Appendix A:

SOUTHWARK SEXUAL HEALTH NEEDS ASSESSMENT

Southwark Sexual Health and HIV Strategy

Sarah Petrie, Public Health Specialist Registrar, Southwark PCT
Emma Robinson, Public Health Consultant, Lambeth PCT
Mashbileg Maidrag, Public Health Specialist, Lambeth PCT
Tracy Walsh, Sexual Health Commissioner, Lambeth and Southwark PCTs

July 2006
Executive Summary - Sexual Health Needs Assessment

South East London and in particular Southwark and Lambeth have high rates of sexually transmitted infections including Chlamydia, gonorrhoea, HIV, and syphilis. In addition to this, Southwark as a local authority, has the highest rate of teenage conceptions and also of terminations of pregnancy in England and Wales in 2004.

This needs assessment has been prepared in collaboration with Lambeth PCT since there are many similarities between the two boroughs and since the two boroughs have been working closely together to improve the sexual health locally as part of the work of the Sexual Health Modernisation Initiative and through LASHHNet (Lambeth and Southwark Sexual Health Network). This needs assessment has been an important part of the development of the Southwark Sexual Health Strategy 2006-2008.

Epidemiological and comparative
Epidemiology indicates high numbers of STIs at GUM clinics compared to rest of London. In general, the total number has fallen in the last couple of years. However, this may be not represent a decline in prevalence in the community as a whole. A significant number of STIs continue to be among young adults. Chlamydia screening shows higher prevalence of chlamydia in black ethnic groups. There are higher rates in men, which could be explained by the fact that about half of the positives identified among men were in contacts. Estimating the prevalence of STIs in the community as a whole is difficult. The best estimates of prevalence are in high-risk groups – GUM attenders and chlamydia screening data from young people. At Guy’s and St Thomas’ the prevalence of chlamydia and gonorrhoea in GUM clinic attenders is 6.8% and 3.8% respectively in 2004. The overall estimated prevalence of chlamydia from the screening programme is 13%. These estimates cannot easily be translated into prevalence in the whole community.

Highest teenage conception rates in Europe, with one in twelve 15-17 years olds becoming pregnant. Black ethnic groups over represented amongst teenage conceptions and termination of pregnancies. Large numbers of people access community RSH health services (Qtr 3 & 4 2004/05 - Lambeth 7722, Southwark 10355, Kings 11105) where they can receive a wide variety of services including contraception and STI testing. The percentage of women using long acting contraception for 2004/05 is 20.4% for England and Wales, 16.4% in Lambeth, 18.2% in Southwark and 27.9% in King’s. Emergency contraception is accessed disproportionately more by black ethnic groups. Terminations data is currently not very detailed. However data from one provider indicates that a higher proportion women from black and ethnic minority groups have abortions than white women.

Demand and capacity data suggests that many services provide simple tests that could be provided in more accessible settings e.g. pregnancy tests, asymptomatic STI screening. In addition, there is some evidence that introducing new systems/ ways of managing demand, it is possible to improve access to services, including waiting times.

Local laboratory data is not available routinely. The only data presented in this report is taken from an ad hoc study. Tests undertaken in primary care for sexual health reasons
make a significant proportion of all pathology tests. The data show that there are long delays in patients receiving results.

**Corporate Involvement**

Stakeholder and user views have been collated from a variety of surveys and local work including the modernisation initiative.

User views have been both positive (friendly and helpful staff) and negative. The keys issues for users are communication (lack of information on where services are and on how the 'pathway' through the clinic), access (long waiting times and not flexible opening times), quality (lack of confidentiality and embarrassment) and staff attitude (sometimes abrupt, dismissive and lack of sensitivity).

Stakeholder views reiterate what the users have said. In addition, stakeholders would like to see more joint working through network development and better information on other local services. Generic sexual health services should be user friendly at all points of access and in addition there is a need for targeted services for high risk groups e.g. black ethnic groups, gay men and young people. There is a need for better, more coordinated and timely data systems. Health promotion and prevention activities need a more cohesive and coordinated approach. Sex and relationships education (SRE) is felt to be a high priority for further development both in and out of schools. Finally, there is optimism about the new MI sexual health model for service delivery.

**Conclusion and recommendations**

Data shows that Southwark and Lambeth has high levels of sexual ill health. Where available, there is evidence to suggest that certain groups of the population are disproportionately affected by sexual ill health - young people, black and ethnic minority groups and gay men. There is a need to address the needs of these specific groups whilst ensuring that generic services are user-friendly.

The local plans for a new type of sexual health service delivery hopes to address many of the issues raised by users and stakeholders. In addition, it will be important to maintain a full range of services, which provide different levels of sexual health care in a variety of settings.¹

Local sexual health network should be strengthened, in the context of South East London sector network development, in order to improve joint working. There is need to improve sexual health data through improving and expanding existing routine data collection and investigating new sources of local data.

Health promotion and prevention is a key part of delivering an effective sexual health service and must be strengthened and explicitly coordinated locally in order that this can happen.

---

Acknowledgements

Ian Dawson – TOPs analysis
Vikki Pearce – Modernisation Initiative data
Kathryn Bevan - KC60 analysis and HIV data
Uche Osuagwu & Jane Miller – Chlamydia screening evaluation
Sarah French – Chlamydia screening data from primary care
Nilam Jani – mapping
Catherine Boundy – Demographics
David Butt – Teenage Pregnancy
Nanak Singh – Emergency hormonal contraception
Alan Maryon Davis - HIV

Abbreviations

AIDS Acquired Immune Deficiency Syndrome
BME Black Minority and Ethnic
BPAS British Pregnancy Advisory Service
COCP Combined Oral Contraceptive Pill
DOH Department of Health
EHC Emergency Hormonal Contraception
GUM Genitourinary Medicine clinics
HAZ Health Action Zone
HCW Health Care Worker
HIV Human Immunodeficiency Virus
IDU Intravenous drug user
IT Information Technology
IUD Intra-Uterine Device
IUS Intra-Uterine System
KC60 Statistical returns from GUM clinics
KT31 Statistical returns from SRH clinics
LARC Long-acting Reversible Contraception
LASSHNet Lambeth and Southwark Sexual Health Network
LSL Lambeth, Southwark and Lewisham
MedFASH Medical Foundation for AIDS and Sexual Health
MI Modernisation Initiative
ONS Office of National Statistics
OTC Over the Counter
PCT Primary Care Trust
PGD Patient Group Directive
POP Progestogen Only Pill
PSHE Personal, Social and Health Education
SE London South East London
SHNA Sexual Health Needs Assessment
SOPHID Survey of Prevalent HIV Infections Diagnosed
SRE Sex and Relationship Education
SRH Community Reproductive Sexual Health Clinic
STIs Sexually Transmitted Infections
TOP Termination of Pregnancy
TP Teenage Pregnancy
1. Background

1.1 Local Context

Demographics
The Inner London borough of Southwark has a very distinct population structure that differs from the average population in England & Wales. A higher proportion of the population in Southwark belongs to the younger age-group – 4 in 5 people in Southwark are under 50 years of age compared to 2 in 3 in the national population. A large proportion of the population concentrated in the 0-4 and 20-40 age ranges. In addition to being a young area, Southwark’s population is also growing - in the 10 years prior to 2001, the number of residents increased by more than 7%, compared to the national average increase of 2.5%.

Figure 1: Population ‘pyramids’ for England and Southwark, with age groups shown as percentages of the total population. Source: ONS, mid-year population estimates.

Ethnicity
Southwark is an area with a diverse, multi-racial and multicultural population. Compared to both England & Wales and London, a lower percentage of the population is White, with just over half of the population (52%) describing themselves as “White British” and less than 70% having been born in the UK compared to more than 90% of the average England & Wales population. The largest minority ethnic groups are Black-African (16%) and Black-Caribbean (8%). The Asian population in Southwark is a third lower than the London average of 6%. Whereas 90% of the Population of England and Wales are born within the United Kingdom, 30% of Southwark’s population are born overseas.
In Southwark, this ethnic structure seems to be a function of age, with much more diverse ethnicity concentrated amongst the young. Nearly a third (29%) of all residents of Southwark under 30 are black, compared with 6% of the same population in London. However, there is a drop in the percentage of black residents in their 20’s in Southwark, which defies the trend between age and ethnicity, and is actually lower than the 30’s and 40’s bracket. Ethnicity from mixed backgrounds is also concentrated in the younger generation, with 64% of Southwark’s ‘mixed’ population under 25 and nearly 90% under 40.

**Figure 2: Ethnic diversity in Southwark (by age band)**

Source: Census 2001

![Ethnic Diversity in Southwark](image)

**Figure 3: Country of Birth (ONS 2001 Census) for Southwark residents**

![Country of Birth](image)
1.2 Sexual health
Sexually transmitted infections (STIs) remain one of the most important public health issues for Southwark and Lambeth. Other STIs also cause significant and increasing problems. Clinics serving residents in Southwark and Lambeth see high numbers of gonorrhoea and chlamydia infections and, since 2002, a substantial rise in cases of syphilis.

Southwark has the highest teenage conception rate (number of conceptions per thousand females aged 15 to 17) in the UK in 2004. The conception rate is calculated annually and is derived from birth registrations, abortions and mid-year population estimates. Some conceptions are intended, but teenage conceptions are more likely to be unwanted and end in abortion. Teenage pregnancies (TP) are associated with poor sexual health. Between a third and a half of sexually active teenagers in the UK do not use contraception at first intercourse, and many continue not to do so. Having unprotected sexual intercourse greatly increases the risk of sexually transmitted infection (STIs).

Lambeth and Southwark is currently benefiting from the involvement of the Modernisation Initiative sexual health programme, which was launched in 2003. The Modernisation Initiative is looking at ways of improving sexual health by empowering people to manage their own sexual health more effectively; increasing access to services and offering clearer sexual health information. The project brings public health specialists and providers of sexual health services – including GPs and pharmacies – together with service users to explore changes in service provision. This programme has provided both PCTs with extensive information on clinics’ demand and capacity, user views and ensuring an evidence base underpins service development.
2. Epidemiological and Comparative data

2.1 Sexually Transmitted Infections
The best available information on sexually transmitted infections (STI) comes from genitourinary (GUM) clinics - the KC60 national data return. This data includes the number of people attending with certain infections but does not give us any indication where the people who attend the clinic are resident. Data is presented below from the three GUM clinics in Lambeth and Southwark – St Thomas’, Guy’s and King’s. The numbers of cases of STIs seen at GUM clinics do not include STIs seen in the community. Therefore fluctuations in numbers seen should be interpreted with caution. For example, it may be that local GUM clinics are seeing less chlamydia and gonorrhoea cases as a consequence of concerted local activity to increase testing in community settings e.g. general practice and SRH services. Finally it is worth noting that the locations of the clinics may affect the data. Although there is no residence-based information for this data, information recently accessed from the King’s GUM clinic suggests that a large proportion of clients at the clinic are Lambeth and Southwark residents (32% Lambeth, 31% Southwark - Caldecot Management Report 2005). However this may not be true for the clinics at Guy’s and St Thomas’ due to their central location and links to excellent public transport. We await data from these clinics to undertake further analysis.

The data below focus on bacterial causes of sexual ill health. Data are presented in this report for the following STIs: genital chlamydial infection (KC60 code C4A,C4C), uncomplicated gonorrhoea (B1,B2), primary and secondary infectious syphilis (A1,A2).

2.1.1 Chlamydia
Genital chlamydial infection (*Chlamydia trachomatis*) is one of the commonest STIs in the UK, and is an important reproductive health problem. The highest rates are seen in young people, especially men and women under 24 years. The organism is spread easily and causes infection of various parts of the genital organs leading to complications. In women these complications include pelvic inflammatory disease (PID), ectopic pregnancy and infertility. A significant proportion of cases, particularly amongst women, are asymptomatic and so are liable to remain undetected. 10-40% of untreated infected women will develop PID.

Screening for genital chlamydia infection may reduce PID, ectopic pregnancy and infertility. The phased implementation of the National Chlamydia Screening Programme NCSP for England aims to detect chlamydial infection among young sexually active women and men so treatment can be offered before complication develop.

- In 2004, 3894 cases were reported in all South East London GUM clinics
- Out of which 2861 cases of chlamydia were diagnosed at King’s, St Thomas’ and Guy’s GUM clinics
- This indicates that over two thirds (73%) of chlamydia cases diagnosed in all SE London GUM clinics were at King’s, St Thomas’ and Guy’s GUM clinics.
- The number of chlamydia diagnosed at the above three clinics in 2004 made up 14% of the total number of cases seen in London clinics overall.
- King’s College and St Thomas’ hospitals saw most cases of chlamydia in 2004
- King’s College Hospital showed a marked increase between 2003 and 2004 (37.2%) in diagnoses of chlamydia, in contrast St Thomas’ and Guy’s hospitals showed a decrease.

**Table 2.1.1 Number of cases of chlamydia diagnosed in SE London and London GUM clinics in 2004 and % change**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>King’s College</td>
<td>1504</td>
<td>37.2%</td>
<td>-2.0%</td>
<td>-2.1%</td>
</tr>
<tr>
<td>St Thomas’ &amp; Guy’s</td>
<td>1457</td>
<td>-23%</td>
<td>-3.9%</td>
<td>-4.3%</td>
</tr>
<tr>
<td>St Thomas’</td>
<td>1266</td>
<td>-17.7%</td>
<td>-3.7%</td>
<td>15.4%</td>
</tr>
<tr>
<td>Guy’s</td>
<td>191</td>
<td>-46.2%</td>
<td>-4.6%</td>
<td>-55.2%</td>
</tr>
<tr>
<td>SE London</td>
<td>3894</td>
<td>1.4%</td>
<td>4.2%</td>
<td>6.9%</td>
</tr>
<tr>
<td>London</td>
<td>20711</td>
<td>2.5%</td>
<td>4.0%</td>
<td>69.4%</td>
</tr>
</tbody>
</table>

The % change for 2002-2003 is shown for comparison.

- In all three clinics, more males than females were diagnosed in all age groups except those under 20 years old. The highest numbers of cases occurred in the 20-24 and 25-34 age groups.

**Figure 4: Number of cases of chlamydia in males and females diagnosed at King’s, St Thomas’ and Guy’s GUM clinics in 2004.**

- The figure below presents the time trend for the number of cases of chlamydia diagnosed in London compared to clinics in Lambeth and Southwark between 1995 and 2004.
2.1.2 Gonorrhoea
Gonorrhoea (Neisseria gonorrhoeae) is another important sexually transmitted infection which can result in serious complication including PID. It is now the second most common bacterial STI in the UK. Young people are most commonly infected, and the highest rates are found in London and predominantly urban areas. These recent rises in gonorrhoea probably reflect increasing unsafe sexual behaviour, particularly among young people and homosexual men. Like chlamydia, people can be infected but have no symptoms. Although gonorrhoea can be effectively treated with appropriate antimicrobials, this has been complicated by the increasing ability of N. gonorrhoeae to develop resistance to antimicrobial agents. The persistence of gonorrhoea, its association with poor reproductive and sexual health outcomes, and the prevalence of antimicrobial resistance have made it a major public health concern.

- In 2004, 1745 cases of uncomplicated gonorrhoea reported from all GUM clinics in SE London, representing a 19.7% decrease compared with 2003
- At King’s, St Thomas’ and Guy’s GUM clinics, 1531 cases were diagnosed
- The number of gonorrhoea diagnosed in above three clinics in 2004 represent 87.7% of the total number of cases seen in all SE London clinics and 19.8% of the total number of cases seen in London clinics overall
- All clinics continued to report a decreased number of diagnoses over the past year
Figure 6: Number cases of gonorrhoea diagnosed in SE London and London Gum clinics in 2004 and % change

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>King’s College</td>
<td>714</td>
<td>-12.1%</td>
<td>-23.4%</td>
<td>-19.7%</td>
</tr>
<tr>
<td>St Thomas’ &amp; Guy’s</td>
<td>817</td>
<td>-26%</td>
<td>-12.9%</td>
<td>-29.0%</td>
</tr>
<tr>
<td>St Thomas’</td>
<td>743</td>
<td>-25.1%</td>
<td>-12.2%</td>
<td>-16.0%</td>
</tr>
<tr>
<td>Guy’s</td>
<td>74</td>
<td>-33.9%</td>
<td>-18.8%</td>
<td>-72.1%</td>
</tr>
<tr>
<td>SE London</td>
<td>1745</td>
<td>-19.7%</td>
<td>-17.0%</td>
<td>-24.1%</td>
</tr>
<tr>
<td>London</td>
<td>7709</td>
<td>-12.7%</td>
<td>-13.1%</td>
<td>10.2%</td>
</tr>
</tbody>
</table>

The % change for 2002-2003 is shown for comparison.

Figure 7: Number of cases of gonorrhoea diagnosed at King’s, St Thomas’ and Guy’s GUM clinics in 2004 by age and sex

- Males were affected to a greater extent than females in all age groups
- The number of cases in males in the 25-34 and 35-44 age groups doubled those of females in same age group
- The figure below presents the time trends of gonorrhoea numbers in London and SE London between 1995 and 2004. The data demonstrate that although the number of gonorrhoea cases in SE London are falling, the numbers still make up a significant proportion of all cases in London.
Figure 8:

Number of gonorrhoea cases diagnosed at GUM clinics in Lambeth and Southwark, SE London and London between 1995 and 2004
2.1.3 Syphilis

Syphilis (*Treponema pallidum*) is a relatively uncommon STI, although in recent years cases have increased nationally and there have been several substantial outbreaks amongst homosexual men and heterosexual men and women. Left untreated it can cause serious complications that can affect heart and nervous system. Infection in pregnant women can cause miscarriage, stillbirth, or foetal abnormality. An infected person may have no symptoms, but still transmit the infection without knowing.

- A total of 147 cases were diagnosed in SE London GUM clinics in 2004
- Out of which 129 were diagnosed at King’s, St Thomas’ and Guy’s clinics, this represents 87.7% of the total number of cases diagnosed in all SE London clinics and 15.2% in all London clinics

**Figure 9: Number of cases of syphilis diagnosed at SE London and London Gum clinics in 2004 and % change**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>King’s College</td>
<td>42</td>
<td>-6.7%</td>
<td>114.3%</td>
<td>2000%</td>
</tr>
<tr>
<td>St Thomas’ &amp; Guy’s</td>
<td>87</td>
<td>2.4%</td>
<td>11.8%</td>
<td>2800%</td>
</tr>
<tr>
<td>St Thomas’</td>
<td>75</td>
<td>4.2%</td>
<td>7.5%</td>
<td>2400%</td>
</tr>
<tr>
<td>Guy’s</td>
<td>12</td>
<td>-7.7%</td>
<td>44.4%</td>
<td>--</td>
</tr>
<tr>
<td>SE London</td>
<td>147</td>
<td>-2.0%</td>
<td>40.2%</td>
<td>2840%</td>
</tr>
<tr>
<td>London</td>
<td>847</td>
<td>17.0%</td>
<td>12.4%</td>
<td>946%</td>
</tr>
</tbody>
</table>

**Figure 10: Number of cases of syphilis diagnosed at King’s, St Thomas’ and Guy’s hospital in 2004 by age and sex**

Number of cases of syphilis in males and females diagnosed in 2004 at King’s, St Thomas’s and Guy’s GUM clinics

![Bar chart showing number of cases by age and sex](image-url)
- Males were affected by syphilis to much greater extent than females, with more than four times the number of females diagnosed in 2004.
- There has been a marked rise in the number of syphilis cases seen at Kings and St Thomas’ over the last five years. This is likely to be as a consequence of a London wide increase in cases amongst gay men and an outbreak of syphilis in South London associated with commercial sex workers (CSWs) and their clients.

Figure 11: No. of cases of syphilis diagnosed at clinics in Lambeth, Southwark, SE London and London between 1995 and 2004.

2.1.4 Chlamydia, Gonorrhoea and Syphilis
The figure below presents all three STIs together by clinic and age group. This demonstrates that the greatest numbers of positive cases (of the three selected STIs) were seen at Kings GUM clinic. The age breakdown appears to be generally similar, except for the older age group (45-64 years) where a greater proportion is being seen at Kings GUM clinic.
Although denominator data is not usually presented for the KC60 data, the number of people screened for an STI is available for the clinics at Guy’s and St Thomas’ (GSTT). This data is not available for King’s.

**Figure 13: Number of people given full sexual health screen and cases of Chlamydia and Gonorrhoea diagnosed in 2003 and 2004 by clinics**

<table>
<thead>
<tr>
<th>Clinics</th>
<th>Number of people screened</th>
<th>Diagnosed for chlamydia (N/%)</th>
<th>Diagnosed for gonorrhoea (N/%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>St Thomas’ Hospital</td>
<td>17202</td>
<td>16369</td>
<td>1538/ 8.9%</td>
</tr>
<tr>
<td>Guy’s Hospital</td>
<td>5929</td>
<td>4939</td>
<td>355/ 5.9%</td>
</tr>
<tr>
<td>GSTT</td>
<td>23131</td>
<td>21308</td>
<td>1893/ 8.2%</td>
</tr>
</tbody>
</table>

*King’s College Hospital did not provide these data for 2003 and 2004*

This data gives us the best estimate of prevalence of STIs at these clinics. The number of cases of STI has generally declined over the last year at GSTT clinics. This data suggests that the prevalence of gonorrhoea and chlamydia at these clinics has also decreased from 2003 to 2004. The reasons for this decrease are not clear. It may be that more attendees come to the clinic for asymptomatic screening rather than presenting with symptoms. Further detailed analysis of GUM clinic data would be needed to ascertain possible reasons, including borough of residence, risk group and reason for attendance. **It is important to remember that this decrease is unlikely to represent a reduction in STIs in the community, as users attend a variety of services in the**
community as well as GUM clinics. STI data, similar to the KC60, is not routinely collected from the community settings.

The STI data indicate that, compared with the previous year, diagnoses of gonorrhoea and syphilis reported from GUM clinics in Lambeth and Southwark has fallen, while the rate of increase of chlamydia diagnoses appears to have slowed. However clinics in Southwark and Lambeth still have high numbers of both chlamydia and particularly gonorrhoea when compared to the total numbers across London. As a result, is unclear whether the data in this report represent a true trend in the incidence of these STIs.

Time trend data of total attendances at GUM and CRSH services indicates a decrease in the total number of attendances at GUM and an increase at CRSH services (see section 2.3). The figures below show the time trend in total attendances at both GUM services. There may be a shift in patients as testing becomes more readily available in the community. National data on the incidence of STI diagnoses in primary care indicated a higher than anticipated number for this setting.

Figure 14: Time trend from 2001 to 2005 of total number of attendances at GSTT GUM service

Total attendances for Guy's and St Thomas's GUM clinics by year

![Graph showing time trend from 2001 to 2005 of total number of attendances at GSTT GUM service.](image-url)
Figure 15: Time trend from 2001 to 2005 of total number of attendances at King’s GUM service
2.2 Chlamydia Screening

Chlamydia is now the most commonly diagnosed sexually transmitted infection in England, Wales and Northern Ireland, with 103,763 cases diagnosed in genito-urinary (GUM) clinics in 2004. The Lambeth, Southwark and Lewisham (LSL) screening programme was one of 10 sites in the first phase of the roll out and was funded for two years by the Department of Health. The Chlamydia Screening Programme is an opportunistic screening programme for genital chlamydial infection, targeting sexually active women and men under 25 years of age. Nationally in 04/05 the national Chlamydia screening programme saw a positivity rate among screened women under 25 years of age of 10.9%, and for men under the age of 25, 11.9%.

The LSL chlamydia screening steering group decided that it was important to evaluate the local service to provide evidence of effectiveness of the local programme for future funding and to refine the programme as it developed.

The findings from the 15-24 age group are presented below as this allows the calculation of screening coverage estimates using the latest GLA population estimates for this age-group. Data from screenings carried out between 01/04/2004 and 31/03/2005:
- 12,980 screening tests were carried out
- Overwhelming majority of screenings were carried out on women (87%)
- The overall estimated coverage of the target age group was about 9%; 2.5% for men and 15% for women
- 75% of screenings took place in Community Reproductive and Sexual Health clinics.

Figure 16: Percentage of chlamydia screens undertaken in LSL by clinic type - 2004/05

![Pie chart showing breakdown of chlamydia screenings by clinic type.](image)

Note: CRSH = Community Reproductive and Sexual Health

---

2 Chlamydia screening pilot programme: Lambeth, Southwark and Lewisham (South East London) – findings from first full year U.Osuagwu on behalf of chlamydia screening steering group

Generally, a wider range of ages was apparent in the women screened. In most age groups men had higher positivity rates than the women. The high rates in men could be explained by the fact that about half of the positives identified among men were in contacts.

Figure 17: Positivity rate by age group and gender from all LSL clinics evaluated.

![Figure 17](image)

Thirty three percent of screenings were undertaken on Whites, 50% were divided amongst the Black Caribbean, Black African or Black British/Black Other attendees. When positivity rates were analysed by sex and ethnicity the highest rates were seen in mixed-race women (14.6%) and other ethnic group men (25%).

Figure 18: Positivity rates by ethnic group and gender from all LSL clinics evaluated.

![Figure 18](image)
Screening tests carried out by Brook Advisory Centres had the highest rates of positive test results and outreach settings had the lowest.

**Figure 19: Positivity rates by type of clinic attended from all LSL clinics evaluated**

![Positivity rates by type of clinic attended](image)

<table>
<thead>
<tr>
<th>Screening venue type</th>
<th>Positivity rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CRSH clinics</td>
<td>13.55%</td>
</tr>
<tr>
<td>GP surgeries</td>
<td>9.30%</td>
</tr>
<tr>
<td>Outreach</td>
<td>5.45%</td>
</tr>
<tr>
<td>Brook</td>
<td>16.35%</td>
</tr>
<tr>
<td>Colposcopy</td>
<td>9.35%</td>
</tr>
<tr>
<td>Antenatal clinic</td>
<td>14.29%</td>
</tr>
<tr>
<td>Prison</td>
<td>8.99%</td>
</tr>
</tbody>
</table>

*Note: CRSH = Community Reproductive and Sexual Health*

**Expanding Chlamydia screening**

The LDP target of screening 50% of sexually active 15-24 year olds annually by 2008 is a challenging one. There are estimated to be 75,561 sexually active 15-24 year olds in LSL, which would mean that 37,780 young people would need to be screened. Based on 12,980 screens on 15-24 year olds 2004/05 in LSL, this represents only 17.2% of sexually active 15-24 year olds. Southwark's Sexual Health Action Plan outlines plans of how the volume and proportion of men being screened will be achieved (see appendix C of strategy).
2.3 Community Sexual & Reproductive Health Clinics

Information on clinic activity is available for community Sexual and Reproductive Health (SRH) services from the KT31 data return. The KT31 provides information on new and first attendances to the SRH clinics. In Lambeth and Southwark there are three SRH services – Southwark, Lambeth and King’s. Lambeth and Southwark services have four clinic sites each, whilst Kings have three sites. The national KT31 return only includes data on method of contraception. However locally the collection of data from this return allows us to look at other aspects of the service.

Large numbers of people access community SRH health services (Qtr 3 & 4 2004/05 - Lambeth 7,722, Southwark 10,355, Kings 11,105) where they can receive a wide variety of services including contraception and STI testing. Data are presented below from the KT31 in 2004/05. For the Kings service, data is only complete for quarters three and four. Therefore the data has been doubled to produce an estimate of full year figures. KT31 data is also presented in section 2.4 on contraceptive prescribing.

The number of chlamydia and gonorrhoea tests performed by each service and the number of treatments given for STIs. The proportion receiving gives a very rough estimate of the prevalence of those STIs in the clinic. However, this proportion will be affected by the number of clients who go elsewhere for their treatment after receiving a positive result. In addition there may be other STIs treated in the clinic e.g. herpes or warts.

**Figure 20: Number of tests for chlamydia and gonorrhoea compared to the number of STI treatments by SRH clinics in Lambeth and Southwark**

![Bar chart showing number of tests and treatments for chlamydia and gonorrhoea in Lambeth, Southwark, and King's College Hospital, 2004/05.](image)
Data in Figure 21 gives an indication of the volume of work undertaken in SRH clinics for clients requesting pregnancy tests and referral for a termination of pregnancy (TOP) (as a percentage of all pregnancy tests). It is not clear whether a percentage of all tests is a useful way to present this data. Further discussions with clinicians as to the usefulness of all the KT31 data are underway.

Figure 21: The number of pregnancy tests and terminations performed at RSH clinics in Lambeth, Southwark and King’s 2004/05

At the Southwark SRH service, more accurate data has been assimilated on the number of chlamydia and gonorrhoea tests and the percentage that are positive. The table below presents this data and can provide a better estimate of the prevalence of chlamydia (6.5%) and gonorrhoea (1.3%) in the Southwark clinic population. This compares to 9.5% for both STIs when using the KT31 data. The difference between the KT31 and the clinic data may be as a consequence of people visiting different services for testing and treatment.

Figure 22: Southwark SRH tests and positive results for chlamydia and gonorrhoea in 2004/05

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of STI tests</td>
<td>4106</td>
<td>(100%)</td>
</tr>
<tr>
<td>Chlamydia infection detected</td>
<td>265</td>
<td>6.5%</td>
</tr>
<tr>
<td>Gonorrhoea infection detected</td>
<td>52</td>
<td>1.3%</td>
</tr>
</tbody>
</table>

The Figures below present the time trend of total attendances for the three CRSH services in Lambeth and Southwark.
Figure 23: Time trend of total attendances at Lambeth SRH service from 2002/03 to 2004/05 (KT31)

Figure 24: Time trend of total attendances at Southwark SRH service from 2002/03 to 2004/05 (KT31)
Figure 25: Time trend of total attendances at Kings SRH service by quarter in 2004/05 (KT31)

NB Only partial data is available for quarter 2

In addition to the KT31, King’s SRH services have collected data on an ad hoc basis. The table below presents postcode data collected by the King’s SRH.

Figure 26: King’s SRH Client Origin by Postcode (637 client episodes in mid August 2005)

<table>
<thead>
<tr>
<th>Borough</th>
<th>Postcode(s)</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southwark</td>
<td>SE15, SE16, SE 17, SE22,</td>
<td>191</td>
<td>30%</td>
</tr>
<tr>
<td>Lambeth</td>
<td>SW2, SW9, SE11, SE27,</td>
<td>133</td>
<td>21%</td>
</tr>
<tr>
<td>Southwark/Lambeth border</td>
<td>SE1, SE5, SE21, SE24, SE5</td>
<td>158</td>
<td>25%</td>
</tr>
<tr>
<td>Lambeth/Southwark/Lewisham borders and other boroughs</td>
<td></td>
<td>155</td>
<td>24%</td>
</tr>
<tr>
<td>Invalid postcodes</td>
<td></td>
<td>1</td>
<td>&lt;1%</td>
</tr>
</tbody>
</table>
2.4 Contraceptive and emergency contraceptive prescribing

2.4.1 Contraception Data in Southwark and Lambeth

Reproductive and Sexual Health (RSH) services routinely collect data on the primary method of contraception chosen by women accessing those services. In addition to this data, as part of the work done by the Sexual Health Modernisation Initiative, an audit of contraception prescribing was conducted in 2004 in Southwark and Lambeth\(^4\). This audit is of particular value in that, it looked for the first time at provision of contraception across \textit{all} services in Southwark\(^5\) and enables a comparison of provision within General Practice and GU services. The audit examined data from April 2003-2004 and considered supply by cycles (for example one month supply for oral contraceptives or a single Intra-Uterine Device IUD), enabling comparison between different methods of contraception. Since service users often travel across boroughs to access contraception Lambeth and Southwark data is considered together.

\textbf{Where is contraception provided?}

The vast majority of contraception is provided within General Practice (73%), followed by Community Reproductive and Sexual Health services (23%) as shown in the diagram below.

\textbf{Figure 27: 2003-2004 Oral and injectable contraceptive cycles by type of service across both Lambeth and Southwark (excludes long term methods e.g. IUD/S and implants)}

The relative proportions of community prescribing (i.e. excluding Acute Trust/GUM ) \textit{within} each borough are shown in Figure 28. This demonstrates that in Lambeth, GPs prescribe a larger relative proportion of contraceptive cycles than Southwark GPs, since RSH services in Lambeth make up a smaller relative proportion.


\(^5\) Data was used from ePACT for General Practice prescribing and from \textit{supplies} to individual services for the same period. Services audited included RSH services, Brook clinics, GUM clinics, Acute trusts (e.g. in Gynaecology), General Practice.
Figure 28: Proportions of Community based contraceptive cycle prescribing in 03/04

<table>
<thead>
<tr>
<th></th>
<th>GP</th>
<th>RSH</th>
<th>Brook</th>
<th>Kings RSH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lambeth</td>
<td>79%</td>
<td>13%</td>
<td>3%</td>
<td>5%</td>
</tr>
<tr>
<td>Southwark</td>
<td>68%</td>
<td>20%</td>
<td>4%</td>
<td>8%</td>
</tr>
</tbody>
</table>

Total prescribing volumes of Contraceptives

In terms of overall numbers of contraceptive cycles\(^6\) prescribed in the community, Lambeth prescribed a higher total amount at 233,288 cycles in 03/04 compared with 171,418 in Southwark\(^7\).

When population size is taken into consideration in 2003/2004 Lambeth prescribed a higher number of cycles (2.83 per women aged 15-49 in 1 year) compared with Southwark (2.36/women aged 15-49 in 1 year). (Note that it is not possible to make any inference about use of contraception by these two populations as a whole from this, since a cycles can relate to one months supply of oral contraception and a single IUD providing up to 5 years contraception. Also, it does not include use of other methods such as condoms. It is presented here solely to demonstrate relative prescribing volumes across all services in comparison to population size).

Use of Long Acting Reversible Contraception (LARC) and other methods.

Recent NICE guidance on Long Acting Reversible Contraception (intrauterine devices [IUDs], the intrauterine system [IUS], injectable contraceptives and implants) advises that women requiring contraception should be given information about and offered a choice of all methods, including long-acting reversible contraception (LARC) methods\(^9\). It states that all contraceptive service providers should be aware that:

\(^6\) Relative proportions of Lambeth versus Southwark users of KCH RSH service based on postcode estimation August 2005 which estimated that 44% of users were Southwark residents and 36% of users were Lambeth residents.

\(^7\) Here contraceptive cycles include, oral contraception, injectables, implants and IUD/IUS. NB: Excludes emergency contraception.

\(^8\) Includes estimation on attributable proportions of KCH RSH users based on postcode estimation August 2005 which estimated that 44% of users were Southwark residents and 36% of users were Lambeth residents.

– “all currently available LARC methods are more cost effective than the combined oral contraceptive pill even at 1 year of use
– IUDs, the IUS and implants are more cost effective than the injectable contraceptives
– increasing the uptake of LARC methods will reduce the numbers of unintended pregnancies”.

Guidance in the Health Care Commission’s National Standards, Local Action indicator on the target relating to access to contraception\textsuperscript{10} highlights the contribution of LARC methods and states that “the proportion of women choosing the IUD, IUS or implant gives an indicator of the range of methods provided by each service”\textsuperscript{11}. This is considered in the figure below for Southwark and Lambeth, compared to England in 04/05.

**Figure 29: Comparison of % primary contraceptive method used as proportion of all primary methods between services (Source: KT-31 returns Q3-4 2004-2005)**

In England as a whole in RSH services, the % of women using LARC as a primary method (as a proportion of all methods including condoms etc) for 2004/05 is 20.4%. Lambeth and Southwark RSH services both have lower proportions (17.0% and 20.2% respectively), whilst Kings Denmark Hill service has a considerably higher proportion (31.2%) as shown in the figure below. Brook has a lower level which may be explained by the younger age group seen.

\textsuperscript{10} Target is to reduce the under-18 conception rate by 50% by 2010 (from 1998 baseline)
Figure 30: Comparison of number and proportions of women choosing LARC methods of contraception (as proportion all primary methods) between RSH services

<table>
<thead>
<tr>
<th>Primary Method Chosen (no. women)</th>
<th>Brook 04/05</th>
<th>KCH Q3-4 04/05</th>
<th>Southwark RSH 04/05</th>
<th>Lambeth RSH 04/05</th>
<th>England RSH 04/05</th>
</tr>
</thead>
<tbody>
<tr>
<td>IUD</td>
<td>34</td>
<td>284</td>
<td>339</td>
<td>281</td>
<td></td>
</tr>
<tr>
<td>IUS</td>
<td>9</td>
<td>80</td>
<td>70</td>
<td>96</td>
<td></td>
</tr>
<tr>
<td>Implant</td>
<td>50</td>
<td>166</td>
<td>119</td>
<td>131</td>
<td></td>
</tr>
<tr>
<td>Injections</td>
<td>356</td>
<td>182</td>
<td>469</td>
<td>459</td>
<td></td>
</tr>
<tr>
<td>All methods inc condoms etc</td>
<td>3746</td>
<td>2284</td>
<td>4940</td>
<td>5677</td>
<td></td>
</tr>
<tr>
<td>LARC</td>
<td>449</td>
<td>712</td>
<td>997</td>
<td>967</td>
<td></td>
</tr>
<tr>
<td>% LARC/all methods</td>
<td>11.99%</td>
<td>31.17%</td>
<td>20.18%</td>
<td>17.03%</td>
<td>19.29%</td>
</tr>
</tbody>
</table>

LARC Prescribing in Primary Care

Ensuring better access to LARC methods across all services is important, particularly in primary care. Data from the SHMI pharmacy audit demonstrates that Lambeth GPs prescribe a considerably higher number of IUD/IUS, injectables and implants than Southwark GPs. However the low percentage of LARC methods as a proportion of IUD/S, injectables, implants and oral contraceptives is relatively similar at 5.9% in Lambeth compared to 4.8% in Southwark general practice as shown in Figure 31.. (Note that this is a proportion of the methods listed and excludes condoms, diaphragms etc and one cannot compare this percentage with that from RSH services since they use a different denominator. For general practice the percentage as a proportion of all primary methods used by women is likely to be lower than shown once other methods such as condoms etc are taken into consideration).

The introduction of training and use of Locally Enhanced Service contracts with General Practice is one way of encouraging improved access to these methods.
Figure 31: Number and proportion of LARC cycles prescribed in 03/04 in general practice in Lambeth and Southwark

<table>
<thead>
<tr>
<th></th>
<th>Lambeth GPs</th>
<th>Southwark GPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>% LARC/total i.e.oral and LARC</td>
<td>5.9%</td>
<td>4.8%</td>
</tr>
<tr>
<td>total injectable cycles</td>
<td>11,037</td>
<td>5,928</td>
</tr>
<tr>
<td>Implanon</td>
<td>29</td>
<td>2</td>
</tr>
<tr>
<td>IUD/IUS</td>
<td>920</td>
<td>310</td>
</tr>
</tbody>
</table>

Variation in prescribing practice between services.

The pharmacy audit revealed variations in prescribing practice between services for example in use of different methods of IUD which have both cost-effectiveness and clinical efficacy implications. Some work has been done locally to update practitioners on which methods are recommended for use locally. Other issues that the audit highlighted included variations in the use of Dianette (not recommended as 1st line contraceptive use) and variable use of Mirena (which has cost implications). Variation in type of IUD used is shown in the following figure.

Figure 32: Use of different methods of IUD/S between services

12 Note that this is a proportion of Oral contraceptive cycles prescribed and is not the proportion of women using LARC as their main method of contraception as a percentage of all contraceptive methods.
Emergency Contraception

Access to Emergency Hormonal Contraception.

Fast access to emergency hormonal contraception (EHC) is extremely important as recent studies have shown that for every 12 hours that treatment is delayed, the risk of treatment failure is increased by 50\%^{13}. Women access EHC across a wide range of services. The largest provider in Lambeth, Southwark and Lewisham (LSL) is through the pharmacy EHC programme (33\% of use) followed by over the counter (OTC) provision at 22\% of use.

**Figure 33: Supplies of Emergency Hormonal contraception by service provider in Lambeth, Lewisham and Southwark (03/04)^{14}. Total number of supplies = 43,936**

![Supplies of Emergency Hormonal contraception by service provider](image)

**LSL Pharmacy Emergency Contraception Programme**

The Lambeth, Southwark and Lewisham wide EHC programme operates in a number of designated pharmacies across the 3 boroughs, where EHC is prescribed by a number of recognised accredited pharmacists under a patient group directive (PGD). This scheme is free for users since medications on prescription for contraceptive purposes are exempt from prescription fees. The scheme has operated since December 1999 and has been subject to a number of evaluations which have demonstrated its

---


^{14} OTC provision data provided by Schering the producers of Levonelle. This LSL wide data was not available disaggregated to Borough level at time of writing.
There are 13 pharmacies in Lambeth and 13 in Southwark currently operating in the scheme with accredited pharmacists. This pharmacy Patient Group Directive (PGD) programme holds two advantages over OTC provision to younger women in particular, since OTC provision costs users approximately £24 and can only be sold to over 16 year olds, whereas under the PGD supplies are available to under 16 year olds and prescriptions are exempt from fees. The total cost to the commissioners per consultation including medication is estimated to about £20.

Age and Ethnicity of scheme users

Women under 25 years old make up the largest group of users of this service (56% across Lambeth and Southwark) as shown in the following figure.

**Figure 34: Numbers of Consultations for EHC PGD in Southwark Community Pharmacies 2004-2005**

<table>
<thead>
<tr>
<th>Age Group</th>
<th>&lt;16</th>
<th>16-19</th>
<th>20-24</th>
<th>25-30</th>
<th>31-40</th>
<th>40+</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Southwark</td>
<td>157</td>
<td>1495</td>
<td>1838</td>
<td>1378</td>
<td>956</td>
<td>176</td>
<td>6000</td>
</tr>
<tr>
<td>% of Total</td>
<td>3%</td>
<td>25%</td>
<td>31%</td>
<td>23%</td>
<td>16%</td>
<td>3%</td>
<td>100%</td>
</tr>
</tbody>
</table>

In terms of ethnicity, White ethnic groups using the scheme are under-represented, whereas Black ethnic groups are over-represented compared with ethnicity of the Borough populations as a whole (ONS 2001 all ages), as shown in the following figures.

---

15 LSL/HAZ (2001) A Timely Service: An LSL HAZ project on access to EHC via accredited community pharmacists. Includes:
- Imogen Savage (June 2001) Community pharmacy supply of emergency contraception under a Patient Group Direction: “A service begging to be done”. An evaluation of the service providers’ perspective of a pilot scheme funded under the HAZ initiative. Pharmacy Practice Group. King’s College London
- Nottingham University (2001) An evaluation of service users’ views on accessing Emergency Hormonal Contraception through accredited community pharmacies using a patient group direction

16 Alyson Turner. (July 2003) Report on Emergency Hormonal Contraception (EHC) provision by community pharmacists in Lambeth, Southwark and Lewisham (LSL), How can mainstreaming be supported?


18 NB: Numbers relate to consultations. Not all consultations result in a supply. No. of consultations are by borough of the pharmacy and not the borough of the residence of the user. Proof of age is not required and therefore it is likely that the proportion of users under 16 years of age is underestimated.
Figure 35: Ethnicity of users of Southwark EHC scheme pharmacies 04/05

Activity levels and issues in the scheme

Lambeth has lower uptake of this service compared with Southwark. This is thought to be related to a lower number of accredited pharmacists in the scheme in Lambeth resulting from a number of them having moved on since the programme was set-up. Brixton’s provision (where high need is anticipated) is located in a pharmacy attached to a GP practice which is no longer open on Saturdays. Expected against predicted activity by month is compared in the following figures which demonstrate that in 04/05 Southwark marginally exceeded predicted activity (by 3%) compared to Lambeth which was 21% below predicted activity.
Some of these issues highlighted within the scheme have been considered as part of a review of the programme done by Southwark Public Health\textsuperscript{19}. This review has compared need within the boroughs (using proxies such as teenage conceptions and numbers of termination of pregnancies) with the current locations of pharmacies in the scheme (see maps 36 and 37). Map 36 compares location of individual pharmacies, how many consultations they provide and where their users are from and demonstrates that in general users do not travel far to access EHC. Map 37 compares ward level conception rates with number of <20 year old consultations for EHC by pharmacy. This may provide useful information to assist in planning of any additional services.

The findings from this report are being considered by a task group currently, lead by the Lambeth and Southwark Sexual Health Commissioner Tracy Walsh. There are particular concerns that whilst it was an initial requirement of the pharmacies being accepted into the scheme that they open on Saturday mornings, a number within the scheme are no longer able to do so. Also EHC will only be available if the accredited pharmacist(s) are present in the pharmacy when the client attends and this is a particular issue in those pharmacies that use high numbers of locum staff or have only one accredited pharmacist.

Figure 36: Map showing location of individual pharmacies, how many consultations they provide and where their users are from.
Figure 37: Map showing the total number of EHC consultations for under 20 year olds for each pharmacy (04/05) and the teenage conception rates for each ward (2000-2002)
Access to Emergency IUD provision

For women seeking emergency contraception after 72 hours, dependant on a number of clinical factors, the intra-uterine devise may be an option as a method of emergency contraception. The numbers of women accessing this as a method of emergency contraception are a very small proportion of the total number of women accessing emergency hormonal contraception. Access to services on Saturday are of particular importance since time limits on use of this method are clearly defined. Recent temporary closure of the Saturday service at King's Denmark Hill RSH service raised particular issues regarding access since alternative provision is extremely limited over the weekend period.
2.5 Teenage Pregnancy\textsuperscript{20}

Preventing unintended teenage pregnancy is an important concern for both Lambeth and Southwark. Teenage pregnancy has been shown to be associated with a number of poor outcomes for both the parents and the child. Teenage mothers are more likely to be poorly qualified, unemployed and suffer poorer mental health. Children of teenage mother suffer as young adults in terms of lower educational attainment, a higher risk of economic inactivity and of becoming a teenage mother themselves. Southwark has set targets to reduce the number of teenage conceptions.

The overall rate of under 18 conceptions remains high for Southwark, with a rate of 85.2/1000 15-17 year old females in 2004. (This is compared to a 1998 baseline of 87.2/1000 and a target trajectory of 74/1000 for 2004).

**Figure 38: Progress since 1998 baseline rate.**

![1998-2004 % reduction in rate](image)

The gap between target and achievement has been widening in the past few years as shown below.

**Figure 39: Progress on reducing teenage conceptions compared with target trajectory for Southwark**

![Progress on reducing teenage conceptions compared with target trajectory for Southwark](image)

\textsuperscript{20} This section is an updated summary of the findings of the following report: D.Butt, S. Petrie, N.Jani (2006) Mapping of hotspots: An analysis of teenage conceptions in Southwark 2002-04. Department of Public Health Southwark PCT.
Births have reduced slightly, whilst there has been a slight increase in terminations to teenagers such that overall the teenage conception rate has remained fairly static.
**Under 16 year old conceptions**

Southwark has particularly high rates of *under 16 year old* conceptions compared with England as a whole. Whilst the overall under 18 conception rate for Southwark is 1.9 times higher than England, the under 16 year old conception rate is 2.3 times higher according to ONS statistics for 2003.

In 2003 22.2% of teenage conceptions were in under 16 year olds in Southwark, compared to 23% in Lambeth and 19% in England. Conception and birth rates increase with age as expected, but rate of abortions in the under 16s are lower than might be expected, highlighting the importance of prompt access to pregnancy counselling and termination services in this age group. (For this period in the under-16 population, the overall proportion of conceptions terminated was 67%, compared with an overall <18yr old proportion of 60%.)

**Timings of conceptions**

There is some evidence of monthly variation in rates but the reasons for this are unclear. Rates seem to peak in May and in recent years there has been an increase in the number of conception towards the end of August and September in line with the end of the school vacation periods. This information highlights the need for targeted education and outreach work preceding and during school holidays, ensuring that young people know how to access contraception and emergency contraception.

**Ward level rates**

Between 2001 and 2003, Livesey and Nunhead had the highest conception rates in Southwark. (Source: number of conceptions ONS, denominator GLA R2005 interim projections)\(^{21}\).

**Figure 42: Ward conception rates 2001-2003 (Source number of conceptions: ONS, source 15-17 ward populations GLA R2005 interim projections).**

\(^{21}\) NB: Ward rates differ according to the estimated population number in the denominator. Rates calculated locally in Southwark based on ONS number of conception/GLA R2005 interim projections are thought to reflect more accurately the 15-17 year old population than the rates released for all local authorities in March 2006 by ONS.
There has not been a steady increase in the number of conceptions across all wards. Local data between 2002 and 2004 shows that Peckham, Grange and South Camberwell have largest increase in rates. Grange has the highest percentage increase, therefore is changing the most significantly. South Bermondsey has shown a large overall and percentage reduction in teenage pregnancy rates. Formally had one of the highest rates in the borough; there may be lessons to be learned from wards which have demonstrated reductions in conception rates.

Figure 43: Change in conception rate between 2002 and 2004. (Locally derived data\textsuperscript{22})

There is a strong link between teenage pregnancy and deprivation. Nationally this association is weakening. It is unclear why this link remains strong in Southwark but may be related to ethnic diversity.

Figure 44: Correlation between deprivation and conception rates by ward, Southwark 2004.

Ethnicity
Equal proportions of teenage births occur in Black teenagers compared with White teenagers in Southwark.

Figure 45: Ethnicity of Teenagers giving birth in Southwark

Consideration of numbers of births alone is misleading without considering conceptions resulting in termination and comparing rates between different ethnic groups within these broad categories. Conception rates and birth rates are highest amongst teenagers from the Black Other category. Conception rates in the Black Caribbean and mixed race groups (white and black African and white and black Caribbean) exceed local target conception rates.

Figure 46:

Due to the way this ethnicity data was collected, Black Other as a category may contain a high number of Black British.
Termination rates in the black African group are higher than expected (74% of pregnancies ending in termination compared with 62% overall for all ethnicities) which does not support any theory that a higher proportion of pregnancies in this group are intended. The proportion of pregnancies terminated in Black Caribbean, and mixed race white and black Caribbean and white and black African groups are higher than the proportion terminated in White British. This may indicate that White British conceptions are more likely to be intended compared with teenage conceptions in other BME groups.

**Figure 47: 2002-2004 Conceptions:**

Map of teenage pregnancy education/prevention, outreach work and support to young parents demonstrates that for the most part this work has occurred predominantly in areas with the highest conception rates.

**Mapping**

Maps have been produced showing hot-spots of areas with high numbers of teenage conceptions. These are available in the report “Mapping of hotspots: An analysis of teenage conceptions in Southwark 2002-04”

Certain estates demonstrate high numbers of teenage conceptions. These include the Rodney estate, Aylesbury estate, Michael Faraday House, Glebe estate, Acorn estate and the North Peckham Estate.

Areas with high numbers of conceptions in different ethnic groups vary considerably. In particular White British teenagers on St. Saviours Estate, Black Caribbean teenagers living in the Rockingham Estate, the Aylesbury, North Peckham and Acorn estates and Black African teenagers in Rockingham, Rodney and Aylesbury estates.

Mapping of teenage pregnancy education/prevention, outreach work and support to young parents demonstrates that for the most part this work has occurred predominantly in areas with the highest conception rates.

---

Review of Teenage Pregnancy

Work to reduce teenage pregnancy and support to teenage parents is currently the subject of a review by Southwark Alliance, the Local Strategic Partnership. The results from this review will be available in Autumn 2006.
2.6 Termination of Pregnancy

Preventing unintended pregnancy and its adverse outcomes is an important concern for LSL. The period abortion rate (equating to the average no. of terminations per woman in reproductive lifespan)\textsuperscript{25} for SE London is higher than any other Strategic Health authority areas (see figure below). High levels of unintended pregnancy resulting in high levels of TOP result in increase cost to the health service across LSL and potential risk to the women concerned.

![Figure 48: Total period abortion rate\textsuperscript{26} for SE London compared with other strategic health authorities (Compendium 2004).](image)

At PCT level Southwark, Lambeth and Lewisham have the highest rates of termination of pregnancies (TOPs) in England and Wales (ranked 1\textsuperscript{st}, 2\textsuperscript{nd} and 3\textsuperscript{rd} respectively amongst local authorities). The figure below demonstrates that LSL have higher rates than might be expected for similar areas of London and one possible reason for this may be because non LSL residents use termination services in LSL.

\textsuperscript{25}Average no. of abortions/births throughout reproductive lifespan if current age specific rates maintained throughout.

\textsuperscript{26}As above.
Figure 49: Comparison of abortion rates per 1000 15-44 year olds between local authorities in England and Wales 2004.

![Graph comparing abortion rates between local authorities in England and Wales.]

Figure 50: Termination of pregnancy rates by age groups for LSL (Source: ONS 2004)

<table>
<thead>
<tr>
<th>Rate per 1000 women</th>
<th>&lt;18 yrs</th>
<th>18-19 yrs</th>
<th>20-24</th>
<th>25-29</th>
<th>30-34</th>
<th>35+</th>
</tr>
</thead>
<tbody>
<tr>
<td>ENGLAND</td>
<td>18</td>
<td>18</td>
<td>33</td>
<td>24</td>
<td>14</td>
<td>7</td>
</tr>
<tr>
<td>Southwark</td>
<td>46</td>
<td>48</td>
<td>99</td>
<td>77</td>
<td>57</td>
<td>36</td>
</tr>
<tr>
<td>Lambeth</td>
<td>43</td>
<td>48</td>
<td>95</td>
<td>77</td>
<td>43</td>
<td>30</td>
</tr>
<tr>
<td>Lewisham</td>
<td>40</td>
<td>38</td>
<td>79</td>
<td>74</td>
<td>52</td>
<td>32</td>
</tr>
</tbody>
</table>

Women in the 20-24 year old age group make up the largest group of women using TOP services in the SE London sector, as shown below. 68% of terminations in SE London occurred in women below 30 years in 2004, whilst 44% of all SE London TOPs occurred in under 25 year olds.

Figure 51: Numbers of terminations by age group (ONS 2004) for SE London (LSL, Bromley, Bexley and Greenwich)

<table>
<thead>
<tr>
<th>Age in Years</th>
<th>&lt;18</th>
<th>18 - 19</th>
<th>20 - 24</th>
<th>25 - 29</th>
<th>30 - 34</th>
<th>35+</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;18</td>
<td>870</td>
<td>1,139</td>
<td>3,225</td>
<td>2,867</td>
<td>1,934</td>
<td>1,803</td>
<td>11,838</td>
</tr>
<tr>
<td>7%</td>
<td>10%</td>
<td>27%</td>
<td>24%</td>
<td>16%</td>
<td>15%</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>
Repeat terminations

There are high numbers of repeat terminations in SE London. According to recent estimates amongst women having terminations in SE London in 2004, overall 43% had had a previous termination. This proportion varies amongst different age groups (33% of <25 year olds and 14% of under 18 year olds having had a previous termination. This emphasises the importance of access to acceptable and effective contraception and emergency contraception locally, particularly amongst young women.

Providers

Termination of Pregnancy (TOP) data is collected from the three main providers for this service – Marie Stopes, BPAS and Kings. The figure below presents data for all these providers in 2004/05.

Figure 52: Number of TOP for Southwark PCT residents 2004/05 by provider

<table>
<thead>
<tr>
<th>Provider</th>
<th>Number of TOPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marie Stopes</td>
<td>752</td>
</tr>
<tr>
<td>BPAS</td>
<td>593</td>
</tr>
<tr>
<td>Kings (estimate)</td>
<td>306</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,651</strong></td>
</tr>
</tbody>
</table>

Unfortunately the data from Marie Stopes and Kings are not complete and so analysis has focused on BPAS. It may be reasonable to suggest that the ethnic group and age breakdown for BPAS would be similar to that of Marie Stopes based on referral procedures. However this may not be the case for King's, where later pregnancies and younger women tend to be referred.

Figure 53: Number of TOPS by BPAS 04/05 – Age group and gestational age for Southwark PCT residents.
2.7 HIV

2.7.1 New HIV diagnoses

The number of new cases of HIV diagnosed is collected routinely providing a good indication of the incidence of new diagnoses.

Figure 54:: Number of new cases diagnosed with HIV in 2004* by gender

![Graph showing number of new cases diagnosed with HIV in 2004 by gender and region]

Source: HIV & AIDS Reporting System (HARS), Centre for Infections, Health Protection Agency.

* Includes reports received to September 2005. Numbers of HIV diagnoses will rise as further reports are received.

Numbers of people diagnosed with HIV in 2004 in SE London are compared to numbers of people in London and England and Wales.

2.7.2 Diagnosed HIV Infection

The best available data on diagnosed HIV prevalence comes from the Survey Of Prevalent HIV Infections Diagnosed (SOPHID). The data is collected from all HIV centres and patients are included at the HIV centre they last attended in each year.

HIV in Southwark

According to SOPHID (the Survey of Prevalent HIV Infections Diagnosed, conducted annually by the Health Protection Agency), there are 1542 people with diagnosed HIV resident in Southwark by 2004 – 1079 males and 463 females. There has been more

---


28 This section is adapted from the findings of the recent report for a recent Southwark Health and Social Care Board meeting: A. Maryon Davis (Oct 2005) HIV prevention in Southwark. Southwark PCT.
than a doubling in the prevalence of diagnosed HIV infection in inner SE London boroughs between 1996 and 2004, with Southwark displaying the second highest prevalence rates in the region after Lambeth. Southwark has a prevalence rate of more than double the rate for London and eight times that for England.

Figure 55: Prevalence of HIV Infection amongst residents of South East London 1996-2004

![Graph showing prevalence of HIV infection in South East London](image)

Source: Survey of Prevalent Diagnosed HIV Infections (SOPHID), Centre for Infections, Health Protection Agency

**Women and children (Unlinked Anonymous Survey Data)**

However, many HIV-infected people are undiagnosed. In order to assess true prevalence, including those cases not diagnosed, the unlinked anonymous surveys provide data from a variety of settings - GUM clinics, antenatal clinics and services for injecting drug users. With women and children, this is performed by carrying out anonymous surveys of blood samples from antenatal women and newborn babies. These surveys provide an indication of the prevalence of HIV in pregnant women, and arguably provide a more accurate measure of the true prevalence of HIV infection in the general population.

Among antenatal women, the rates at our two main clinics (Guy's & St Thomas’ (GST) and Kings (KCH)) were 0.70% and 1.04% in 2004 respectively (see graph).
Figure 56: Antenatal Clinic Attenders Survey: Prevalence rates 1992 – 2004

Source: Antenatal Clinic Attenders Survey, Centre for Infections, Health Protection Agency.

A prevalence of 0.72% in babies born to mothers in Lambeth, Southwark and Lewisham (LSL) in 2004 means that one newborn baby in 140 is HIV positive – six times higher than the national rate.

Figure 57: Newborn babies: Prevalence rates 1992 – 2004 LSL and England


**Antenatal Infection Surveillance Scheme**

Antenatal screening includes testing for HIV, syphilis and hepatitis B. The following figure presents data by trust including uptake rate and prevalence per 1000 population.
Figure 64: Antenatal testing undertaken at Guy’s & St Thomas’ and King’s

<table>
<thead>
<tr>
<th></th>
<th>Guy’s &amp; St Thomas’</th>
<th>King’s</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage uptake</td>
<td>98.7%</td>
<td>93.8%</td>
</tr>
<tr>
<td>Prevalence per 1000 women tested</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV</td>
<td>8</td>
<td>7.7</td>
</tr>
<tr>
<td>Syphilis</td>
<td>7.6</td>
<td>11.1</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>21.9</td>
<td>23.1</td>
</tr>
</tbody>
</table>

Source: Antenatal Infection Surveillance Scheme, Regional Epidemiology Unit, HPA London

Contributory factors to high prevalence
The main contributors to the increase in prevalence in the UK are:
- increased immigration and travel to and from areas of the world with high prevalence
- an increase in HIV amongst gay men
- increased survival of people living with HIV due to better treatment with antiretroviral drugs

Ethnocultural
In Southwark there is a particularly strong association with our large African community. Since 1996, Black Africans have emerged as the group in which the greatest numbers of new cases of HIV infection occur in SE London, accounting for much of the increase in incidence overall. More than two thirds of HIV infections diagnosed in the UK last year were due to heterosexual sex, 90% of those infections were caught abroad, 80% in Africa.

Figure 58: SE London New Diagnoses of HIV 1992 - 2004 by ethnic group

Source: HIV & AIDS Reporting System (HARS), Centre for Infections, Health Protection Agency.
Transmission

Acquisition attributed to sex between men and women is increasingly important (heterosexual transmission). In SE London in 2004, 24% of new diagnoses were likely to have been acquired through sex between men (MSM), 71% through heterosexual transmission, 2% through intravenous drug use and 3% through vertical transmission (mother to child).

However, it is likely that the majority of this heterosexual transmission occurred in Africa and not the UK. In heterosexually acquired infections diagnosed in SE London in 2004, 74% of exposure was thought to be abroad (88% of which in Africa), 19% were thought to be acquired in the UK and the remainder was either from a partner with a high risk e.g. MSM or IDU (0.86%) or was unknown (6.6%)\(^\text{30}\). In contrast, it is likely that the majority of infections in men who have sex with men is acquired in the UK/Europe. In 2004 in SE London there were 157 new diagnoses of HIV in MSM compared with 467 in heterosexual men and women, of whom 87 were thought to have acquired their infection heterosexually in the UK. Therefore it is important that health promotion messages continue to target both MSM and African communities in SE London.

---

\(^{29}\) This section contains data from new diagnosis reports. This is not true representation of what 2005 data will be since it only includes reports received to the end of September 2005.

\(^{30}\) HPA Centre for Infections and Institute of Child Health (October 2005). Strategic Health Authority HIV diagnoses surveillance tables.
Figure 60: New diagnoses of HIV infection SE London 1992-2004, by probable route of infection (NB: Data not currently available on IDU and sex between men for 2004)

Source: HIV & AIDS Reporting System, Centre for Infections, Health Protection Agency.

Figure 61: Numbers of diagnosed HIV-infected patients in 2004 by probable route of infection

Source: Survey of Prevalent Diagnosed HIV Infections (SOPHID), Centre for Infections, Health Protection Agency

Gender

Among diagnosed HIV infected patients in Southwark there are more than twice as many men than women.
**Gay men**

HIV prevalence in the UK’s gay men varies from 4% in rural areas to 12% in London. However, the Gay Men’s survey is amongst high risk MSM (i.e. those who use clubs, saunas and attend GUM clinics) and therefore may not reflect the overall prevalence of gay men in general.

In the UK incidence among gay men has increased by 40% in the last five years. Some of this may be due to more gay men coming forward for HIV tests, and some to an increase in immigrant gay men (particularly from southern Europe) who are able to live openly in the UK where they may not have done in the country of birth.

**HIV Care**

Southwark has the second highest rate of residents seeking HIV care in London as shown in the following figure.
Figure 63: Residents of London living with diagnosed HIV infection and seeking care, by Strategic Health Authority (SHA) and Primary Care Trust (PCT) of residence per 10,000 population

(Reported through the HPA survey of prevalent diagnosed HIV infection (SOPHID) in 2004 (HPA London Surveillance Bulletin November 2005)

2.7.3 Sexual Health survey of Gay Men

The Centre for Sexual Health & HIV Research conducts an annual sexual health survey among gay men. In 2003 this survey questioned 2,452 in a variety of setting across London (gay bars, clubs, saunas and GUM clinics)31. Of all the men recruited, 62.9% (1,541) were recruited for a saliva test.

---

31 This survey may therefore not reflect the overall prevalence in gay men in general.
The HIV prevalence in the 2003 survey was 12.3%, with 44.1% of HIV positive men remaining undiagnosed. The proportion having tested HIV positive among those who had unprotected anal intercourse (UAI) with one and more partners in the last year has increased from 49.6% to 54.5% in 2003. The proportion reporting UAI with partners of an unknown or discordant HIV status has not changed. 45.9% of the HIV negative men reported UAI in the last year compared with 54.5% of HIV positive men. At the same time, 27.8% of HIV positive men and 20.6% of HIV negative men reported UAI with partners of an unknown or discordant status. More than half of the total sample (57.2%) had attended a GUM clinic in the last year.

HIV saliva positive men were
- Older with median age of 36 compared to 33 in HIV saliva negative men
- Less likely to be employed than the HIV negative men
- More likely to be non-white
- Less likely to be educated after the age of 16

Those having UAI with one or more partners in the last year were:
- More likely to be younger
- Significantly more likely to have attended a GUM clinic in the last year
- More likely to have had an STI in the last year
- More likely to have had an HIV test
- More likely to report their last HIV test to be positive
2.8 Demand and Capacity – Modernisation Initiative

The modernisation initiative has collected a huge volume of data on demand and capacity of sexual health services in Lambeth and Southwark. Only a small fraction of the data is presented in this section. Much of the data looks at how structures and processes in the clinics could be improved.

The figure below presents data collected from one of the community SRH services over a four-week period. The data gives an indication of the most commonly undertaken activities at the clinic. Specialist staff are appropriately undertaking many of these activities. However, there are some activities that could be undertaken in a different setting. For example, this service undertook 71 pregnancy tests during that time period. Pregnancy tests represent one activity that could be delivered on a self-management basis rather than by utilising specialist staff.

Figure 54: Data collected from one community clinic for a four week period:
Figure 55: Transit time data at King’s GUM clinic 4 days before and 4 days after the introduction of a slot system

This figure demonstrates how transit times were decreased by introducing a new slot system into the clinic’s processes for dealing with patients. The figure below gives an indication of the proportions of each type of activity undertaken in each setting.

Figure 56: Sexual health concerns presentations at all services in Lambeth & Southwark for one week

Providers & Sexual Health Concern (scaled up figures, per week)

Source: Demand & Capacity Data Collection Week 2004
The figure below presents data from one GUM clinic and gives a more detailed picture of the proportions of each type of activity delivered in the clinic. For example, almost 30% of activity is screening asymptomatic patients. This is another example of an activity that could be undertaken in a different setting using non-specialist staff or even self managed.

**Figure 57: Demand and capacity data from one GUM clinic in Lambeth and Southwark**

**Figure 58: Primary Care Demand Detail By Gender and Type of Sexual Health Enquiry**
Figure 59: Sexual health activity and appointment requests in primary care by practice and type of activity

Sexual Health Activity and Total Appointment Requests

Source: Demand & Capacity Data Collection Week 2004

Figure 60: Projected volume of sexual health concerns presenting to GPs LS wide

Projected Sexual Health Concerns Presenting to GPs LS Wide

Source: Demand and Capacity data collection, MI
2.9 Laboratory service data

2.9.1 Sexual Health Laboratory Service Evaluation

An evaluation of the diagnostic sexual health services provided by one acute trust in SE London – Kings College Hospital. This work was part of the Modernisation Initiative.

Increase in demand for sexual health services, both in SE London as well as nationally, has increased the workload of diagnostic laboratories. Patients are currently advised that it may take up to two weeks for a test result to be available, although positive results are usually reported more quickly. Service users and providers have expressed dissatisfaction with the methods and duration of reporting test results. The implications of delayed results are continued transmission of infection\textsuperscript{32}, increased sexual health morbidity, and anxiety for the patient and others concerned. In order to reduce the waiting time for test results, and therefore improve outcomes for patients, it was necessary to know where delays occurred. Once identified, could these delays be reduced, without compromising diagnostic accuracy?

Data were collected from stakeholder interviews, laboratories and clinics, and by participant observation and included case notes review and process mapping. Raw data for all intervals within the process of laboratory testing were calculated including ‘transport time’ (days from sample taken to sample booked in to the laboratory); ‘laboratory turnaround time’ (days from sample booked in to date reported); and ‘total test time’ (days from sample taken to date reported). Case notes from the GUM clinic for all cases of CT diagnosed during one month were identified for review of contact tracing. The number of contact slips given out and contacts identified was recorded.

The best areas of the service were laboratory structures, diagnostic procedures and test appropriateness. The most serious failings identified were transport of specimens to the laboratories, and the time taken for Chlamydia results to be reported.

The key results were as follows:

- The transport time for chlamydia samples, and the proportion that arrive within 1 and 3 days (including weekends). The median transport time is 1 or 2 days, but as high as 16 days. Less than 80\% of all samples from sites other than the GUM clinic arrive within 3 days.
- The number of working days from arrival of specimen in the laboratory to reported result. Median times range from 2 (negative gonorrhoea) to 7 days (positive chlamydia).
- The total test time for positive samples at two sites where the arrival of results was recorded at the clinic. The longest median time (11 working days) is for positive chlamydia results from a community clinic.
- The proportion of results reported within 10 working days. For most tests, over 90\% of results are reported within this time, but positive chlamydia tests fall short with less than 75\% meeting the standard (interviews and data analysis).
- Over a one month period 149 cases of chlamydia were diagnosed at the GUM clinic among both sexes. For each patient the number of potential contacts was

\textsuperscript{32} Transmission of infection is related to the basic reproductive number (R\textsubscript{0}). This depends on the probability of transmission, the duration of infectiousness and the rate of sex partner change. Prompt diagnosis and effective treatment of patient and partners will reduce the duration of infectiousness, and thus further reduce transmission of infection in the community.
recorded, and a further record was kept of how many of these presented for treatment. A total of 61 contacts were known to have returned, giving a figure of 0.4 contacts per case diagnosed.
3. Corporate Needs Assessment

3.1 User involvement

Public and service user involvement mechanisms for facilitating feedback have an important role to play in improving the quality of services (MedFASH). Both Southwark and Lambeth PCT work together with other agencies in partnership with service users and service providers. Over the last few years, opinions and views of service users have been gained through a variety of surveys and focus group discussions conducted in clinical and non-clinical settings. The following documents contain the main evidence, which are summarised for the purposes of this document.

- User Service Mapping carried out by the Sexual Health Modernisation Initiative;
- Mystery Shopper Feedback (March –April 2005), Southwark PCT Sexual and Reproductive Health
- ‘Involving service users in sexual health service development’, study conducted among young people by Paula Baraitser et al.; J Fam Plann Reprod Health Care 2005;
- Young Black Fathers and Maternity Services, Sue Pollock(University of Bristol, Richmond Trew (St Michaels’s Fellowship), Kathy Jones (Fathers Direct)
- Sexual health survey of gay men – London 2003;
- SHIBAH research of sexual health issues affecting Black Africans living with HIV in Lambeth, Southwark and Lewisham (LSL) 2003;
- ‘Outsider status’ Stigma and discrimination experienced by Gay men and African people with HIV, 2004;
- Sigma research on ‘What do we need’ national survey of people living with HIV, 2002;
- Project NASAH - an investigation into the HIV treatment information and other needs of African people with HIV resident in England,2003;
- Rethinking of HIV service user involvement in South London: Findings from a consultation, April 2005, South London HIV Partnership and
- Other unpublished reports.

Although generalisation of these findings raise questions, the surveys focused on those elements of user’s experiences that common to many users and across services, in this way identifying the ways to improve the important areas of a service improvement. We reviewed all available information in this field and grouped into themes reflecting main views and concerns for general service users. In addition we attempted to list the specific concerns raised by those living with HIV, gay men and young people respectively. These findings again cannot necessarily be generalised to all these specific groups of the community members, given the relatively small number.

3.1.1 Main areas of concern of general service users:

- Poor communication - Available services are poorly advertised. Service users are not aware of the existing sexual health services and are not sure where to get information about these services. Service users often do not get enough information from health care professionals. Lack of clear guidance on referral to specialist help and related clinical procedures create unnecessary anxiety among service users. For example, lack of explanation what would happen during the first visit to clinic,
when they should know about results of their test, whether they should refrain from sex or not during this time.

- Access to service - Some service users expressed difficulties in booking appointment over telephone and in person, long waiting for the appointment and not flexible opening times for those working.
- Quality of service - Stigma and embarrassment attached to attending sexual health clinics, lack of confidentiality due to space management of reception and waiting area and waiting time is longer than expected.
- Attitude of health service providers - Attitude of administrative staff especially receptionists at the clinics were regarded as poor and unwelcome. Service users experienced lack of sensitivity, dismissiveness, abruptness and failure to listen to their concern.

3.1.2 Service users living with HIV

This group felt that attitudes of health professionals had been explicitly discriminatory mainly because of HIV status, but also because of sexuality, immigration status and age. They complained about professional knowledge of HIV some health care professionals predominantly GPs, simply did not have the understanding of HIV to give them an acceptable service. Lack of continuity of care and restrictions on which services they can access are confusing, frustrating and reduce their choice. The following key issues were raised by HIV service users:

- Isolation
- Poor communication due to poor English
- Poor resources limit participation in community work
- Lack of involvement in the decision making process
- Lack of training and support for those wanted to be involved in advocacy
- Lack of support for those who wanted to work
- Lack of organised events and activities at community level to bring people together and share information and experiences

3.1.3 Gay men

For gay men living with HIV, current hostile environment has a negative impact on their physical and psychological health. Some hide their HIV status and experience stress and social isolation. Many of those who are open about their HIV status experience flagrant and explicit discrimination. For example, some health care workers, dentists and doctors refuse to provide care or avoid patients who are gay, and many gay men living with HIV/AIDS do not seek (or may not seek early enough) the treatment they need. Further focus group is being planned with gay men in particular to discuss the new model of service provision.

3.1.4 Young people

Further focus group is being planned with young people in particular to discuss the new model of service provision as part of a Lambeth and Southwark young people’s sexual health provision needs assessment

---

33 Dr Ruhi Jawad. (SpR N. Southwark SRH service) Ongoing 2006.
3.1.5 Expectant mothers and fathers, and young parents
Young men do not feel that they are part of the equation. They desired to be included in
the pregnancy and in its all stages as their girlfriends/partners. They felt that antenatal
clinics are feminised, medicalised environment and ignorant attitude of receptionists put
them at unease.
3.2 Stakeholder views
Stakeholder views have been assimilated from a number of events including the MI conference ‘Pulling it together’.

3.2.3 Modernisation Initiative ‘Pulling it Together’ Conference
56 participants from 19 organisations – including representatives from general practice, voluntary sector & local authority representation

a. Gaps for strategy development
(i) Prevention & health promotion
- Cross local boundaries – more joint commissioning; borough boundaries not important to real people; service configuration to reflect how people really live
- Poor info / co-ordination / mixed messages in health promotion – need to co-ordinate & agree consistent messages
- Poor links to national campaigns – often hear about it too late to tie in with local work – only effective if happens at all levels
- More outreach to where people really are (community, schools, social venues, etc) – co-ordinate under network with SH strategy as a driver
- Realistic & rigorous evaluation of prevention work
- Evidence based - must address health inequalities
- Target groups – needs to acknowledge not all groups are equally affected – young people, gay men, some BME communities need targeted work
- Partnership for public health approach is vital – must work across voluntary sector, Local Authority (including looked after children, those educated out of borough, excluded children, etc), schools, Youth Offending Teams, etc
- How do we know what we don’t know? Need better needs assessment & information collection. Strategy should map population-based expectations of need
- The Network is a model / vehicle for improving co-ordination

(ii) IT
- Co-ordinated, integrated services need joint IT systems
- Results, records, data & monitoring info – 1 system across all services
- IT system to improve monitoring
- IT links needed to labs for results
- Need more creative use of interactive IT / websites
- Monitoring service use – any Oyster Card type technology available & appropriate?

(iii) Diversity issues
- Target groups to reflect local epidemiology
- Translated materials – must have these available to reflect languages spoken locally and different literacy levels
- Target groups can use (and often want to use ) mainstream services but these need training and support to make it a welcoming and appropriate environment

b. Meeting the national targets
- More Chlamydia screening – especially for men
- More easy access, longer term prescriptions for contraception
• More PGDs and use of pharmacy
• Quicker training for staff – courses often take too long

c. New Service Model
A resounding yes to the new model proposals but questions – mainly practical, especially for new centres:

(i) New Community-based SH centres:
• Need some specialist input in new centres – what is really suitable for self-management?
• How feasible / practical is non invasive / point of care / testing outside clinical settings? Evidence? Breaking down pre-conceived ideas?
• Premises - attractive High St location – will help to break down stigma / normalise sexual health. Are people ready for this? Will need slick marketing
• Staffing – existing staff or newly recruited. All has an implication for existing services
• Needs to reduce health inequalities
• Links to wider issues – services for drugs, alcohol, refugees etc to have clear relationship / referral pathways into centres
• Long opening hours – essential for good access; also good transport links
• Clinical governance – how this is done will depend upon who runs it. Important to get it right.

(ii) Combined specialist GUM & SRH:
• Yes to combining SRH & GUM – has to happen, but who moves & is there a risk of continued under investment in SRH
• Co-location of services or more?
• Training will need to reflect the proposed integrated nature of specialist services – staff who can do GUM and SRH
• What if HCWs don’t want to do it?

(iii) Basic level of provision in community pharmacy & general practice:
• Pharmacy – can do a lot but not complex stuff and will struggle with some of it. Needs support. Some not appropriate (e.g. HIV)
• Likewise general practice will need support
• Look also at how pharmacy services link with new community SH centres

(iv) Other issues around the model:
• Phased implementation – over 5 years.
• Major issue – what use do we make of existing estates & facilities? Any buildings suitable?
• Can be time consuming & costly. Can we build from scratch?
• HIV testing in the community – does it end up taking longer? Reliability?
• Non invasive testing in non health settings – clinical governance? How feasible?
• Need to present evidence about these new technologies & approaches – requires culture change – needs to be supported by the strategy
4. Current Service Provision

Generally, local GUM clinics are open during office hours Monday-Friday with some early and late clinics. None are open at the weekend. Southwark community SRH services are provided in a number of community clinic locations and at different times. Work with service users by the MI indicated that consistent hours were preferred e.g. 8am-8pm. The table below gives an overview of the general availability of services. More detailed maps of additional primary care provision are available from Public Health.

<table>
<thead>
<tr>
<th>Services available</th>
<th>Before 9am</th>
<th>AM</th>
<th>PM</th>
<th>After 5pm</th>
<th>Weekend</th>
</tr>
</thead>
<tbody>
<tr>
<td>GSTT (Lydia Clinic – St Thomas’ Hospital)</td>
<td></td>
<td>Mon, Tues, Thurs, Fri</td>
<td>Mon, Tues, Wed, Thurs, Fri</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GSTT (Lloyd Clinic – Guy’s Hospital)</td>
<td></td>
<td>Mon, Tues, Thurs, Fri</td>
<td>Mon, Tues, Thurs</td>
<td>Tues (Gay/bisexual)</td>
<td>Wed (Under 25s)</td>
</tr>
<tr>
<td>Southwark SRH –3 clinics</td>
<td></td>
<td>Mon, Tues, Wed Thurs, Fri</td>
<td>Mon, Tues, Wed Thurs, Fri</td>
<td>Mon, Tues, Wed Thurs, Fri</td>
<td></td>
</tr>
<tr>
<td>King’s SRH – Denmark Hill</td>
<td></td>
<td>Mon, Wed, Thurs, Fri</td>
<td>Mon, Wed, Thurs, Fri</td>
<td>Mon, Wed, Thurs up to 7.30pm, Fri up to 6.30pm</td>
<td></td>
</tr>
<tr>
<td>Kings SRH – Townley Road</td>
<td></td>
<td>Wed</td>
<td>Mon</td>
<td>Mon up to 8pm</td>
<td></td>
</tr>
<tr>
<td>Kings SRH – Peckham Pulse</td>
<td></td>
<td>Wed</td>
<td>Mon, Tues, Wed, Thurs</td>
<td>Mon, Tues, Thurs up to 7pm</td>
<td></td>
</tr>
<tr>
<td>Brook Young People’s Service – East Street</td>
<td></td>
<td>Mon, Tues, Wed Thurs, Fri</td>
<td>Mon, Tues, Wed Thurs, Fri</td>
<td>Sat</td>
<td></td>
</tr>
<tr>
<td>King’s GUM (Caldecot Centre)</td>
<td>Tues, Wed (from 8am)</td>
<td>Mon, Tues, Wed, Thurs, Fri</td>
<td>Mon, Tues, Thurs, Fri</td>
<td>Wed (Gay/bisexual), Thurs (under 20s)</td>
<td></td>
</tr>
</tbody>
</table>

Activity data

Estimating the numbers of people using services is difficult as most service data relates to attendances rather than individuals. We know the number of people attending HIV Centres, as data are collected through SOPHID (Survey of prevalent HIV diagnoses), the number of teenage conceptions and the number of women seeking terminations of pregnancy.

Other services collect attendance data which means that the number of people cannot be estimated as people may attend for more than one reason or for repeat treatments if re-infected. Another complication is that GUM services are open access, confidential services and Southwark/Lambeth residents can attend a clinic in any area. More than
50% of people living with HIV attend HIV centres in North London and it is likely that a proportion of the GUM population are also attending clinics elsewhere in London. The table below summarises the information on service utilisation by Southwark residents and should be treated with caution as 12-month projections have been extrapolated from small datasets in some cases:

<table>
<thead>
<tr>
<th>Service</th>
<th>Type of data</th>
<th>Estimated 12 months activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV</td>
<td>No of people using local HIV services</td>
<td>919</td>
</tr>
<tr>
<td></td>
<td>No of people using other HIV services</td>
<td>623</td>
</tr>
<tr>
<td>HIV total</td>
<td>No of people</td>
<td>1542</td>
</tr>
<tr>
<td>GUM clinics</td>
<td>No of attendances estimated from:</td>
<td></td>
</tr>
<tr>
<td>King’s (Caldecot)</td>
<td>- GUM management report (Southwark estimated 50% of total)</td>
<td>15,000</td>
</tr>
<tr>
<td>GSTT (Lydia &amp; Lloyd)</td>
<td>- Contract monitoring report (This is an LSL-wide report, assume 50% Southwark residents as in overall Trust SLA activity split)</td>
<td>22,000</td>
</tr>
<tr>
<td>Other GUM clinics</td>
<td>- No data on Southwark residents, assume 50% of local total</td>
<td>12,500</td>
</tr>
<tr>
<td>GUM total</td>
<td>Attendances</td>
<td>49,500</td>
</tr>
<tr>
<td>Southwark SRH</td>
<td>KT31 statutory return, Qtrs 3 and 4 2004/05</td>
<td>20,710</td>
</tr>
<tr>
<td>King’s SRH</td>
<td>KT31 statutory return (Assume 50% Southwark activity of King’s SRH total)</td>
<td>22,210</td>
</tr>
<tr>
<td>Brook East Street</td>
<td>KT31 statutory return</td>
<td>6,440</td>
</tr>
<tr>
<td>Community total</td>
<td>Attendances</td>
<td>49,360</td>
</tr>
<tr>
<td>General practice</td>
<td>50% of MI demand and capacity data (note scaled up from 1 week’s data only and based on small sample)</td>
<td>76,024</td>
</tr>
<tr>
<td>Pharmacies</td>
<td></td>
<td>119,600</td>
</tr>
<tr>
<td>Primary care total</td>
<td>Attendances</td>
<td>195,624</td>
</tr>
</tbody>
</table>
Reasons for attendance at the different services are captured in the graph below, which although based on one week’s demand and capacity data alone, gives some idea of the split of contraception, STI screening and management and other work across the range of providers in Lambeth and Southwark.

The GP and community data above have been extrapolated to produce the figures in the service utilisation table are purely indicative. The potential for community pharmacies to meet routine need e.g. pregnancy testing, repeat prescription of oral contraceptives is important to note.
5. Conclusion

The data presented in this report shows that Southwark and Lambeth have high levels of sexual ill health. Teenage conceptions in Southwark in 2004 were the highest in the UK and Southwark has the highest rate of terminations amongst local authorities in England and Wales. Whilst the number of diagnoses of chlamydia and gonorrhoea have fallen slightly, 20% of all gonorrhoea diagnosed in London GUM clinics is diagnosed in GSTT and King’s GUM services.

Where the data is available, there is evidence to suggest that certain groups of the population are disproportionately affected by sexual ill health - young people, black and ethnic minority groups and gay men. There is a need to address the needs of these specific groups whilst ensuring that generic services are user-friendly.

The local plans for a new type of sexual health service delivery hopes to address many of the issues raised by users and stakeholders. In addition it will be important to maintain a full range of services, which provide different levels of sexual health care in a variety of settings.\textsuperscript{34}

Health promotion and prevention is a key part of delivering an effective sexual health service and must be strengthened and explicitly coordinated locally in order that this can happen.

There is need to improve sexual health data through improving and expanding existing routine data collection and investigating new sources of local data. Local sexual health network should be strengthened, in the context of South East London sector network development, in order to improve joint working.

\textsuperscript{34} Our health, our care, our say: a new direction for community services. Department of Health. 2006.
6. Recommendations

Information and surveillance
- Improvements to local and national sexual health surveillance systems
- Initiate STI data collection from community RSH services.
- Initiate disaggregated data collection from all services to include postcode, ethnic group, sexual orientation, age and gender.
- Address local laboratory issues including transit times from sample taking to result with patient and improved data provision for surveillance purposes.
- Work with the SEL HPU to improve existing routine data collection including KC60, HIV, Co-Surv and other laboratory reporting.
- Review the agreed common dataset to ensure local work incorporates national plans.

Service delivery
- Modernise local services to reduce long waiting times at specialist services and provide easy access in the community e.g. STI and pregnancy testing in any setting.
- Continue to ensure general practice is able to manage common sexual health problems in a user friendly way.
- Continue to address targets for TOPs under 9 weeks and increasing contraceptive access including EHC in pharmacies.
- In line with the new NICE guidance, ensure services offer long acting contraception where appropriate.

Health promotion and prevention
- Health promotion is an essential of delivering an effective sexual health service and must be incorporated at all levels of service delivery.
- Ensure a more coordinated health promotion service.
- Ongoing and improved targeted work to address the needs of young people, black ethnic groups and men who have sex with men.
- Need for universal sexual health education in schools and targeted in other settings.

Further information
If you would like any further information or wish to make any comments on the contents of this report please contact sarah.petrie@southwarkpct.nhs.uk.