis of HIV enables better treatment outcomes and prevents onward transmission
- A multi-dimensional approach is needed to tackle late diagnosis of HIV, including ways to expand HIV testing in primary care as per national HIV testing guidance
- Patients with specific indicator conditions or from high risk groups should be routinely recommended to have an HIV test
- Implementation of rapid HIV POCT in primary care settings may reduce undiagnosed and late presentation of disease
- Persistent and correct use of condoms reduce the risk of HIV acquisition and transmission
- Good general education and evidence based behaviour change interventions that aim to increase knowledge and awareness of HIV are effective in reducing risk-taking behaviour
- A targeted public campaign using print or digital media sources may increase awareness of HIV, promote HIV testing and improve signposting to HIV services
- Investment in HIV prevention measures is cost effective and can result in financial saving and health gain

## 6. Dudley Demographic data

This section aims to provide socio-demographic description of the Dudley population.

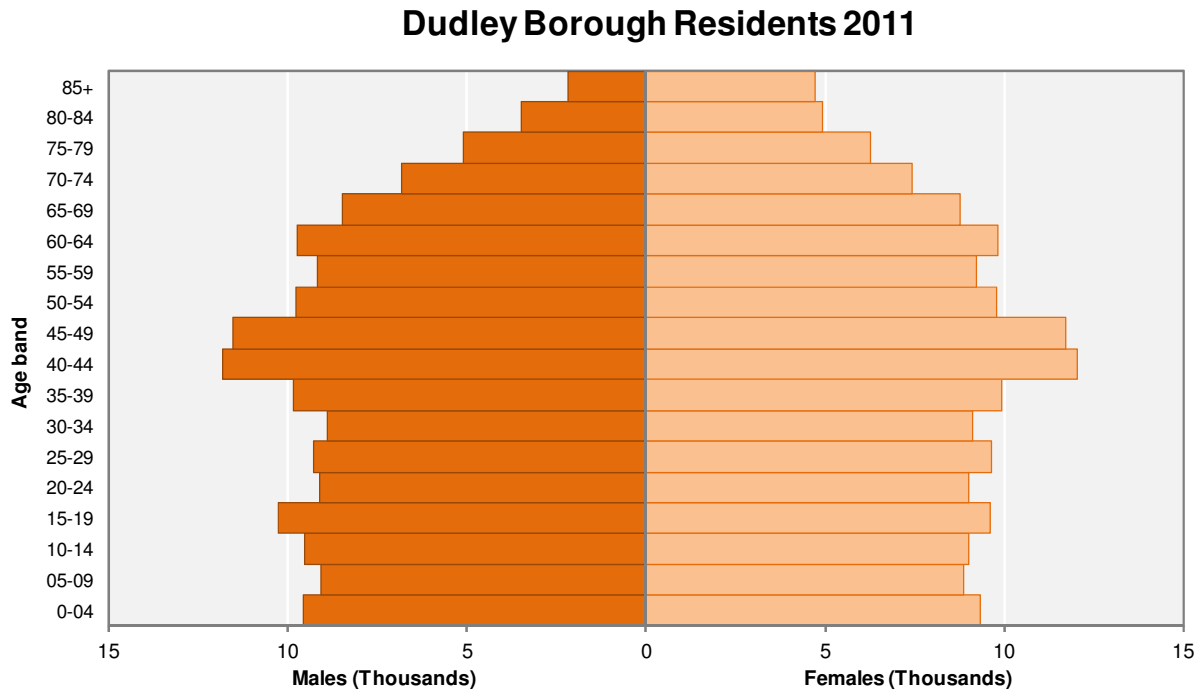
Dudley is located on the western part of the West Midlands conurbation, approximately 9 miles west of Birmingham and 6 miles south of Wolverhampton. Dudley is the third largest local authority district in the West Midlands Region based on population. The borough includes four main town centres: Dudley towards the north of the borough, Stourbridge in the southwest, Halesowen in the southeast and Brierley Hill near the centre.

The resident population of Dudley Borough from the 2011 Census is estimated to be 312,925. The population has been growing at a modest rate in recent years, with 7,925 more people in the borough now compared to the 2001 estimate. The population is projected to increase by 7.4% (22,600 people) to 328,900 people between 2008 and 2033 with a small increase of 2.6% for the 20-29 age group[1].

### I. Distribution by age and sex

In Dudley borough, 30% of people are aged under 25 and 19% are 65 and over (Census 2011). Its distribution by five year age band and gender is given in Figure 1. There is a slightly higher proportion of female residents (51%) to males (49%). Dudley has a comparatively higher proportion of people aged 40-50 years with more females than males surviving in the oldest age groups.

*Figure 1: Population estimate by age group and gender for Dudley residents, 2011*

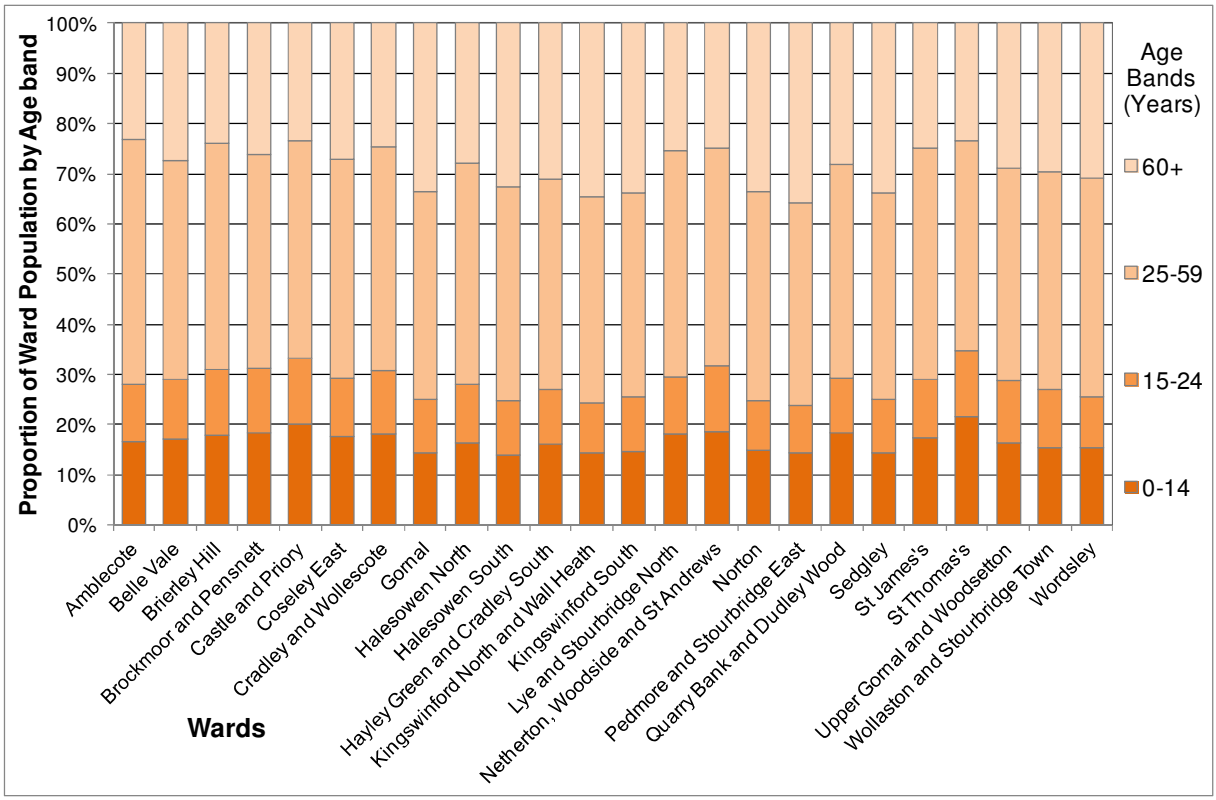



Source: 2011 Census, ONS

[1] *All about Dudley Borough, JSNA 2012*

The population distribution across the 24 wards in the borough is given in Figure 2. Netherton, Woodside & St Andrews, St Thomas's, Brierley Hill, Castle & Priory, and Brockmoor & Pensnett have the highest proportion of their population aged 15-24 years (Figure 2). The age profile is markedly different between the wards in the more deprived central areas (figure 3) and the more affluent wards around the periphery of the borough where over 25% of the population are over 60.

*Figure 2: Population 2011 Census estimates by 2004 Electoral ward*




Source: 2011 Census, ONS

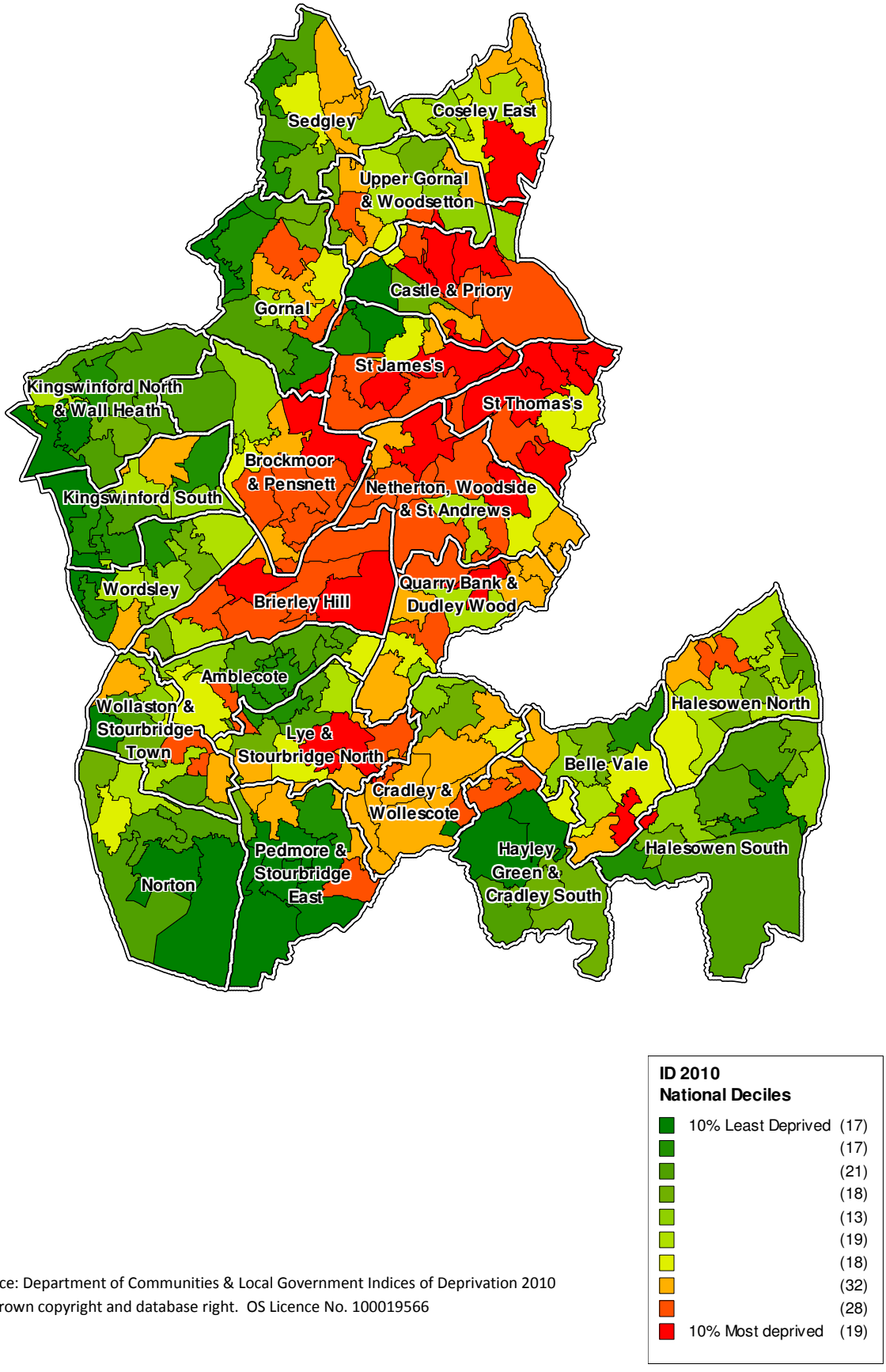
## II. Distribution by Index of Multiple Deprivation

It is well established that sexual ill-health and HIV are strongly related to deprivation in developed world. A study aiming to determine the prevalence of HIV in North West England demonstrated that the prevalence of HIV was 6.6 times higher than in the least deprived quintile, and the prevalence of new HIV cases was 13.3 times higher than that in the most affluent areas.[2]

Dudley is ranked as the 104th most deprived of the 326 local authority districts in England (where 1 is most deprived), a lower ranking than five of the other six districts in the West Midlands conurbation. While this suggests Dudley is relatively affluent compared with the rest of the West Midlands conurbation, a large disparity in levels of deprivation exists across the borough (figure 3). The deprivation indices from 2010 indicated that 23.9% of the population in Dudley were in the 20% most deprived in England. These are principally found in a zone covering Dudley, Pensnett, Netheron and Brierley Hill, but also include parts of Coseley, Lye, Halesowen and Stourbridge[3].

[2] *Cook P, Hargreaves S C: Inequalities in HIV. Centre of Public Health, Liverpool John Moores University*
[3] *All About Dudley Borough*

*Figure 3: Index of Multiple Deprivation 2010 National Deciles, Dudley LSOAs*



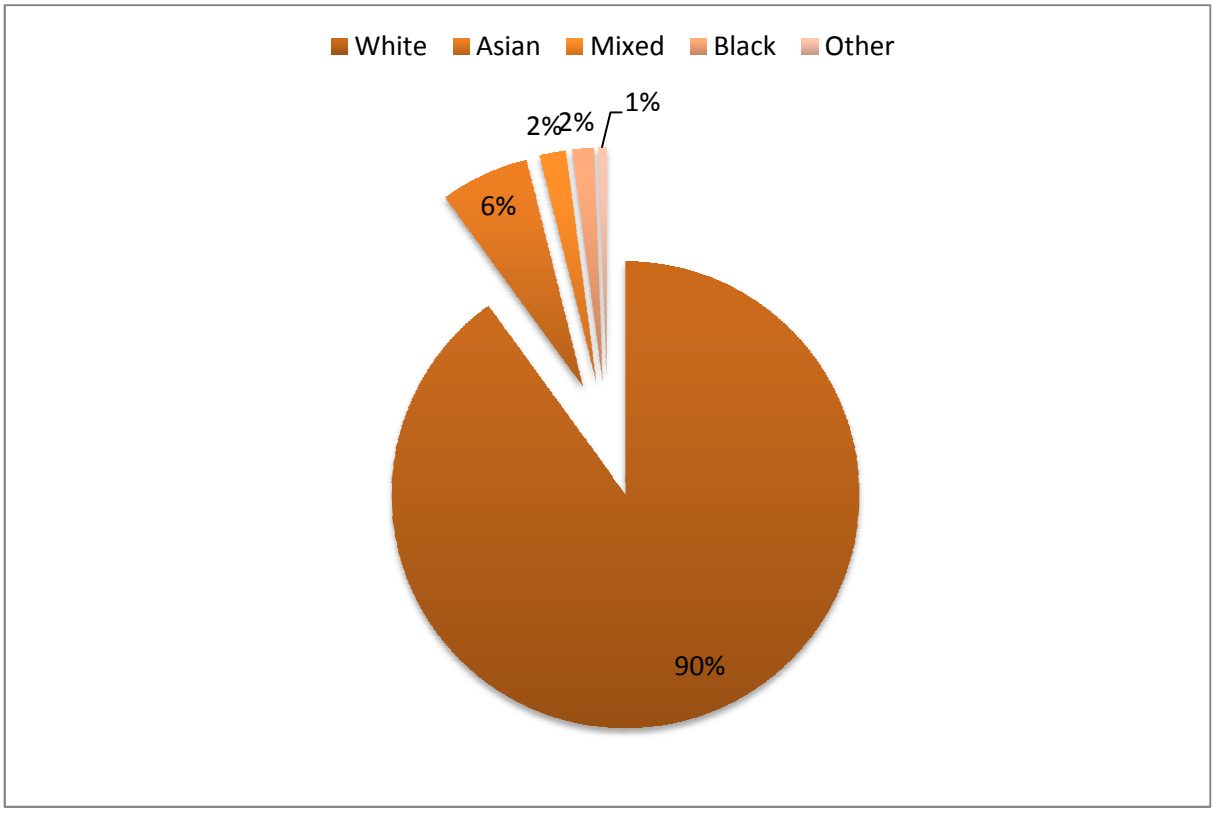

Source: Department of Communities & Local Government Indices of Deprivation 2010

## III. Ethnicity

According to the 2011 Census, ethnic minority groups make up 10% of the Borough population as a whole (Figure 4). Dudley has become more ethnically diverse since 2001 when the figure was 7.5%. The largest ethnic minority group is Asian, at 6% of the population, with the largest individual groups in the borough being Pakistani (3.3%) and Indian (1.8%). Two percent of people are from mixed ethnic groups, 1% Black ethnic groups and a further 1% from White groups other than British.

There are strong concentrations of the ethnic minority population within certain neighbourhoods in Dudley Borough, pushing the local proportions up as high as 40%. These neighbourhoods include; Dudley, Blowers Green and Lye.

*Figure 4: Dudley Borough Residents by Ethnic group (Source: Census 2011)*




## IV. Men who have sex with men (MSM)

Men who have sex with men (MSM) are most at risk of acquiring HIV. There are no population data which reliably estimate the MSM population within Dudley. Recent National Survey of Sexual Attitudes and Lifestyles (NATSAL) reported changing sexual behaviour over time nationally as higher proportion of men are having same-sex experience than in the previous decade[4]. According to this national health survey, Gay, bisexual and other men who have sex with men (MSM) constitute an estimated 5.5% of the UK male population[5].

[4] *The Third National Survey of Sexual Attitudes and Lifestyle, 2013*
[5] *Mercer, C.H et al. Natsal. The Lancet - 30 November 2013 (Vol. 382, Issue 9907, Pages 1781-1794)*

**Summary points**

- The population of Dudley has been growing at a sustainable modest rate in recent years, 2.5% rise since 2001.
- 64% of the Dudley Borough population are in the sexually active age band (i.e. aged 15-64).
- Dudley, Pensnett, Netheron, Brierley Hill with some parts of Coseley, Lye, Halesowen and Stourbridge are most deprived across the Dudley Borough.
- A larger proportion of 15-64 years old in Dudley Borough live in the most deprived areas than in the affluent areas.
- The black ethnic group constitutes 1% of the Borough population.
- There are strong concentrations of the ethnic minority population within Dudley, Blowers Green and Lye neighbourhoods in Dudley Borough.
- MSM constitute an estimated 5.5% of the UK male population.

## 7. HIV epidemiology in Dudley

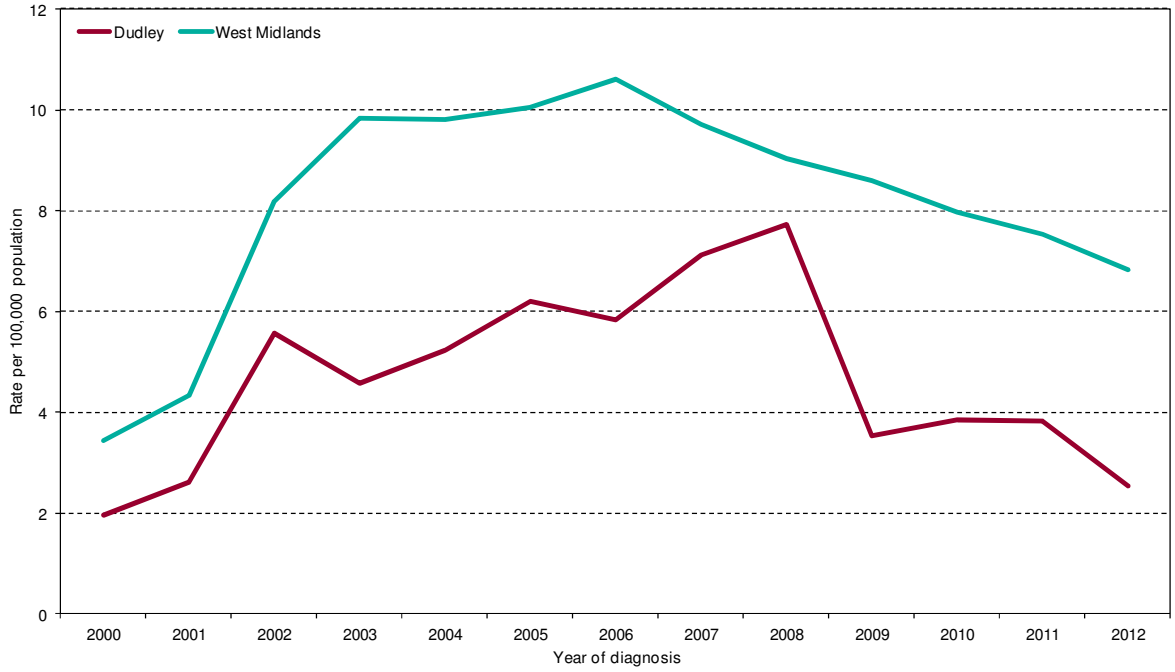
Public Health England collects data on new HIV and AIDS diagnoses, deaths due to HIV, and people who are accessing HIV-related care.

This section aims to provide an overview of the trends in HIV across Dudley and comparators such as West Midlands, UK, etc to the end of 2012. Analysing data at these levels allows comparisons to be made in order to construct an understanding of the magnitude of the problem in the local population. In addition, it enables to understand which population groups are most at risk, effectiveness of current services and considerations for future service developments and redesign.

The authors emphasise that the new HIV diagnoses data presented in this section refer to patients diagnosed at hospital or clinics in Dudley; some of the HIV diagnoses data involve people who are not resident in Dudley; some Dudley residents would have been diagnosed elsewhere and that the information is presented by year of diagnosis, which is frequently later than the year of infection.

### I. New HIV diagnoses

**Figure 1: New HIV diagnosis rates per 100,000 population, Residents of Dudley and West Midlands, 2000-2012**

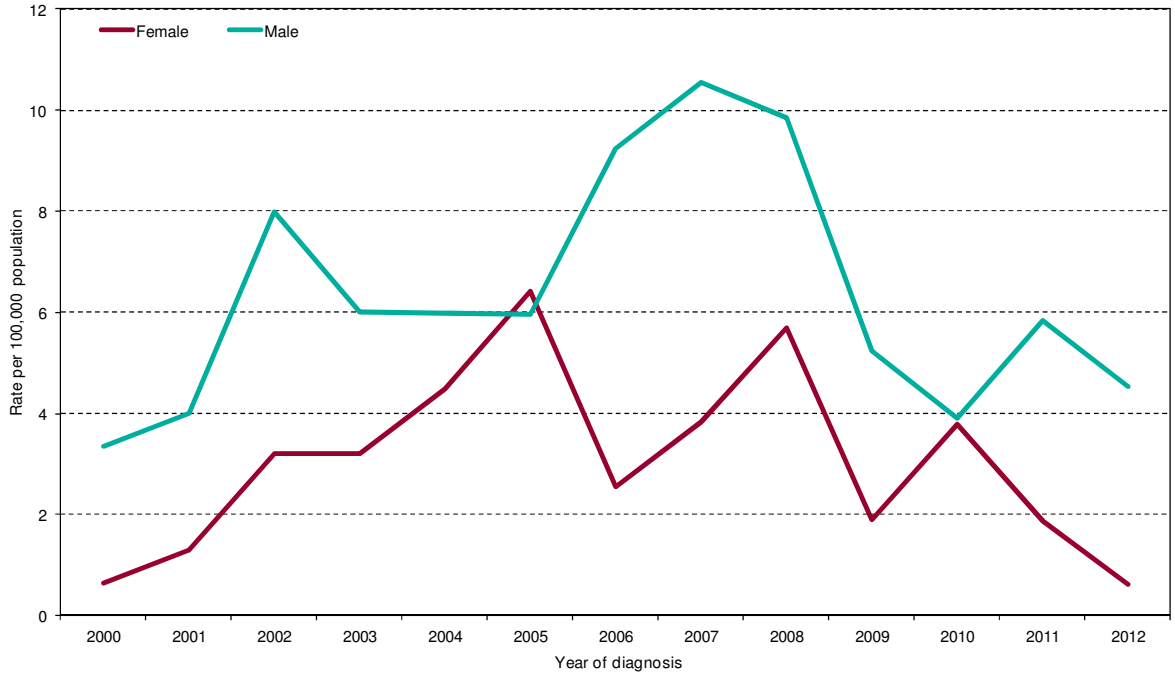



Source: Public Health England, HIV and AIDS New Diagnosis Database; Office for National Statistics mid-year population estimates.

The rate of new HIV diagnosis in Dudley was 2 per 100,000 population in 2000 but rose steadily over the next 8 years. The diagnosis rates peaked in 2008, to 7.7 cases (4 fold rise since 2000), but fallen by 50% to 3.8 cases in 2011. The rate has further fallen to 2.6 cases in 2012, but it still remains higher by 25% than those in 2000. Overall, the rates of new HIV diagnosis remain lower in Dudley compared to that in West Midlands region as a whole since 2000.

## II. New HIV diagnoses by gender

**Figure 2: New HIV diagnosis rates per 100,000 population by gender, Residents of Dudley, 2000-2012**

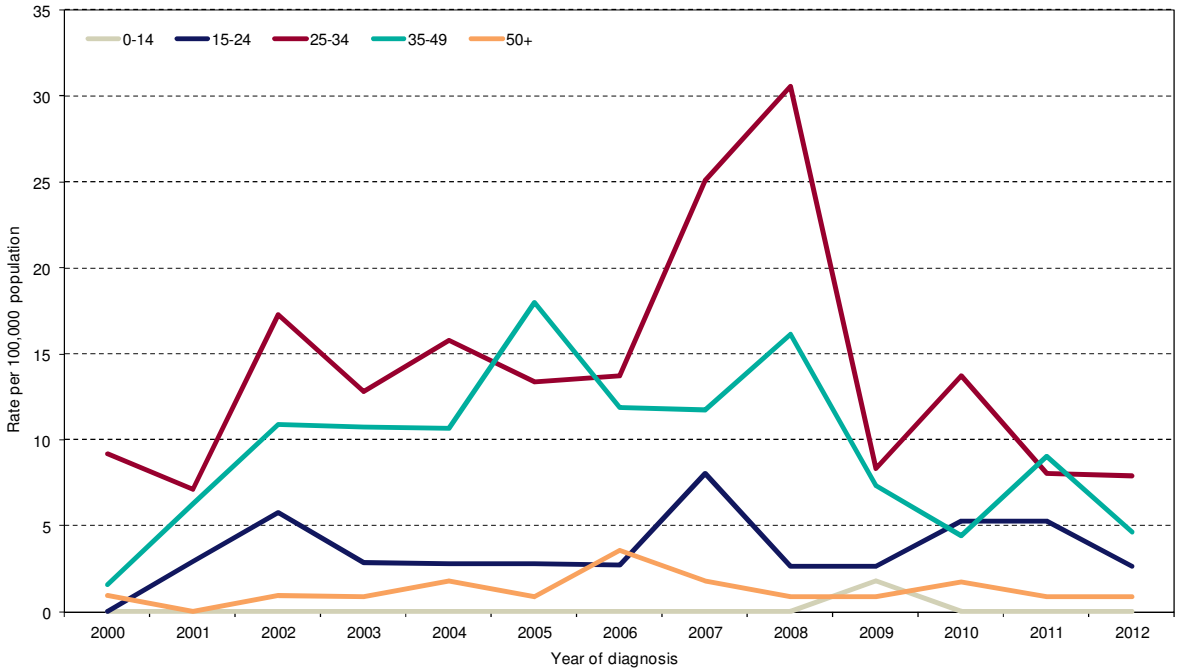



Source: Public Health England, HIV and AIDS New Diagnosis Database; Office for National Statistics mid-year population estimates.

New HIV diagnoses rates were higher in males than in females in all years apart from 2005 to 2010 in Dudley, which corresponds closely to the trend for the West Midlands region as a whole (West Midlands HIV report 2013). The only year in which the female rate exceeded slightly the male rate was 2005. In 2012, 4.5 new cases per 100,000 male population were reported in Dudley, whereas it was 0.6 cases for female residents.

### III. New HIV diagnoses by age

**Figure 3: New HIV diagnosis rates per 100,000 population by age group, Residents of Dudley, 2000-2012**

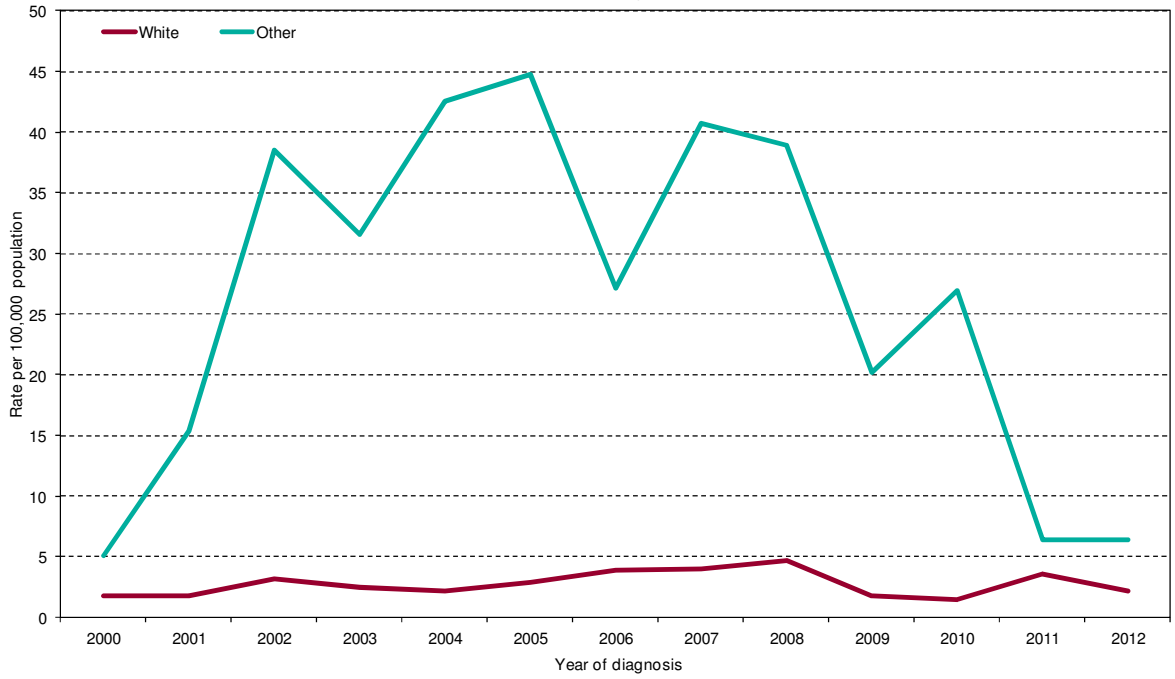



Source: Public Health England, HIV and AIDS New Diagnosis Database; Office for National Statistics mid-year population estimates.

Most new HIV infections were in the 25 to 49 age group in Dudley. New HIV diagnoses rates have generally been highest in the 25-34 age group, which corresponds closely to the trend for the West Midlands region as a whole (West Midlands HIV report 2013). However, the diagnoses rate is not consistent over time as the rate has been higher in the 35-49 age group on 2 occasions, in 2005 and 2011. The rates in children younger than 14 years of age were negligible all years apart from 2009, when a case was reported in Dudley.

## IV. New HIV diagnoses by ethnicity

**Figure 4: New HIV diagnosis rates per 100,000 population ethnic group, Residents of Dudley, 2000-2012**




Source: Public Health England, HIV and AIDS New Diagnosis Database; Office for National Statistics experimental population estimates and 2011 census population.

Large ethnic inequalities are clearly illustrated by the difference in rates of infection between white and other ethnic groups (data not shown separately for different ethnic minorities groups due to their smaller population in Dudley). The other ethnic group includes residents of black Africans, black Caribbean, Indian, Pakistani, Bangladeshi, Chinese, etc.

The number of new HIV diagnoses has been lower in Dudley residents of white ethnicity compared to those of other ethnicities in all years. The rate of new HIV diagnosis in residents of white ethnicity remained almost steady between 2000 and 2012, with slight rise to 4.7 per 100,000 population in 2008, before dropping back to 2 cases in 2012. There had been a great variation in the number of new diagnoses in residents of other ethnicities (may be related to population migration), with rates rising from 5.1 cases in 2000 to 38.5 in 2002, and then fluctuating between 22.2 and 44.7 cases until 2010 before dropping back to 6.4 cases in 2011 and 2012.

**Table 1: New HIV diagnoses by ethnic group, residents of Dudley, 2000-2012**

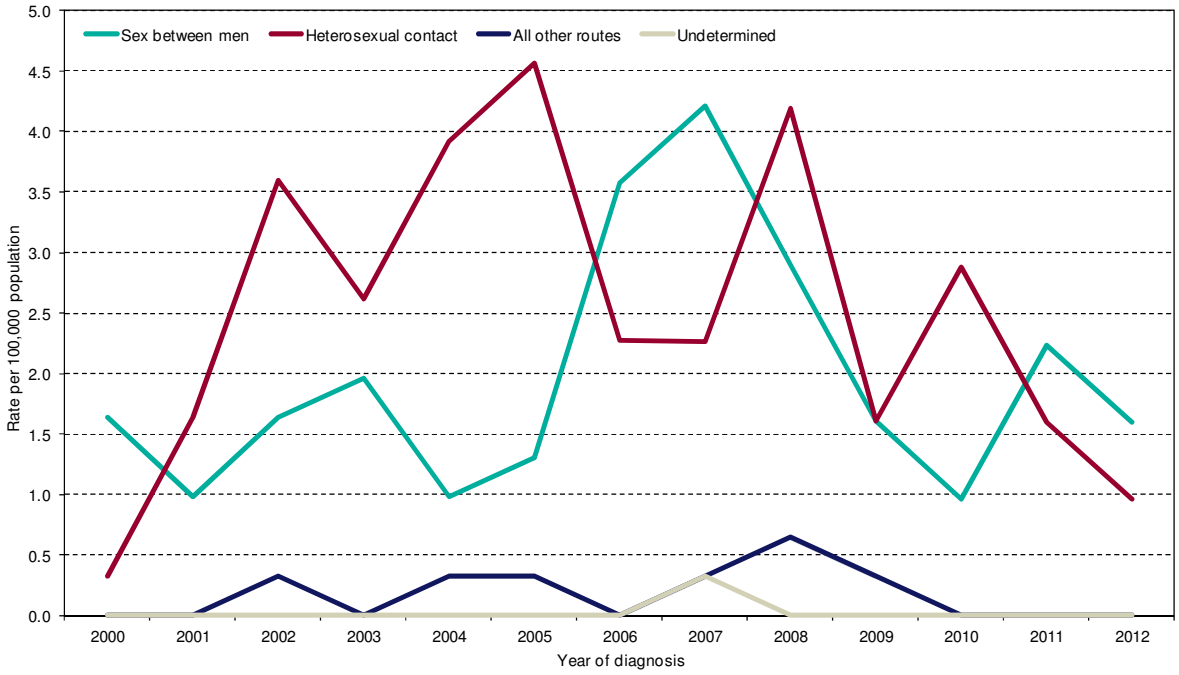
| Ethnic group | Number | Population | Percent |
|---|---|---|---|
| Black | 75 | 4671 | 1.61% |
| White | 100 | 281607 | 0.04% |
| Other | 12 | 26647 | 0.05% |

Source: Public Health England, HIV and AIDS New Diagnosis Database; Census 2011

Overall rates of new diagnoses in Dudley residents of black ethnicity remain disproportionately high (representing 1.6% percent of the population) compared to that for the white or other ethnic residents. This suggests that HIV prevention messages need to be improved for the wider population and specific services continue to be needed for the black ethnic group in Dudley.

## V. Probable route of transmission

**Figure 5: New HIV diagnosis rates per 100,000 population by probable exposure category, Residents of Dudley, 2000-2012**




Source: Public Health England, HIV and AIDS New Diagnosis Database; Office for National Statistics mid-year population estimates.

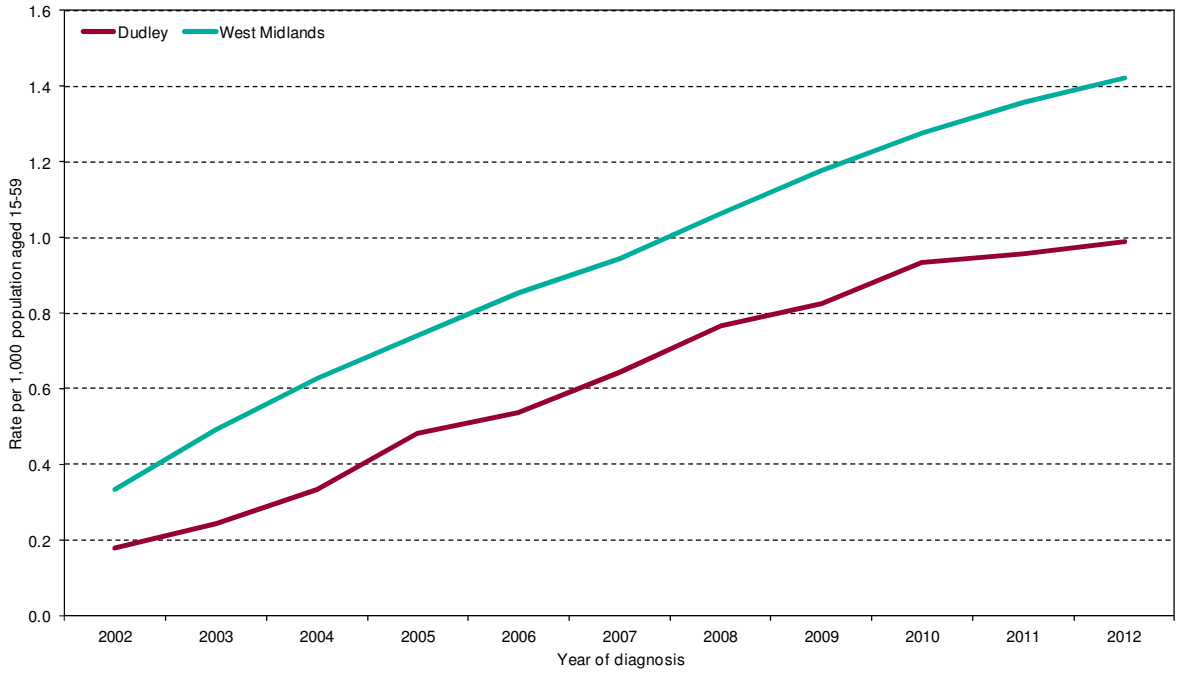
MSM remains the group most at risk of acquiring HIV infection since 2011 in Dudley, although rates have decreased from the 2007 peak.

People who acquired their infection through heterosexual contact were the second largest group of people newly diagnosed with HIV in 2012. This infection route has been generally exceeding the rates in MSM since 2001 until 2011. The estimated number of new diagnoses acquired via heterosexual contact has continued to fall from the peak seen in 2005 (4.6 cases) to 1.0 case in 2012. But the incidence rates were still three times higher than that seen in 2000 (0.3 cases).

New HIV diagnoses thought to have been acquired through other routes such as injecting drug, from blood or blood products or through mother to infant transmission remain low in Dudley.

## VI. HIV prevalence in Dudley

**Figure 6: Diagnosed HIV prevalence rate per 1,000 persons aged 15-59, Residents of Dudley and West Midlands, 2002-2012**

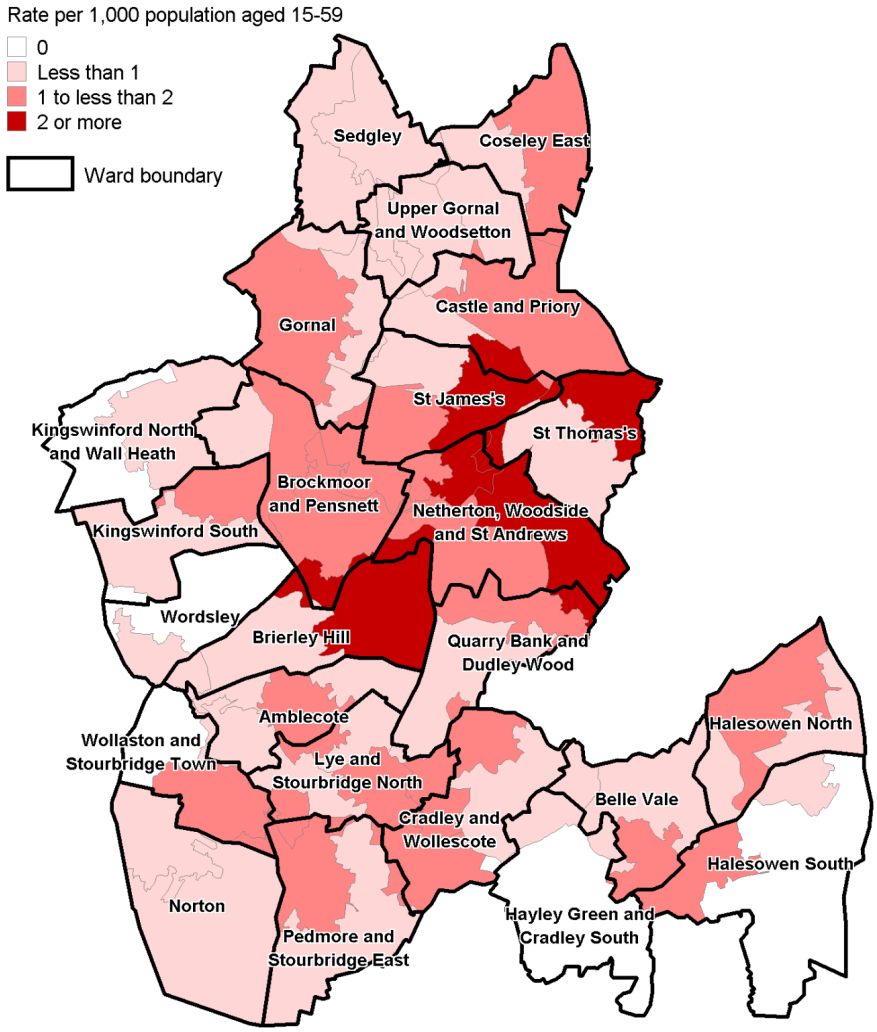



Source: Public Health England, Survey of Prevalent HIV Infections Diagnosed (SOPHID); Office for National Statistics mid-year population estimates.

Dudley has a diagnosed HIV prevalence rate lower than that in West Midlands, however it has been gradually increasing since 2002 (rose by 5.5 times from 0.18 cases in 2002 to 0.99 per 1,000 population aged 15-59 in 2012). The overall prevalence in the UK was estimated at 1.5 per 1000 across all ages in 2012.

## VII. Mapping across Dudley

**Figure 7: Prevalence of diagnosed HIV infection in 15-59 year olds by MSOA, Dudley, 2012**





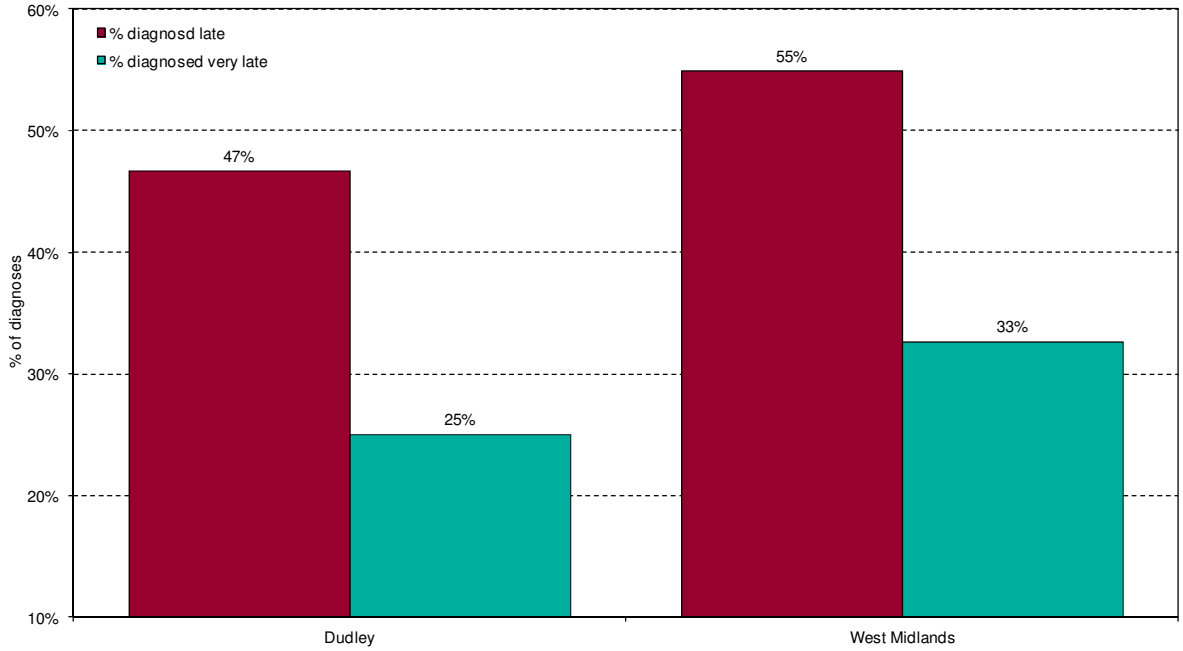

Note: includes Dudley residents aged 15-59 with diagnosed HIV who are accessing HIV related care.

Source: Public Health England – Survey of Prevalent HIV Infections Diagnosed (SOPHID); Office for National Statistics (ONS) mid-year population estimates.

Rates of HIV infection varied greatly across Census Wards in Dudley Borough in 2012. Four wards in central Dudley (St Thomas's, St James's, Brierley Hill and Netherton, Woodside & St Andrews) had a prevalence of diagnosed HIV of at least 2 per 1000 population aged 15-59 in 2012, the threshold at which expanded HIV testing (in medical admissions and primary care registrations) in adults is recommended.

## VIII. Late HIV diagnoses

**Figure 8: Percentage of HIV infections diagnosed late and very late (ages 15+), Residents of Dudley and West Midlands, 2008-2012**

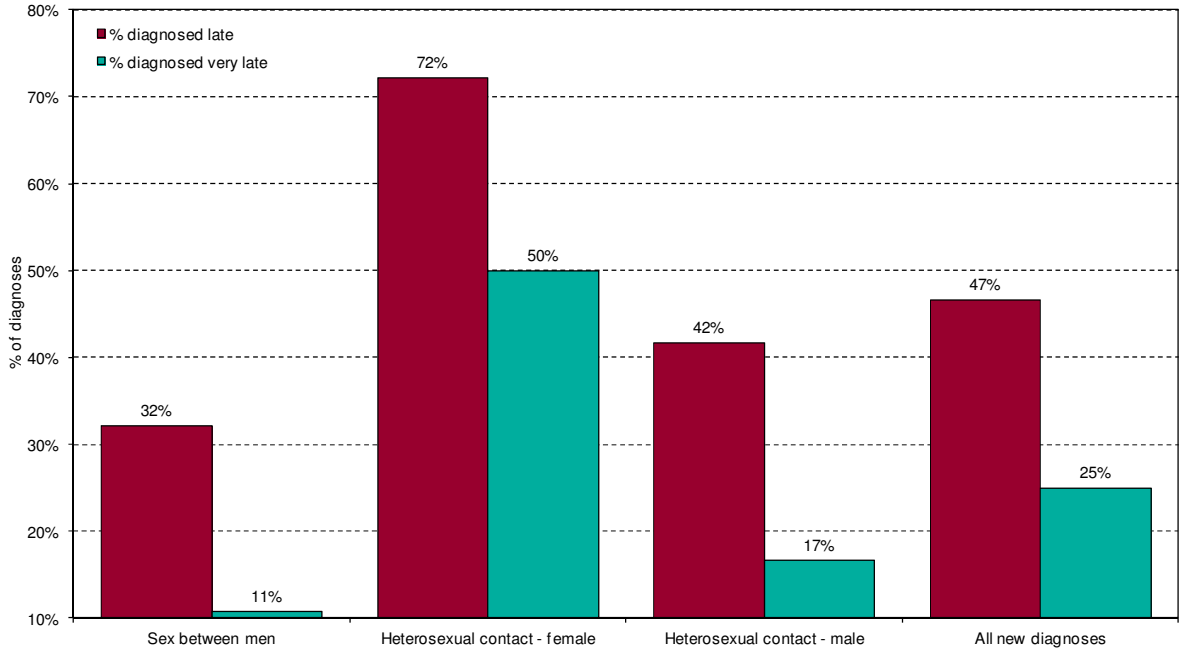



Late diagnosis defined as CD4 count <350 cells/mm$^3$ within 3 months of diagnosis; very late diagnosis defined as CD4 count <200 cells/mm$^3$ within 3 months of diagnosis.
Source: Public Health England, HIV and AIDS new Diagnosis Database.

The late diagnosis data for the last five years had been combined (n=60) as the figures in single years were very small.

Just under half of the new diagnoses reported in Dudley since 2008 had been diagnosed at a late stage of infection (i.e. with a CD4 cell count <350 cells/mm3 within 3 months of diagnosis) including one in four who were severely immunocompromised at diagnosis (i.e. CD4 cell count <200 cells/mm3). These figures were similar to those of national figures (47% diagnosed late, 28% severely immunocompromised) and slightly better than overall figures for the West Midlands for 2012 (55% diagnosed late, 33% severely immunocompromised).

**Figure 9: Percentage of HIV infections diagnosed late and very late by probable exposure category (ages 15+), Residents of Dudley, 2008-2012**




Late diagnosis defined as CD4 count <350 cells/mm$^3$ within 3 months of diagnosis; very late diagnosis defined as CD4 count <200 cells/mm$^3$ within 3 months of diagnosis.
Source: Public Health England, HIV and AIDS new Diagnosis Database.

Heterosexual cases were twice as likely to be diagnosed late (60%) than MSM (32%). A higher proportion of female heterosexuals were diagnosed late (72%) compared to male (42%).

## IX. Offer and uptake of HIV testing in GUM clinics in Dudley

**Table 2: Number of HIV tests offered in Russells Hall Hospital GUM clinic, 2013-2014**

| Attendance type | Population | Number offered HIV test | Proportion offered HIV test |
|---|---|---|---|
| First attendance | 6,500 | 5142 | 79% |
| Follow up | 1,882 | 450 | 24% |
| **Total** | **8,382** | **5592** | **67%** |

Source: 2013 - 2014 Genitourinary Medicine Clinic Activity Dataset (GUMCAD)

Nationally, the majority of HIV tests take place in GUM clinics. In total, 5592 HIV tests, i.e. 67% of individuals attending the service, were offered a HIV test in GUM clinics in Dudley in 2013-2014.

**Table 3: HIV test uptake and coverage by gender and male sexual orientation, Russells Hall Hospital GUM clinic, 2009-2012**

| Gender / sexual orientation | % HIV test uptake[1] | | | | % HIV test coverage[2] | | | |
|---|---|---|---|---|---|---|---|---|
| | 2009 | 2010 | 2011 | 2012 | 2009 | 2010 | 2011 | 2012 |
| All females | 80 | 75 | 80 | 78 | 70 | 66 | 67 | 69 |
| All males | 81 | 80 | 86 | 81 | 69 | 68 | 71 | 70 |
| *Males - heterosexual* | *80* | *80* | *85* | *80* | *69* | *69* | *70* | *69* |
| *Males - MSM* | *93* | *87* | *93* | *87* | *78* | *76* | *80* | *80* |
| **Total** | **80** | **77** | **83** | **79** | **69** | **67** | **69** | **69** |

Notes

[1]Of those eligible new GUM episodes (a visit to a GUM clinic and all subsequent GUM attendances in the following six weeks) in which a HIV test was offered, % uptake represents the proportion of tests accepted (i.e. number of HIV tests taken/number of HIV tests offered). A maximum of one test per eligible new GUM episode is included. Attendances by known HIV positive patients or where a HIV test was not appropriate are excluded.

[2]Of those eligible new GUM attendees (a patient attending a GUM clinic at least once during a calendar year), % coverage represents the proportion of tests taken (i.e. number of HIV tests taken/number of eligible new GUM attendees). A maximum of one test per eligible new GUM attendee is included. Patients known to be HIV positive or for whom a HIV test was not appropriate are excluded.

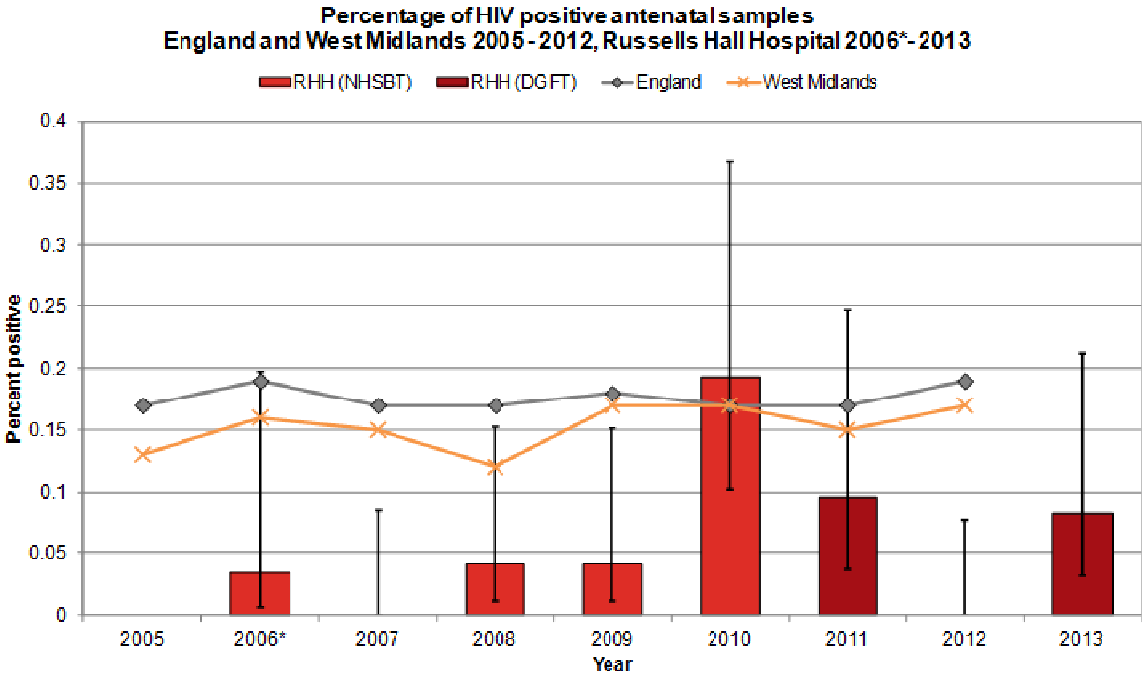
Source: Public Health England, Genitourinary Medicine Clinic Activity Dataset (GUMCAD)

In 2012, Uptake of HIV testing among GUM clinic attendees in Dudley, who were offered a test and were not previously diagnosed with HIV, was 79%.

There was an 87% uptake of HIV tests amongst MSM who attended Dudley GUM clinics in 2012. This was a 6% decline on the uptake reported for 2011 (93%). Amongst male heterosexuals attending Dudley GUM clinics, there was an 80% uptake of HIV tests. This was 5% lower than in 2011 (80%). There was higher uptake of HIV tests amongst MSM than heterosexuals in all years. The uptake of HIV test was higher amongst heterosexual males than females in all years.

## X. Antenatal testing in Dudley

**Figure 10**




Source: NHS Blood & Transplant tested Russells Hall Hospital's (RHH) samples from April 2006 to March 2011, testing transferred to Dudley Group Foundation trust (DGFT) from April 2011. *Only 3 quarters worth of data available in 2006 at RHH. Source for England and West Midlands data: PHE

**Table 4: Antenatal HIV screening, Russells Hall Hospital, 2012 & 2013**

| Indicator | 2012 | 2013 |
|---|---|---|
| Number screened | 4,820 | 4,849 |
| Number positive | <5 | <5 |
| % positive | <0.1% | <0.1% |

Source: Public Health England, National Antenatal Infections Screening Monitoring (NAISM)

According to data from the National Antenatal Infection Surveillance Monitoring (NAISM), >99% of women attending antenatal clinics in Dudley in 2013 took up the offer of an HIV test, the same proportion as seen in 2012. In 2013, <0.1% women screened in Dudley antenatal clinics tested positive for HIV. This proportion was very similar to the results reported for 2012. The national percentage of pregnant women who tested positive for HIV was 0.19% in 2012, which is higher than that in Dudley.

**Summary points:**

- The HIV prevalence has been gradually increasing in Dudley since 2002 (0.99 per 1,000 population aged 15-59 in 2012; England rate 1.89).

- There were 8 new HIV diagnoses made in Dudley clinics in 2012. Although there has been a steady decline in new diagnoses since 2008, probably due to changing patterns of migration, the number of new HIV diagnoses in 2012 was still approximately 25% higher than in 2000.

- New HIV diagnoses rates are disproportionally higher in male residents, in the 25-34 age groups and in BME residents in Dudley.

- The most common HIV infection route is through sex between men (MSM) followed by heterosexual sex.

- HIV prevalence has exceeded the threshold of >2/1000 population in four wards in central Dudley, the threshold at which HIV testing should be offered to all adults registering in general practice and all general medical admissions.

- Just under half (47%) of the new diagnoses reported in Dudley in 2012 were diagnosed at a late stage of infection (i.e. CD4 cell count <350 cells/mm3) with female heterosexuals being the group most at risk.

- Screening of all attendees at GUM clinics is recommended. Only 67% of attendees were offered a test in GUM clinics in Dudley in 2013-2014.

- In 2012, uptake of HIV testing among those offered a test was 79%.

- HIV testing uptake in antenatal screening remains very high.

- The percentage of pregnant women who were tested positive for HIV was <0.1% in 2012, trends comparable to recent years.

## 8. Mapping of current HIV prevention services in Dudley

Since April 2013, Local Authorities have been responsible for HIV prevention and sexual health promotion commissioning. This includes services locally commissioned from genitourinary medicine, contraception services, general practices, pharmacies and third sector organisations. Services for HIV treatment and care including sexual assault referral centres (SARCs), health services for prisoners or other services commissioned by either NHS England or Clinical Commissioning Groups (CCGs) are not within the scope of this mapping exercise.

This section provides a brief mapping of the current HIV prevention services in Dudley Borough. The mapping exercise took place between January and March 2014.

### Stakeholder Engagement

The office of public health (OPH) carried out a questionnaire survey to map the HIV prevention and support service provision in Dudley and to explore the views of key stakeholders on current HIV prevention services and future service development. Professional input was also sought through individual interviews, telephone conversations and meetings with professionals providing HIV prevention and support services. The exercise provided a snap shot to obtain qualitative information on perceived barriers or gaps in current services and how these could be improved.

### Methodology

The principal research tool used was a questionnaire (see appendix), which was designed and produced after thorough consultation with professionals from the OPH.
While designing the questionnaire, a major concern raised was the time it would take respondents to complete it. Therefore the length of the questionnaire was kept to essential minimum to avoid any impact on the extent to which respondents provided responses. The questionnaire was designed to ensure that an informed consent was obtained prior to completing it.
Questionnaires were distributed to different key stakeholders including GUM service, CASH service, GP surgeries, Pharmacies, Brook and Summit house via emails or by hand. Respondents were given the opportunity of completing and returning the questionnaire by post or email. Participation in the survey was entirely voluntary. Non respondents were sent reminder e-mails and their input was sought through individual interviews or telephone conversations.

### Service Maping

The HIV prevention, testing and support services currently available in Dudley are:

a) GUM clinic
b) Contraception services
c) Brook sexual health clinic
d) Summit house
e) General Practice
f) Pharmacies
g) Antenatal screening
h) Condom distribution scheme
i) Needle/syringe sharing programme

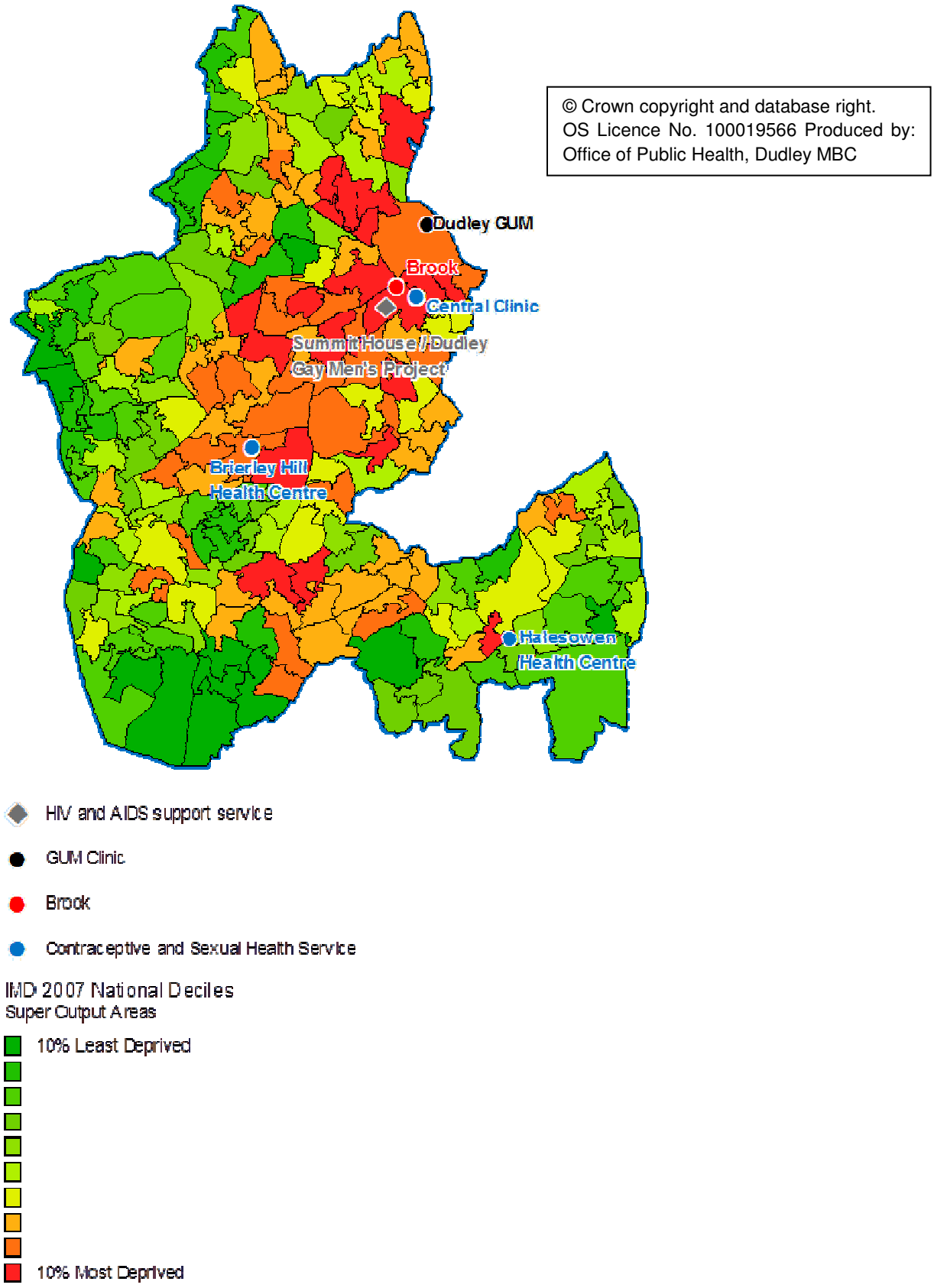



*Figure 1: Geographical position of specialist sexual health services within Dudley Borough that provide HIV prevention, testing and support services.*

**a) GUM Service**

**Location:** The Gum service in Dudley is based at Russell's Hall Hospital.

It provides a free, friendly and confidential integrated sexual health service, including confidential screening and treatment of HIV and advice on all aspects of sexual health. Specifically, GUM service provides following HIV support and prevention services:

- Free HIV testing, counselling and specialist treatment
- Contraception (up to level 3)
- STI testing & treatment (up to level 3)
- HIV Point Of Care Test (POCT)
- PEPSE (post exposure prophylaxis following sexual exposure)
- Referral to other HIV related services
- Communication with primary care provider
- Free condoms
- Antiretroviral (ARV) adherence clinic

**Clinic times:** The clinics run both a drop in as well as appointment session.

- Monday - 8.15am to 5.00pm
- Tuesday - 8.15am to 5.00pm
- Wednesday - 8.15am to 6.30pm
- Thursday - 8.15am to 5.00pm
- Friday - 8.15am to 4.30pm
- Saturday - 10.00am to 12.30pm (nurse-led drop in clinic)

**Skill Mix:**

- x 3 Consultants
- x 1.3 WTE associate specialists
- x 1 nurse in charge
- x 4 nurses band 6
- x 2 nurses band 5

**What HIV prevention, testing and support services are provided?**

| Service | Yes/No (√/×) | Details |
|---|---|---|
| **Condom provision** | √ | Free condoms, integrated service |
| **Screening of STIs** | √ | |
| **HIV serological testing** | √ | |
| **HIV POCT** | √ | |
| **PEPSE** | √ | |
| **Contact tracing** | √ | |
| **STI/HIV prevention leaflets** | √ | |

| | | |
|---|---|---|
| **Outreach support** | √ | HIV outreach testing |
| **HIV counselling** | √ | |
| **HIV support** | √ | Provided by nurses, health advise, triage and support with treatment compliance |
| **Disabled access** | √ | |
| **Interpreting service** | √ | |
| **Referrals to GPs or other HIV support services were appropriate** | √ | Summit house, GP, contraception service |
| **Other: Specialist treatment for people with HIV/AIDS** | √ | |

**b) Contraception Services**

The contraception service including provision of free condoms is provided in several community health and social care centres in Dudley by the Dudley Group. The clinics run both a drop in as well as appointment session. The contraception service offers a range of contraception methods including barrier methods and advice to HIV positive individuals.

**Clinics Location and times:**

**Brierley Hill Health & Social Care Centre**

- Tuesday – 10am to 5.30pm
- Wednesday – 10am to 5.30pm
- Thursday – 9am to 8.30pm
- Friday – 9am to 5.00pm

**Dudley Central Clinic**

- Monday – 1.30pm to 8.00pm
- Thursday – 1.30pm to 3.00pm

**Halesowen Health Centre**

- Wednesday – 5pm to 8.30pm

**What HIV prevention, testing and support services are provided?**

| Service | Yes/No (√/×) | Details |
|---|---|---|
| **Condom provision** | √ | Free condoms |
| **Screening of STIs** | √ | Chlamydia testing through the national screening programme |
| **HIV serological testing** | × | |
| **HIV POCT** | √ | providing test since august 2014 |
| **PEPSE** | × | |
| **Contact tracing** | × | |
| **STI/HIV prevention** | √ | |

| | | |
|---|---|---|
| **leaflets** | | |
| **Outreach support** | √ | |
| **HIV counselling** | √ | |
| **HIV support** | × | |
| **Disabled access** | √ | |
| **Interpreting service** | √ | Language line |
| **Referrals to other sexual health clinic or other services were appropriate** | √ | GUM, GP |
| **Other: Contraception including LARCs, EC** | √ | |

**CASH stakeholder engagement:**

It was reported that the service provided both written and verbal information on HIV on request and on display.

The clients were routinely assessed for HIV risk and asked about their HIV status. High risk clients with no recent HIV testing were sign-posted to GUM service. The service had clear referral pathways to HIV care providers for customers who requested an HIV test or at risk of contracting HIV infection.

The team felt confident in their ability to offer or recommend an HIV test to high risk clients. The team had access to regional teaching sessions, which were held every Wednesday, as well as to BHIVA and BASHH guidelines. Team members also kept updated by attending BASHH Conferences and regular update meetings. Team had also attended a training session for the point of care test, provided by trainers from Summit house.

The service was willing to provide a venous HIV blood test and other HIV prevention services, if suitably staffed, appropriately funded and properly trained. It was commented that time restrains, lack of funding and staff were the key barriers in embedding or establishing effective HIV testing and HIV prevention actions in CASH service.

The following suggestions were provided to improve HIV prevention and testing services or interventions in CASH service in Dudley:

*"More awareness campaigns for the public to break the barriers associated with the label and fear of being HIV positive"*
*"Outreach work to help vulnerable and ethnic minority patients overcome the potential barriers, which may restrict them from requesting the test"*
*"Dudley-wide multi-agency care model and greater partnership working"*
*"Staff training related to HIV related issues including breaking news on HIV infection"*
*"A dedicated HCA who can carry out HIV POCT and other HIV prevention actions"*
*"A dedicated HIV clinical nurse specialist in Dudley"*

**c) Brook Advisory Centre, Dudley**

Brook provides free and confidential advice and support on a wide range of sexual health related issues to young people under the age of 25. The service offers a walk in facility as well as an appointments schedule.

**Clinics Location and times:** The service is located at 31 Priory Street.

- Monday: 10:00am - 2:45pm
- Tuesday: 6:00pm - 8:45pm
- Wednesday: Closed
- Thursday: Closed
- Friday: 12:00pm - 5:00pm
- Saturday: 1:30pm - 4:15pm
- Sunday: Closed

**What HIV prevention, testing and support services are provided?**

| Service | Yes/No (√/×) | Details |
|---|---|---|
| **Condom provision** | √ | Free condoms |
| **Screening of STIs** | √ | Chlamydia testing through the national screening programme |
| **HIV serological testing** | × | |
| **HIV POCT** | × | |
| **PEPSE** | × | |
| **Contact tracing** | × | |
| **STI/HIV prevention leaflets** | √ | |
| **Outreach support** | √ | Clinics at outreach locations and domiciliary visits |
| **HIV counselling** | √ | |
| **HIV support** | × | |
| **Disabled access** | √ | |
| **Interpreting service** | × | |
| **Referrals to other sexual health clinic or other services were appropriate** | √ | GUM, GP, contraception service |
| **Other: Contraception including LARCs, EC** | √ | |

**Brook Stakeholder engagement:**

It was reported that the Brook service provided both written and verbal information on HIV on request and on display.

The clients were routinely assessed for HIV risk and high risk clients were sign-posted to GUM service. The service had clear referral pathways to HIV care providers. It was felt that access to

teaching sessions and guidelines related to HIV infection would be useful to gain confidence. It was reflected that the availability of condoms and the promotion of their consistent use was the key for HIV prevention. It was commented that a lack of communication between HIV service providers and Brook, time restrains, lack of funding and staff were the key barriers in embedding or establishing effective HIV testing and HIV prevention actions in Brook service.

**d) Summit house**

Summit House is a charity providing free support to people living with and affected by HIV in Dudley and Sandwell with an aim to help these people live a healthy life. They also support carers and families of HIV positive people and run training courses for them. They offer advice and support including housing, benefits, counselling, social activities and aromatherapy to HIV+ people. They also provide HIV/AIDS awareness training to local statutory and voluntary sector agencies.

Individuals can be referred from the GUM clinic or another agency, or can contact them directly by phone or e-mail to make an appointment to see one of their workers. They run peer support groups for Gay Men's, Women only group, Mixed Gender group and Positivity group.

**Clinics Location and times:** The service is located at Holloway House, Martin Hill Street, DY2 8RT.

- Tuesday Drop In 11am - 4pm, 1 to 1 appointments available
- 3rd Tuesday each month Women`s Group 1-3pm
- 4th Tuesday each month Adherence Group 1-3pm
- Every Thursday Drop In 12pm -5pm
- 2nd & 4th Saturdays each month Gay Men`s Group 11am - 2pm
- HIV POCT testing available on site by appointment

**What HIV prevention, testing and support services are provided?**

| Service | Yes/No (√/×) | Details |
|---|---|---|
| **Condom provision** | √ | Free condoms |
| **Screening of STIs** | × | |
| **HIV serological testing** | × | |
| **HIV POCT** | √ | available on site by appointment |
| **PEPSE** | × | |
| **Contact tracing** | × | |
| **STI/HIV prevention leaflets** | √ | |
| **Outreach support** | √ | |
| **HIV counselling** | √ | |
| **HIV support** | √ | |
| **Disabled access** | √ | |
| **Interpreting service** | √ | |
| **Referrals to other sexual health clinic or other services were appropriate** | √ | GUM, GP, contraception service, fertility service |
| **Other: support to** | √ | |

| | | |
|---|---|---|
| **carers of HIV+ people** | | |

**Summit House stakeholder engagement:**

Professional input was sought through individual meetings with Summit house professionals directly supporting people living with HIV.

Summit house staff reported that people with HIV needed and benefited greatly from counselling, 'one to one' behavioural interventions as well as practical support including benefits, housing and financial management. Staff reflected that support groups and social gatherings where this client group and their carers could share and talk about emotional things and everyday living in general were important in securing positive outcomes for clients.

Staff acknowledged good working relationships and felt well supported by the office of public health. Staff reported that overall satisfaction levels of people accessing the service were high; however, it was felt that additional resources would enhance and extend the services which could be offered to this client group and their carers. Staff believed that they had identified a growing need for emotional and practical support for people who are infected or affected by HIV.

Staff believed that it would be advantageous if there was a closer link between GUM services and summit house. It was felt that communication between GUM services and the local voluntary organisations was the key to the process of continuous care and support for people with HIV. A need for a co-ordinated referral pathway was noted. Regular Multi-Agency meetings were welcomed and valued. Thinking about service development, ongoing support for rapid HIV testing in the service was proposed. It was proposed that the team could provide HIV/AIDS awareness and HIV rapid testing training to local statutory and voluntary sector agencies with additional resources.

**e) Community pharmacies**

To map HIV prevention and sexual health promotion service provision in pharmacies, a questionnaire survey was sent to all pharmacies in Dudley. In total 30 pharmacies in Dudley completed the questionnaire.

**Key findings**

- Only 9 responding pharmacies (30%) provided written information on HIV. The map below (figure 2) shows the geographical position of both responding and non-responding pharmacies by postcode district and whether or not they provide written information on HIV. It illustrates that very few pharmacies provide written information in areas of central Dudley where HIV prevalence has exceeded the threshold of >2/1000 population.

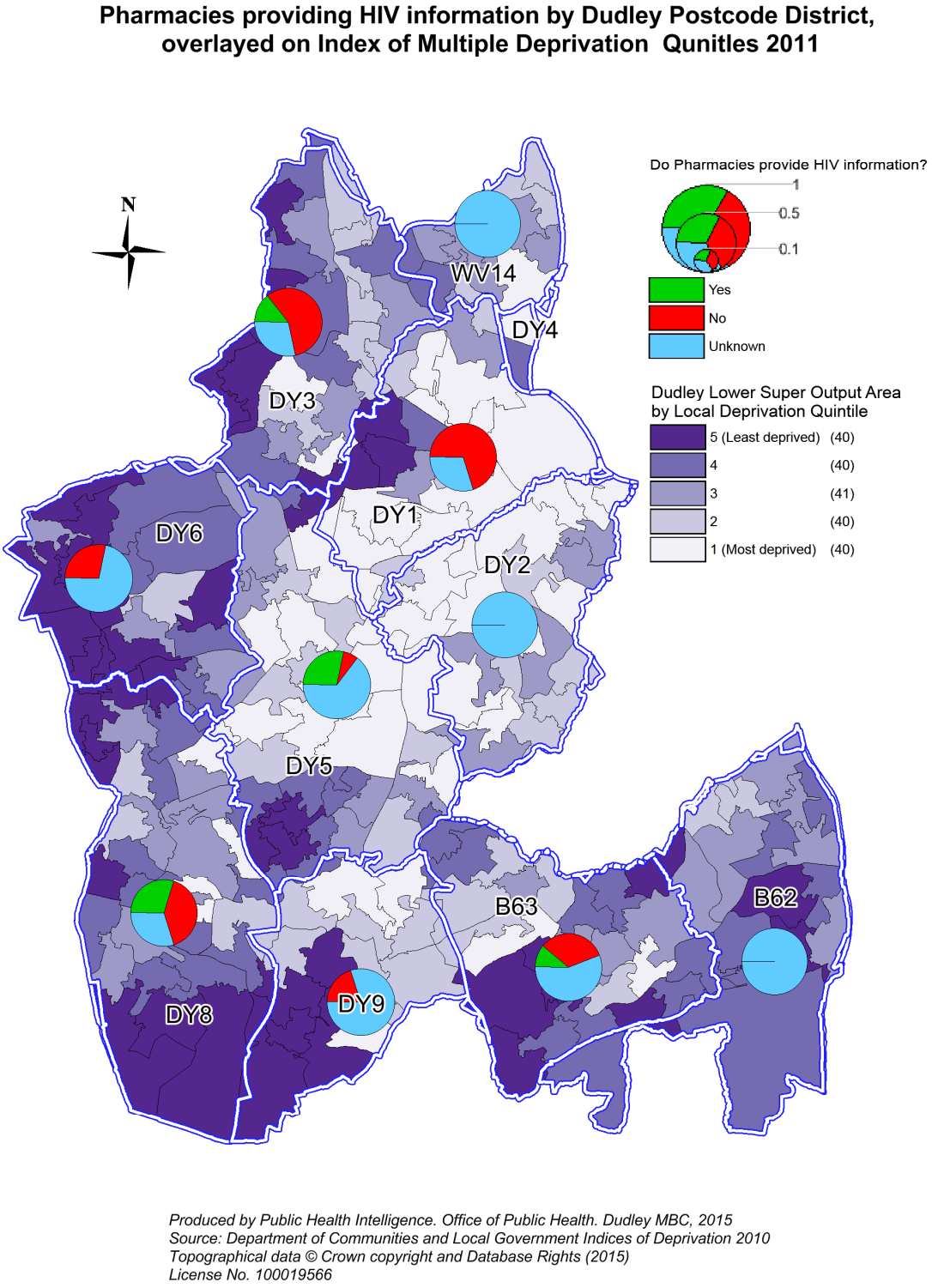
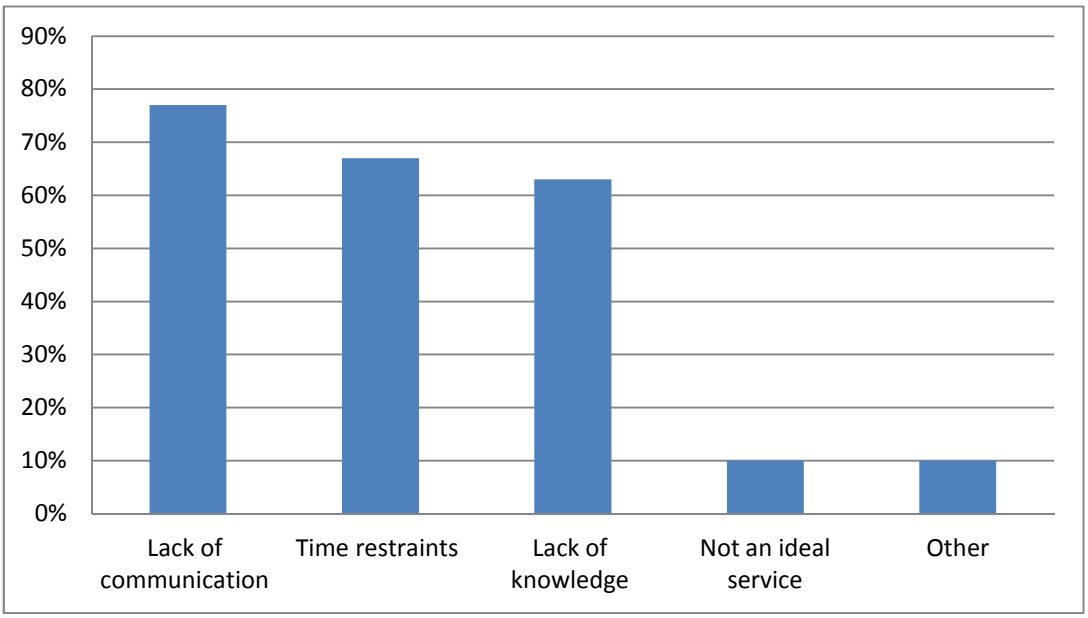



*Figure 2: Geographical position of both responding and non-responding pharmacies and whether or not they provide written information on HIV within Dudley Borough.*

- 7 of 9 (78%) pharmacies who provide written information commented that the information was available on display and the rest provided on request. Only one pharmacy provided family planning association (FPA) HIV booklet.
- Five pharmacies commented that they provided verbal, not written, information on HIV on request.
- To the questions “How does your organisation currently contribute to HIV prevention actions”, 12 (40%) of 30 responding pharmacies commented that they provided written or verbal information on HIV, 2 (7%) provided free condoms and safe sex advice, and one provided needle exchange service. Rest of the responding pharmacies (50%) commented that they provided no contribution to HIV prevention actions.
- None of the responding pharmacies provided HIV finger prick test or any HIV risk assessment.
- Only 2 of 30 (7%) pharmacies had clear referral pathways to refer clients to HIV care providers for customers who requested an HIV test or at risk of contracting HIV infection.
- 20 of 30 (67%) pharmacies commented that they or their team members did not feel confident in their ability to offer or recommend an HIV test to high risk clients.
- All except one (97%) felt that access to teaching sessions related to HIV infection and guidelines would be useful to gain confidence and to raise awareness among staff.
- All except one (97%) commented that their organisation would be willing to provide HIV risk assessment, appropriate HIV related information and referral to HIV services, if appropriate funding and training for staff was available.
- 24 of 30 (80%) pharmacies commented that their organisation would be willing to provide an HIV finger prick test to high risk clients, if funded appropriately and staff was appropriately trained. None of the responding pharmacies were willing to offer an HIV venous blood test. We can add a map.
- A large proportion of respondents commented a lack of communication between pharmacies and HIV service providers or GP, time restrains and lack of knowledge of HIV infection were the key barriers in embedding or establishing effective HIV prevention and HIV testing services in pharmacies. Few (10%) felt that pharmacies were not an ideal service to provide HIV prevention or testing services. Other barriers included fear of disease, staff misconceptions about HIV, embarrassment of people enquiring about service, and stigma attached with the condition.

*Figure 3: Key barriers in embedding or establishing effective HIV prevention and HIV testing services in pharmacies*




- The following were the suggestions provided to improve HIV prevention and testing services or interventions in community pharmacies in Dudley by the respondents:

*•Increasing HIV awareness by campaigns and advertising (posters/leaflets)*
*•Condom use should be promoted*
*• More publicity via media to encourage people to visit pharmacies for free condoms/clean needles*
*•Be able to refer clients to the appropriate services when required; signposting and improved link to sexual health*
*•With training and support, pharmacies can supplement delivery of HIV treatment – anti-retroviral drug therapy support in community setting. This will improve convenience and can monitor compliance.*
*•Pharmacies come across substance misuse clients and already offer services such as needle exchange which can be one of the risk factors for HIV infection. Pharmacies should be further engaged to deliver preventative measures targeting this group of clients.*
*•Going to high schools and colleges to talk about HIV to teenagers and to give them free condoms*
*•Discrete written information or signposting available so that people do not have to ask about it*
*•Free condoms from all pharmacies*
*•Better training for pharmacists to allay fears of staff engagement in service*
*•Patient education about the availability of testing and efforts to reduce the associated stigma*

**f) General Practice**

A report, published by the former Health Protection Agency (HPA) in 2011, assessing the feasibility and acceptability of HIV testing in community based settings demonstrated that the routine offer of an HIV test in primary care settings was feasible and acceptable to both staff and patients.

In a study to identify opportunities for earlier HIV diagnosis within primary and secondary care settings in the UK in Africans with newly diagnosed HIV infection, it was evident that 76.4% (out of 263 participants) had seen their GP in the year before diagnosis.[1]

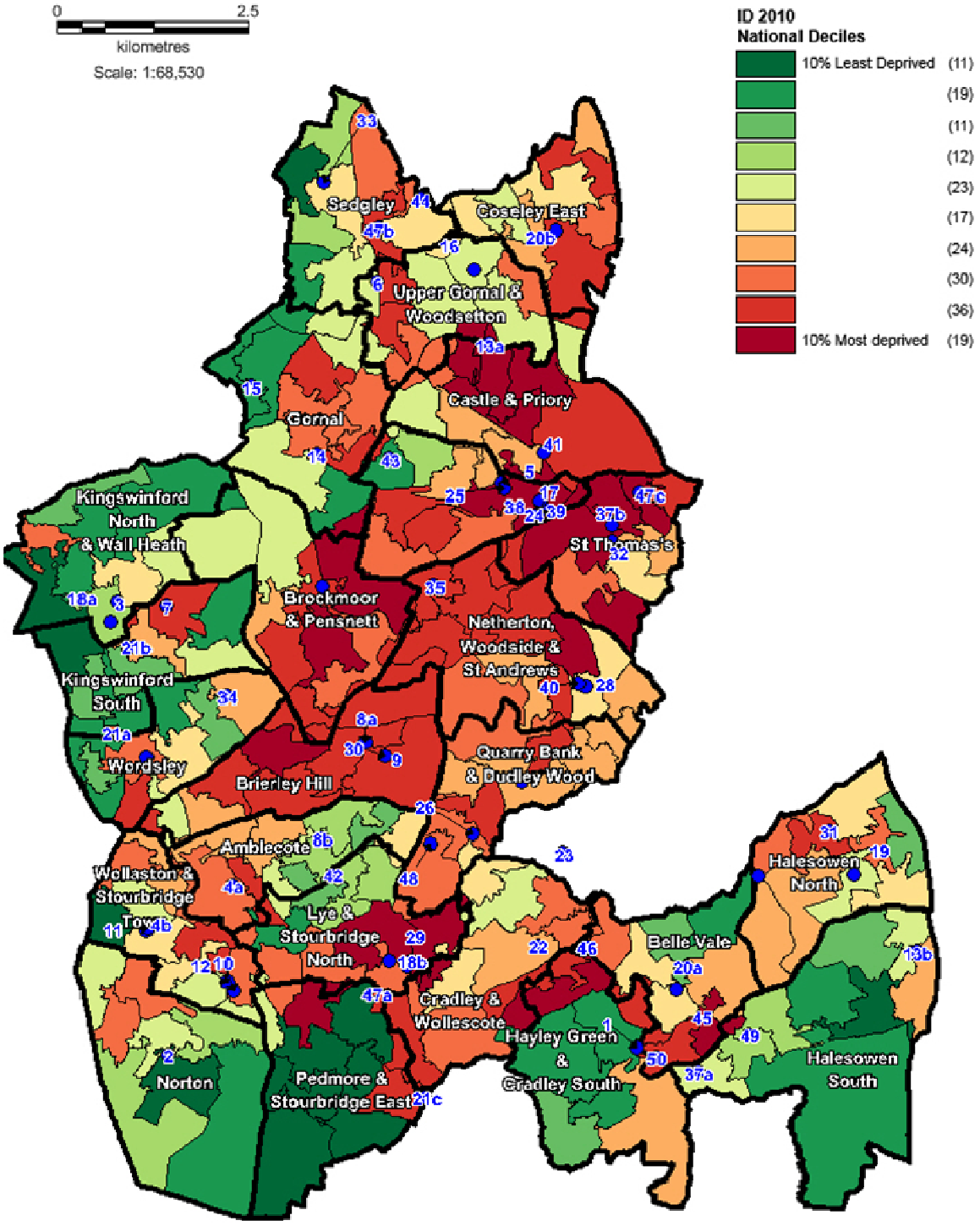
The Public Health England 2012 report recommended that HIV testing by general practitioners should be widely promoted. It also reported that estimated annual cost of expanding testing into general practices nationally in areas of high prevalence with coverage of 75% would be £1.3 million and the cost for an average high prevalence former PCT would be £19,000 per 100,000 population.

To map HIV prevention and sexual health promotion service provision in GP surgeries, a questionnaire survey was sent to all GP surgeries in Dudley. In total 8 GP surgeries in Dudley completed the questionnaire. The response rate was poor, despite reminder e-mails and phone calls.

**Key findings**

- Only 4 responding GP surgeries (50%) provided written information on HIV. Of these, only 2 surgeries had the information on display.
- All GP surgeries commented that they provided written or verbal information on HIV on request.
- To the questions “How does your organisation currently contribute to HIV prevention actions”, 5 (62%) respondents commented that they provided written or verbal information on HIV and 3 (28%) provided HIV risk assessment and referral to HIV services.
- None of the responding GP surgeries provided HIV finger prick test.
- Only 1 GP surgeries routinely offered HIV testing to high risk patients; whereas rest commented that they did not routinely offer test for HIV to at risk groups.
- Five (62%) GP surgeries had clear referral pathways to HIV care providers for customers who requested an HIV test or at risk of contracting HIV infection. Rest of the respondents were not sure about those pathways.
- 2 of 8(25%) GP surgeries commented that they or their team members did not feel confident in their ability to offer or recommend an HIV test to high risk clients.
- All except one felt that access to teaching sessions related to HIV infection would be useful to gain confidence and to raise awareness among staff.
- Six (75%) GP surgeries commented that their organisation would be willing to provide an HIV finger prick test to high risk clients and other HIV prevention services, if suitably staffed, appropriately funded and properly trained. Only one of the responding GP surgeries was willing to offer an HIV venous blood test.
- Majority of respondents commented that a lack of communication between HIV service providers and GPs, time restrains and lack of knowledge of HIV infection were the key barriers in embedding or establishing effective HIV prevention and HIV testing services in GP surgeries.

*Figure 4: Location of GP surgeries within Dudley Borough overlayed on IMD Qunitles 2010*




Map created by Public Health Intelligence, Dudley MBC. Topographic data © Crown Copyright and database rights (2014) Ordnance Survey 100019566

*See appendix 5 for practice code on the map.*

**g) Condom distribution scheme (C Card)**

The C Card scheme is a coordinated approach to free condom distribution through a variety of settings such as youth centres and colleges for young people under the age of 25 years via a smart card. In addition the registered card holder can access free sexual health advice, condoms, Chlamydia testing and pregnancy testing. The smart card is used to monitor the access to the service.

There were 1038 new registrations for a C Card in 2013-2014, although not all these would be currently accessing the scheme. The tables below illustrate the activity relating to the C-Card scheme by gender and age between April and December 2013. Young men and individuals between 15 and 17 years of age are more likely to use the scheme.

*Table1: Dudley C-Card Scheme Visits by month and Gender 2013*

| Month | Female | | Male | | Total |
|---|---|---|---|---|---|
| | Number | % | Number | % | Number |
| April | 61 | 30.7 | 138 | 69.3 | 199 |
| May | 64 | 40.5 | 94 | 59.5 | 158 |
| June | 28 | 32.6 | 58 | 67.4 | 86 |
| July | 54 | 39.4 | 83 | 60.6 | 137 |
| August | 33 | 37.5 | 55 | 62.5 | 88 |
| September | 69 | 48.6 | 73 | 51.4 | 142 |
| October | 54 | 32.5 | 112 | 67.5 | 166 |
| November | 69 | 38.3 | 111 | 61.7 | 180 |
| December | 89 | 43.2 | 117 | 56.8 | 206 |
| **Total** | **521** | **38.3** | **841** | **61.7** | **1362** |

*Source: Dudley C-Card Scheme. Office of Public Health, Dudley MBC.*

*Table2: Dudley C-Card Scheme Visits by Age and Quarter 2013*

| Age | Q1 | Q2 | Q3 | Total | % of Total |
|---|---|---|---|---|---|
| Under 14 | 34 | 19 | 20 | 73 | 5.4 |
| 14 | 55 | 28 | 39 | 122 | 9.0 |
| 15 | 100 | 107 | 52 | 259 | 19.0 |
| 16 | 84 | 69 | 153 | 306 | 22.5 |
| 17 | 64 | 72 | 168 | 304 | 22.3 |
| 18 | 46 | 35 | 65 | 146 | 10.7 |
| 19 | 20 | 13 | 19 | 52 | 3.8 |
| 20 | 14 | 7 | 13 | 34 | 2.5 |
| 21 | 7 | 6 | 6 | 19 | 1.4 |
| 22 | 7 | 2 | 6 | 15 | 1.1 |
| 23 | 5 | 3 | 4 | 12 | 0.9 |
| Over 23 | 7 | 6 | 7 | 20 | 1.5 |
| **Total** | **443** | **367** | **552** | **1362** | **100.0** |

*Source: Dudley C-Card Scheme. Office of Public Health, Dudley MBC.*

[1] Burns FM et al., Missed opportunities for earlier HIV diagnosis within primary and secondary healthcare settings in the UK. AIDS, Jan 2008, vol./is. 22/1(115-22), 0269-9370;1473-5571

**Summary:**

- There is a need for improved communication and collaborative work between GUM service and local primary care health services or third-sector agencies that provide HIV prevention and support services
- There is a need for a multi-disciplinary models of HIV prevention and care where GUM service, local primary care health services or third-sector agencies are working together using multi-agency referral pathway to establish effective HIV prevention and support actions
- There is a need for integrating HIV prevention programmes into wider sexual health services
- There is a need to involve GPs in HIV prevention programmes including provision of rapid HIV testing
- Expanding and normalising HIV testing is a key measure to increase uptake of testing and prevent HIV
- Public education about HIV is important and there is a need for targeted HIV awareness and prevention campaigns aimed at the communities most at risk of HIV
- HIV testing needs to be introduced in a variety of community and primary care settings
- Behavioural interventions can add value to clinical interventions and support the individual, especially when working with individuals with multiple risk factors, for example gay men with alcohol and substance misuse problems
- The availability of condoms and the promotion of their consistent use was seen as a key HIV prevention intervention
- Lack of funding, lack of specific commissioned activity for prevention, capacity issues, staff training and skills were often quoted as key barriers to HIV prevention work being incorporated into various organisations
- There is a need to invest in training health professionals including pharmacists, GPs and those who have an important role in educating local population about HIV and delivering HIV prevention actions

## 9. Finding the needs of local population: What communities said?

The office of public health (OPH) carried out a questionnaire survey to explore the knowledge of various local community members about HIV infection, their experiences of using current HIV prevention services and their views on future service development. In addition, a focus group session was organised with local people living with HIV (PLWH) to obtain qualitative information on perceived gaps in current services and how these could be improved. The exercise provided a snap shot to illustrate some of the experiences of a range of people living in Dudley Borough.

### Methodology

The public consultation took place between January and March 2014. The principal research tool used was a questionnaire (see appendix), which was developed in through consultation with professionals from the OPH, key stakeholders and relevant Third Sector organisations in Dudley who had previously carried out qualitative research among various local community groups including ethnic minority groups.

While designing the questionnaire, a major concern raised was the time it would take respondents to complete it. Therefore the length of the questionnaire was kept to essential minimum to avoid any impact on the extent to which respondents provided responses. The questionnaire was designed to ensure that an informed consent was obtained prior to completing it. The design also guaranteed the anonymity of participants and maintained strict confidentiality. The questionnaire did not contain any personal information through which an individual might possibly be identified.

Separate information was given to respondents explaining the purpose of the questionnaire. They were given assurance about confidentiality.

Questionnaires were distributed to different members of local community by key stakeholders and relevant Third Sector organisations in Dudley including Summit house, Centre for Equality & Diversity (CfED), Brook, Age UK and Aquarius. Questionnaires were also made available online. Individuals were approached directly, via email, through phone calls, at drop in sessions from staff and volunteers in Dudley. Respondents were given the opportunity of completing and returning the questionnaire independently, by post or email, or with support either in groups or in one to one sessions.

Individuals who were HIV positive and their cares who were attending Summit house, a local organization that provides support to people living with and affected by HIV and AIDS in Dudley, were invited to put themselves forward for inclusion in a focus group. The purpose was to gain better understanding on perceived service gaps and the potential for future development from individuals who had a good knowledge of current local HIV services.

**Profile**

In total 59 individuals in Dudley completed the questionnaire. Of these, 54% (n=31) were male and 46% (n=26) female. The age of the respondents ranged between 18 and 65 years old, with 46% (n=27) being in the 25-44 age group. Approximately one third of the respondents were homosexual (Table 1). The percentage of black and minority ethnic (BME) respondents were at 31% (Table 2).

*Table 1 Profile of the needs assessment population*

| ***Age*** | **Number of responses (%)** |
|---|---|
| 18-24 | 6 (10%) |
| 25-44 | 27 (45%) |
| 45-65 | 26 (44%) |
| | |
| ***Gender*** | |
| Male | 31 (54%) |
| Female | 26 (46%) |
| | |
| ***Sexuality*** | |
| Heterosexual | 31 (67%) |
| Gay/Lesbian | 14 (31%) |
| Bisexual | 1 (2%) |
| | |
| **Known HIV status** | |
| Yes | 39 (71%) |
| No | 16 (29%) |

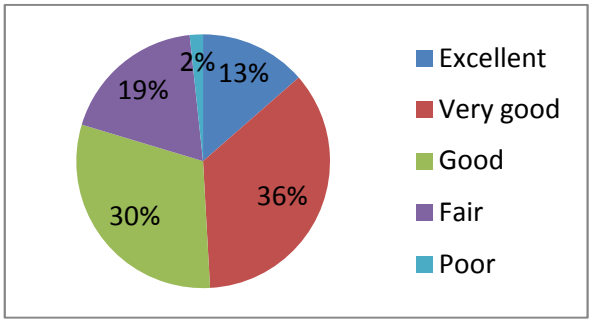
*Table 2 Ethnicity of needs assessment population*

| ***Ethnicity*** | **Number of responses (%)** |
|---|---|
| White-British | 37 (64%) |
| Mixed-white and Black Caribbean | 2 (3%) |
| Mixed-White and Asian | 1 (2%) |
| Mixed-Other | 2 (3%) |
| Asian or Asian British-Indian | 1 (2%) |
| Any other Asian Background | 4 (7%) |
| Black or Black British-Caribbean | 2 (3%) |
| Black or Black British-African | 9 (16%) |

**Key findings**

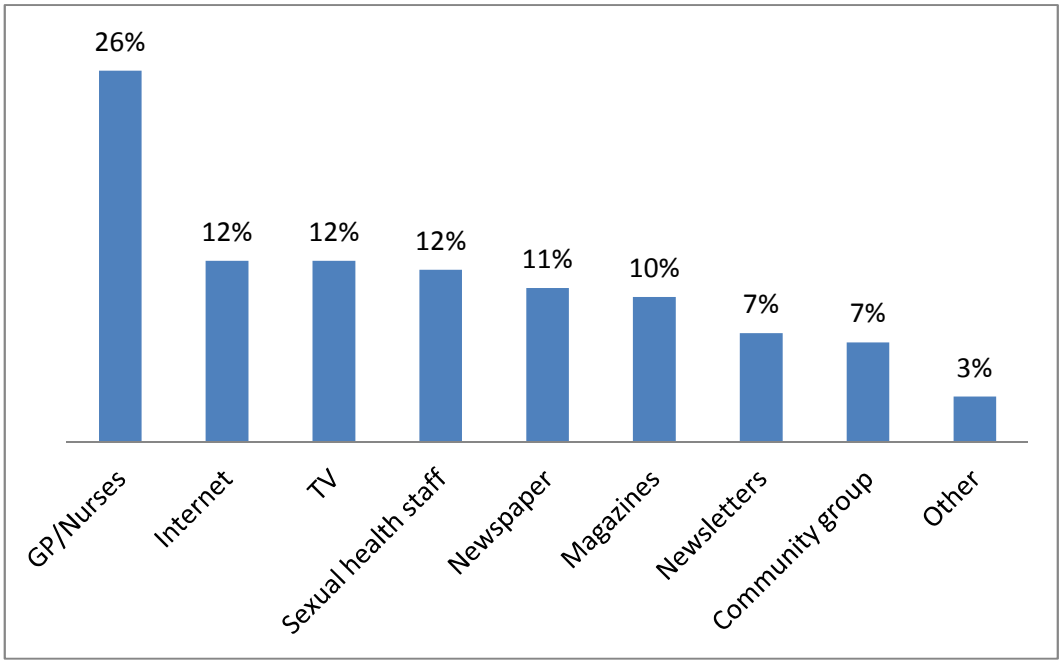
**HIV knowledge and testing**

**Figure 1: How would you rate your knowledge about how HIV infection is passed on?**




Just over two-third (79%) of participants in the survey had a good to excellent awareness of ways of HIV transmission but fewer felt that they had inadequate knowledge of the major routes of HIV transmission.

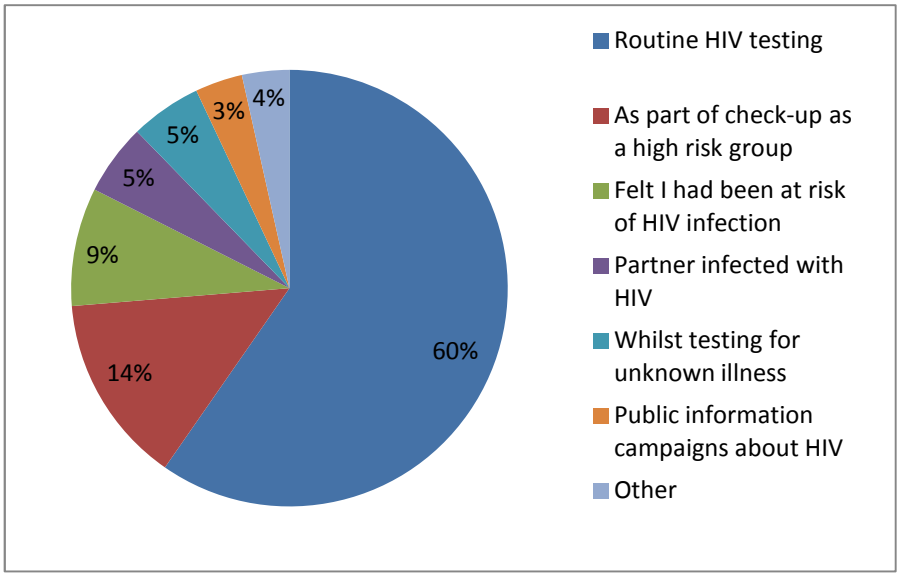
**Figure 2: How do you best like to receive information about HIV?**




*Sources of HIV information: Percentages were calculated using the number of actual responses to the question. Some respondents selected more than one option.*

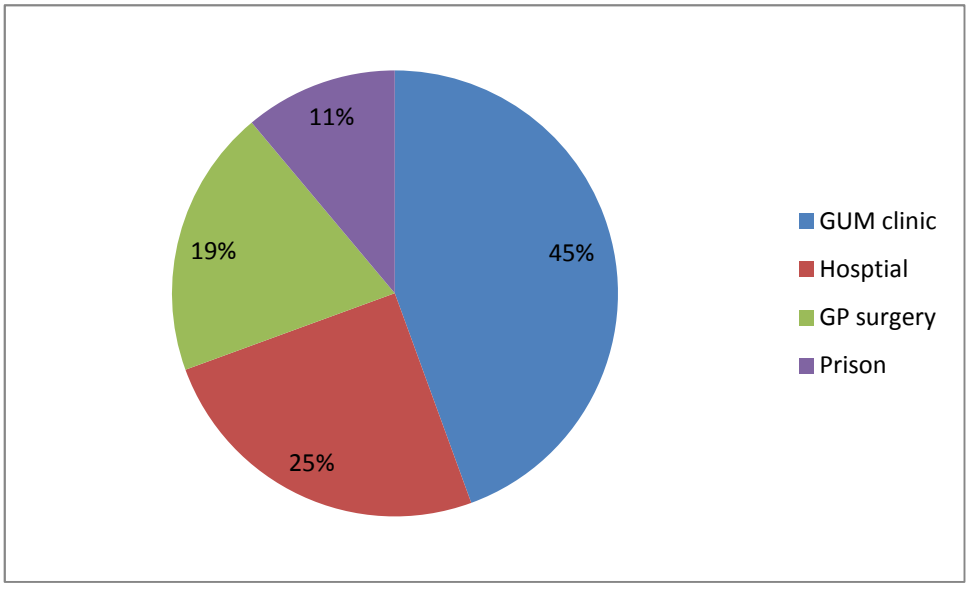
One in four respondents selected GP or nurses as their 1st choice to get HIV related information. Internet, television and sexual health staff were the next preferred sources of information, followed by brochures and newsletters.

**Figure 3: Reason for HIV testing in the past?**



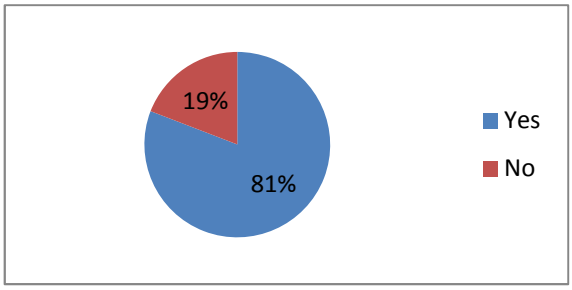

Just under two third (64%) of the respondent reported that they had received HIV testing in the past. Among these, almost one third stated that they were tested for HIV as part of routine care in antenatal clinics or sexually transmitted infection (STI) clinics or due to blood donation. Nine percent received testing as they perceived themselves to be at risk of HIV. Only a minority of respondents (4%) opted to be tested following public information campaigns about HIV. The "other" reason given for receiving HIV testing was due to "visa requirement".

**Figure 4: Where did you have your last HIV test?**



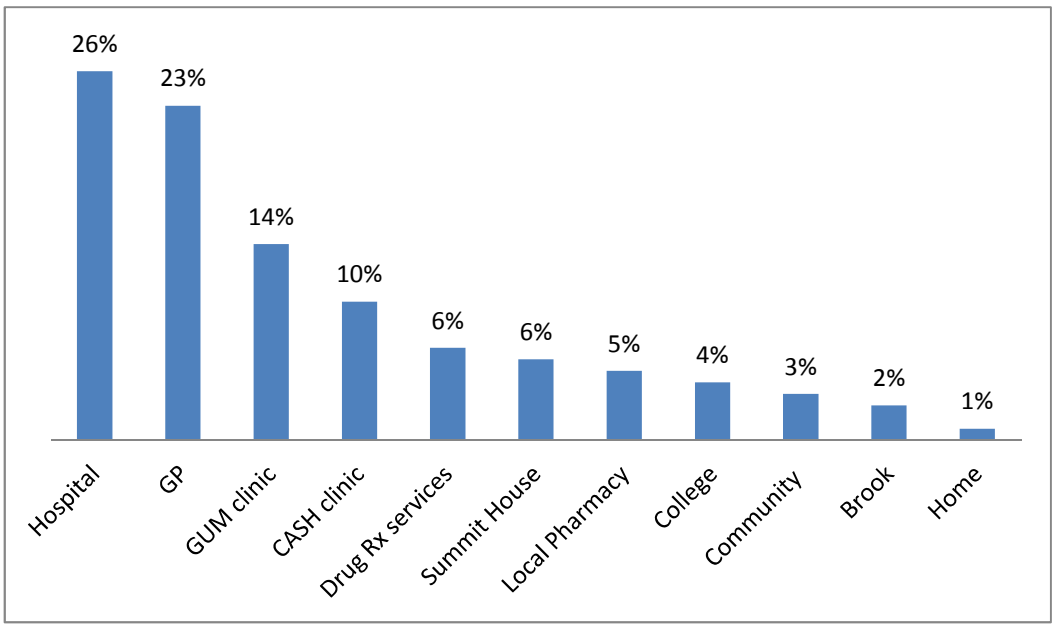

The greatest number of HIV testing was achieved in sexual health setting with a highest proportion of the HIV testing occurring in a GUM clinic (45%). Only one in five tests was conducted in GP surgeries and minority in a prison. One in four HIV testing occurred as part of care in general medical and surgical departments.

**Figure 5: Would you recommend others to have the HIV test at the same place?**




Nearly four in five respondents (81%) reported that they would be happy to use the service again. However, one in five (19%) would not recommend the service due to inappropriate staff attitudes, inconvenient location of the service, concern about confidentiality and lack of provision of clear information on HIV testing process.

**Figure 6: Where would you prefer to access HIV testing?**




The survey findings suggested the need of the expansion of HIV testing beyond the antenatal and GUM clinic settings as a large proportion of the participants (60%) advocated access to routine HIV testing in general practices and in other local primary care settings such as Community Sexual Health Clinics (CASH), drug treatment and HIV support services, pharmacies, local colleges, libraries, community centres etc.

**Table 3: What do you think are the barriers that would prevent you or others from getting an HIV test?**

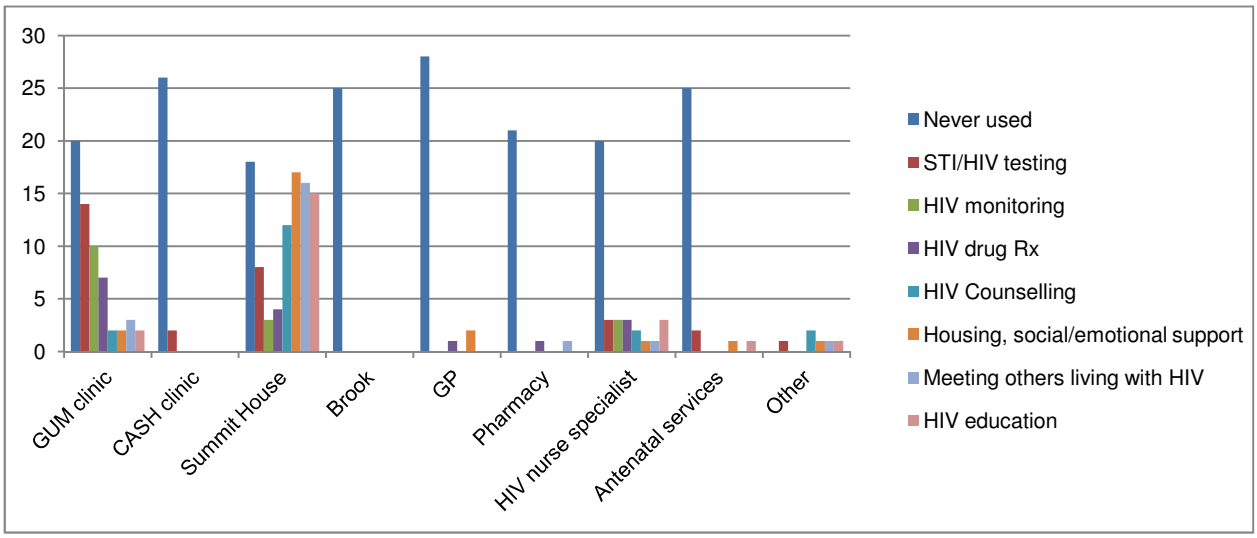
| ***Barrier*** | **Number of responses (%)** |
|---|---|
| Fear of HIV positive result | 33 (56%) |
| Worried about confidentiality | 32 (54%) |
| Fear of how others will treat me | 31 (52%) |
| Impact on relationships with others | 24 (41%) |
| Impact on personal relationship(s) | 22 (37%) |
| No barriers | 17 (29%) |
| Worried about medication/treatment | 17 (29%) |
| Fear of unknown/death | 17 (29%) |
| Worried about insurance companies finding out | 16 (27%) |
| Worried about employers reaction | 13 (22%) |
| Worried about GP's knowing who might have to inform others | 13 (22%) |
| Not knowing where to go for testing | 9 (15%) |
| No way I could catch HIV infection | 9 (15%) |
| Fear of prosecution | 4 (7%) |
| Judgmental and patronising GPs | 1 (2%) |

More than two third of the respondents (71%) felt that there were still cultural, social and structural barriers that prevent people from getting tested, either voluntarily or when offered a test by a health worker. Some of the commonly cited client-related barriers were fear of disease or death; confidentiality issues; fear of stigma, shame and discrimination in the community or at work; the fear of impact on patient-GP relationship and lack of access to testing and care, if the test is positive for HIV infection.

**Are current HIV prevention and treatment services in Dudley meeting public needs?**

Participants were asked questions related to current HIV prevention and treatment services in Dudley to identify gaps in current services and to further develop them to meet public requirements.

**Figure 7: which service(s) have you used in the past for HIV testing or management or support in Dudley and what did you use the service/s for?**




The service most frequently accessed by participants for HIV testing was the GUM clinic and the Summit house. Very few individuals accessed family planning/CASH service and none assessed the GP, the Pharmacy service or the Brook for HIV testing.

The service most frequently accessed by individuals who were HIV positive, for HIV monitoring and HIV drug treatment, was the Dudley's GUM clinic. Some individuals accessed Summit house or visited the HIV nurse specialist for HIV monitoring. Summit House was ranked highest in terms of usage by participants for counselling, education, advice, support and meeting others living with HIV.

**Table 4: In your opinion, how can the HIV testing and prevention services/interventions in Dudley be improved?**

| Suggestions | Number of responses (%) |
|---|---|
| More public information campaigns about HIV and sexual health | 46 (78%) |
| More counselling services | 29 (50%) |
| More self help/support groups | 29 (50%) |
| More social and emotional support | 24 (41%) |
| Flexible opening hours | 23 (39%) |
| HIV testing available in community settings | 23 (39%) |

**Box 1: Additional suggestions for improving HIV prevention and testing services/interventions in Dudley**

- *Services users should to be taught about how to educate children or relatives on HIV to prevent the spread of infection*
- *HIV should be talked about more and those who stigmatise others should be informed that it could happen to them whilst sexually active*
- *Everyone should be encouraged to get tested before indulging in a sexual relationship*
- *To educate the public to alleviate stigma and judgement*
- *More counselling sessions and support groups, more testing and advice*
- *More support and services for children whose families affected by HIV*
- *Prevention of embarrassment, more secrecy*

A targeted public campaign to increase awareness of HIV infection was considered key to improve HIV awareness, local testing rate and HIV prevention among local population. Deliveries of effective HIV awareness and education programmes involving families, communities, and many other sectors of society, were recommended to help reduce risk behaviours among local population. Other recommendations to improve current services included increasing access to HIV testing by extending the availability of testing times; widening access to HIV testing in community and non-traditional clinical settings with new and innovative ways of reaching communities.

Participants living with HIV recommended that current local HIV support services could be strengthened and improved by increasing access to counselling sessions, widening the target groups and working with new partners to improve social and emotional support.

**Findings from the Focus group**

The focus group was attended by eight HIV positive individuals and their cares who were attending Summit house, representatives from the Well-Being service (those living with HIV and their carers) and the LGBTQ (Lesbian, Gay, Bisexual, Transgender communities as well as those Questioning their sexuality) services. A senior service team leader facilitated the group using a set of open-ended key questions about local HIV services.

**1. Best ways of promoting and accessing information on HIV?**

Participants felt that there should be a wide range of ways of accessing information on HIV and local support services from a variety of places. Examples included generic health settings such as hospitals, GP's, walk-in centres, pharmacies, dentists, etc; colleges; university; libraries; pubs; community centres including Centre for Diversity, Refugee & Migrant centre, etc.; and public transport.

Participants thought it was important for information to be provided using different sources such as online resources; adverts in local press and radio; posters; information screens; adverts; and flyers. Keeping up with new technology; using mobile phone apps, internet, 24 hour helpline, and using innovative ways such as credit card size information cards with smart-tag were also considered important. Face to face discussion with a health care professional appeared to be important.

*"Information screens in public areas are ideal as people can access information without being seen to – picking up a leaflet or writing down details from a poster can be too obvious"*
*"Posters in public buildings, e.g. pubs should be in private areas to allow confidential access. Rest rooms are good as long as they are presented in a professional manner"*
*"Clinical settings may not be conducive to receiving information on HIV"*
*"Sharing information with peers is the ideal situation, especially those newly diagnosed"*

**2. Best ways of accessing HIV testing?**

Participants felt that HIV testing should be widely available in a variety of generic settings.

*"More places the better to suit different groups e.g. gay venues, refugee & migrant centres, specific community groups"*
*"Pharmacies (ideal where private space for multi-use is available"*
*"Walk-in Centres"*
*"Colleges and Universities – link into other testing (think about incentives to get tested - freebies)"*
*"Mobile testing unit"*
*"Offer to groups as part of awareness events"*
*"Social venues (but not where alcohol is involved)"*
*"Outdoor events in the summer (dedicated tent or mobile unit)"*

**3. What should the ideal HIV services look like?**

*"Should be warm and friendly"*
*"Should avoid information overload – services users should be able to access at their own pace without being overwhelmed"*
*"Customers shouldn't feel rushed/on a production line – more relaxed environment"*
*"Service should check in if someone has not attended for a while – text/e-mail/phone call"*
*"Outreach nurse"*
*"Ensure customers feel supported"*
*"Important that someone is available for a chat"*

Participants felt that individuals with newly diagnosed HIV should be provided with improved support.

*"More counselling"*
*"More practical advice/what can I expect?"*
*"Adequate information/someone to answer questions/help with the right questions"*
*"Peer support/budding/shared life experience"*
*"Disclosure – support with reactions of others/specific info and support for those disclosed to, confidence & self-esteem building"*
*"Dedicated discussion group, small and focused; ease into established groups"*
*"Make the experience positive"*

**4. How could current GUM services providing clinical care be improved?**

*"Layout at Russells Hall is poor could be improved"*
*"Would welcome a more relaxed, warmer, more human approach, less clinical"*
*"Support services or workers are needed in waiting area – help with completing forms/information/emotional support to reduce the fear. Those newly attending would have a recognisable face someone they could gain the confidence to approach".*
*"Confidential space, should not be able to be overheard"*
*"Improve communication"*
*"Leaflets and information on other services should be made available (info screens)"*
*"Not feeling rushed/immediately abandoned after diagnosis without signposting or referral to support agency"*

**Summary points:**

- There are gaps in local public's knowledge about HIV as one in five respondents reported poor knowledge of routes of HIV transmission.
- The community members suggested that they rely on both health professionals as well as print or media sources to get HIV related information.
- Participants felt that there should be a wide range of ways of accessing information on HIV and local support services from a variety of places.
- Respondents preferred getting information from people—including GP, nurses, sexual health staff and community groups.
- Half of the HIV testing in Dudley took place in sexual health clinic settings.
- A large proportion of the participants recommended the expansion of HIV testing in GP practices and other primary care/community services beyond the antenatal and GUM clinic settings.
- Currently, in Dudley very few individuals are accessing the CASH service, the GP, the Pharmacy service or the Brook for HIV testing, counselling or education.
- Summit House was ranked highest in terms of usage by participants for counselling, education, advice, support and meeting others living with HIV.
- Fear of diagnosis, stigma related to HIV testing and confidentiality issues are key suggested barriers that prevent people from getting tested, either voluntarily or when offered a test by a clinician.
- A brief pre-test discussion and education on HIV/AIDS with confidentiality assurance may improve uptake of HIV testing.
- A targeted public campaign including individual, group and community level activities were suggested as the key to increase awareness of HIV, promote HIV testing and improve access to HIV services
- Participants felt that individuals with newly diagnosed HIV should be provided with improved psychological and social support.

**Appendix 1**

*HIV prevention interventions*

| Category | Sub-category |
|---|---|
| **Education** | |
| | Information/knowledge |
| | Skill building (general) |
| | Perception/Attitude |
| | Interpersonal skills training |
| | condom use skills training |
| | Self-efficacy |
| | Role play |
| | Condom promotion |
| | Service promotion |
| | Motivational |
| **Prevention** | |
| | Needle/syringe sharing |
| | Condom distribution scheme |
| | Circumcision |
| | Contact tracing / partner notification |
| | Screening/testing |
| **Support** | |
| | Counselling |
| | Peer group support |
| | Social support |
| | Support network |
| | Mentoring/coaching |
| | Behavioural (inc Cognitive/CBT) |
| | Hotline/ help lines |
| | Case Management |
| | Community Support Group |
| | Family/friend |
| **Media** | |
| | Mass media |
| | Newspaper/magazines |
| | Leaflets/posters |
| | TV |
| | Website/internet |
| | Advertising |
| | Social network website |
| | Texting |
| | Multi-media |
| **Biomedical** | |
| | Drug treatment (ART) |
| | Opioid substance therapy |
| | PEP |
| | PrEP |

*Source: FCLHPS project steering group, 2013*

**Appendix 2: Stakeholder engagement**

## QUESTIONNAIRE FOR PRACTICE MANAGER/HEALTH PROFESSIONALS

# Would you like to help shape HIV prevention services and testing available in Dudley?

This information is being collected by the Office of Public Health Dudley to identify the barriers or reasons that stop or delay people coming forward for HIV testing.

Your answers will help us improve our services in order to reach out to our local population and benefit those people who are at risk of HIV.

**This survey is completely anonymous (Your name or name of your organisation will not be used).**

**If you are willing to take part in this survey, please tick this box** ☐

**Please select your choice by double clicking the box and selecting "checked".**

Thank you for your help. Your responses will be treated in confidence.

1. **Does your practice take a sexual history from patients?**

   ☐ Yes ☐ No

2. **Does your organisation provide written information on HIV?**

   ☐ Yes ☐ No, If the answer is no, please go to question 4

3. **How does your organisation provide information on HIV to patients?**

   ☐ On request ☐ On display ☐ None of the above
   ☐ Other, please specify.....

4. **How does your organisation currently contribute to HIV prevention actions?**
   (Please tick all the applicable boxes)

   ☐ By offering HIV finger prick test ☐ By offering HIV venous blood test
   ☐ By providing written/verbal information on HIV
   ☐ By providing HIV risk assessment and referring to HIV services
   ☐ By providing HIV care and treatment
   ☐ Other, please specify.....
   ☐ None of the above

**5. If indicated, do you or your organisation routinely offer HIV testing to patients?**

☐ No ☐ Yes to all patients
☐ Yes to high risk patients only ☐ Yes to new patient registration only
☐ Other.....

**6. Does your organisation have clear referral pathways to refer patients to HIV care providers?**

☐ Yes ☐ No ☐ Not sure

**7. How confident do you or your team members feel in the ability to take a sexual history and talking to patients about HIV?**

☐ Very confident ☐ Confident ☐ Fairly confident ☐ Not so confident
☐ Not confident at all

**8. How confident do you or your team members feel in the ability to offer and recommend an HIV test?**

☐ Very confident ☐ Confident ☐ Fairly confident ☐ Not so confident
☐ Not confident at all

**9. Do you think that access to HIV teaching sessions/guidelines would be useful?**

☐ Yes ☐ No ☐ Not sure

**10. If funded appropriately and staff are appropriately trained, would your organisation be willing to provide an HIV finger prick test to high risk patients in the future?**

☐ Yes ☐ No ☐ Not sure

**11. If appropriate funding and training for staff is available, what other ways do you think your organisation could contribute to HIV prevention actions in future?**
(Please tick all the applicable boxes)

☐ By offering HIV finger prick test ☐ By offering HIV venous blood test
☐ By providing written/verbal information on HIV
☐ By providing HIV risk assessment and referring to HIV services
☐ By providing HIV care and treatment
☐ Other, please specify.....
☐ None of the above

**12. For your organisation to implement HIV prevention actions and HIV finger prick testing, what external support, input, or mentoring would be needed?**
(Please tick all that apply)

- ☐ Financial support
- ☐ Mentoring/guidance
- ☐ Teaching/training
- ☐ More staff
- ☐ Other, please specify.....

**13. What do you see as the barriers in embedding/establishing effective HIV prevention actions/ HIV testing in your organisation?**
(Please tick all that apply)

- ☐ Not an ideal service to provide HIV testing
- ☐ Time restraints
- ☐ No knowledge of HIV infection or treatments
- ☐ There a lack of communication with GUM department and GP practices
- ☐ Not confident in taking a sexual history/talking about HIV
- ☐ Other, please specify.....

**14. What other HIV prevention activities/services do you think should be offered in primary care?**

**.....**
**.....**
**.....**

**Additional comments**

Please provide us with any comments/ suggestions that you feel would help us to improve HIV testing services in Dudley

.....

.....

**Thank you very much for taking the time to fill in this questionnaire**

**Please return the completed questionnaire before 3rd February 2014,**

**by email to vinod.kumar@dudley.gov.uk or**

**by post to: Louise Grainger**
**Public Health Support & Challenge Manager**
**Office of Public Health**
**Dudley Metropolitan Borough Council**
**8th Floor, Falcon House, Dudley, DY2 8PG**

**Appendix 3: Finding the needs of local population**

## Invitation to help shape HIV prevention services and testing in Dudley!

This is an invitation to complete the enclosed HIV Needs Assessment Questionnaire.

The information you provide will assist the Office of Public Health Dudley to identify the barriers or reasons that stop or delay people coming forward for HIV testing.

Your answers will help us improve our services in order to reach out to our local population and benefit those people who are at risk of HIV.

We would like to encourage all to complete and submit the questionnaire to help us address any potential issues/needs. Your input will help us shape HIV prevention services and testing in Dudley.

The questionnaire will take no more than 10 – 20 minutes to complete. Please note that your name or any other details will remain completely confidential and the answers you give will be amalgamated with the answers from other respondents to gain an overall picture. The results of this survey will be available to the public in near future.

Please return the completed questionnaire before 24 February 2014, using a sealed envelope if you prefer, to the person who gave it to you or by email to: Louise.Grainger@dudley.gov.uk.

If you would be willing to share your thoughts further (telephone interview or focus group) please contact Louise Grainger on 01384 816321 or Louise.Grainger@dudley.gov.uk.

Many thanks

Dr V. Kumar
SpR to Dr Mayada Abu Affan
Office of Public Health
Dudley Metropolitan Borough Council
8th Floor, Falcon House
The Minories, Dudley DY2 8PG
Tel: 01384 816028

# Would you like to help shape HIV prevention services and testing available in Dudley?

This information is being collected by the Office of Public Health Dudley to understand your experience and barriers or reasons that stop or delay people coming forward for HIV testing.

This information will help us improve our services in order to reach out to our local population and benefit those people who are at risk of HIV.

**This survey is confidential and anonymous.**

**If you are willing to take part in this survey, please tick this box** ☐

**If you are completing this survey online, please select your choice by double clicking the box and selecting "checked".**

**Part 1: HIV awareness and testing**

**A. HIV knowledge**

**1.** How would you rate your knowledge about how HIV infection is passed on?

☐Excellent ☐Very good ☐Good ☐Fair ☐Poor

**2.** How do you best like to receive information about HIV?
(Please tick all the applicable boxes)

☐GP ☐Nurses ☐Sexual health staff
☐Magazines ☐Newspaper ☐Newsletters
☐Television ☐Internet ☐Community group
☐Other, please specify.....
.....
.....

**B. HIV testing**

**3.** Have you ever had a test for HIV?

☐Yes ☐No
If the answer is no, please go to question 7

**4.** Why did you have the HIV test?

☐ Routine HIV testing
☐ As part of a sexually transmitted infection (STI) check-up
☐ As part of check-up as a high risk group
☐ Testing during pregnancy
☐ Partner infected with HIV
☐ Whilst testing for unknown illness
☐ Felt I had been at risk of HIV infection
☐ Public information campaigns about HIV on TV or in the media
☐ Other, please specify ……

**5.** Where did you have your last HIV test?

☐ GUM clinic ☐ Hospital ☐ Brook
☐ GP surgery ☐ Pharmacy ☐ Summit house
☐ Contraception clinic (CASH)
☐ Other, Please specify……

**6.** Would you recommend others to have the HIV test at the same place?

☐ Yes ☐ No
If the answer is no, please indicate why:

☐ Location ☐ Unwelcoming environment ☐ Concern about confidentiality
☐ Staff attitudes ☐ Lack of interpreting services
☐ Other, Please specify the difficulties/ problems encountered?
……

**7.** Where would you prefer to access HIV testing?
(Please tick all the applicable boxes)

☐ Brook ☐ Hospital ☐ In my local Pharmacy
☐ GUM clinic ☐ At college ☐ GP
☐ Community Sexual Health clinics (CASH)
☐ In the community (libraries, community centres etc)
☐ In drug treatment services
☐ At a service I currently use (please specify which)……..
☐ Anywhere else, please specify……

**8.** What do you think are the barriers that would prevent you or others from getting an HIV test?

(Please tick all the applicable boxes)

☐ No Barriers
☐ Worried about confidentiality
☐ Fear of prosecution
☐ Fear of HIV positive result
☐ Not knowing where to go for testing
☐ No way I could catch HIV infection
☐ Worried about medication/ treatment
☐ Fear of how others will treat me
☐ Fear of unknown/death
☐ Worried about employer's reaction
☐ Worried about GPs knowing who might have to inform others
☐ Worried about insurance companies finding out
☐ Impact on personal relationship(s)
☐ Impact on relationships with others e.g. family, friends, etc.
☐ Other, Please specify

.....
.....
.....
.....

**Part 2: Services currently available in Dudley**

We are asking the following questions to understand if the current services in Dudley are meeting public needs. Your answers will help us identify gaps in our current services, and further develop them to meet public requirements.

9. **Which service(s) have you used in the past for HIV testing or management or support in Dudley and what did you use the service/s for?**
   (Please tick all the applicable boxes)

| Service | Not/ never used | STI/HIV testing | HIV monitoring/ blood tests | HIV drug treatment | HIV Counselling | Housing advice, Financial advice, Social and emotional support | Meeting others living with HIV | HIV education |
|---|---|---|---|---|---|---|---|---|
| **GUM clinic** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Sexual Health clinic (CASH)** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Summit House** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Brook** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **GP** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Pharmacy** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **HIV nurse specialist** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Antenatal services** | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Other, Please specify** **.....** | | | | | | | | |

**10.** Where do you get your information about HIV from?
(Please tick all the applicable boxes)

| | | |
|---|---|---|
| ☐ Health professionals | ☐ Newspaper | ☐ Work |
| ☐ TV | ☐ Radio | ☐ School |
| ☐ College | ☐ Friends | ☐ Internet |

☐ Other, Please specify……

**11.** In what way are you affected by HIV?
(Please tick all the applicable boxes)

| | |
|---|---|
| ☐ Not affected | ☐ I know someone who is HIV +ve |
| ☐ Mental health issues | ☐ Social stigma |
| ☐ Employment problems | ☐ Relationship problems |
| ☐ Side-effects of treatment | ☐ Physically ill from infection(s) |

☐ Other, Please specify……

**12.** In your opinion, how can the HIV testing and prevention services be improved?
(Please tick all the applicable boxes)

☐ More public information campaigns about HIV and sexual health
☐ Flexible opening hours
☐ More counselling services
☐ More social and emotional support
☐ More self help/support groups
☐ HIV testing available in community settings
☐ Other, Please specify……

**Additional comments**

Please provide us with any comments/ suggestions that you feel would help us to improve HIV prevention and testing services in Dudley

……

……

……

**Part 3: Describe yourself**

This survey is completely confidential and your identity will remain anonymous. Please remember it is voluntary. However, the following information will help us to further develop our services by understanding the local population that use our services.

**13. Your Age** ☐17 and under ☐18 – 24 ☐25 – 44
☐45 – 65 ☐65+

**14. Gender** ☐Male ☐Female ☐Transgender

**15. Sexuality** ☐Heterosexual ☐Gay / Lesbian ☐Bisexual
☐other, please specify…….

**16. Country where you were born** ☐

**17. Which area of Dudley Borough do you live in?**

☐DY1 ☐DY5 ☐B62 ☐DY2 ☐DY6 ☐B63

☐DY3 ☐DY8 ☐WV14 ☐DY4 ☐DY9

☐Other, If other, please give us the first part of your postcode……

**18. How do you describe your ethnicity?**

**White:** ☐British ☐Irish ☐Any other White background

**Mixed:** ☐White and Black Caribbean ☐White and Black African

☐White and Asian ☐Any other mixed background

**Asian or Asian British:** ☐Indian ☐Pakistani ☐Bangladeshi

☐Chinese ☐Any other Asian background

**Black or Black British:** ☐Caribbean ☐African ☐Any other Black background

☐ Any other ethnic background

☐Prefer not to say

**19. Do you know your HIV status?** ☐Yes ☐No ☐Don't know

**Thank you very much for taking the time to fill in this questionnaire**

**Please return the completed questionnaire before 24 February 2014, using a sealed envelope if you prefer, to the person who gave it to you or by email to Louise.Grainger@dudley.gov.uk.**

**If you would be willing to share your thoughts further (telephone interview or focus group) please contact Louise Grainger on 01384 816321 or Louise.Grainger@dudley.gov.uk**

**Appendix 4: GP surgeries within Dudley Borough**

| ID | Practice Code | Practice Name |
|---|---|---|
| 1 | M87001 | Meadowbrook Road Surgery |
| 2 | M87002 | Norton Medical Practice |
| 3 | M87003 | Moss Grove Surgery |
| 4a | M87005 | Three Villages Medical Practice (Stourbridge HSCC) |
| 4b | M87005 | Three Villages Medical Practice (Bridgnorth Rd) |
| 5 | M87006 | Eve Hill Medical Practice |
| 6 | M87007 | The Ridgeway Surgery |
| 7 | M87008 | Kingswinford Health Centre |
| 8a | M87009 | AW Surgeries (Albion House Surgery) |
| 8b | M87009 | AW Surgeries (Withymoor Surgery) |
| 9 | M87010 | The Waterfront Surgery |
| 10 | M87011 | Lion Health |
| 11 | M87012 | The Greens Health Centre |
| 12 | M87014 | Lapal Medical Practice |
| 13a | M87015 | Lower Gornal Medical Practice |
| 13b | M87015 | Lower Gornal Medical Practice (Masefield Rd Surgery) |
| 14 | M87016 | Woodsetton Medical Centre |
| 15 | M87017 | Steppingstones Medical Practice |
| 16 | M87018 | The Summerhill Surgery |
| 17 | M87019 | The Limes Surgery |
| 18a | M87020 | Feldon Lane Practice |
| 18b | M87020 | Feldon Lane Practice (Hawne Lane Surgery) |
| 19 | M87021 | Coseley Medical Centre |
| 20a | M87023 | Wordsley Green Health Centre |

| | | |
|---|---|---|
| 20b | M87023 | Wordsley Green Health Centre (Market St Surgery) |
| 21a | M87024 | Wychbury Medical Group |
| 21b | M87024 | Wychbury Medical Group (Chapel House Surgery) |
| 21c | M87024 | Wychbury Medical Group (Cradley Rd) |
| 22 | M87025 | Cross Street Health Centre |
| 23 | M87026 | St James Medical Practice (White) |
| 24 | M87027 | Quarry Bank Surgery |
| 25 | M87028 | Netherton Health Centre |
| 26 | M87030 | Pedmore Medical Practice |
| 27 | M87034 | Clement Road Medical Centre |
| 28 | M87036 | Bean Road Surgery |
| 29 | M87037 | Northway Medical Centre |
| 30 | M87041 | Rangeways Road Surgery |
| 31 | M87601 | Keelinge House Surgery |
| 32 | M87602 | Halesowen Medical Practice |
| 33 | M87605 | Central Clinic |
| 34 | M87612 | St James Medical Practice (Porter) |
| 35a | M87617 | Netherton Surgery |
| 35b | M87617 | Netherton Surgery (Hazel Rd) |
| 36 | M87618 | Quincy Rise Surgery |
| 37 | M87620 | Castle Meadows Surgery |
| 38 | M87621 | Bath Street Surgery |
| 39 | M87623 | Alexandra Medical Centre |
| 40 | M87625 | Crestfield Surgery |
| 41 | M87628 | Chapel Street Surgery |
| 42 | M87629 | Bilston Street Surgery |

| | | |
|---|---|---|
| 43 | M87634 | St Thomas's Medical Centre |
| 44 | M87638 | Thorns Road Surgery |
| 45a | Y01756 | The Abbey Practice Group (Halesowen Rd) |
| 45b | Y01756 | The Abbey Practice Group (Tenlands Rd) |
| 45c | Y01756 | The Abbey Practice Group (Coombs Rd)) |
| 46 | Y02212 | Dudley Partnership for Health |
| 47 | Y02653 | High Oak Surgery |
| 48 | Y02737 | Dudley Walk in Centre |

**Appendix 5: Dudley demographic data**

**Distribution by age and sex**

**Table 1:** Population estimate by age group and gender for Dudley residents (Source: Census 2011)

| | Dudley | | |
|---|---|---|---|
| **Age band** | **Male** | **Female** | **Persons** |
| | | | |
| 00-04 | 9,554 | 9,313 | 18,867 |
| 05-09 | 9,069 | 8,865 | 17,934 |
| 10-14 | 9,528 | 9,011 | 18,539 |
| 15-19 | 10,270 | 9,593 | 19,863 |
| 20-24 | 9,124 | 9,017 | 18,141 |
| 25-29 | 9,299 | 9,648 | 18,947 |
| 30-34 | 8,917 | 9,107 | 18,024 |
| 35-39 | 9,866 | 9,932 | 19,798 |
| 40-44 | 11,824 | 12,024 | 23,848 |
| 45-49 | 11,547 | 11,701 | 23,248 |
| 50-54 | 9,797 | 9,786 | 19,583 |
| 55-59 | 9,186 | 9,203 | 18,389 |
| 60-64 | 9,731 | 9,816 | 19,547 |
| 65-69 | 8,487 | 8,768 | 17,255 |
| 70-74 | 6,839 | 7,408 | 14,247 |
| 75-79 | 5,119 | 6,260 | 11,379 |
| 80-84 | 3,476 | 4,942 | 8,418 |
| 85+ | 2,186 | 4,712 | 6,898 |
| **Total** | **153,819** | **159,106** | **312,925** |

**Table 2:** Population estimate by ethnic group and broad age group for male Dudley residents (Source: Census 2011)

| | | Ethnic Group | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Gender** | **Age band** | **White** | **Mixed/multiple ethnic group** | **Asian/Asian British** | **Black/African/Caribbean/Black British** | **Other ethnic group** | **Grand Total** | **White** | **Mixed/ multiple ethnic group** | **Asian/Asian British** | **Black/African/Caribbean/Black British** | **Other ethnic group** |
| **Males** | **0 to 4** | 7651 | 540 | 1072 | 150 | 141 | 9554 | 80.1% | 5.7% | 11.2% | 1.6% | 1.5% |
| | **5 to 7** | 4524 | 294 | 556 | 107 | 86 | 5567 | 81.3% | 5.3% | 10.0% | 1.9% | 1.5% |
| | **8 to 9** | 2847 | 173 | 358 | 75 | 49 | 3502 | 81.3% | 4.9% | 10.2% | 2.1% | 1.4% |
| | **10 to 14** | 8041 | 430 | 812 | 146 | 99 | 9528 | 84.4% | 4.5% | 8.5% | 1.5% | 1.0% |
| | **15** | 1823 | 71 | 177 | 32 | 18 | 2121 | 86.0% | 3.3% | 8.3% | 1.5% | 0.8% |
| | **16 to 17** | 3662 | 172 | 344 | 83 | 38 | 4299 | 85.2% | 4.0% | 8.0% | 1.9% | 0.9% |
| | **18 to 19** | 3374 | 127 | 262 | 61 | 26 | 3850 | 87.6% | 3.3% | 6.8% | 1.6% | 0.7% |
| | **20 to 24** | 8026 | 268 | 636 | 127 | 67 | 9124 | 88.0% | 2.9% | 7.0% | 1.4% | 0.7% |
| | **25 to 29** | 8015 | 176 | 887 | 122 | 99 | 9299 | 86.2% | 1.9% | 9.5% | 1.3% | 1.1% |
| | **30 to 34** | 7604 | 100 | 923 | 186 | 104 | 8917 | 85.3% | 1.1% | 10.4% | 2.1% | 1.2% |
| | **35 to 39** | 8725 | 94 | 783 | 182 | 82 | 9866 | 88.4% | 1.0% | 7.9% | 1.8% | 0.8% |
| | **40 to 44** | 10728 | 117 | 664 | 276 | 39 | 11824 | 90.7% | 1.0% | 5.6% | 2.3% | 0.3% |
| | **45 to 49** | 10729 | 80 | 435 | 264 | 39 | 11547 | 92.9% | 0.7% | 3.8% | 2.3% | 0.3% |
| | **50 to 54** | 9115 | 56 | 409 | 165 | 52 | 9797 | 93.0% | 0.6% | 4.2% | 1.7% | 0.5% |
| | **55 to 59** | 8640 | 34 | 402 | 84 | 26 | 9186 | 94.1% | 0.4% | 4.4% | 0.9% | 0.3% |
| | **60 to 64** | 9418 | 17 | 245 | 30 | 21 | 9731 | 96.8% | 0.2% | 2.5% | 0.3% | 0.2% |
| | **65 to 69** | 8284 | 11 | 139 | 45 | 8 | 8487 | 97.6% | 0.1% | 1.6% | 0.5% | 0.1% |
| | **70 to 74** | 6591 | 21 | 133 | 87 | 7 | 6839 | 96.4% | 0.3% | 1.9% | 1.3% | 0.1% |
| | **75 to 79** | 4954 | 12 | 95 | 46 | 12 | 5119 | 96.8% | 0.2% | 1.9% | 0.9% | 0.2% |
| | **80 to 84** | 3368 | 10 | 53 | 30 | 15 | 3476 | 96.9% | 0.3% | 1.5% | 0.9% | 0.4% |
| | **85 and over** | 2122 | 6 | 33 | 19 | 6 | 2186 | 97.1% | 0.3% | 1.5% | 0.9% | 0.3% |
| | **Total** | **138241** | **2809** | **9418** | **2317** | **1034** | **153819** | **89.9%** | **1.8%** | **6.1%** | **1.5%** | **0.7%** |

**Table 3:** Population estimate by ethnic group and broad age group for female Dudley residents (Source: Census 2011)

| | | Ethnic Group | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Gender** | **Age band** | **White** | **Mixed/multiple ethnic group** | **Asian/Asian British** | **Black/African/Caribbean/Black British** | **Other ethnic group** | **Grand Total** | **White** | **Mixed/ multiple ethnic group** | **Asian/Asian British** | **Black/African/Caribbean/Black British** | **Other ethnic group** |
| **Females** | **0 to 4** | 7438 | 570 | 993 | 184 | 128 | 9313 | 79.9% | 6.1% | 10.7% | 2.0% | 1.4% |
| | **5 to 7** | 4394 | 270 | 572 | 104 | 64 | 5404 | 81.3% | 5.0% | 10.6% | 1.9% | 1.2% |
| | **8 to 9** | 2826 | 173 | 354 | 56 | 52 | 3461 | 81.7% | 5.0% | 10.2% | 1.6% | 1.5% |
| | **10 to 14** | 7631 | 387 | 767 | 152 | 74 | 9011 | 84.7% | 4.3% | 8.5% | 1.7% | 0.8% |
| | **15** | 1781 | 88 | 128 | 36 | 10 | 2043 | 87.2% | 4.3% | 6.3% | 1.8% | 0.5% |
| | **16 to 17** | 3387 | 153 | 296 | 67 | 24 | 3927 | 86.2% | 3.9% | 7.5% | 1.7% | 0.6% |
| | **18 to 19** | 3131 | 156 | 244 | 55 | 37 | 3623 | 86.4% | 4.3% | 6.7% | 1.5% | 1.0% |
| | **20 to 24** | 7843 | 278 | 682 | 144 | 70 | 9017 | 87.0% | 3.1% | 7.6% | 1.6% | 0.8% |
| | **25 to 29** | 8215 | 221 | 941 | 162 | 109 | 9648 | 85.1% | 2.3% | 9.8% | 1.7% | 1.1% |
| | **30 to 34** | 7702 | 146 | 967 | 199 | 93 | 9107 | 84.6% | 1.6% | 10.6% | 2.2% | 1.0% |
| | **35 to 39** | 8770 | 104 | 829 | 181 | 48 | 9932 | 88.3% | 1.0% | 8.3% | 1.8% | 0.5% |
| | **40 to 44** | 10886 | 117 | 711 | 266 | 44 | 12024 | 90.5% | 1.0% | 5.9% | 2.2% | 0.4% |
| | **45 to 49** | 10803 | 113 | 460 | 295 | 30 | 11701 | 92.3% | 1.0% | 3.9% | 2.5% | 0.3% |
| | **50 to 54** | 9169 | 49 | 417 | 117 | 34 | 9786 | 93.7% | 0.5% | 4.3% | 1.2% | 0.3% |
| | **55 to 59** | 8680 | 33 | 401 | 63 | 26 | 9203 | 94.3% | 0.4% | 4.4% | 0.7% | 0.3% |
| | **60 to 64** | 9478 | 19 | 252 | 47 | 20 | 9816 | 96.6% | 0.2% | 2.6% | 0.5% | 0.2% |
| | **65 to 69** | 8531 | 19 | 155 | 53 | 10 | 8768 | 97.3% | 0.2% | 1.8% | 0.6% | 0.1% |
| | **70 to 74** | 7190 | 18 | 118 | 73 | 9 | 7408 | 97.1% | 0.2% | 1.6% | 1.0% | 0.1% |
| | **75 to 79** | 6063 | 9 | 125 | 48 | 15 | 6260 | 96.9% | 0.1% | 2.0% | 0.8% | 0.2% |
| | **80 to 84** | 4799 | 13 | 80 | 38 | 12 | 4942 | 97.1% | 0.3% | 1.6% | 0.8% | 0.2% |
| | **85 and over** | 4649 | 13 | 32 | 14 | 4 | 4712 | 98.7% | 0.3% | 0.7% | 0.3% | 0.1% |
| | **Total** | **143366** | **2949** | **9524** | **2354** | **913** | **159106** | **90.1%** | **1.9%** | **6.0%** | **1.5%** | **0.6%** |

**Appendix 6: Dudley HIV related data**

**Figure 1: New HIV diagnosis rates by year of diagnosis, Dudley and West Midlands residents, 2000 2012**

| Geography | | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Dudley | Number | 6 | 8 | 17 | 14 | 16 | 19 | 18 | 22 | 24 | 11 | 12 | 12 | 8 |
| | Population | 304,664 | 305,052 | 305,645 | 305,585 | 306,171 | 307,004 | 307,846 | 308,686 | 310,377 | 311,088 | 312,206 | 313,261 | 313,589 |
| | Rate | 2.0 | 2.6 | 5.6 | 4.6 | 5.2 | 6.2 | 5.8 | 7.1 | 7.7 | 3.5 | 3.8 | 3.8 | 2.6 |
| West Midlands | Number | 181 | 229 | 434 | 523 | 525 | 541 | 575 | 530 | 497 | 475 | 443 | 422 | 385 |
| | Population | 5,269,626 | 5,282,600 | 5,301,243 | 5,325,475 | 5,346,376 | 5,380,687 | 5,415,521 | 5,451,924 | 5,496,240 | 5,528,007 | 5,565,866 | 5,608,667 | 5,642,569 |
| | Rate | 3.4 | 4.3 | 8.2 | 9.8 | 9.8 | 10.1 | 10.6 | 9.7 | 9.0 | 8.6 | 8.0 | 7.5 | 6.8 |

Source: Public Health England, HIV and AIDS New Diagnosis Database; Office for National Statistics mid-year population estimates.

**Figure 2: New HIV diagnosis rates by year of diagnosis and gender, Dudley residents, 2000-2012**

| Gender | | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Female | Number | 1 | 2 | 5 | 5 | 7 | 10 | 4 | 6 | 9 | 3 | 6 | 3 | 1 |
| | Population | 155,185 | 155,411 | 155,597 | 155,562 | 155,717 | 156,066 | 156,458 | 157,089 | 157,860 | 158,212 | 158,799 | 159,370 | 159,509 |
| | Rate | 0.6 | 1.3 | 3.2 | 3.2 | 4.5 | 6.4 | 2.6 | 3.8 | 5.7 | 1.9 | 3.8 | 1.9 | 0.6 |
| Male | Number | 5 | 6 | 12 | 9 | 9 | 9 | 14 | 16 | 15 | 8 | 6 | 9 | 7 |
| | Population | 149,479 | 149,641 | 150,048 | 150,023 | 150,454 | 150,938 | 151,388 | 151,597 | 152,517 | 152,876 | 153,407 | 153,891 | 154,080 |
| | Rate | 3.3 | 4.0 | 8.0 | 6.0 | 6.0 | 6.0 | 9.2 | 10.6 | 9.8 | 5.2 | 3.9 | 5.8 | 4.5 |

Source: Public Health England, HIV and AIDS New Diagnosis Database; Office for National Statistics mid-year population estimates.

**Figure 3: New HIV diagnosis rates by year of diagnosis and age group, Dudley residents, 2000-2012**

| Age group | | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0-14 | Number | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 |
| | Population | 57,334 | 56,830 | 56,601 | 56,197 | 55,998 | 55,704 | 55,483 | 55,321 | 55,487 | 55,261 | 55,469 | 55,380 | 55,350 |
| | Rate | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 1.8 | 0.0 | 0.0 | 0.0 |
| 15-24 | Number | 0 | 1 | 2 | 1 | 1 | 1 | 1 | 3 | 1 | 1 | 2 | 2 | 1 |
| | Population | 32,773 | 33,755 | 34,556 | 35,356 | 35,822 | 36,270 | 36,910 | 37,408 | 37,765 | 37,877 | 38,014 | 37,957 | 37,472 |
| | Rate | 0.0 | 3.0 | 5.8 | 2.8 | 2.8 | 2.8 | 2.7 | 8.0 | 2.6 | 2.6 | 5.3 | 5.3 | 2.7 |
| 25-34 | Number | 4 | 3 | 7 | 5 | 6 | 5 | 5 | 9 | 11 | 3 | 5 | 3 | 3 |
| | Population | 43,485 | 41,955 | 40,440 | 39,004 | 38,042 | 37,326 | 36,427 | 35,840 | 36,018 | 36,157 | 36,427 | 37,169 | 37,874 |
| | Rate | 9.2 | 7.2 | 17.3 | 12.8 | 15.8 | 13.4 | 13.7 | 25.1 | 30.5 | 8.3 | 13.7 | 8.1 | 7.9 |
| 35-49 | Number | 1 | 4 | 7 | 7 | 7 | 12 | 8 | 8 | 11 | 5 | 3 | 6 | 3 |
| | Population | 63,061 | 63,521 | 64,417 | 64,967 | 65,773 | 66,680 | 67,502 | 67,974 | 68,061 | 67,833 | 67,439 | 66,536 | 65,057 |
| | Rate | 1.6 | 6.3 | 10.9 | 10.8 | 10.6 | 18.0 | 11.9 | 11.8 | 16.2 | 7.4 | 4.4 | 9.0 | 4.6 |
| 50+ | Number | 1 | 0 | 1 | 1 | 2 | 1 | 4 | 2 | 1 | 1 | 2 | 1 | 1 |
| | Population | 108,011 | 108,991 | 109,631 | 110,061 | 110,536 | 111,024 | 111,524 | 112,143 | 113,046 | 113,960 | 114,857 | 116,219 | 117,836 |
| | Rate | 0.9 | 0.0 | 0.9 | 0.9 | 1.8 | 0.9 | 3.6 | 1.8 | 0.9 | 0.9 | 1.7 | 0.9 | 0.8 |

Source: Public Health England, HIV and AIDS New Diagnosis Database; Office for National Statistics mid-year population estimates.

**Figure 4: New HIV diagnosis rates in Dudley by year of diagnosis and ethnic group, Dudley residents, 2008-2012**

| Ethnic group | | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| White | Number | 5 | 5 | 9 | 7 | 6 | 8 | 11 | 11 | 13 | 5 | 4 | 10 | 6 |
| | Population | 285,500 | 285,500 | 284,400 | 282,600 | 281,500 | 280,700 | 279,500 | 278,300 | 277,900 | 277,000 | 277,000 | 281,607 | 281,607 |
| | Rate | 1.8 | 1.8 | 3.2 | 2.5 | 2.1 | 2.9 | 3.9 | 4.0 | 4.7 | 1.8 | 1.4 | 3.6 | 2.1 |
| Other | Number | 1 | 3 | 8 | 7 | 10 | 11 | 7 | 11 | 11 | 6 | 8 | 2 | 2 |
| | Population | 19,500 | 19,500 | 20,800 | 22,200 | 23,500 | 24,600 | 25,800 | 27,000 | 28,300 | 29,700 | 29,700 | 31,318 | 31,318 |
| | Rate | 5.1 | 15.4 | 38.5 | 31.5 | 42.6 | 44.7 | 27.1 | 40.7 | 38.9 | 20.2 | 26.9 | 6.4 | 6.4 |
| Not reported | Number | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 |

Source: Public Health England, HIV and AIDS New Diagnosis Database; Office for National Statistics experimental population estimates and 2011 census population.

**Figure 5: New HIV diagnosis rates by year of diagnosis and probable exposure category, Dudley residents, 2000-2012**

| Exposure category | | 2000 | 2001 | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Sex between men | Number | 5 | 3 | 5 | 6 | 3 | 4 | 11 | 13 | 9 | 5 | 3 | 7 | 5 |
| | Population | 304,664 | 305,052 | 305,645 | 305,585 | 306,171 | 307,004 | 307,846 | 308,686 | 310,377 | 311,088 | 312,206 | 313,261 | 313,589 |
| | Rate | 1.6 | 1.0 | 1.6 | 2.0 | 1.0 | 1.3 | 3.6 | 4.2 | 2.9 | 1.6 | 1.0 | 2.2 | 1.6 |
| Heterosexual contact | Number | 1 | 5 | 11 | 8 | 12 | 14 | 7 | 7 | 13 | 5 | 9 | 5 | 3 |
| | Population | 304,664 | 305,052 | 305,645 | 305,585 | 306,171 | 307,004 | 307,846 | 308,686 | 310,377 | 311,088 | 312,206 | 313,261 | 313,589 |
| | Rate | 0.3 | 1.6 | 3.6 | 2.6 | 3.9 | 4.6 | 2.3 | 2.3 | 4.2 | 1.6 | 2.9 | 1.6 | 1.0 |
| All other routes | Number | 0 | 0 | 1 | 0 | 1 | 1 | 0 | 1 | 2 | 1 | 0 | 0 | 0 |
| | Population | 304,664 | 305,052 | 305,645 | 305,585 | 306,171 | 307,004 | 307,846 | 308,686 | 310,377 | 311,088 | 312,206 | 313,261 | 313,589 |
| | Rate | 0.0 | 0.0 | 0.3 | 0.0 | 0.3 | 0.3 | 0.0 | 0.3 | 0.6 | 0.3 | 0.0 | 0.0 | 0.0 |
| Undetermined | Number | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 | 0 | 0 | 0 | 0 | 0 |
| | Population | 304,664 | 305,052 | 305,645 | 305,585 | 306,171 | 307,004 | 307,846 | 308,686 | 310,377 | 311,088 | 312,206 | 313,261 | 313,589 |
| | Rate | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.3 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 |

Source: Public Health England, HIV and AIDS New Diagnosis Database; Office for National Statistics mid-year population estimates.

**Figure 6: HIV prevalence rates per 1,000 persons aged 15-59, Dudley and West Midlands residents, 2002-2012**

| Geography | | 2002 | 2003 | 2004 | 2005 | 2006 | 2007 | 2008 | 2009 | 2010 | 2011 | 2012 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Dudley | Number | 32 | 44 | 60 | 87 | 97 | 116 | 138 | 148 | 168 | 172 | 177 |
| | Population | 180,629 | 180,216 | 180,045 | 180,268 | 180,478 | 179,904 | 180,014 | 179,814 | 179,761 | 179,792 | 179,149 |
| | Rate | 0.18 | 0.24 | 0.33 | 0.48 | 0.54 | 0.64 | 0.77 | 0.82 | 0.93 | 0.96 | 0.99 |
| West Midlands | Number | 1,059 | 1,567 | 2,007 | 2,384 | 2,761 | 3,060 | 3,462 | 3,844 | 4,189 | 4,480 | 4,710 |
| | Population | 3,166,600 | 3,182,958 | 3,192,013 | 3,213,245 | 3,238,101 | 3,246,381 | 3,259,516 | 3,266,203 | 3,278,405 | 3,298,171 | 3,309,009 |
| | Rate | 0.33 | 0.49 | 0.63 | 0.74 | 0.85 | 0.94 | 1.06 | 1.18 | 1.28 | 1.36 | 1.42 |

Source: Public Health England, Survey of Prevalent HIV Infections Diagnosed (SOPHID); Office for National Statistics mid-year population estimates.

**Figure 8: Percentage of new HIV diagnoses diagnosed late, Dudley and West Midlands residents aged 15+, 2008 to 2012**
Note: only includes diagnoses with a reported CD4 cell count taken with 91 days of diagnosis; late diagnosis defined as CD4 count <350 cells/$mm^{3;}$ very late diagnosis defined as CD4 count <200 cells/$mm^3$.

| Geography | | 2008-2012 |
|---|---|---|
| Dudley | Late | 28 |
| | Very late | 15 |
| | Total | 60 |
| | % Late | 47% |
| | % Very late | 25% |
| West Midlands | Late | 923 |
| | Very late | 549 |
| | Total | 1,682 |
| | % Late | 55% |
| | % Very late | 33% |

Source: Public Health England, HIV and AIDS New Diagnosis Database; Office for National Statistics mid-year population estimates.

**Figure 9: Percentage of new HIV diagnoses diagnosed late by route of infection, Dudely residents aged 15+, 2008 to 2012**
Note: only includes diagnoses with a reported CD4 cell count taken with 91 days of diagnosis; late diagnosis defined as CD4 count <350 cells/$mm^{3;}$ very late diagnosis defined as CD4 count <200 cells/$mm^3$.

| Route of infection | | 2008-2012 |
|---|---|---|
| Sex between men | Late | 9 |
| | Very late | 3 |
| | Total | 28 |
| | % Late | 32% |
| | % Very late | 11% |
| Heterosexual contact - female | Late | 13 |
| | Very late | 9 |
| | Total | 18 |
| | % Late | 72% |
| | % Very late | 50% |
| Heterosexual contact - male | Late | 5 |
| | Very late | 2 |
| | Total | 12 |
| | % Late | 42% |
| | % Very late | 17% |
| All new diagnoses | Late | 28 |
| | Very late | 15 |
| | Total | 60 |
| | % Late | 47% |
| | % Very late | 25% |

Source: Public Health England, HIV and AIDS New Diagnosis Database; Office for National Statistics mid-year population estimates.

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