



The London Sexual Health Programme



London Health Observatory



# Sex and our city

Achieving better sexual health services for London  
Project findings & recommendations

Medical Foundation for AIDS & Sexual Health  
(MedFASH)

with

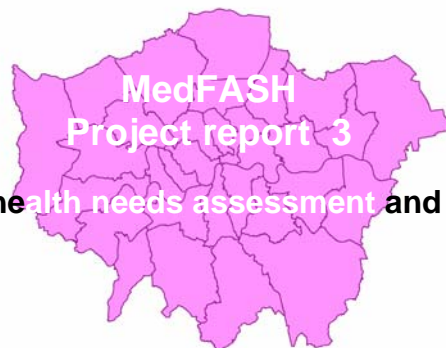
London Health Observatory

and

Health Protection Agency

for

London Sexual Health Programme



London sexual health needs assessment and service mapping

Published online November 2008

## The London sexual health needs assessment and service mapping project

This report is one of four outputs from the first sexual health needs assessment and service mapping undertaken across London, which was managed by the Medical Foundation for AIDS & Sexual Health (MedFASH) between January and November 2008.

The project was established to assist the NHS in London in its task of further developing and delivering high quality and world class sexual health services. As such, it set out to provide a detailed picture of sexual health needs and the current commissioning and configuration of sexual health services. It also aimed to pilot *Sexual health needs assessments (SHNA): a how to guide* (Design Options/NHS, 2007) and provide national learning for the Department of Health (DH) about the process of undertaking a regional needs assessment and service mapping.

The project was commissioned by Lambeth Primary Care Trust (PCT) on behalf of London PCTs for the London Sexual Health Programme. It was jointly funded by the DH Sexual Health Policy Team, the DH National Support Team for Sexual Health and the London Sexual Health Programme. In managing the project, MedFASH commissioned the London Health Observatory (LHO) which worked with the Health Protection Agency (HPA) to produce the needs assessment. Both the LHO and the HPA deployed additional resources to support the project, notably the considerable time devoted to the needs assessment by many staff at the HPA Centre for Infections and London Regional Epidemiology Unit, and to the development of the web tool by the LHO project team.

A Project Advisory Group, whose membership was drawn from commissioners and providers across London, offered expert advice and guidance throughout the project.

The following project reports were published by MedFASH in November 2008.

**Report 1:** *London sexual health indicators: a data-driven needs assessment* prepared by the London Health Observatory and the Health Protection Agency, and commissioned by MedFASH for the London Sexual Health Programme.

**Report 2:** *London sexual health service mapping: results & analysis*. A report by MedFASH based on questionnaire responses from PCT commissioners and sexual health service providers.

**Report 3:** *Sex and our city: project findings & recommendations for London*. This report by MedFASH combines the findings of the needs assessment and service mapping, and makes recommendations for the NHS in London.

In addition, the London Health Observatory produced an interactive web tool enabling comparison between sexual health indicators at London borough level, and a workbook with supplementary tables. The web tool can be accessed at the LHO website ([www.lho.org.uk](http://www.lho.org.uk)).

All three reports are available to download as pdfs on the LHO ([www.lho.org.uk](http://www.lho.org.uk)) and MedFASH ([www.medfash.org.uk](http://www.medfash.org.uk)) websites.



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Cover image: London map showing PCT boundaries, based on Ordnance Survey material © Crown Copyright 2008. All rights reserved. Department of Health 100020290 2008

# Contents

Foreword	page 5
Executive summary	page 6
1 Introduction	page 10
1.1 Sexual health and the city	page 10
1.2 Project objectives	page 10
1.3 The policy context	page 11
1.4 Limitations of this work	page 12
2 The picture of sexual health in London	page 13
2.1 A unique world city	page 13
2.2 Unique challenges	page 13
2.3 Key prevention groups	page 14
2.4 Responsibility for understanding and addressing needs	page 15
3 Commissioning sexual health services in London	page 16
3.1 Leading the local NHS	page 16
3.2 Making sound financial investment	page 16
3.3 Managing knowledge and assessing need	page 18
3.4 Prioritising investment	page 18
3.5 Promoting improvement and innovation	page 21
3.6 Securing procurement skills	page 21
3.7 Managing the health system	page 21
3.8 Engagement with clinicians, the public and patients	page 21
3.9 Emerging themes for commissioning	page 22
4 Sexually Transmitted Infections (STIs)	page 23
4.1 GUM services in London	page 24
4.2 Improving prevention and reducing inequalities	page 24
4.3 Reducing late diagnosis of HIV infection	page 25
4.4 Improving access to GUM clinics	page 26
4.5 Increasing rates of screening for chlamydia	page 27
4.6 Emerging themes for STIs	page 28
5 Fertility	page 30
5.1 Contraception	page 30
5.2 Teenage Conceptions	page 31
5.3 Abortion	page 32
5.4 Emerging Themes for Fertility	page 34
6 Social Marketing and Promotion of Sexual Health	page 36
7 Recommendations	page 37
8 Acknowledgements	page 39
9 Resources	page 41

<b>10 Appendix</b>		<b>page 42</b>
Appendix Table 1:	Key social demographic and sexual health indicators by Inner London PCTs and Outer London PCTs	page 43
Appendix Table 2:	Spend on sexual health in Inner London PCTs and Outer London PCTs per head of population	page 44

# FOREWORD

## Foreword

As Sexual Health PCT Chief Executive Lead for the NHS in London, I am pleased to commend this important report that, for the first time, gives a state of sexual health needs and services in London.

Sexual health is a particularly demanding public health and financial challenge for London. It affects the majority of the population, is linked increasingly with poverty and inequality, and is still associated with stigma. In London, we face the highest rates of sexual ill-health in the country and have adopted sexual health and HIV as one of our public health priorities.

The London Sexual Health Programme identified the need for more information on sexual health services commissioned and provided, and on the pattern of sexual health needs, across the capital. As a result, London PCTs, with support from the Department of Health, commissioned MedFASH to manage a London sexual health needs assessment and service mapping.

This is the first time this level of detail has been collected. Spanning a diverse range of services for the prevention and control of fertility and sexually transmitted infections, the commissioning picture is complex. *Sex and our city* and its companion publications equip us with vital knowledge, both pan-London and by individual PCT.

Every one of the 31 PCTs and the 63 major sexual health service providers in London have shown their commitment to this project, by responding with detailed input to the service mapping. At pan-London level, the contribution of the London Health Observatory and the Health Protection Agency has been invaluable, through their thorough and expert analysis of a broad range of sexual health indicators and their help in ensuring the accuracy of this final report. The project was fortunate to benefit from the expert advice of a multidisciplinary advisory group drawn from PCTs and services across London to assist with designing the project methodology and formulating its conclusions and recommendations, and from the role of MedFASH in coordinating and ensuring the quality of such a massive piece of work.

We now have an evidence base that will be a huge benefit to our planning and commissioning of sexual health services in London. It presents us with a challenging picture of significant variation in sexual health needs and inconsistency in the provision of services to meet these across the city. We must improve health outcomes for the whole population and reduce health inequalities, ensuring equity of access to high quality, personalised sexual healthcare for every Londoner.

We can be proud of our recent achievements, such as the massive improvements in access to GUM services driven by the 48-hour target and the reduction in the gap between teenage pregnancy rates in Inner and Outer London. However, as these reports show us, there is still much to do. Direct responsibility for making improvements lies with London PCTs, through world class commissioning. It is clearly not an option to accept things as they are; we must accept the responsibility to change them and improve sexual health in London.

Diana Middleditch  
Chief Executive, Kensington and Chelsea Primary Care Trust  
and PCT Chief Executive Lead on Sexual Health for the NHS in London

# Executive summary

## 1. Introduction

This report is one of three published by MedFASH to assist the NHS in London in its task of further developing and delivering high quality sexual health services. These reports were developed with the prime objective of assisting commissioners in making strategic and operational decisions. As such, they provide a detailed picture of both sexual health needs and the current configuration of sexual health services.

This report, *Sex and our city*, is intended to provoke discussion and stimulate change. Bringing together the key findings of the London sexual health needs assessment (SHNA) and service mapping (SM) reports, it provides a starting point for understanding sexual health in London.

This report, *Sex and our city*, is published online by MedFASH and freely available to download. In the interests of fair and open competition, it does not contain any information that would be considered by the NHS as commercially sensitive. Additional financial information has been included in an expanded version of the report, submitted in confidence to PCT chief executives only.

## 2. Key Findings

### A. Commissioning sexual health services in London

While sexual health needs do vary between London's 31 PCTs, there is no consistent pattern of variation. Moreover, there do not appear to be obvious reasons from the epidemiological patterning of sexual health need across London to justify the substantial inconsistencies that are reported by PCTs in terms of financial investment in sexual health service provision.

Twenty-six PCTs reported that they had conducted some form of sexual health needs assessment to inform commissioning within the last three years, and 22 had a sexual health strategy which had been written or reviewed in the same time period. However, the lack of consistent use of commissioning best practice, in particular the development, implementation and monitoring of service specifications, would suggest that PCTs within London are not always maximising value for money in terms of investment and outcomes.

### B. Sexually Transmitted Infections (STIs)

The SHNA demonstrated that genital chlamydia accounts for almost one in four of all diagnoses of sexually transmitted infections in London GUM clinics. The National Chlamydia Screening Programme was fully introduced across London in 2007/08, when screening rates varied between PCTs from 1.1 to 19.9% of the 15-24 year old population. The average for London was 4.9% compared to a target of 15%. This variation is partly due to the phased roll-out of the programme. The maximum impact of the NCSP on the prevalence of chlamydia and the morbidity associated with chlamydial infection will only be achieved if sufficient screening coverage is attained, along with effective partner notification.

Total spend on sexual health reported by commissioners across London was £129.6 million in 2007/08 (excluding GP prescribing). PCT spend on GUM in 2007/08 varied from £0 to just under £10 million, representing 55% of total expenditure on sexual health. There is a need to revisit the funding differential after the implementation of Payment by Results (PbR) and dehosting, and in addition any discrepancy in provider delivery costs, to determine if any remaining disparity in spend or cost has an impact on service outcomes.

It is a major achievement that the percentage of people offered an appointment to be seen at a GUM clinic within 48 hours in London has increased from an average of 68.9% in 2005 to 97.9% in 2008 (data to March). However, GUM access times vary considerably with significant differences in reported gaps between rates 'offered' and 'seen' within 48 hours. Individual service providers together with commissioners are in a position to examine the potential causes of this disparity.

Late diagnosis of HIV impacts on both early death and onward transmission. Like the rest of the country, London has an unacceptably high percentage of HIV infections diagnosed late, and this is most marked in some Outer London PCTs.

### C. Fertility

To understand the true rates of access to contraceptive services and quality of service provision, information from GP practices together with information on Community Sexual and Reproductive Health (CSRH) services must be routinely gathered. Current IT capability and data collection processes in CSRH services mean that PCTs are unable to identify the residence of attendees at the contraceptive services they fund.

The variation between PCTs in the percentage of total NHS-funded abortions performed under 10 weeks gestation is significant. London has a high level of repeat abortions. There is a need to ensure that all abortion providers (NHS and non-NHS) are maximising access to contraception, and particularly long-acting reversible contraception (LARC), as part of their commissioned service.

There is a need to explore the limited improvement as a whole in teenage conception rates within the Outer London area.

### 3. Key Themes

The resident population of London, together with those who work in or visit the capital, faces many health challenges, only one of which is poor sexual health.

It is therefore not surprising that in the face of different local priorities, both the commissioning processes and the sexual health services delivered vary widely in their performance.

Though the degree of priority given to sexual health varies between PCTs, on average each PCT is currently committing over 1% (range 0.23% to 2.99%) of its total budget to these services. This considerable PCT investment does not take account of the impact of redistribution of costs following dehosting of GUM, nor the potential future additional costs of tariffs currently in development.

But even in the face of such significant levels of funding, both service provision and outcomes vary widely. Spending more does not equate to better outcomes across London.

Sexual health is of course multi-factorial, but with a growing evidence base for cost effective interventions, the variation in outcomes could be considered to be due in part to PCTs as commissioners failing to ensure consistently that value for money is being obtained from providers.

With the need for all PCTs to evolve into world class commissioners and the clearer separation of commissioner and provider functions, there is an opportunity to address these issues in relation to sexual health.

#### 4. Recommendations

In reviewing the evidence from the needs assessment and service mapping reports, the following recommendations are made to address the issues raised.

1. PCTs should agree formal and robust commissioning/joint commissioning and strategic leadership arrangements, including clear accountability. Taking account of the variability and potential inequity between PCTs reported in this mapping exercise, each PCT should determine whether it wishes to identify a dedicated commissioning lead or share a commissioning function with neighbouring PCTs.
2. PCTs, ideally across a sector or network, should consider which activities should be commissioned at a PCT, sector or pan-London level.
3. PCTs should commission for outcomes, equitable access and value for money, in line with World Class Commissioning guidance. As part of this, they should ensure that service specifications are in place, together with cost and activity information.
4. PCTs need to commission prevention and health promotion services to meet local need. PCTs should individually examine their commissioned prevention activities, maximise the potential within existing provider contracts and work collaboratively on social marketing and screening opportunities.
5. Priority should be given to commissioning sexual health interventions with the greatest potential for cost effectiveness and impact on health outcomes. These include incentivising LARC through all contraceptive service providers and abortion service providers, population level chlamydia screening, HIV testing and prompt access to abortion and GUM.
6. PCTs should work with providers of GUM services to review their hours of operation, and to identify reasons for any significant disparity in achievement of the GUM targets between the percentage of patients offered an appointment and the percentage of those seen within 48 hours.
7. PCTs, together with providers of Community Sexual and Reproductive Health and GUM services, should review the existing skills of the workforce and move forward towards the delivery of fully integrated sexual health services.
8. PCTs should review with providers of Community Sexual and Reproductive Health services their IT and informatics infrastructure to ensure they are fit for purpose for the commissioning process.
9. PCTs commissioning sexual health services also need to consider the role of primary care within the provider landscape and the relative priority of the



development of Levels 1, 2 and 3 sexual health services, including development and monitoring of enhanced service specifications. This will require a review of training capacity within London, particularly among specialist services.

10. PCTs and networks should use the detail contained in the sexual health needs assessment and service mapping to understand, and explore further, their local picture.

# 1 Introduction

This report is one of three published by MedFASH to assist the NHS in London in its task of further developing and delivering high quality sexual health services.

The senior management of London's PCTs may feel that it has already been a time of change for the planning and delivery of sexual health services. However the evidence in these three reports suggests a pressing and urgent need for further improvement.

These reports were developed with the prime objective of assisting commissioners in making strategic and operational decisions. As such, they provide a detailed picture of both sexual health needs and the current configuration of sexual health services.

This report, *Sex and our city*, is intended to provoke discussion and stimulate change. It provides a starting point for understanding sexual health in London. It brings together the findings of the sexual health needs assessment (SHNA)<sup>1</sup>, carried out by the London Health Observatory with the Health Protection Agency for MedFASH, and the service mapping (SM)<sup>2</sup> undertaken by MedFASH, drawing out key themes and making recommendations. Although there are limitations to current data collection, all three reports present detailed information that will be useful. Further analysis at local level will be required to make best use of this information, particularly to investigate the reasons for variation in sexual health outcomes.

This report, *Sex and our city*, is published online by MedFASH and freely available to download. In the interests of fair and open competition, it does not contain any information that would be considered by the NHS as commercially sensitive. Additional financial information has been included in an expanded version of the report, submitted in confidence to PCT chief executives only.

## 1.1 Sexual health and the city

London has the highest rates of sexual ill-health in the UK. Sexual health services are complex across the city; they have not necessarily been developed strategically, based on the needs of the population, but rather are the result of historic patterns of service provision.

The Department of Health (DH) and the London Sexual Health Programme (LSHP) identified the need for more information on the state of sexual health, and sexual health services currently commissioned and provided, across London. As a result, MedFASH was commissioned to deliver this project by Lambeth Primary Care Trust (PCT) on behalf of London PCTs for the LSHP, with funding from the DH Sexual Health Policy Team, the DH National Support Team for Sexual Health and the LSHP itself.

## 1.2 Project objectives

1. To carry out a data-driven needs assessment using recommendations for data analysis in the National Support Team's '*How to Guide*'<sup>3</sup>.

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<sup>1</sup> *London sexual health indicators: a data-driven needs assessment*. London Health Observatory with Health Protection Agency for MedFASH, November 2008

<sup>2</sup> *London sexual health service mapping: results & analysis*. MedFASH, November 2008

<sup>3</sup> *Sexual health needs assessments (SHNA): a how to guide*. Design Options for DH National Support Teams for Sexual Health and Teenage Pregnancy, 2007

2. To undertake a comprehensive mapping of sexual health services commissioned by each PCT across London. This included GUM, contraception, integrated sexual health, abortion and outreach services, plus to a limited extent sexual health promotion, provided by a range of NHS and non-NHS organisations in different settings.
3. To produce a report on the findings of (1) and (2), offering a pan-London analysis, but enabling data to be disaggregated by PCT, clinical network and provider.

### 1.3 The policy context

A key driver for improving sexual health in England is the *National strategy for sexual health and HIV* (2001). A review of the 10-year strategy, focusing particularly on progress to date and how to accelerate implementation, was recently undertaken for the Independent Advisory Group on Sexual Health and HIV by MedFASH (*Progress and priorities - working together for high quality sexual health* (2008)). The review identifies a number of recommendations for implementation at local and regional levels, some of them particularly pertinent in view of the findings of this report and useful for informing next steps in London.

Among the priorities for action in the review is commissioning for improved sexual health, based on local needs assessment of need. Recommendations to support effective commissioning include the establishment of information infrastructures, including both IT equipment and systems for data collection and analysis. PCTs are urged to ensure service level agreements (SLAs) are explicit about what providers are commissioned to provide, with services auditable against robust quality standards and funding relating to activity and outcomes. While there may be shifts in where care is provided, users should experience equal service quality whichever provider they choose to use. Service networks should be established and maintained across PCT boundaries, with regional support.

The strategy review highlights the need for adequate investment in prevention. This should include both well-resourced health promotion services at PCT or cross-PCT level, and the integration of prevention activities within specifications for sexual health services.

The public health White Paper *Choosing Health* (2004) included targets for chlamydia screening coverage, Genitourinary Medicine (GUM) waiting times and a reduction in gonorrhoea, to supplement the existing target for a reduction in teenage conceptions. It also pushed home the point that "Preventing poor sexual health has significant potential not just for better sexual health, but for the better use of finite resources".

*High Quality Care for All* (2008), the final report of the NHS Next Stage Review led by Lord Darzi, sets out a vision of a health and care system that is "fair, personalised, effective, and safe", with quality at its heart. Improving sexual health is one of the six key goals identified for the comprehensive wellbeing and prevention services to be commissioned by PCTs in partnership with local authorities.

To help realise this vision, *World Class Commissioning* (2007) is designed to have a direct impact on population health and significantly reduce inequalities between the areas with the worst health, and the population as a whole. It builds on *Commissioning a Patient-Led NHS* (2005) which required partnerships between the NHS and local government to promote health and wellbeing, and announced the separation of PCT commissioning and provider arms. Provider services are now undergoing a review to implement this policy within the next 12 months and this has significant implications for sexual health services, notably specialist contraceptive providers.

## 1.4 Limitations of this work

The service mapping provides a 'snapshot' of responses from PCT commissioners and services at a single moment in time. The responses are for a single year (2007/08) and it is not known whether the patterns observed are constant over time.

Responses to the service mapping are self-reported and not verified independently. While the findings may be useful for comparative purposes, they do not indicate what constitutes good or poor practice. In several areas (for instance - capacity, planning, use of service specifications and even levels of investment) it is not known 'how much' is adequate for effective practice.

Many of the financial data relate to the year 2007/08 when 'block' contracts were still in use for GUM services. Recent introduction of Payment by Results (PbR) and the implementation of GUM dehosting after 2007/08 limits interpretation in some areas.

In assessing need and service provision, many of the datasets are based on clinic activity rather than PCT of registration; this again limits population level analysis.

HIV is included in the sexual health needs assessment which has important implications for the commissioning of HIV and STI prevention, and HIV testing, initiatives. However, although local primary prevention of HIV was addressed in the service mapping, it is important to remember that specialist HIV treatment and care services (and their costs) were not included in its scope.

For all these reasons, the three reports should be seen as a first step in describing London's sexual health needs and the response from PCTs. They should also be viewed as a call to those responsible for the provision of sexual health services in London to review current arrangements in order that future needs may be addressed.

## 2 The picture of sexual health in London

### 2.1 A unique world city

The 7.5 million people who live in London make it by far the most populous city in the country, and one of the most populous in the world. An additional 722,000 people commute to London for work from the surrounding areas<sup>4</sup>. More than two million Londoners travel for work from their borough of residence to another borough in London. The biggest inflow of commuters is to Westminster (463,000) and the City of London (310,000). London is also home to 390,000 students<sup>5</sup>.

London is the world's most popular city for international visitors. A study carried out by [Euromonitor](#) in October 2007 put London at first place out of 150 of the world's most popular cities, attracting 15.6 million international tourists in 2006.

The size of London's population and the high levels of movement of people within London have a significant impact on both overall need and use of sexual health services. 'Open access' to sexual health services - whereby people are able to self-refer to services of their choice, including those not provided by the PCT where they live - is crucial to effective sexual health service provision, as it maintains user choice, provides reassurance about confidentiality and facilitates access. Ensuring that there is open access requires coordination and consultation between commissioners and clinicians in surrounding PCTs.

### 2.2 Unique challenges

London's unique social make-up helps to explain the unique set of challenges for commissioners of sexual health services. Social inequality, a young population, large numbers of people living and arriving in London from abroad, an open and well established gay culture and changing patterns of social and sexual mixing - all contribute to the picture of sexual health need described in this report.

London is a place of extreme wealth and of significant social deprivation. Of the 33 Local Authority areas in London, 20 rank within the top 50 most deprived areas (out of 354) in England on at least one measure. Hackney, Newham and Tower Hamlets are the most deprived London boroughs, while Richmond-upon-Thames, City of London and Kingston-upon-Thames are the least deprived. Within affluent PCT areas there are wards with high deprivation and disproportionate sexual ill-health.

London has a higher birth rate than the rest of the country. Natural population growth in London accounted for 70% of the total natural growth of the UK in 2001, even though it had only 12% of the total population. While the population of London as a whole is younger than for the rest of England, the population of Inner London is younger than that of Outer London; a third of this population is aged 20-34 compared to Outer London (23%) and England (20%).

London is one of the most culturally and ethnically diverse cities in the world. There are more than 300 languages spoken in London and more than 50 non-indigenous communities with a population of 10,000 or more. The 2001 census showed that London was home to 46% of England's total black and minority ethnic (BME) population. In the Inner London

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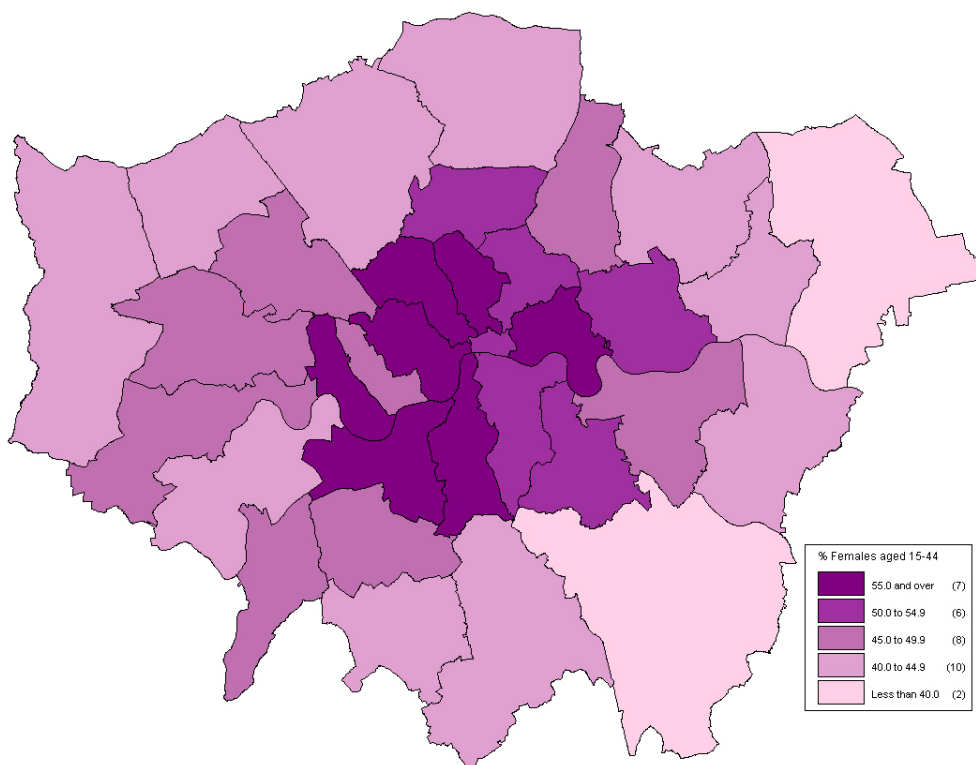
<sup>4</sup> *Commuting in London*. DMAG (Data Management and Analysis Group) Briefing 2007-03, February 2007, Gareth Piggott, Greater London Authority

<sup>5</sup> London Higher website ([http://www.londonhigher.ac.uk/about\\_ls.htm](http://www.londonhigher.ac.uk/about_ls.htm))

boroughs, 36% of the population belong to a black or minority ethnic group. In individual boroughs, this figure rises higher still: in Brent to 57% and in Newham to 67%.

The young age profile of London's population, and the large numbers of people who travel to London from overseas, have important consequences both for the epidemiological picture of sexual health in London and for the demand for Genitourinary Medicine (GUM), contraceptive and abortion services.

**Map 1: Inner London Youth - proportion of females aged 15-44 by London borough,**



**2006**

Based on Ordnance Survey material. (c) Crown Copyright 2008. All rights reserved. Department of Health 100020290 2008

Source: Office for National Statistics mid year population estimates, 2006

## 2.3 Key prevention groups

The epidemiological picture of sexual health in London is one of huge and varying levels of need, marked by social and demographic changes - with some key population groups in greater need of certain services.

In 2007, London had the highest number of sexually transmitted infections (STIs) recorded in England. Around two in five diagnoses of infectious syphilis and gonorrhoea, more than one in five diagnoses of genital chlamydia and genital warts, over a quarter of genital herpes diagnoses and half of HIV diagnoses were made in the capital.

Young people, black minority communities and men who have sex with men (MSM) are consistently identified as those who are most affected by STIs. The trends in STIs and HIV

vary considerably in these different sub-populations, and therefore, public health interventions need to be targeted accordingly.

## **2.4 Responsibility for understanding and addressing needs**

Responsibility for commissioning sexual health services to meet the needs of London's population rests with the 31 PCTs of London. At various points in this report, reference is made to 'PCT sectors'. This term refers to the five geographical groupings of PCTs in London - North West, North Central, North East, South West and South East London.

Appendix Table 1 lists some of the key indicators of sexual health need, shown by PCT. It shows that the PCTs in Inner London (in purple) tend to be more deprived, and have larger populations of young people and of BME groups. However, the pattern of sexual health evident from this set of measures suggests that need across London does not correlate well with any single set of demographic indicators.

## 3 Commissioning sexual health services in London

Effective commissioning requires a process of analysis, planning including prioritisation, action and review.

The Government's World Class Commissioning (WCC) programme sets out a strategy for transforming the way services in the NHS are commissioned, to ensure they are of the best clinical quality and based on robust evidence. There are currently 11 WCC competencies. The findings of the three reports from this project should assist local organisations in addressing several of the WCC commissioning competencies, particularly in the areas of leading the local NHS, managing knowledge, assessing need and prioritising investment, managing the local health system, promoting improvement and securing the capacity to effectively procure better sexual health outcomes. This report makes some comment but does not focus on mapping or analysing the ongoing work in London to engage community partners, engage the public and patients or collaborate with clinicians.

The service mapping (SM) exercise together with information from the sexual health needs assessment (SHNA) starts to provide an indication of the current commissioning position against the indicators of WCC.

### 3.1 Leading the local NHS

The SHNA demonstrates the complex nature of sexual health need across the capital whilst the SM report highlights the variation and inconsistency in commissioning capacity, service provision and investment levels.

Though there is a general direction informed by national sexual health policy, London lacks a coherent city-wide response to the challenges posed by the broad range of sexual health problems it faces.

The SM found that approaches to commissioning varied between PCTs. Responsibility for sexual health commissioning rested with Commissioning (12 PCTs), Public Health (7 PCTs) or a combination of both and/or other departments (12 PCTs).

Capacity, in terms of commissioner time to lead, shape and effectively contract with providers also varied. Seven PCTs, all in Inner London, had a designated post wholly dedicated to sexual health and HIV. Of the rest, four PCTs had a post that had more than 50% of its time dedicated to sexual health and HIV commissioning.

Conclusions cannot be drawn from the SHNA and SM reports (no direct correlation between need, capacity and outcomes) to make recommendations on the precise amount of commissioning capacity required within each PCT.

### 3.2 Making sound financial investment

The financial information provided by the SM report highlights the levels and patterns of investment in sexual health across London. The information available in this report refers only to the period 2007/08. It does not take account of the full impact of Payment By Results (PbR) and dehosting for GUM activity.

The total level of investment in London's sexual health services identified by this study (see Table A) was in the region of £129.6 million for the period 2007/08, excluding GP prescribing costs. More than half of the total investment was for GUM services. Across London, GUM services accounted for 55% (£71,660,000) and Community Sexual and



Reproductive Health (CSRH) services for 17% (£21,793,000). Abortion services accounted for a further 13% (£17,239,000).

**Table A: Investment in sexual health by London's 31 PCTs (2007/08)**

Area of activity	Investment (£ millions)	% of total	Mean total spend by PCTs (range)
GUM	£71.7	56%	£2,311,623, (£0-£9,558,972)
CSRH	£21.8	17%	£703,028 (£63,790-£2,294,000)
Abortion	£17.2	13%	£556,096 (£141,800-£996,066)
Prevention	£8.0	6%	£259,702 (£0-£914,000)
Other sexual health services	£4.2	3%	£136,080 (£0-£810,00)
NCSP	£3.9	3%	£126,413 (£1,241-£436,357)
Enhanced services in general practice	£1.7	1%	£53,684 (£0-£346,510)
Pharmacy	£1.0	1%	£34,112 (£0-£125,000)
<b>Total</b>	<b>£129.6</b>	<b>100%</b>	

Expenditure at PCT level on commissioned sexual health services (excluding GP contraceptive prescribing) ranged from £646,452 in Bexley PCT (equivalent to £2.90 per resident) to £12,610,277 in Camden PCT (equivalent to £53.10 per resident). The average (mean) level of investment in terms of expenditure per resident in the PCT was £15.50. If GP contraceptive prescribing costs are included, expenditure per resident ranged from £5.46 (Bexley PCT) to £57.67 (Camden PCT). (See Appendix Table 2)

There is a thirteen-fold variation in terms of the percentage of total PCT budget committed to commissioned sexual health services (excluding GP prescribing). The range was 0.23% (Bexley PCT) to 2.99% (Camden PCT) of the overall PCT budget, with an average (mean) spend of 1.07% of London PCTs' overall budgets invested in sexual health. Again, it must be noted that the analysis of investment does not take into consideration the full impact of GUM PbR and dehosting, which is considerable.

Assessment of PCTs' expenditure on GUM services was complicated by the transition from block contracts to Payment by Results (PbR) during the study period, and by the fact that data presented were for hosted services, which no longer apply. However, some London PCTs reported investing more than £5 million in GUM services, while others invested less than £500,000.

From calculations made by the London Sexual Health Programme and validated by PCTs, it is estimated that with the introduction of PbR some PCTs will lose financially, while others will gain as they receive payment from other PCTs for the use of their sexual health services.

### 3.3 Managing knowledge and assessing need

Evidence of good understanding of population needs and of good forward planning is indicative of effective health commissioning.

Twenty-six PCTs reported that they had conducted some form of sexual health needs assessment to inform commissioning within the last three years, with significant variation in the degree of complexity. Four PCTs had never undertaken a sexual health needs assessment and a further one had not done so since 2002. Twenty-two PCTs had a written sexual health strategy that had been produced or reviewed within the past three years.

The SHNA and the SM reports identify the need for a thorough review of knowledge management across London PCTs, from basic data capture at all levels (including activity within services and prescribing data) to analysis and reporting.

There are poor quality information technology systems throughout CSRH services. Many services were found to lack basic computing facilities to record activity.

Sexual health needs are not confined by PCT administrative boundaries. Similarly, people's use of services is not determined by where they live. However, current recording systems mean that in the case of CSRH services, PCTs are unable to establish the residency of service users.

The KC60 return collects data on activity within GUM clinics in aggregate form. Few demographic details are captured and patient PCT of residence is not recorded. The limitations of the KC60 return have been recognised and a new disaggregate return, the GUM Clinic Activity Data (GUMCAD), will replace the KC60 return when it ceases at the end of March 2009. The KT31 return, which monitors activity in CSRH services, is an aggregate return. It collects a limited range of information about clinic attenders but cannot be used to attribute the services offered to patients and does not record PCT of residence. These weaknesses have been recognised and the Department of Health is reviewing options for replacing the KT31 return with a new disaggregate system.

### 3.4 Prioritising investment

#### For Sexually Transmitted Infections

While the level of investment in sexual health services varies greatly between London PCTs, the evidence of sexual health need identified in the SHNA report would suggest that the variation in investment is not based wholly on need.

For example in the case of diagnoses of gonorrhoea, the epidemiological evidence indicates that the range between sectors is only two-fold (see Table B) whilst investment by individual PCTs in GUM varied from £0 to £10 million (see Table A).

**Table B: Diagnoses of uncomplicated gonorrhoea in GUM clinics by (a) sector of clinic and (b) gender (and male sexual orientation), London, 2002 - 2006**

Sector of clinic	2002	2003	2004	2005	2006
North Central London	1755	1501	1472	1269	1263
North East London	2350	2101	1684	1368	1218
North West London	2229	1994	1903	1805	1907
South East London	2618	2172	1745	1386	1276
South West London	1205	1094	884	859	768
<b>Gender/MSM</b>					
Male	7114	6221	5592	5086	4876
<i>of which MSM*</i>	<i>1658</i>	<i>1800</i>	<i>1957</i>	<i>2219</i>	<i>2221</i>
Female	3043	2641	2096	1601	1556
<b>London total</b>	<b>10157</b>	<b>8862</b>	<b>7688</b>	<b>6687</b>	<b>6432</b>

\* Men who have sex with men (MSM) are a subcategory of Male. Therefore, the number of diagnoses in males includes the number of diagnoses in MSM.

Source: HPA (KC60)

Though implementation of PbR and dehosting will obviously reduce the differential in commissioning spend, there may still remain variation in the cost/budget allocated for running GUM treatment services compared to need. Commissioners will need to ensure that the implementation of dehosting delivers equitable and effective service provision in line with local needs.

### For Fertility

The SM report found a 35-fold variation in spending by London PCTs on Community Sexual and Reproductive Health (CSRH) services. In 2007/08 the range of spending by PCT on CSRH services was from £63,790 to £2,294,000.

Across London, a total of over £9 million was spent on contraceptive prescribing in general practice, ranging from nearly £600,000 to under £200,000 per PCT. Taking the size of the female population of reproductive age into account, the cost of prescribing per woman aged 15-44 shows a two-fold difference between the highest and the lowest.

Another tangible example of the variation in the costs of fertility services is the cost per NHS-funded abortion, with the highest over 50% more than the lowest. Many factors affect this differential, including the proportion of later abortions, when the procedure is more expensive (a higher proportion potentially indicating poor access and delays at earlier gestations and/or, conversely, good access at later gestations to NHS-funded procedures). Other factors include the provision of additional services (eg chlamydia screening or contraceptive provision) and the inclusion of the pre-abortion consultation or overheads in the costs calculated. But these factors may not completely explain such variation. Bearing in mind that the average cost of an abortion in the NHS has been calculated as £650<sup>6</sup>, PCTs may wish to revisit their contracts and costs for abortion services.

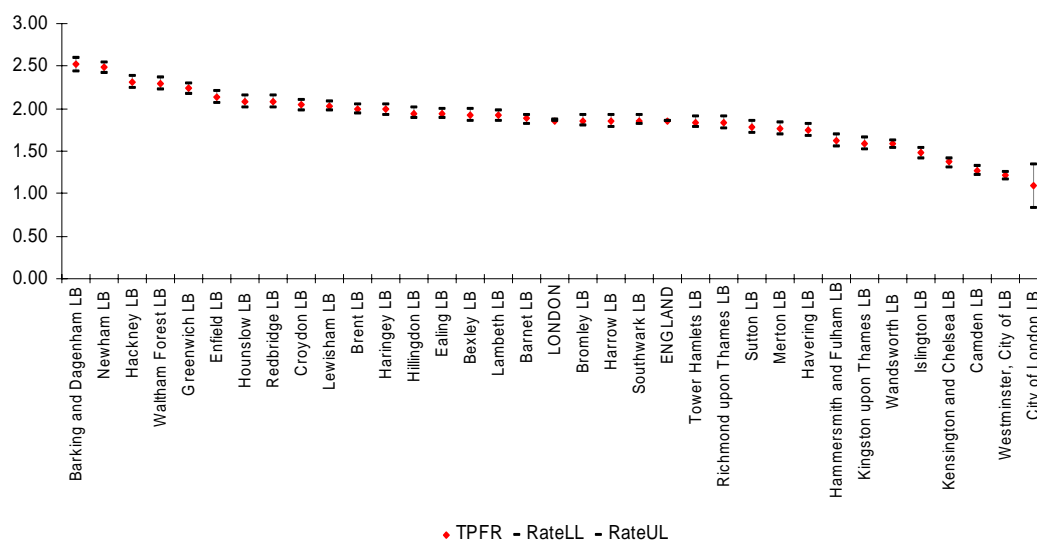
Evidence from the SM also shows that there is a seven-fold variation in total expenditure by London PCTs on abortion services, ranging from £141,800 to £996,066. This represents an over four-fold variation in PCT expenditure on abortion per resident woman of reproductive age.

<sup>6</sup> Dawn Primarolo. House of Commons Hansard Written Answers for 16 June 2008. Column 743W.

The Total Period Fertility Rate (TPFR) and the Total Period Abortion Rate (TPAR) (see Charts 1 and 2) are two indicators of sexual health/fertility need. The TPFR shows the average number of children a woman would have were she to experience the current age specific fertility rate. The TPAR demonstrates the number of abortions as a percentage of the total number of conceptions.

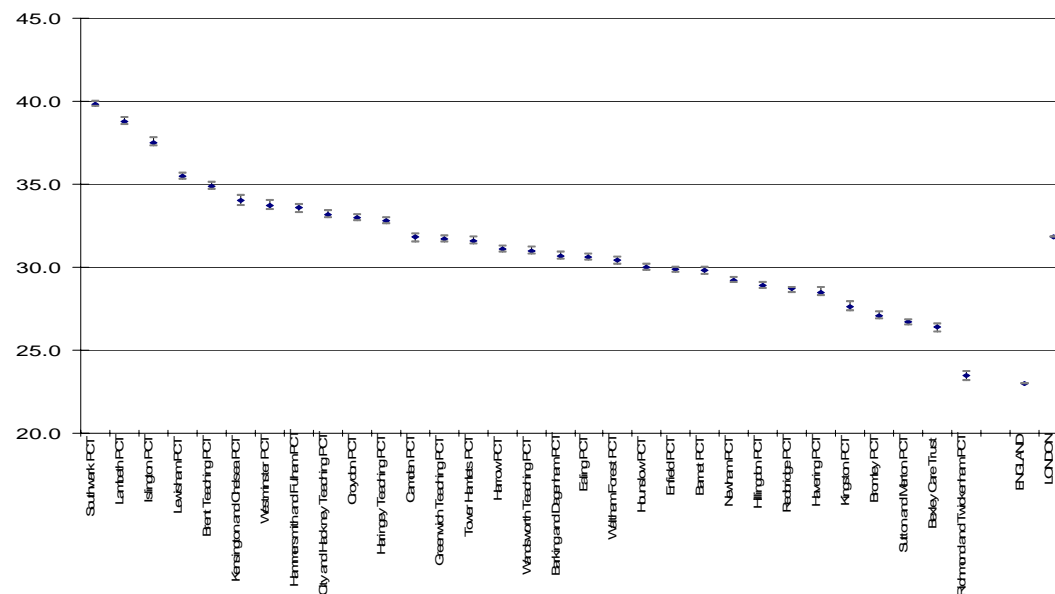
Both indicators point to around a two-fold variation between London PCTs, compared to a four-fold variation in spend per woman aged 15-44 on contraception (CSRH services plus GP prescribing) or abortion.

Chart 1: Total period fertility rate (TPFR) by London borough 2006



Source: National Centre for Health Outcomes Development (NCHOD)

Chart 2: Total period abortion rate as a percentage of potential fertility rate, by PCT 2006



Source: National Centre for Health Outcomes Development (NCHOD)

### 3.5 Promoting improvement and innovation

Though many innovative schemes were highlighted in the SM, there was inconsistency in commissioners' approaches to developing services and in monitoring improvements in service outcomes.

### 3.6 Securing procurement skills

Despite the impact of *Commissioning a patient-led NHS*, few London PCTs use detailed service specifications for all of their sexual health service provision. Only 13 of London PCTs commissioned GUM services, and only 12 commissioned abortion services, against service specifications, despite the availability of draft service specifications developed by the London Sexual Health Programme for both these areas of healthcare. Even where service specifications were used, there were few cases of PCTs using comprehensive specifications covering all sexual health services.

There also appeared to be evidence of a difference of understanding between commissioners and providers about what services had been commissioned and what was being provided (for example, abortion contracts in relation to LARC).

### 3.7 Managing the health system

An important consideration is the need for greater consistency of approaches to the improvement of sexual health. These include consensus on the pricing of services, PbR and tariffs, standards of service, and an acknowledgement of the benefits of the economies of scale that may be derived from pan-London activities in all areas and in particular prevention activities.

The role and function of the clinical sexual health networks was unclear to some providers and commissioners.

Integrating the different aspects of sexual health within PCT boundaries and across wider areas is a key consideration arising from these reports. Integration in this context means ensuring that there is easy, seamless and equitable access to the full range of sexual health services including contraception, abortion, testing and treatment for STIs, as well as to primary prevention.

### 3.8 Engagement with clinicians, the public and patients

All 31 PCTs described formal mechanisms by which to engage with sexual health service providers.

There was evidence that many PCTs were unclear about their mechanisms for engaging with service users. Two PCTs reported that they had not consulted with service users and had no mechanisms to do so.

Commissioners, clinicians and other service providers could be more engaged in the development and commissioning of services in all areas of sexual health (other than HIV services, which were not the focus of this study).

As previously highlighted, clinicians within provider services responding to the questionnaires were unsure of the role of the clinical networks.

### 3.9 Emerging themes for commissioning

Commissioning accountability arrangements were not always clear from the responses to the survey questionnaires.

An important finding is that while sexual health needs do vary between London's 31 PCTs, there is no consistent pattern of variation. Moreover, there do not appear to be obvious reasons, from the epidemiological patterning of sexual health need across London, to justify the substantial inconsistencies that are reported by PCTs in terms of financial investment in sexual health service provision. Similarly, there are no obvious reasons for the considerable variations in costs of sexual health service provision identified in this report.

The factors that influence sexual health are complex. Therefore it is not surprising that the picture of sexual health need and of service provision that emerges from the SHNA and SM reports as a whole is one of no clear pattern overall, with no direct association between need, investment, commissioning and outcomes.

The lack of consistent use of commissioning best practice, in particular the development, implementation and monitoring of service specifications, would suggest that PCTs within London are not always maximising value for money in terms of investment and outcomes.

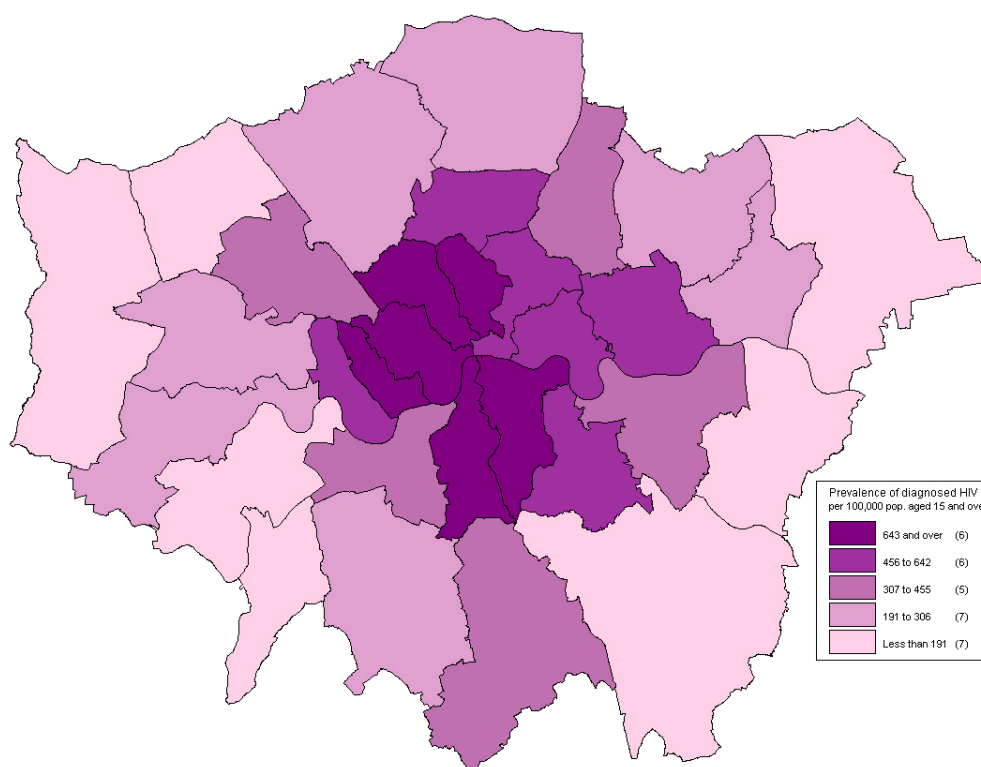
In taking forward the development of services, London PCTs are encouraged to explore further the local data relating to their areas in the reports from this project. PCTs should also be aware of, and utilise, other datasets and mapping information on services related to sexual health, including intelligence from the National Treatment Agency and a recent study of teenage pregnancy services.

## 4 Sexually Transmitted Infections (STIs)

As a world capital, London has experienced massive social and demographic change over the past few decades. The evolution of new epidemics of sexually acquired infections, notably HIV, syphilis, gonorrhoea, chlamydia and Lymphogranuloma venereum (LGV), reflect changing patterns of sexual behaviour and mixing among London's residents and among groups that have settled in London. Men who have sex with men (MSM) and Black Africans are especially over represented in HIV infection figures. Young people aged up to 25 years are disproportionately affected by chlamydia.

Despite recent increases in prevalence of HIV infection in Outer London PCTs, the greatest burden of sexual ill health, as measured by prevalence of HIV, continues to be borne by the Inner London PCTs, which are home to sizeable populations of key prevention target groups.

**Map 2: Prevalence of diagnosed HIV per 100,000 population aged 15 and above by PCT of residence, London, 2006**



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Source: Health Protection Agency (SOPHID data) and Greater London Authority 2007 Round Ethnic Group Population Projection (EGPP) figures

## 4.1 GUM services in London

There are 29 specialist GUM services in London. In the service mapping GUM providers reported 580,446 attendances at these services in 2007/08. The size of GUM services varies considerably, with the smallest (in Enfield PCT) reporting fewer than 8,000 attendances, compared to the larger ones (in Tower Hamlets and Westminster PCTs) reporting more than 50,000.

The majority of GUM services provide mixed access arrangements offering both a walk-in and appointments service. Access ranged from 14 to 85 hours per week (mean 41.2 hours per week). Evening and weekend access was offered by 23 of the 29 services in the capital with a mean of 2.2 hours of 'out of hours' access offered. In total 18 of the 29 GUM services in London reported providing outreach services in addition to Levels 1 to 3 GUM services. PbR and dehosting are currently being implemented for GUM, creating a major impact on the spending profile of PCTs within London which is not reflected in the service mapping data for 2007/8.

The promotion and uptake of HIV testing among people at greatest risk of infection is a vital component of efforts to reduce HIV infection overall. The SHNA report identifies an increase in uptake of HIV testing among people attending GUM clinics in London from 67% in 2003 to 76% in 2006: rates were high regardless of sex and sexual orientation. This figure surpasses the target of 60% testing uptake set by the *National strategy for sexual health and HIV*.

While this is welcomed, performance can still be improved to ensure that no one accessing GUM who is infected with HIV, but has not yet been diagnosed, leaves without being tested. There remains a differential between provider GUM services on uptake of HIV testing.

## 4.2 Improving prevention and reducing inequalities

On almost every measure identified by these reports, there is evidence of variation and difference between London PCTs, leading to inequality of service provision based on area of residence.

In 2007, the most common STI diagnosed in GUM clinics in London was genital chlamydia, followed by genital warts, gonorrhoea and genital herpes. New diagnoses of syphilis rose by 18%, genital herpes by 17% and chlamydia by 10% since 2006.

Young people are disproportionately affected by most STIs, especially chlamydia. In women, the highest rates of genital chlamydial infection are in 16 to 19 year olds, whilst in men, highest rates are seen in those aged 20 to 24. The impact of acute STIs is also high for younger Black Caribbeans, Black Africans and other Black populations.

Marked increases in bacterial STIs occurred at the end of the 1990s and, since 1998, diagnoses of genital chlamydia have doubled in London, while gonorrhoea infections have increased by one third. In recent years diagnoses of gonorrhoea made in heterosexuals have fallen slightly but increased substantially in MSM. MSM account for a third of people diagnosed with gonorrhoea and around 60% of those diagnosed with infectious syphilis in London and this has been an increasing problem, with the numbers of all STIs, apart from herpes, rising over the last five years in MSM.

Though the SM report does not address HIV treatment and care services, the range of SHNA indicators relating to HIV provide important information to guide the commissioning

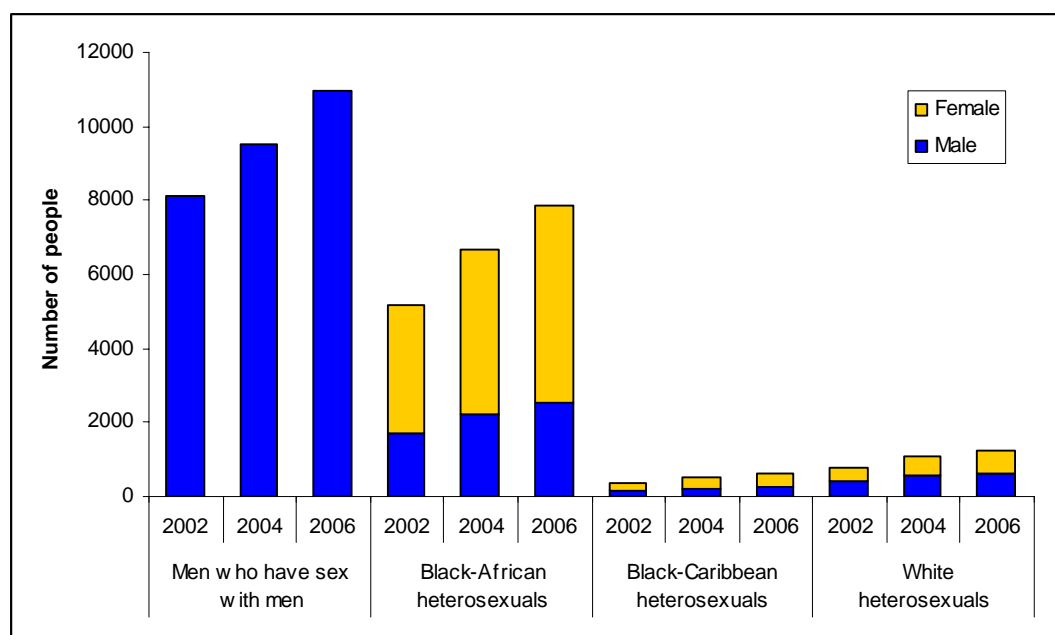


of both HIV and STI prevention initiatives, and (unlike data on new STI diagnoses) they are valuable for being based on PCT of residence.

For all STIs including HIV, the numbers of infections are high. In all but one of the 31 London PCTs, the population prevalence of HIV infection is more than 1 in 1000 adults. In Lambeth PCT HIV infection affects 1 in 100 adults. Among all the key prevention groups in London, levels of HIV infection increased between 2002 and 2006.

There are particular concerns relating to the high prevalence and incidence of HIV infection among MSM, where the number of people accessing HIV-related care rose by 35% between 2002 and 2006, and among Black African heterosexuals, where the number rose by 52% (Chart 3).

**Chart 3: Adults resident in London accessing care for HIV by key prevention group, 2002, 2004 and 2006**



Source: Health Protection Agency (SOPHID data)

### 4.3 Reducing late diagnosis of HIV infection

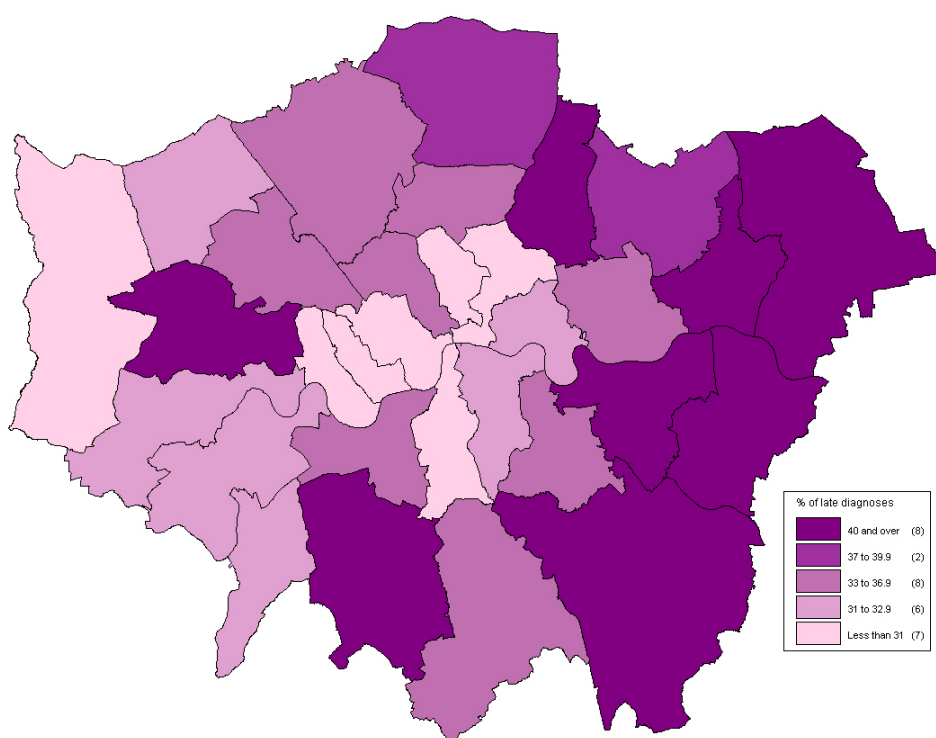
Late diagnosis of HIV is linked to higher risks of earlier death, since the BHIVA audit (2006) showed 1 in 4 people who were diagnosed late died within the first year of diagnosis.

Testing for earlier diagnosis of HIV can reduce the risk of AIDS and death and allows diagnosed people to make behavioural changes to avoid infecting others. It can also reduce infectivity due to earlier initiation of antiretroviral therapy.

Reducing the number of people who are diagnosed with HIV late is a public health priority, as reflected by the new London HIV prevention target, and this will require a London-wide approach. Innovative collaborative arrangements involving commissioners and service providers will be needed to identify possible solutions. For the period 2005/06, a third (33%) of London residents diagnosed with HIV, were diagnosed late, that is with a CD4 count less than 200 cells per mm<sup>3</sup>. There were considerable variations in the proportion of people diagnosed late by PCT, from 19% in Westminster PCT to 48% in Havering PCT.

As the map below shows (Map 3), late diagnosis of HIV infection was higher in many of the Outer London PCTs. These are also the PCTs where the percentage increase in diagnosed HIV prevalence in the period 2002-2006 was greatest. Diagnosed prevalence is associated with the size of populations of key prevention groups that live in each PCT, and in some PCTs increases in prevalence may reflect the growth of their resident Black African population, among whom late diagnosis tends to be higher. (Nationally 40% of HIV-infected Black Africans and Black Caribbeans, versus 20% of MSM, are diagnosed late.) However, this combination of high increases in HIV infection, coupled with high levels of late diagnosis for HIV, suggests that these Outer London PCTs may need to increase their attention to the delivery of HIV prevention and targeted HIV testing for key prevention groups.

**Map 3: Late diagnosis (CD4<200 cells per mm<sup>3</sup>) of HIV infection by PCT of residence, 2005-2006**



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Source: Health Protection Agency (SOPHID)

Of the eight PCTs with rates of late HIV diagnosis of 40% or above, three were in North East London and three in South East London. In the PCT with the highest rate (Havering), the level of prevention spend was low, but this was not mirrored in neighbouring PCTs with similar late diagnosis rates.

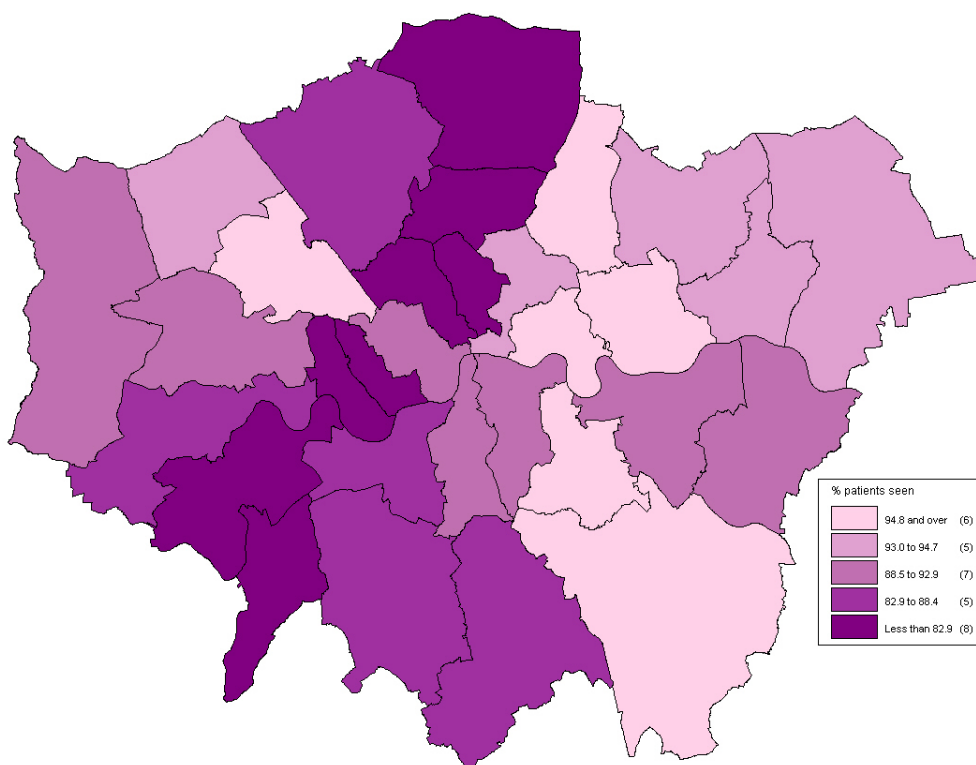
#### 4.4 Improving access to GUM clinics

Effective and accessible diagnostic and treatment services for STIs are key elements of sexual health promotion. Poor access to sexual health services has been highlighted as contributing to the continuing increase in STIs, while delayed treatment and untreated infections fuel increases in STIs as further individuals become infected.

The Operating Framework for the NHS in England<sup>7</sup> identified 48-hour access to Genitourinary Medicine Clinics as a priority in 2006/07 and 2007/08. The percentage of people offered an appointment to be seen at a GUM clinic within 48 hours in London has increased steadily from an average of 68.9% in 2005 to 97.9% in 2008 (data to March). This major achievement reflects significant service modernisation and commitment to improving access.

Maintaining and improving on current performance remains a priority for PCTs with a target of 95% of patients to be seen within 48 hours complementing that requiring 100% to be offered an appointment within 48 hours. Monthly data for April 2008 reported in the SHNA showed that the percentage of patients seen at a GUM clinic in London within 48 hours ranged from 67.1% in Barnet PCT to 97.5% in Newham PCT (see Map 4 for 2007/08 data). Across London in the same month, 98.1% of patients were offered an appointment within 48 hours. Lambeth and Kensington & Chelsea PCTs had the highest percentage of patients offered an appointment within 48 hours, 99.9%, in April 2008.

**Map 4: Percentage of patients seen in a Genitourinary Medicine clinic within 48 hours, 2007/08, by PCT**



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Source: Department of Health GUMAMM (GUM access monthly monitoring) data

#### 4.5 Increasing rates of screening for chlamydia

The National Chlamydia Screening Programme (NCSP) provides screening to asymptomatic people aged under 25 years in healthcare and non healthcare settings across England. Its goal is to control genital chlamydia through the early detection and treatment of asymptomatic infection, to prevent development of sequelae and to reduce onward

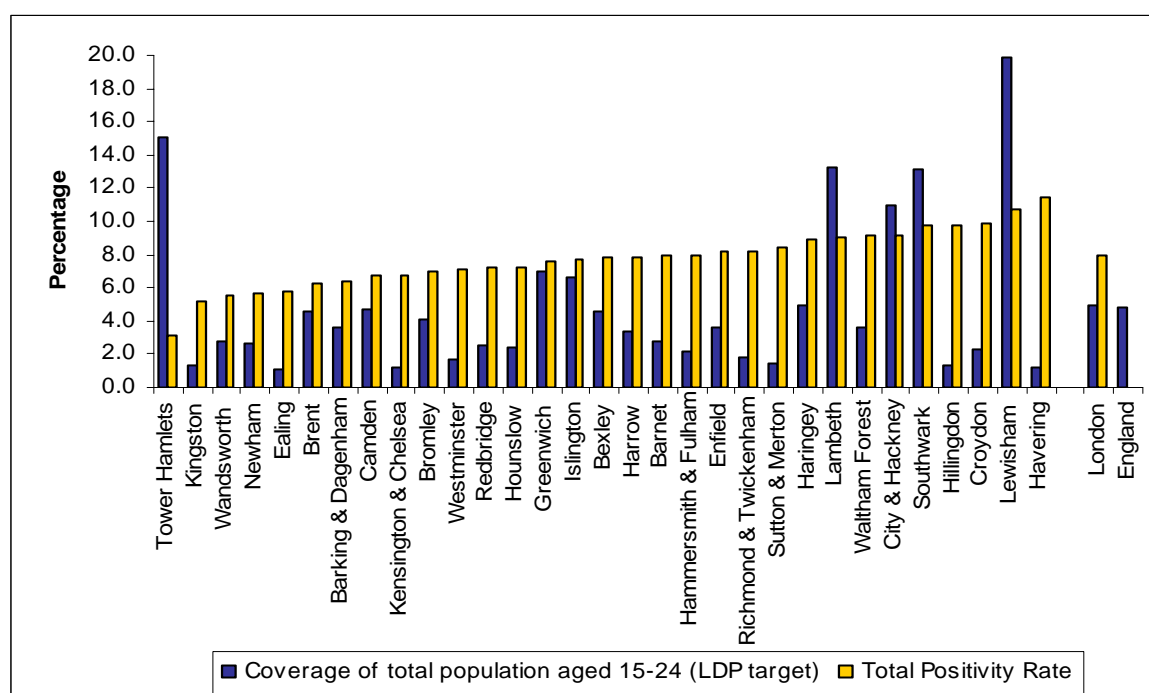
<sup>7</sup> *The NHS in England: The operating framework for 2006/07*. Department of Health, 2006

disease transmission, thereby reducing the pool of infection within the community. The 'Vital Signs' Indicator for 2008/9 includes a target of 17 per cent coverage of chlamydia screening and testing in young people between 15 and 24 years of age.

In 2007/08, rates of screening for chlamydia through the NCSP were low overall at 4.9% for London and nationally. There was wide variation in coverage across London, ranging from only 1.1% in Ealing PCT to 19.9% in Lewisham PCT. Lewisham and Tower Hamlets were two of the three PCTs nationally that reached the LDP target of 15%. The NCSP has been implemented in phases which accounts in part for the observed differences in screening coverage.

However, coverage alone does not determine how well a programme is being implemented. It is important to consider both coverage and positivity. Comparing coverage and positivity rates shows that some PCTs are more effective in targeting their programme. Tower Hamlets PCT, while achieving high coverage, had the lowest positivity rates in London. Conversely, Havering PCT had high positivity but very low coverage. Lambeth PCT, Southwark PCT and Lewisham PCT all had both high coverage and high positivity.

Chart 4: NCSP: Positivity compared to coverage in London PCTs, April 2007-March 2008



Source: NCSP

#### 4.6 Emerging themes for STIs

GUM access times vary considerably with significant differences in reported rates between offered and seen. Individual service providers together with commissioners are in a position to examine the potential causes of this disparity. In addition a number of GUM providers offered no 'out of hours' service provision.

It is difficult to draw conclusions based on a comparison of funding levels compared to outcomes, where outcomes are measured in terms of achieving access targets and GUM patient HIV screening rates, as the SM and SHNA reports did not take account of the

impact of PbR and dehosting, therefore the funding levels reported were significantly skewed by hosting arrangements.

There is a need to revisit the funding differential after the implementation of PbR and dehosting, and in addition any discrepancy in provider delivery costs, to determine if any remaining disparity in spend or cost has an impact on service outcomes.

Like the rest of the country, London has an unacceptably high percentage of HIV infections diagnosed late, and this is most marked in some Outer London PCTs. The following are evidence-based interventions for reducing late diagnoses:

- enhanced prevention messages targeted at those most at risk of HIV infection;
- ensuring that these groups are made aware of their increased risk of infection, and that they are enabled to access services easily;
- continuing improvements in GUM (and antenatal) screening.

HIV testing should be extended into non-traditional settings. New UK HIV testing guidelines<sup>8</sup> recommend that in PCTs where the prevalence of diagnosed HIV exceeds 2 per 1,000 population, testing should be considered for all men and women registering with a general practitioner and for all general medical admissions.

The maximum impact of the NCSP on the prevalence of chlamydia and the morbidity associated with undiagnosed chlamydial infection will only be achieved if sufficient screening levels are achieved.

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<sup>8</sup> *UK national guidelines for HIV testing*. British Association for Sexual Health and HIV, British HIV Association and British Infection Society, 2008

## 5 Fertility

### 5.1 Contraception

Ensuring wide and appropriate access to reproductive health services for the sexually active population is vital to the successful delivery of local strategies to improve sexual health. The Audit Commission (2003) reported that for every £1.00 spent on contraceptive services, the net gain to the NHS was £11.00.

However, planning of service provision is difficult in the absence of information relating to the full range of service providers, and in the case of NHS provision of contraceptive care, the picture is complex. It is estimated nationally that three quarters of contraceptive consultations take place in general practice, whilst the majority of the remaining provision takes place in Community Sexual and Reproductive Health (CSRH) services.

There are 30 CSRH services in London. In 2007/08, according to data provided for the service mapping, there were 439,570 attendances (vs 547,500 reported in the SHNA from published KT31 data, representing 292,000 different women and 21,400 different men). The number of female attendances is equivalent to 15% of the female population in London aged 13-44 years, a higher proportion than in any other region. The corresponding rate for England is 10%. Some PCTs with low access rates to CSRH services, such as Kingston, have a high contraceptive prescribing spend through general practice. Indicators of access to both services must be considered to determine the equity of service uptake.

The majority of CSRH services provide mixed access arrangements, offering both a walk-in service and appointments. Evening and weekend access was offered by all 30 services with a mean of 11.2 hours of 'out of hours' access offered. Of the 30 CSRH services in London, 24 reported providing outreach in addition to Levels 1-3 contraceptive care.

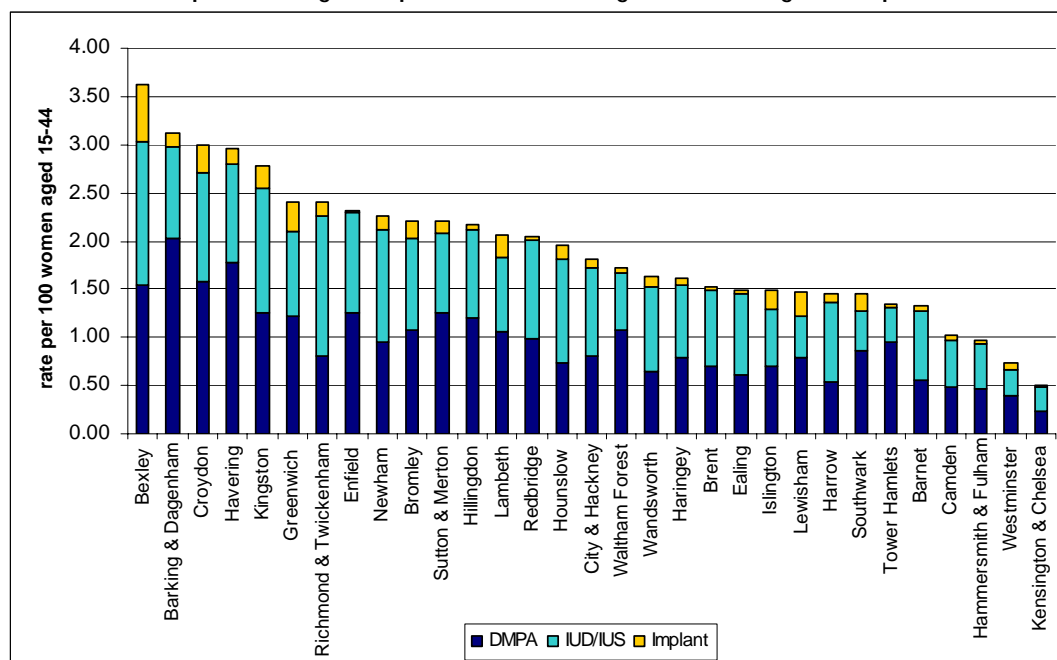
It is well recognised that the data available on clinical activity and quality from both major contraceptive settings are inadequate to fully inform modern commissioning decisions. Most of the limited information that is currently available from one setting is not usefully comparable with that from the other.

The National Institute for Health and Clinical Excellence (NICE) and the National Collaborating Centre for Women's and Children's Health have produced a guideline<sup>9</sup> recommending that long-acting reversible contraception (LARC) should be offered to all women as part of their contraceptive choices. A number of national reports and policy documents have suggested that the prescribing rate of these cost effective methods in general practice would be a useful local indicator of choice and access to the range of contraceptive methods. This indicator shows more than seven-fold variation in prescribing of LARC from general practice between PCTs (Chart 5).

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<sup>9</sup> *Long-acting reversible contraception: the effective and appropriate use of long-acting reversible contraception*. National Collaborating Centre for Women's and Children's Health. Commissioned by the National Institute for Health and Clinical Excellence, October 2005, RCOG Press.

Chart 5: LARC prescribing rate per 100 women aged 15-44 in general practice, 2007/08



Source: Prescription Pricing Authority, Exeter registered population data

Unfortunately the information collected from CSRH services does not reliably capture the choice and provision of LARC methods, and is thus not comparable with GP prescribing data. However, LARC provision could also be an indicator for monitoring local CSRH services as their information systems are improved.

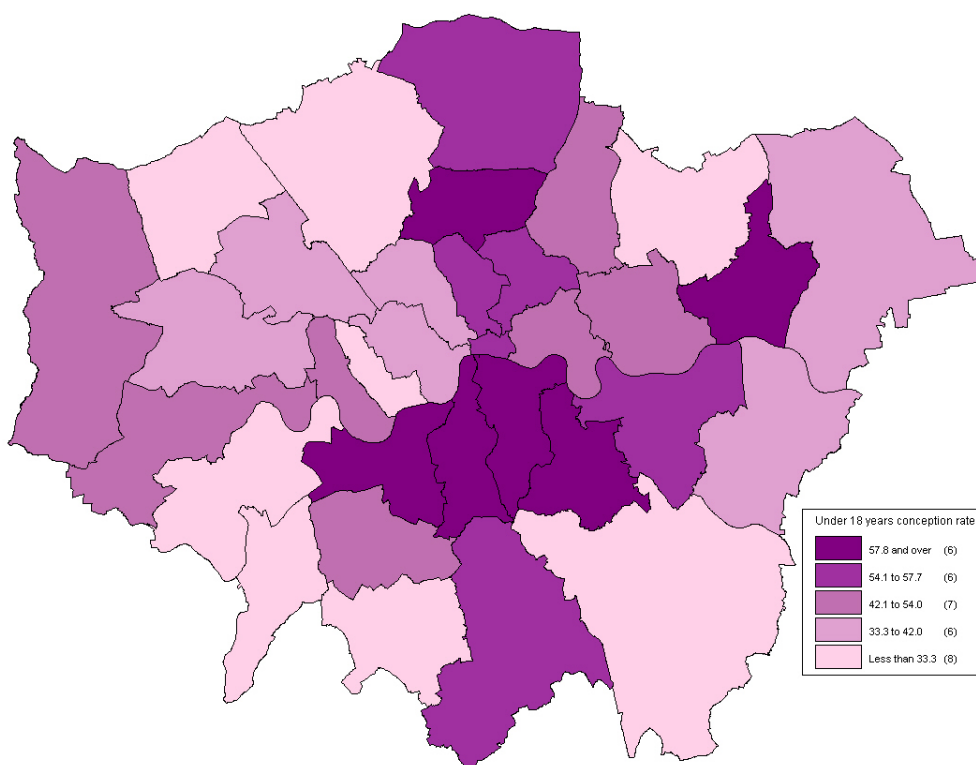
## 5.2 Teenage conceptions

Teenage pregnancy is a health inequality and social exclusion issue and leads to poor health and social outcomes for the mother and baby. It is also inter-generational and the child of a teenage mother is more likely to become a teenage parent themselves. Teenage pregnancy is defined as conception in a female aged less than 18 years.

There is a 10-year government national teenage pregnancy strategy led by the Department for Children, Schools and Families to tackle the issue with PCTs as key partners in delivery. The national target is to halve the under-18 conception rate by 2010 (from 46.6 per 1,000 in 1998), and establish a firm downward trend in the under-16 rate, with local London under-18 conception rate reduction targets of between 40% and 60%.

The teenage conception rate in London was 45.4 per 1,000 15-17 year old females compared to 40.4 per 1,000 for England in 2006. In Inner London, the rate was 55.7 per 1,000 but in Outer London it was 40.1 per 1,000. Teenage pregnancy rates have fallen both nationally and in London though the reduction across London is not as great as that seen nationally, with a reduction of 11.1% compared to a national reduction of 13.3%. The Inner London PCTs are outperforming the Outer London PCTs on percentage reduction.

Map 5: Conception rate per 1000 girls aged 15-17 years, 2006, London boroughs



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Source: Teenage Pregnancy Unit

While teenage conception rates have been falling, the proportion ending in abortion has increased. In 2006, 61% of all under-18 conceptions in London led to an abortion, a higher proportion than in England (49%). The percentage of teenage conceptions that result in an abortion is similar in Inner and Outer London despite the higher teenage conception rate in Inner London.

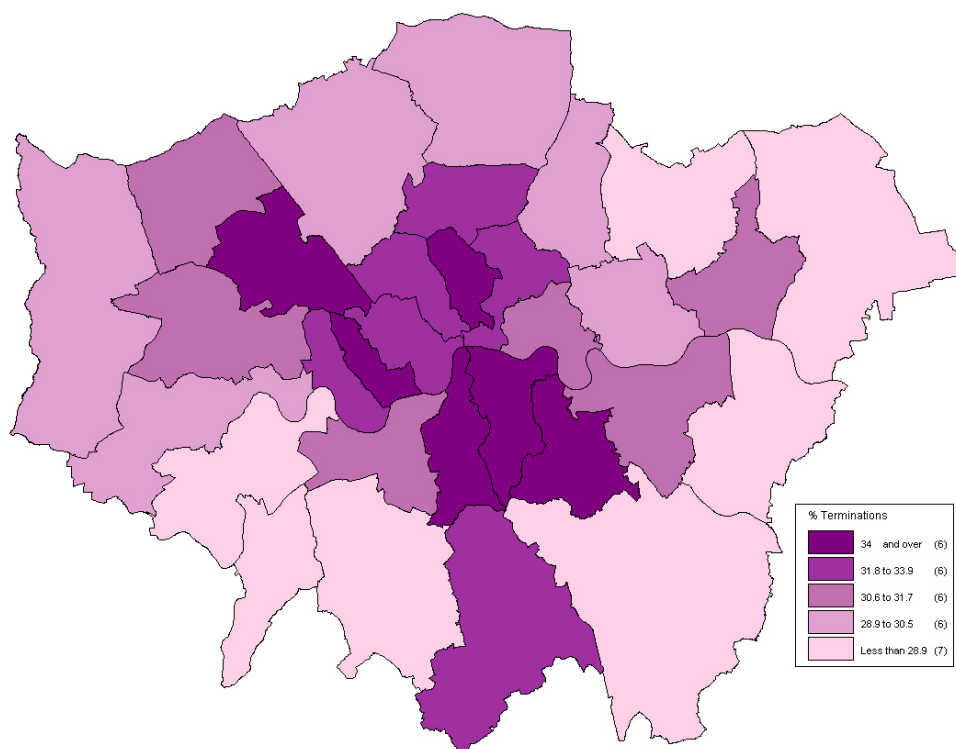
### 5.3 Abortion

The total period abortion rate as a percentage of potential fertility rate shows the number of abortions as a percentage of the total number of conceptions. This indicator provides a focus for where contraceptive service provision, as well as information on safer sex and abortion, could best be targeted, and includes women of all ages. Over 80% of abortions are for women aged over 20 years<sup>10</sup>.

<sup>10</sup> *Abortion Statistics England and Wales: 2007*. Department of Health, 2008



Map 6: Total period abortion rate as a percentage of potential fertility rate, 2006, London



Source: National Centre for Health Outcomes Development (NCHOD)

In London in 2006, the total period abortion rate as a percentage of potential fertility rate was approximately 32% (over 50 000 abortions per year). The London rate is higher than that of England, which had a figure of around 23%. Within London, there was wide variation from almost 40% in Southwark PCT to around 24% in Richmond & Twickenham PCT.

NHS-funded abortion services are provided by a mix of NHS provider trusts and non-NHS providers. Contracts were in place for non-NHS providers, with the majority including some access to LARC and referral or opt out for chlamydia testing.

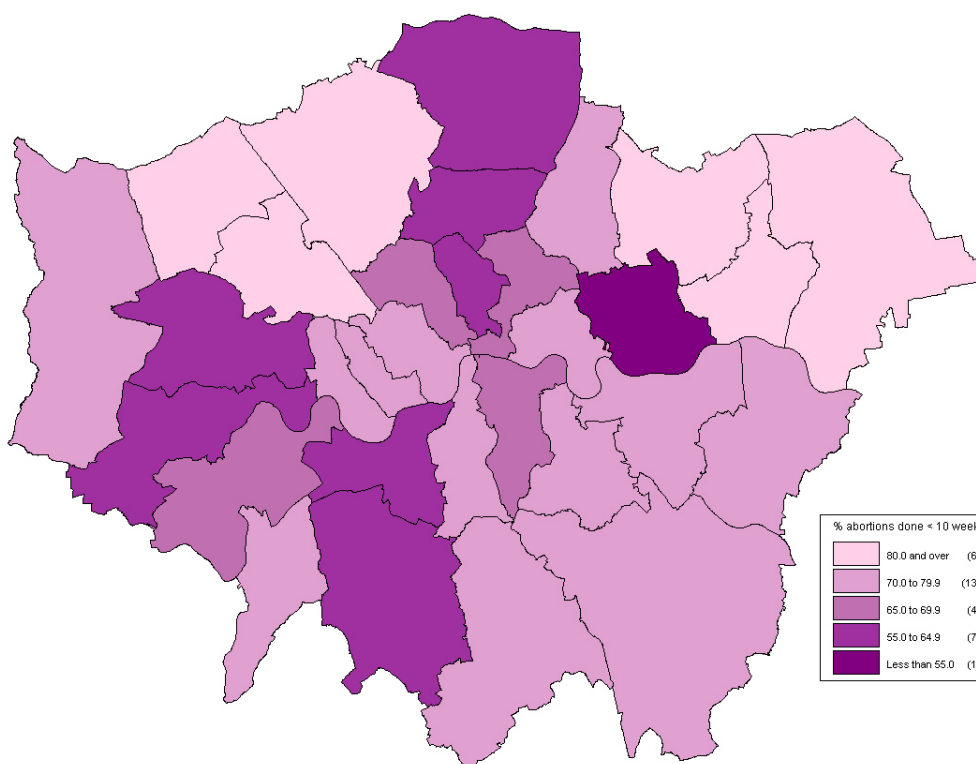
In London 20% of abortions are self-paid and not NHS-funded, which is almost double the proportion in the other English SHAs.<sup>11</sup>

The percentage of NHS-funded abortions performed under 10 weeks is a sexual health indicator that is used as a performance measure for PCTs. It is indicative of early access to abortion services and responsiveness of services. The Chief Medical Officer has recently recommended that all PCTs should be working actively towards 70% of NHS-funded abortions undertaken within this time frame<sup>12</sup>. In London, 74% of all abortions (NHS-funded and private) and 70% of NHS-funded abortions were carried out under 10 weeks in 2007. The latter is similar to England as a whole (68.3%). Havering PCT had the highest percentage (85%) of NHS-funded abortions performed under 10 weeks. 12 PCTs were below the recommended level, with Newham the lowest (43%).

<sup>11</sup> *Abortion Statistics England and Wales: 2007*. Department of Health, 2008

<sup>12</sup> *Chief Medical Officer letter to PCT and SHA Chief Executives regarding late abortions*. Gateway reference: 5463, dated 21 September 2005. [www.dh.gov.uk/assetRoot/04/11/96/19/04119619.pdf](http://www.dh.gov.uk/assetRoot/04/11/96/19/04119619.pdf)

**Map 7: Percentage of all NHS-funded abortions done under 10 weeks gestation in London by PCT, 2007**



Based on Ordnance Survey material. (c) Crown Copyright 2008. All rights reserved. Department of Health 100020290 2008  
Source: DH Statistical Bulletin Abortions 2007

In 2006, 40% of all abortions done under seven weeks were early medical abortions, with Barking & Dagenham PCT (17%) followed by Havering PCT (18%) having the lowest proportion, and Richmond & Twickenham PCT (69%) the highest.

In London 30% of abortions performed to women aged under 25 years were repeat abortions, i.e. the woman had had a previous abortion in addition to the one recorded for 2007. In England this figure was 24%. Within London rates again vary with Barking & Dagenham and Redbridge PCTs having the highest repeat abortion rate of 35% and Wandsworth the lowest at 25%.

Not all PCTs commission abortions up to the legal limit of 24 weeks.

## 5.4 Emerging themes for fertility

To understand the true rates of access to contraceptive services and quality of service provision, information from GP practices together with information on CSRH services must be routinely gathered, including prescribing of the range of contraceptive methods, notably LARC.

Current IT capability and data collection processes in CSRH mean that PCTs are unable to identify the residence of attendees at the contraceptive services they fund, or to gain an

accurate picture of the choice and provision of contraceptive methods in this setting, especially LARC.

PCT commissioning for CSRH services remains largely by 'block contracts' with wide variation in volume (not directly related to resident population), cost and attendance. There is a lack of proper costing of CSRH services and inconsistency between PCTs in what is included in the funding base, with consequent distortion of funding patterns.

A move to understand total service provider costs (CSRH and GP) together with activity will assist both commissioners and providers in understanding the impact of future PbR tariffs and allow benchmarking of reference costs to inform commissioning decisions.

When the current figures for spending by PCTs on CSRH services (although for services provided in their PCT, rather than for their PCT residents) and the GP prescribing for all contraception are combined, and then analysed by number of women of reproductive age registered with a GP in the PCT, there is a four-fold variation in spend per head.

Likewise, there is a wide range of expenditure on abortion, with an over four-fold variation in PCT expenditure on abortion per resident woman of reproductive age.

The variation in the percentage of total NHS-funded abortion procedures performed under 10 weeks gestation is significant. There is also a wide variation between PCTs in the proportion of abortions under seven weeks which are performed using the early medical method.

London has a high level of repeat abortions. There is a need to ensure that all abortion providers (NHS and non-NHS) are maximising access to contraception, and particularly LARC, as part of their commissioned service.

The standardisation of requirements on abortion providers has been addressed through the London Sexual Health Programme but not all contracts have yet been amended in line with the recommendations.

There is a need to explore the limited improvement as a whole in teenage conception rates within the Outer London area.

## 6 Social marketing and promotion of sexual health

The majority of PCTs responded to the SM questionnaire outlining a range of commissioned prevention activities including support groups, targeted health promotion campaigns, self help groups, targeted sexual health outreach screening, workshops and assessments for high risk communities, counselling, training of front line staff, and condom distribution. The majority of prevention activities were related to HIV and targeted MSM, young people and African communities.

Effective sexual health promotion activities include social marketing techniques, in particular in relation to the uptake of screening, use of condoms in high risk groups, choice of LARC, consistent sexual health messages, peer education and building aspirations. This area of commissioning activity would benefit from a continued and enhanced collaborative approach.

The following initiatives are planned by the London programme. These were not included in the SM reports but it was felt that there was a need to include them in this report for completeness.

- Social marketing campaigns are being commissioned to promote sexual health and access to services. These will increase awareness and tailor messages to vulnerable groups.
- A London-wide framework to increase access to contraception, in particular LARC, will be implemented. This will also include access to sexual health promotion information and support.
- A pilot sexual health self management tool is being developed. This is based on the principles of the Expert Patient Programme where peer educators support skills development so that people can better self-care, plan and manage their health and life choices.
- London-wide condom schemes are being developed that will enable access to lower cost condoms that can be purchased from the internet. A London-wide free C-card condom scheme where young people (post 16 years old) can access free condoms and safer sex information and support is also being planned.

## 7 Recommendations

The resident population of London, together with those who work in or visit the capital, faces many health challenges, only one of which is poor sexual health.

PCTs, as both commissioners and in some instances providers of services, are responsible for improving the health of the population whilst reducing health inequalities and ensuring the delivery of high quality cost effective services to meet those challenges.

It is therefore not surprising that in the face of different local priorities, both the commissioning processes and the services delivered vary widely in their refinement.

Though the degree of priority given to sexual health varies between PCTs, on average each PCT is currently committing over 1% (range 0.23% to 2.99%) of its total budget to these services. This considerable investment does not take account of the impact of redistribution of costs following dehosting of GUM, nor the potential future additional costs of tariffs currently in development.

But even in the face of such significant levels of funding both service provision and outcomes vary widely. Spending more does not equate to better outcomes across London. Sexual health is of course multi factorial, but with a growing evidence base for cost effective interventions, the variation in outcomes could be considered to be due in part to PCTs as commissioners failing to ensure consistently that value for money is being obtained from providers.

With the need for all PCTs to evolve into World Class Commissioners and the clearer separation of commissioner and provider functions, there is an opportunity to address these issues in relation to sexual health.

In reviewing the evidence from the needs assessment and service mapping reports, the following recommendations are made to address the issues raised.

1. PCTs should agree formal and robust commissioning/joint commissioning and strategic leadership arrangements, including clear accountability. Taking account of the variability and potential inequity between PCTs reported in this mapping exercise, each PCT should review the priority it gives to the commissioning of sexual health services based on need, outcomes and expenditure and determine whether it wishes to identify a dedicated commissioning lead or share a commissioning function with neighbouring PCTs.
2. PCTs, ideally across a sector or network, should consider which activities should be commissioned at a PCT, sector or pan-London level.
3. PCTs should commission for outcomes, equitable access and value for money, in line with World Class Commissioning guidance. As part of this, they should ensure that service specifications are in place, together with cost and activity information.
4. PCTs need to commission prevention and health promotion services to meet local need. In view of the lack of clarity found among commissioners on the profile of preventive activities within the sexual health commissioning portfolio, PCTs should

individually examine their commissioned prevention activities, maximise the potential within existing provider contracts and work collaboratively on social marketing and screening opportunities.

5. Priority should be given to commissioning sexual health interventions with the greatest potential for cost effectiveness and impact on health outcomes. These include incentivising LARC through ALL contraceptive service providers and abortion service providers (to reduce unwanted pregnancies and repeat abortions), population level chlamydia screening (to reduce prevalence of chlamydia), HIV testing (to reduce late diagnosis of HIV and facilitate access to effective treatment, thereby increasing healthy life expectancy and reducing infectivity) and prompt access to abortion and GUM.
6. PCTs should work with providers of GUM services to review their hours of operation and ensure out of hours provision to meet the needs of the whole population, including those in work. In addition, they should examine the percentage of patients offered an appointment versus those seen within 48 hours, to identify reasons for the wide variation across London.
7. PCTs, together with providers of Community Sexual and Reproductive Health and GUM services, should review the existing skills of the workforce and move forward towards the delivery of fully integrated sexual health services, i.e. where the patient receives STI screening, treatment and contraception as part of one package of care.
8. PCTs should review with providers of Community Sexual and Reproductive Health services their IT and informatics infrastructure to ensure that they are fit for purpose for the commissioning process. Key issues include PCT of registration/residency and proportion of patients prescribed LARC.
9. PCTs commissioning sexual health services also need to consider the role of primary care within the provider landscape and the relative priority of the development of Levels 1, 2 and 3 sexual health services, including development and monitoring of enhanced service specifications. This will require a review of training capacity within London, particularly among specialist services, to ensure both that the specialist workforce can be renewed and that professionals working at Levels 1 and 2 have the skills and knowledge required to provide services of consistent and high quality.
10. PCTs and networks should use the detail contained in the sexual health needs assessment and service mapping to understand, and explore further, their local picture.

## 8 Acknowledgements

This project would not have been possible without the time, commitment and guidance of the Project Advisory Group. Lengthy and sometimes difficult discussions have reflected the complexity of commissioning sexual health services for the people of the capital.

The group included representatives from commissioning, clinical services and public health. Whilst its deliberations covered many issues, this report and the recommendations within it are restricted to the information captured in the needs assessment and service mapping reports. Acknowledgement is due to the authors of those reports for the use of sections of text and data within this synthesis report.

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# 10 Appendix

Appendix Table 1: Key social demographic and sexual health indicators by Inner London PCTs (purple) and Outer London PCTs (blue)

	Overall IMD 2007 score	% Pop age 20-34yrs 2006	% Pop BME	U-18yr conception rates per 1,000 female pop aged 15-17yrs, 2006†	Age standardised abortion rate per 1,000 women aged 15 - 44, 2007†	% Abortions repeat women aged under 25	Fertility Rate per 1,000 females aged 15-44, 2006†	% Patients seen GUM clinic 48 hrs (April 2008)	% Patients offered GUM clinic 48 hrs (April 2008)
Barking & Dagenham PCT	34.5	21.9	25.6	59.6	40	35	84.43	90.7%	99.3%
Barnet PCT	21.2	22.9	30.9	30.0	25	30	65.57	67.1%	81.9%
Bexley Care Trust	16.2	18.2	11.9	36.9	24	28	60.32	91.9%	98.7%
Brent Teaching PCT	29.2	28.0	57.8	40.1	35	29	71.30	92.4%	99.3%
Bromley PCT	14.4	17.6	11.4	30.9	23	29	60.90	94.0%	99.5%
Camden PCT	28.6	36.4	29.6	37.6	19	29	45.57	81.3%	97.7%
City Hackney Teaching PCT	44.9	28.9	40.1	56.0	36	31	62.02	94.6%	99.5%
Croydon PCT	21.3	20.8	38.8	56.9	33	34	66.33	93.2%	99.4%
Ealing PCT	25.1	27.3	45.0	34.5	27	26	69.70	86.9%	96.8%
Enfield PCT	26.2	21.7	30.0	55.4	30	32	71.38	84.7%	89.6%
Greenwich Teaching PCT	33.9	25.1	30.0	57.0	35	29	78.32	88.4%	99.0%
Hammersmith & Fulham PCT	28.1	34.8	23.8	43.8	27	32	58.37	72.9%	99.8%
Haringey Teaching PCT	35.7	29.4	35.2	63.7	32	30	69.93	83.0%	95.9%
Harrow PCT	15.6	21.5	50.2	25.8	27	30	63.06	91.5%	98.3%
Havering PCT	16.1	17.5	6.8	39.0	25	29	54.22	93.3%	99.1%
Hillingdon PCT	18.6	22.0	28.0	43.3	26	31	64.55	87.5%	95.7%
Hounslow PCT	23.2	26.7	41.8	44.4	30	29	73.81	84.8%	98.9%
Islington PCT	39.0	34.4	25.7	54.5	27	30	52.06	81.6%	98.4%
Kensington & Chelsea PCT	23.5	29.1	22.2	33.8	18	32	51.63	77.8%	99.9%
Kingston PCT	13.1	25.9	21.3	22.4	19	28	55.50	94.4%	98.1%
Lambeth PCT	34.9	33.9	37.3	78.4	39	32	67.11	90.6%	99.9%
Lewisham PCT	31.0	27.0	39.1	68.2	37	33	70.08	93.9%	99.6%
Newham PCT	43.0	28.8	68.4	48.6	27	30	89.14	97.5%	99.8%
Redbridge PCT	20.4	22.5	45.9	30.4	30	35	71.45	90.9%	99.2%
Richmond & Twickenham PCT	9.6	21.0	10.9	26.9	16	32	68.72	86.8%	96.3%
Southwark PCT	33.3	32.0	38.4	75.0	41	34	66.50	94.3%	99.6%
Sutton & Merton PCT	14.3	24.2	27.4	42.1 (Merton), 31.4 (Sutton)	22	27	79.84	88.5%	96.8%
Tower Hamlets PCT	44.6	36.6	49.0	44.1	27	26	69.53	95.8%	99.9%
Waltham Forest PCT	33.2	25.7	40.6	48.4	36	31	78.69	94.2%	99.4%
Wandsworth Teaching PCT	20.3	38.1	21.9	57.8	22	25	59.00	81.9%	99.8%
Westminster PCT	26.3	36.7	28.5	37.5	18	29	44.08	85.2%	99.7%

† Resident population

**Appendix Table 2: Spend on sexual health in Inner London PCTs (purple) and Outer London PCTs (blue) per head of population**

	Spend on sexual health services (including GP contraceptive prescribing) per head of population in 2007/08† (£)
Barking & Dagenham PCT	14.93
Barnet PCT	9.03
Bexley Care Trust	5.46
Brent Teaching PCT	18.43
Bromley PCT	10.73
Camden PCT	57.67
City & Hackney PCT	34.13
Croydon PCT	15.99
Ealing PCT	11.10
Enfield PCT	11.95
Greenwich Teaching PCT	18.04
Hammersmith & Fulham PCT	26.46
Haringey Teaching PCT	15.50
Harrow PCT	8.77
Havering PCT	6.90
Hillingdon PCT	10.24
Hounslow PCT	13.05
Islington PCT	19.92
Kensington & Chelsea PCT	42.40
Kingston PCT	12.41
Lambeth PCT	32.31
Lewisham PCT	20.17
Newham PCT	17.01
Redbridge PCT	9.01
Richmond Twickenham PCT	9.10
Southwark PCT	28.87
Sutton & Merton PCT	8.46
Tower Hamlets PCT	40.47
Waltham Forest PCT	13.41
Wandsworth PCT	26.35
Westminster PCT	32.50

† GP registered population

Source: London sexual health service mapping report; Prescription Prescribing Authority e-PACT database; Exeter registered population data.