The London Sexual Health Programme

London sexual health indicators

A data-driven needs assessment

London Health Observatory

and

Health Protection Agency

commissioned by

Medical Foundation for AIDS & Sexual Health (MedFASH)

for

London Sexual Health Programme

London sexual health needs assessment and service mapping

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).

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

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Thanks are also due to the members of the Project Advisory Group, who provided valuable guidance and expert advice at all stages of the project.

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INTRODUCTION

Sexual health is a key national priority. The public health white paper[1], *Choosing Health,* published in 2004, included specific targets for chlamydia screening coverage, Genitourinary Medicine (GUM) waiting times and reductions in gonorrhoea rates. More recently, the 2007/2008 operating framework[2] for the NHS confirmed that sexual health and access to GUM services will continue to be a priority area for the NHS.

Sexual health is also a priority for London. London has the highest prevalence of sexual ill health in the UK and this has a disproportionate impact on inequalities, public health and financial burden to London's health commissioners.

This report, in combination with a London sexual health service mapping report, contributes to a newly commissioned needs assessment for sexual health in London. For the first time, the NHS in London will have a baseline mapping of sexual health services and needs.

The purpose of these reports is to support the NHS in London and the Department of Health in strategic decision making and effective use of resources to improve sexual health in London.

This is the first baseline, data rich, needs assessment which has been commissioned in London and will provide an overview of current sexual health in London. It will support decision making about the strategic direction for sexual health and services.

Structure of the report

This report provides a comprehensive range of indicators which are presented in nine sections covering all areas of sexual health including the wider determinants. The section on each indicator includes:

- rationale for inclusion
- what the data show and relevant comparisons
- relevant trend data
- map and/or table of the most recent data at PCT/borough level if available
- metadata (a description of the indicator or data)
- limitations of the data

Some sections may depart from this format slightly, for example, the sections on surveys. An interactive web tool enabling comparison between sexual health indicators at borough level and an Excel workbook with additional tables are available from the LHO website. (http://www.lho.org.uk).

Throughout the report, maps are used to illustrate the indicator pattern across London by Primary Care Trust (PCT) or London borough. These maps do not have borough or PCT labels. The following map shows PCT boundaries in London.

Figure 1: Primary Care Trust boundaries in London, 2008

Indicators and limitations

The indicators were chosen in consultation with the multi-disciplinary project advisory group and are based on the National Support Teams for Sexual Health and Teenage Pregnancy Design Options *How To Guide*[3]. Inclusion of indicators was determined by a number of criteria:

- Are the data routinely available?
- Are the data robust?
- Do the data provide meaningful insight into various aspects of sexual and reproductive health?

Given the wide range of data sources, it is not surprising that some data did not meet all of the criteria. An additional criterion was added to allow for this:

- If not routinely available, could bespoke robust analyses be performed?

This allowed for:

- novel analyses of data that are not routinely published, e.g. some of the sexually transmitted infections indicators, and
- the creation of new indicators, e.g. rate of long acting reversible contraception (LARC) prescribing in general practices.

Despite the widening of the criteria, it was not possible to provide indicators on some important aspects of sexual health services provided in community settings. The KT31 data are of limited use. It was not possible to obtain and analyse the raw data from community contraception services as the vast majority have no computerised systems. As a result, a pragmatic decision was taken not to include an indicator on method of contraception chosen.

The Department of Health is developing a Common Data Set for Sexual Health (CDSSH) which will provide a single, standard structure for collecting data on sexual health within the National Health Service[4]. The KT31 form is currently undergoing revision by the Department of Health[5].

This report is a joint production by the London Health Observatory (LHO) and the Health Protection Agency (HPA). It was commissioned by MedFASH (Medical Foundation for AIDS & Sexual Health) for the London Sexual Health Programme and was jointly funded by the Department of Health (DH) Sexual Health Policy Team, the DH National Support Team for Sexual Health and the London Sexual Health Programme.

Section 1. Demography

Introduction

London is one of the largest cities in the world in terms of both size and population. At a size of 1,584 square kilometres and approximately 7.5 million residents (based on Greater London Authority (GLA) population estimates for 2006), it is a city of great contrasts, in terms of both the population that makes up the city and the conditions in which they live.

Compared with the rest of the country, London has a higher proportion of women of childbearing age, leading to London's comparatively high birth rate.
A recent survey[6] claims that there are more than 300 languages spoken in London and over 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 Ethnic Minority (BME) population. At over 30%, minority ethnic groups make up a higher proportion of the population in London than in the rest of the country. [7] London is also home to some of the country's most affluent and deprived areas.

Indicator 1.01 Population by age

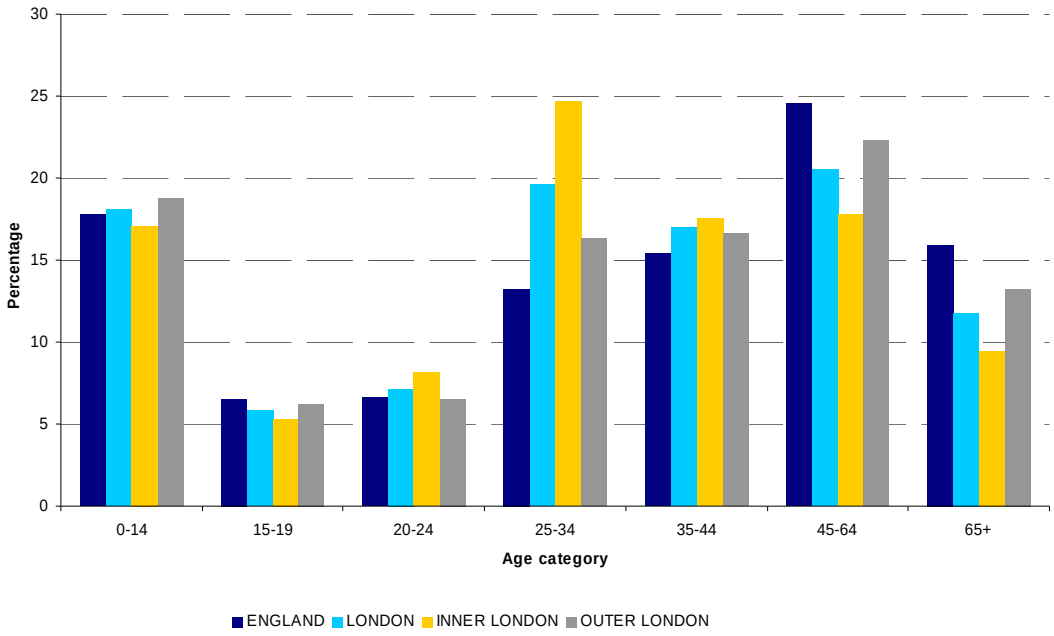
Rationale for inclusion

England has a population of around 50 million people. Around 7.5 million of these (15%) live in London, making London by far the most populous city in the country, and one of the most populous in the world. Such a vast number has a large impact on overall need. The age and sex structure of the population has important implications for sexual health, Genitourinary Medicine (GUM) services and maternity services.

What does this indicator show?

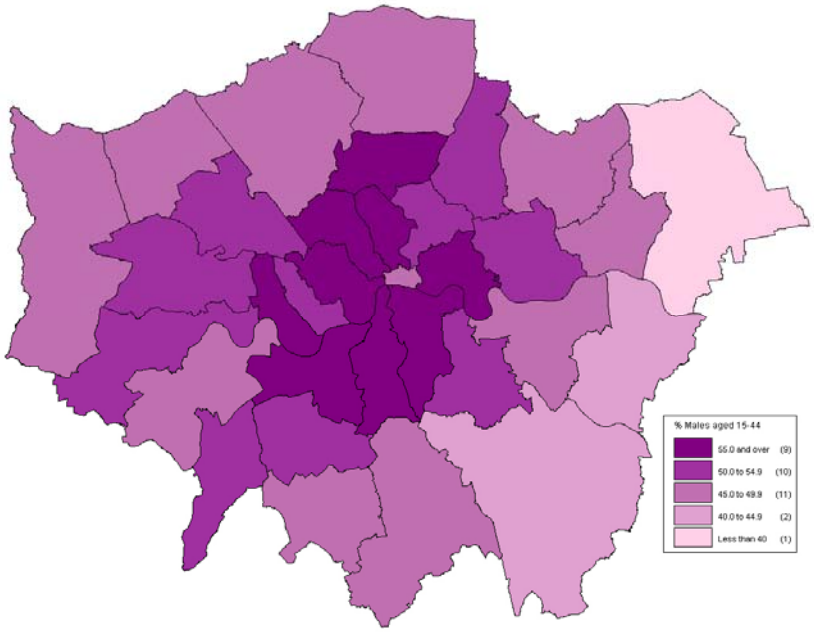
- In London, half of the population is between the ages of 15 and 44, compared to 42% for England as a whole.
- The population of inner London is younger than that of outer London; a third of the population is aged 20-34 compared with 23% in outer London and 20% in England.
- Compared with England, London has a lower percentage of those aged 45-64 years and of those aged 65+.
- The 20-34 age group illustrates the differences in population structure across London
- Wandsworth borough has the highest percentage (38%) of residents aged 20-34 years. Westminster, Tower Hamlets, Camden, Hammersmith & Fulham, Islington and Lambeth boroughs all have over a third of their resident population in this age group.
- Havering, Bromley and Bexley boroughs have less than 20% of their population in the 20-34 age group.

Figure 2: Percentage of population in different age bands, by area of London, 2006



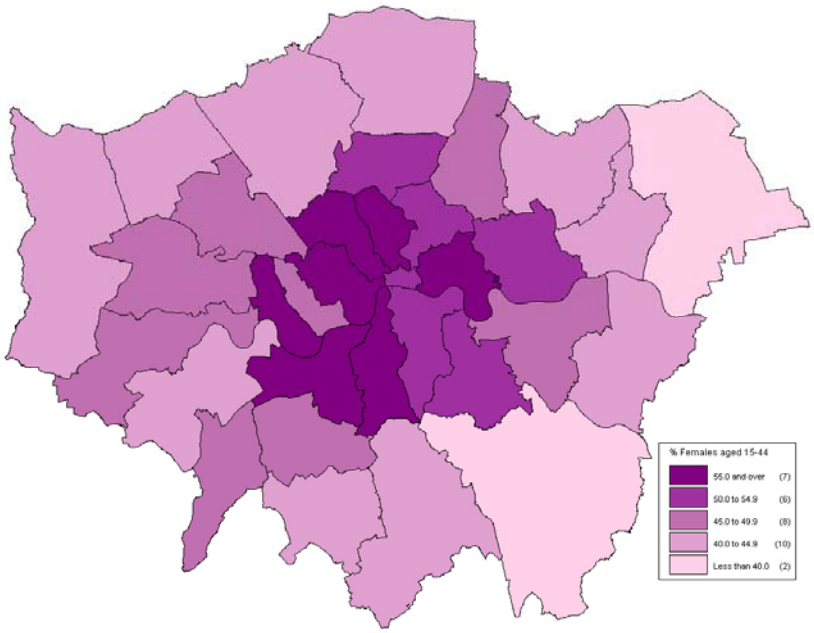
Source: ONS

Figure 3: Percentage of males aged 15-44, by London borough, 2006



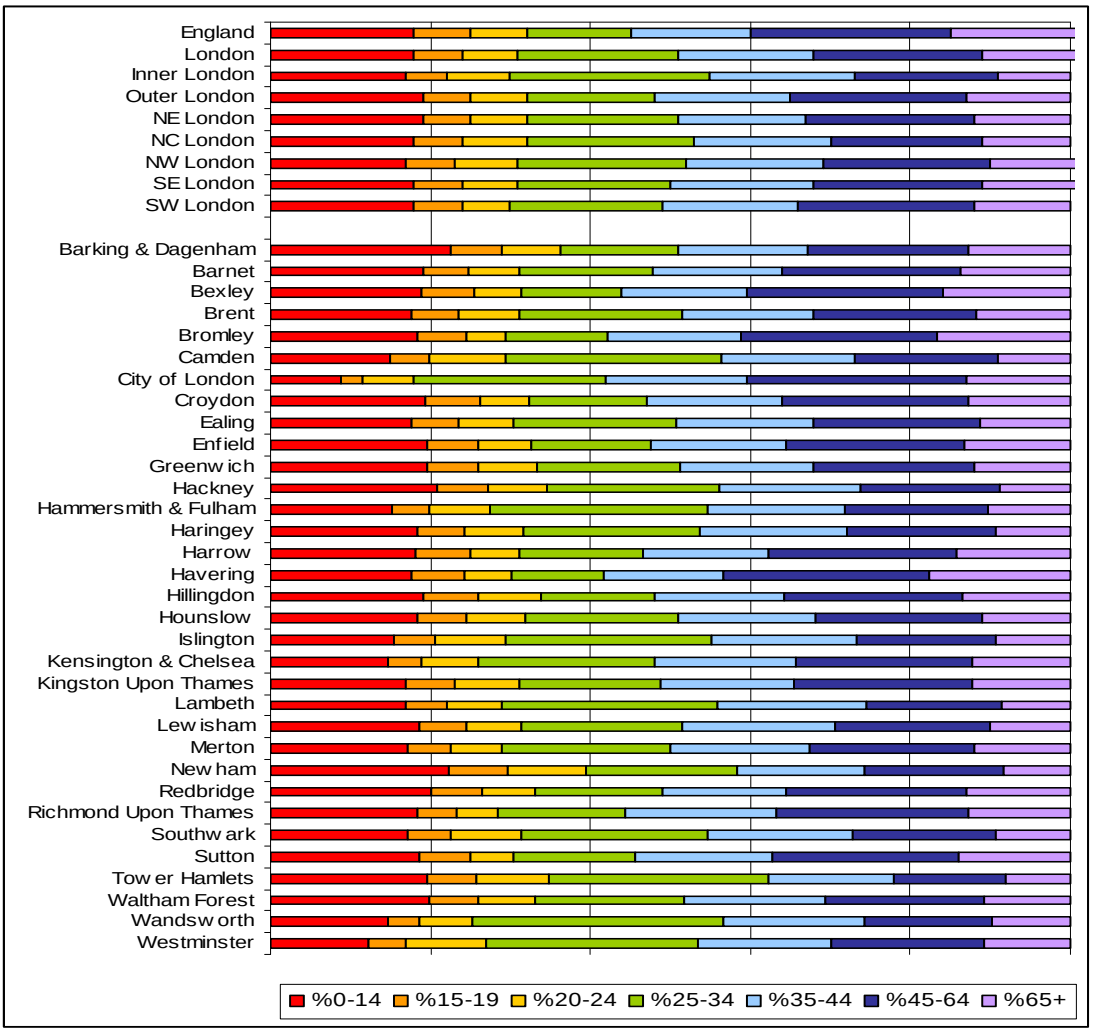
Source: ONS

Figure 4: Percentage of females aged 15-44, by London borough, 2006



Source: ONS

Figure 5: Percentage of population in different age bands by London location



Source: ONS

Metadata

Indicator description	Resident population by age.
Source of data	Office for National Statistics mid-year population estimates 2006.
Numerator definition	Number of resident people in the specified age/sex/area group.
Denominator definition	Figure 2 – total resident population in the specified area 2006 Figure 3 – total males resident in the London borough 2006 Figure 4 – total females resident in the London borough 2006 Figure 5 – total resident population in the specified area 2006
Geography	London borough, London sector, Inner London, Outer London, London, England.
Timeliness	Mid-year population estimates are produced by the ONS every year.
Disclosure control	There is no disclosure control associated with this indicator.
Data accuracy & completeness	This dataset can be considered to be accurate and complete.

Indicator 1.02 Population by ethnicity

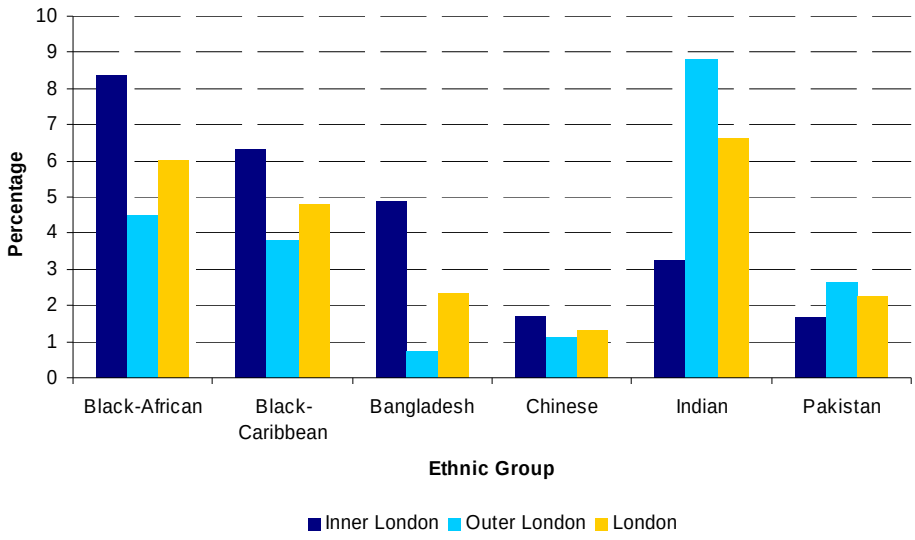
Rationale for inclusion

The UK is often referred to as a multi-cultural society, and London is considered to be the most culturally diverse city in the UK. The 2001 Census showed that 2.1 million, or around 29%, of London's population, belonged to a Black or Minority Ethnic (BME) group. The Census also showed that although 14% of the total England and Wales population lived in London, 46% of the country's BME population lived in London. Recent figures from the Greater London Authority (GLA) estimate that London's BME population has risen to about 33%. In the UK, the prevalence of sexually transmitted infections and HIV varies according to ethnicity.

What does this indicator show?

- 33% of London's resident population is from a BME group.
- In Inner London, 36% of the resident population is from a BME group
- Across the boroughs, the percentage varies from 67% in Newham and 57% in Brent to 6% in Havering.
- The distribution of people from BME groups across London is also far from uniform. Over 10% of the population of Southwark and Newham is Black African while in Brent and Lambeth more than 10% of the population is Black Caribbean.
- Over 25% of the population of Harrow is Indian.
- A third of the population of Tower Hamlets is Bangladeshi.

Figure 6: Percentage of population in different BME groups, by area of London, 2007.



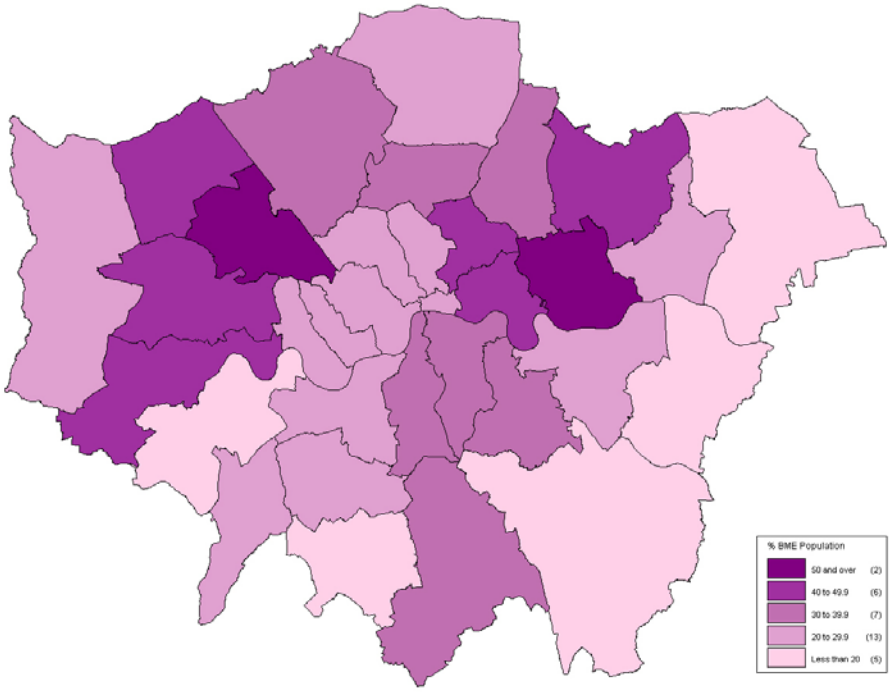
Source: GLA

Table 1: Percentage of population from a BME group by area of London, 2007

Area	Population	% BME		Area	Population	% BME
London	7,571,900	33		North Central London	1,231,100	31
Inner London	2,998,000	36		North West London	1,840,000	37
Outer London	4,573,900	30		South East London	1,569,800	28
North East London	1,582,874	37		South West London	1,337,795	22

Source: GLA

Figure 7: Percentage of the population from a BME group, by London borough, 2007



Source: GLA

Metadata

Indicator description	Population of London by ethnic group.
Source of data	Greater London Authority (GLA). Population projections by ethnic group.
Numerator definition	Number of people of specified ethnicity resident in the area specified, 2007.
Denominator definition	Number of people resident in the area specified, 2007.
Geography	London borough, London sector, Inner London, Outer London, London.
Timeliness	Ethnic projections are produced by the GLA every year.
Disclosure control	Numbers have been rounded to the nearest hundred.
Data accuracy & completeness	These projections have been demographically modelled based on 2001 census data: the most detailed source of data on ethnicity. Therefore modelled output is as a result of demographic trends as at 2001. More recent migration patterns will not be reflected in these projections, for example EU accession migration from Eastern Europe.

Limitations

The population estimates are based on the decennial census and are modelled taking into account birth rates, death rates and migration patterns. More recent migration patterns may not be reflected in these projections, for example EU accession migration from Eastern Europe.

Indicator 1.03 Deprivation

Rationale for inclusion

London is a city of great contrast. This can be seen quite vividly in terms of variation in deprivation using the index of multiple deprivation (IMD) 2007. This measure is used by central government and other bodies to identify levels of deprivation by area in order to allocate material and financial resources efficiently. The index is made up of 38 indicators across seven domains. These domains are:

- Income
- Employment
- Health deprivation & disability
- Education skills & training
- Barriers to housing & services
- Crime & disorder
- Living environment

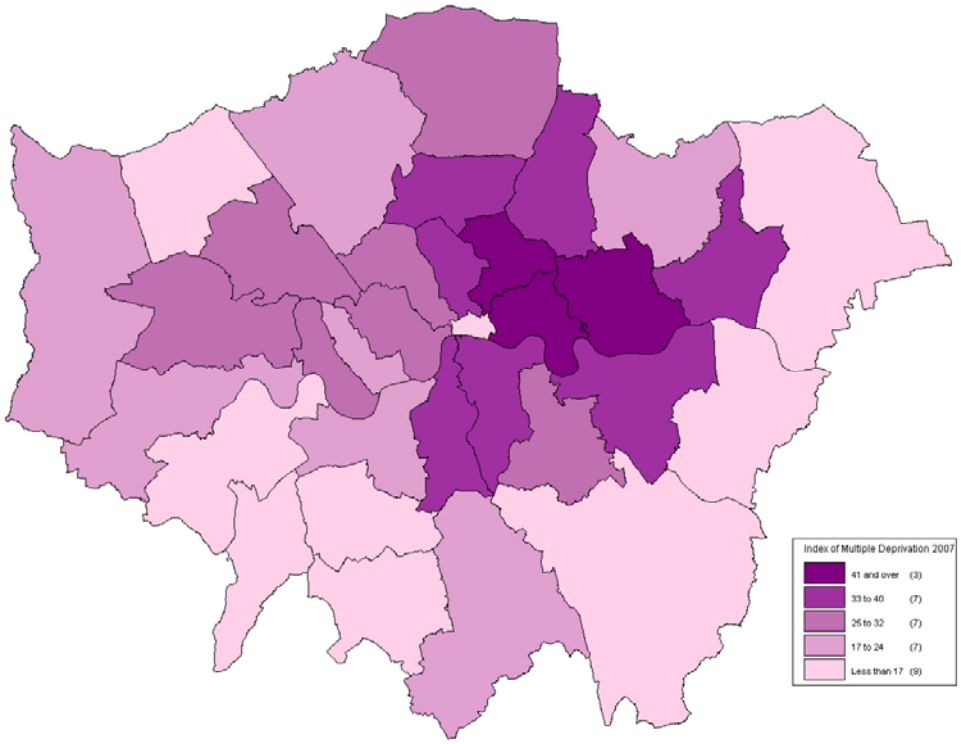
These indicators combine to provide a single deprivation score for each Lower Super Output Area (LSOA) in England, and for each local authority area. The domain scores from the areas of the IMD which may contribute to poor sexual health have been included in the Excel workbook.*

What does this indicator show?

- 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 domain.
- Hackney and Tower Hamlets rank within the top 50 on all domains.
- Overall, 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.
- London also has significant variability within the measure of deprivation. Richmond is ranked as the least deprived in London across all of the domains, though such consistency is unusual. For example, Barnet is ranked as the second most deprived London borough in terms of housing, but the third least deprived in terms of education, while Havering is ranked second least deprived in terms of housing but fourth most deprived in terms of education.
- Although 28% of Lower Super Output Areas (LSOAs) in London are among the 20% most deprived in the country, the deprivation is largely in the areas of housing and services. Relatively few LSOAs rank among the most deprived in terms of education, skills and training deprivation.
- London has the fewest LSOAs ranked among the 20% least deprived out of all regions in England.

* This is available at www.lho.org.uk

Figure 8: Index of Multiple Deprivation score by London borough, 2007



Source: Dept. of Communities and Local Government

Metadata

Indicator description	Index of Multiple Deprivation 2007. Income domain score, housing domain score and education domain score from Index of Multiple Deprivation 2007.
Source of data	Department of Communities and Local Government.
Numerator definition	N/A
Denominator definition	N/A
Geography	London borough, lower super output area (LSOA).
Timeliness	English indices of deprivation are produced every 3-4 years.
Disclosure control	There is no disclosure control associated with this indicator.
Data accuracy & completeness	These data were originally produced at LSOA level. This means there are some issues when aggregating scores to a district level. Firstly districts can vary enormously in population size. The make-up of a district's population can very enormously from one district to the next, helping to account for the differing degrees of variability in deprivation. Also, some local authorities may experience deprivation in small concentrated areas as opposed to having an even spread. The income, housing and education scores have been calculated as a weighted average of the LSOA scores.

Section 2. Sexually transmitted infections (STIs) and the Human immunodeficiency virus (HIV) in London

Sexually transmitted infections (STIs), including HIV, are one of the greatest infectious disease problems in the UK today. The associated morbidity is substantial and ranges from the acute and chronic disease manifestations of HIV to complications such as pelvic inflammatory disease, ectopic pregnancy and tubal factor infertility from untreated chlamydial and gonococcal infection, and cervical cancer from human papilloma virus (HPV). Rising numbers of STIs over the last ten years have placed a major strain on health services.

London has the highest number of sexually transmitted infections (STIs) in England, compared with any other region. In 2007, 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. These groups are referred to in this report as key prevention groups. Trends in STIs and HIV vary considerably in these different sub-populations and, therefore, public health interventions need to be targeted accordingly.

Sexually transmitted infections

There were 96,223 new STIs diagnosed in London GUM clinics in 2007 (7% up on 2006). Additional infections will have been diagnosed in other settings, such as GP surgeries and community reproductive and sexual health (CSRH) clinics. In 2007, the most common STI diagnosed in London GUM clinics was genital chlamydia followed by genital warts, gonorrhoea and genital herpes.

New diagnoses of syphilis have risen by 18%, genital herpes by 17% and chlamydia by 10% since 2006. 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.

Chlamydia and gonorrhoea can often be asymptomatic and about 1 in 10 young people screen positive through the National Chlamydia Screening Programme (NCSP). Positivity rates across London among populations screened by Chlamydia Screening Offices (CSOs) ranged from 2.9% to 21.6%.

Table 2: Numbers and rates (per 100,000 population) of selected STIs diagnosed in GUM clinics by gender and year of diagnosis, London, 2003-2007

Condition	Gender	2003		2007	
		Number	Rate	Number	Rate
Genital chlamydia	Male	9,914	271	11,705	315
	Female	10,416	278	11,088	291
	Total	20,330	-	22,793	-
Gonorrhoea	Male	6,221	170	4,938	133
	Female	2,461	70	1,845	48
	Total	8,862	-	6,783	-
Infectious syphilis	Male	626	17	866	24
	Female	105	3	86	2
	Total	731	-	972	-
Genital herpes	Male	1,995	56	2,443	66
	Female	2,872	79	3,706	98
	Total	4,867	-	6,149	-
Genital warts	Male	7,234	192	7,806	212
	Female	5,777	149	6,348	167
	Total	13,011	-	14,224	-

Source: HPA (KC60)

HIV

(i) New HIV and AIDS diagnoses

The annual number of new HIV diagnoses rose dramatically over the five years up to 2003. Numbers now appear to be stabilising - at a level however that is almost double that seen ten years ago. In 2006, there were 3,036 new diagnoses in London: 2,993 adults and 43 children. There were around 1.7 adult males diagnosed for each adult female. Just over half of those diagnosed were probably infected heterosexually. Three quarters of these people had acquired their infection abroad, mostly in Sub-Saharan Africa, and more than 70% were of Black African ethnicity.

In 2006, sex between men was the probable route of infection of just over 40% of those diagnosed in 2006. Over three-quarters of this group were white and the majority had been infected in the UK.

Only 81 (3%) of those newly diagnosed had acquired their infection through injecting drug use.

In 2006, there were 55 new diagnoses in London of people infected through vertical transmission (from mother to unborn child or through breastfeeding) but almost half of these people were born abroad.

The numbers of AIDS diagnoses and deaths among HIV infected people fell rapidly during the late 1990s following the introduction of antiretroviral treatment. Numbers have remained low over the past five years. In 2006 there were 243 AIDS diagnoses in London and 189 reported deaths.

(ii) People accessing care for HIV

The prevalence of diagnosed HIV (all ages) in London is more than five times the figure for England outside London. In 2006, 23,986 London residents accessed care for their HIV infection. Overall, almost half were MSM and a third were Black African

heterosexuals. However, the spread of these key prevention groups varies across London, with Black African heterosexuals predominating in some areas and MSM in others.

(iii) Undiagnosed HIV infections

In London, an estimated 27% of HIV-infected adults aged 15-59 years remained unaware of their infection in 2006. Unlinked anonymous surveillance in eight GUM clinics across London found that the prevalence of previously undiagnosed HIV was 4.4% amongst MSM and 0.6% amongst heterosexuals. Amongst heterosexuals born in sub-Saharan Africa, the prevalence was 2.7% amongst women and 1.6% amongst men. Four percent of London intravenous injecting drug users (IDUs) and around 0.4% of pregnant women in London are HIV infected.

(iv) Late diagnoses and HIV testing

Improved uptake of testing for HIV is vital for early detection and treatment to reduce morbidity and mortality. There is evidence that a high proportion of London residents were diagnosed with HIV late: 33% of those diagnosed in 2005 to 2006 had a CD4 count less than 200 cells per mm^3.

Three quarters of those offered an HIV test at GUM clinics across London in 2006 chose to test. Unlinked anonymous testing in eight GUM clinics across London revealed that HIV test uptake was lower amongst those found anonymously to be HIV positive (57%) compared to those found anonymously to be HIV negative (85%). Some HIV positive MSM who refused an HIV test may have been aware of their status but chose not to disclose it to the GUM clinic. Nevertheless, it appears that a significant proportion of people with HIV remain undiagnosed after their GUM visit, including over half of MSM with HIV (52%).

It is encouraging that the uptake of HIV testing among pregnant women in antenatal care in London has substantially increased the number of women who are aware of their HIV diagnosis before giving birth. If a woman's HIV infection is identified before she gives birth, transmission to her baby during and after its birth can be prevented.

Key prevention groups

(v) Young people

Young people are disproportionately affected by most STIs, particularly chlamydia. In women, the highest rates of genital chlamydial infection are in 16 to 19 year olds (2002 per100,000 population) whilst in men, highest rates are seen in those aged 20 to 24 years old (1338 per 100,000). Gonorrhoea is also common in young people. As with chlamydia, the highest rates of gonococcal infection are seen among 16 to 19 year old women (414 per 100,000) and 20 to 24 year old men (437 per 100,000).

(vi) Men who have sex with men (MSM)

HIV is not the only STI which affects MSM disproportionately. They also make up a third of those diagnosed with gonorrhoea and around 60% of those diagnosed with infectious syphilis in London. This has been an increasing problem, with the numbers of all STIs apart from genital herpes rising over the last five years in MSM.

In recent years in London there have been a number of STI outbreaks which have particularly affected MSM, including outbreaks of infectious syphilis, hepatitis A, and sexually acquired shigella infection. A Lymphogranuloma venereum (LGV) outbreak in MSM has been ongoing for five years. LGV is caused by 3 serovars of *Chlamydia trachomatis* which were previously considered rare. Over 400 cases have now been

reported in London, of which 99% were in MSM. The majority of cases were co-infected with HIV.

In recent years there has also been an estimated 20% year-on-year increase in the number of reports of newly acquired Hepatitis C (HCV) infections among HIV infected MSM in London and the Southeast. HCV transmission in MSM is thought to occur primarily through sexual contact. A 2006 survey of GUM and HIV clinics across London and the Southeast Region found a total of 389 cases of newly acquired HCV in HIV positive MSM between January 2002 and June 2006.

(vii) Black minority communities

The increased burden of HIV in Black African populations has been described earlier. Evidence from national data sources reveals that the impact of acute STIs is also high for younger Black Caribbeans, Black Africans and other Black populations. Information from the National Chlamydia Screening Programme (NCSP) reveals that chlamydia positivity is higher in people of Black Caribbean ethnicity (14%) than in those of white ethnicity (10%).

The disproportionate burden of gonorrhoea in Black minority communities is also seen in data from the Gonococcal Resistance to Antimicrobials Surveillance Programme (GRASP) which showed that in 2006 Black Caribbeans accounted for 17% of gonorrhoea diagnoses, while Black Africans accounted for 4.3%.

Indicator 2.01 Prevalence of diagnosed HIV in adults (aged 15 years and above), by primary care trust (PCT), 2006

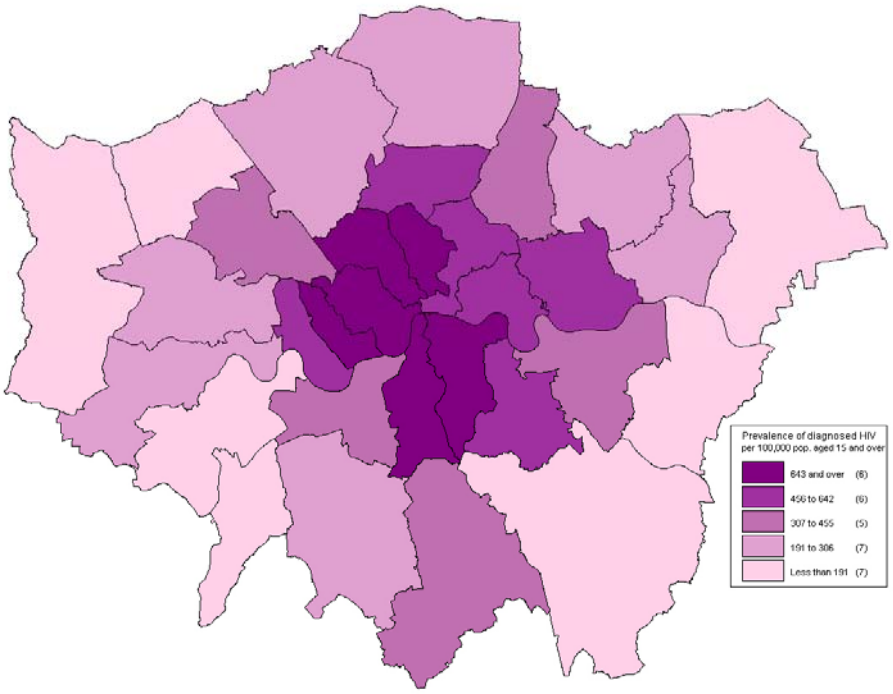
Rationale for inclusion

The distribution of people accessing care for HIV is not uniform throughout London. Geographical variations have important implications for the planning and commissioning of services. In addition, as the distributions of (i) those yet to be diagnosed and (ii) those at risk of acquiring an HIV infection are believed to be similar, this information can help us to target testing and prevention initiatives.

What does this indicator show?

- The prevalence of diagnosed HIV in adults (aged 15 years and above) was highest in central London PCTs and almost reached 1 in 100 in Lambeth.
- In all London PCTs except Havering, the rate was greater than 1 in 1000.
- Diagnosed prevalence is associated with the size of populations of key prevention groups that live in each PCT.

Figure 9: Prevalence of diagnosed HIV in adults per 100,000 population aged 15 and above, by PCT of residence, London: 2006



Source: HPA (SOPHID) / GLA population projections

Metadata

Indicator description	Prevalence of diagnosed HIV infection in adults per 100,000 population aged 15 years and above in 2006.
Source of data	Numerator: The Survey of Prevalent HIV Infections Diagnosed (SOPHID) is a cross-sectional survey of all persons who attend for HIV-related care at an NHS site in England, Wales and Northern Ireland (E, W & NI) within a calendar year. Denominator: GLA 2007 Round Ethnic Group Population Projection (EGPP) figures, by 5-year age band, from 2002 to 2007 (constrained to the GLA 2007 Round Demographic Projections - PLP Low).
Numerator definition	The total number of HIV-infected London residents aged 15 years and above who accessed HIV-related care at an NHS site in E, W & NI in 2006, by PCT of residence.
Denominator definition	The population of London residents aged 15 years and above in each borough in 2006. These are almost coterminous with PCTs in London. There were two cases in which it was necessary to merge a pair of boroughs: the boroughs of City of London and Hackney were merged to create a denominator for City & Hackney PCT; the boroughs of Sutton & Merton were merged to create a denominator for Sutton & Merton PCT.
Geography	The data are presented according to PCT of residence.
Timeliness	Data are complete for 2006: there is no reporting delay. Data for 2007 will be available by the end of August 2008.
Disclosure control	No names are collected. No patient-level data are ever released and aggregate data are only published after ensuring that deductive disclosure cannot occur. HIV voluntary reporting systems have approval (renewed each year) under the Section 60 regulations of the Health and Social Care Act (Statutory Instrument 1438, June 2002). In addition, all data are stored on restricted and secure databases at the HPA, with strict adherence to the Data Protection Act and Caldicott Guidelines[8].
Data accuracy and completeness	Data are likely to be very accurate and complete as these data are used for the national allocation of funding and for national and local commissioning. Duplicate reports from across England, Wales & Northern Ireland are identified and excluded from the numbers published so that each individual is only represented once in the data. Some London residents will have been seen for care in clinics outside London. Similarly, some London clinics will have provided care to residents of PCTs outside London.

Limitations

Data are disseminated in time for commissioning plans to be based on data to the end of the previous year but further improvements in timeliness are dependent on timely data reporting by Trusts across England, Wales & Northern Ireland.

Indicator 2.02 Percentage increase in the prevalence of diagnosed HIV infection in adults (aged 15 years and above), by PCT of residence, 2002-2006

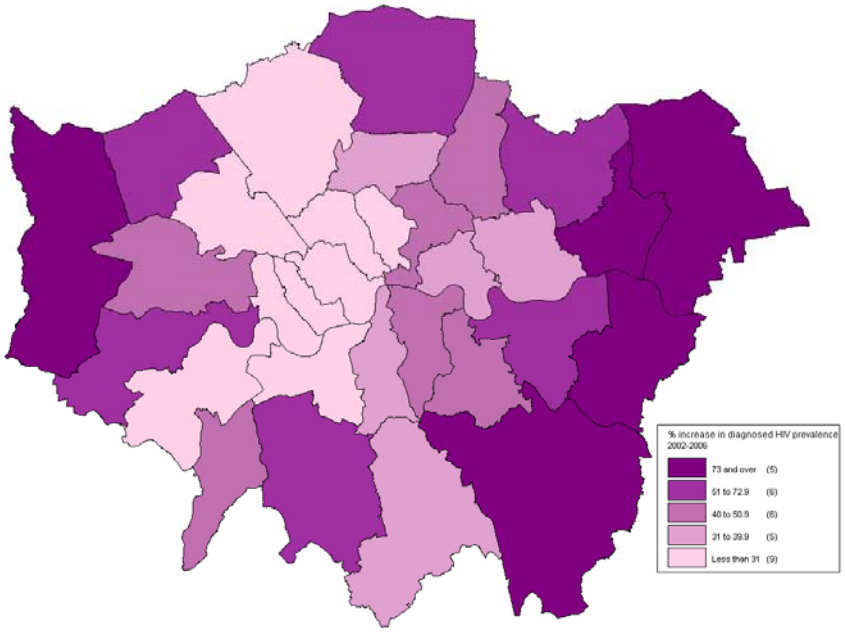
Rationale for inclusion

Geographical trends in the prevalence of diagnosed HIV have important implications for the planning of services which provide HIV-related care. Increases seen in the prevalence of diagnosed HIV at PCT level are influenced by a number of factors: (i) increases in the number of PCT residents being tested and therefore diagnosed; (ii) migration in and out of the PCT; (iii) increases in the number of PCT residents becoming infected with HIV and (iv) decreased mortality due to the availability of effective therapy.

What does this indicator show?

- The prevalence of diagnosed HIV in adults (aged 15 years or more) tended to increase faster in PCTs in outer London than in those in inner London and in PCTs in east London compared to those in west London.
- Three PCTs (Barking & Dagenham, Bexley, Hillingdon) saw their prevalences double in the five years from 2002 to 2006. However, the diagnosed prevalences in 2006 in both Bexley and Hillingdon were still amongst the lowest seen in any PCT in London, while the prevalence seen in Barking & Dagenham was around average for London.
- The increase seen in Barking & Dagenham may reflect the growth of its Black African population during that period.
- Substantial increases were also seen in PCTs where the prevalence was already high, including Lambeth and Southwark which both saw rises of greater than 40%

Figure 10: Percentage increase in prevalence of diagnosed HIV in adults (per 100,000 population aged 15 years and above) by PCT of residence, London, 2002-2006



Source: HPA (SOPHID) / GLA population projections

Table 3: Percentage increase in prevalence of diagnosed HIV in adults (per 100,000 population aged 15 and above) by PCT of residence, London, 2002-2006

PCT of Residence	Prevalence of diagnosed HIV		% increase in prevalence
	2002	2006	
Barking & Dagenham	140.7	306.8	118.1%
Barnet	145.9	191.0	30.9%
Bexley	56.9	119.6	110.4%
Brent	249.8	317.8	27.2%
Bromley	66.9	116.0	73.3%
Camden	605.5	713.8	17.9%
City & Hackney	430.5	613.4	42.5%
Croydon	228.7	310.1	35.6%
Ealing	170.7	257.3	50.7%
Enfield	150.8	260.2	72.6%
Greenwich	240.0	391.8	63.2%
Hammersmith & Fulham	555.0	631.7	13.8%
Haringey	424.0	558.9	31.8%
Harrow	91.1	142.1	56.1%
Havering	32.1	61.3	91.2%
Hillingdon	88.2	175.8	99.2%
Hounslow	185.3	297.4	60.5%
Islington	529.4	693.2	31.0%
Kensington & Chelsea	579.8	668.7	15.3%
Kingston	97.3	145.7	49.8%
Lambeth	699.0	978.5	40.0%
Lewisham	335.5	494.2	47.3%
Newham	432.9	579.6	33.9%
Redbridge	120.6	196.4	62.9%
Richmond & Twickenham	107.7	133.2	23.6%
Southwark	561.8	807.3	43.7%
Sutton & Merton	118.7	194.6	63.9%
Tower Hamlets	338.2	456.0	34.8%
Waltham Forest	253.0	374.3	48.0%
Wandsworth	296.4	383.6	29.4%
Westminster	499.0	643.4	28.9%

Source: HPA (SOPHID)

Metadata

Indicator description	Percentage increase of diagnosed HIV in adults resident in London between 2002 and 2006. The prevalence rate is per 100,000 population aged 15 years and above.
Source of data	Numerator: The Survey of Prevalent HIV Infections Diagnosed (SOPHID) is a cross-sectional survey of all persons who attend for HIV-related care at an NHS site in England, Wales and Northern Ireland (E, W & NI) within a calendar year. Denominator: GLA 2007 Round Ethnic Group Population Projection (EGPP) figures, by 5-year age band, from 2002 to 2007 (constrained to the GLA 2007 Round Demographic Projections - PLP Low).
Numerator definition	The total number of HIV-infected London residents aged 15 years and above who accessed HIV-related care at an NHS site in E, W & NI in 2002 and 2006, by PCT of residence.
Denominator definition:	The population of London residents aged 15 years and above in each borough in 2002 and 2006. These are almost coterminous with PCTs in London. There were two cases in which it was necessary to merge a pair of boroughs: the boroughs of City of London and Hackney were merged to create a denominator for City & Hackney PCT; the boroughs of Sutton and Merton were merged to create a denominator for Sutton & Merton PCT.
Geography	The data are presented according to PCT of residence.
Timeliness	Data are complete for 2002 and 2006: there is no reporting delay. Data for 2007 will be available by the end of August 2008.
Disclosure control	No names are collected. No patient-level data are ever released and aggregate data are only published after ensuring that deductive disclosure cannot occur. HIV voluntary reporting systems have approval (renewed each year) under the Section 60 regulations of the Health and Social Care Act (Statutory Instrument 1438, June 2002). In addition, all data are stored on restricted and secure databases at the HPA, with strict adherence to the Data Protection Act and Caldicott Guidelines[8].
Data accuracy and completeness	Data are likely to be very accurate and complete as these data are used for the national allocation of funding and for national and local commissioning. Duplicate reports from across E, W & NI are identified and excluded from the numbers published so that each individual is only represented once in the data.

Limitations

Data are disseminated in time for commissioning plans to be based on data to the end of the previous year but further improvements in timeliness are dependent on timely data reporting by Trusts across England, Wales and Northern Ireland. Some London residents will have been seen for care in clinics outside London. Similarly, some London clinics will have provided care to residents of PCTs outside London.

Indicator 2.03 Key prevention groups – trends in the number of adult (aged 15 and above) London residents who accessed HIV-related care, 2002, 2004 and 2006

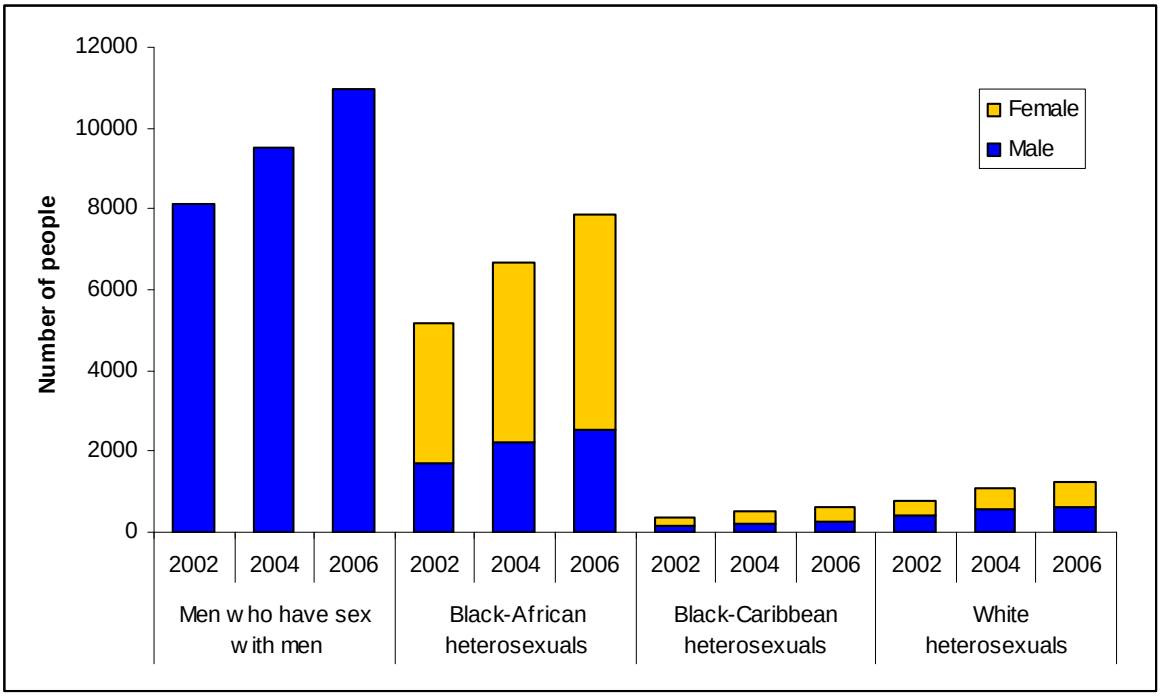
Rationale for inclusion

There are a number of sub-populations within London which are disproportionately affected by HIV. These are referred to as key prevention groups and include men who have sex with men (MSM) and Black African heterosexuals. Large differences are observed in the demographic, behavioural and clinical profiles of different prevention groups. Cultural differences are also seen in the way that prevention groups access services and in attitudes towards HIV infection. For example, issues of stigma affect some groups more strongly than others. Understanding trends for key prevention groups is therefore essential to the provision of accessible and culturally competent HIV care.

What does this indicator show?

- The number of MSM resident in London and accessing HIV-related care increased by 35% from 8,118 in 2002 to 10,967 in 2006.
- The number of Black African heterosexual adults accessing HIV-related care increased by 52% from 5,174 in 2002 to 7,857 in 2006 (two-thirds of these were women).
- Although the numbers are smaller, between 2002 and 2006 the number of heterosexual Black Caribbean London residents with diagnosed HIV infection increased by 83% (345 in 2002 to 631 in 2006)
- The number of heterosexual white London residents with diagnosed HIV increased by 57% (788 in 2002 to 1,234 in 2006).

Figure 11: Adults resident in London accessing care for HIV by key prevention group, 2002, 2004 and 2006



Source: HPA (SOPHID)

Table 4: Number of patients accessing care for HIV in London by key prevention group, 2002 – 2006

Sex	Men who have sex with men			Black African heterosexuals			Black Caribbean heterosexuals			White heterosexuals		
	2002	2004	2006	2002	2004	2006	2002	2004	2006	2002	2004	2006
Male	8118	9501	10967	1714	2225	2509	148	225	270	391	552	605
Female	N/A	N/A	N/A	3460	4462	5348	197	285	361	397	512	629

Source: HPA (SOPHID)

Metadata

Indicator description	Number of adult London residents belonging to key prevention groups who accessed HIV-related care: 2002, 2004 and 2006.
Source of data	The Survey of Prevalent HIV Infections Diagnosed (SOPHID) is a cross-sectional survey of all persons who attend for HIV-related care at an NHS site in England, Wales and Northern Ireland (E, W & NI) within a calendar year.
Numerator definition	The number of adults (aged 15 years and above), resident in London and belonging to key prevention groups, who accessed HIV-related care at an NHS site in E, W & NI in 2002, 2004 and 2006.
Denominator definition	Not applicable.
Geography	The data presented are for the whole of London.
Timeliness	Data are complete for 2002, 2004 and 2006: there is no reporting delay. Data for 2007 will be available by the end of August 2008.
Disclosure control	No names are collected. No patient-level data are ever released and aggregate data are only published after ensuring that deductive disclosure cannot occur. HIV voluntary reporting systems have approval (renewed each year) under the Section 60 regulations of the Health and Social Care Act (Statutory Instrument 1438, June 2002). In addition, all data are stored on restricted and secure databases at the HPA, with strict adherence to the Data Protection Act and Caldicott Guidelines[8].
Data accuracy and completeness	Data are likely to be very accurate and complete as these data are used for the national allocation of funding and for national and local commissioning. Duplicate reports from across E, W & NI are identified and excluded from the numbers published so that each individual is only represented once in the data. Some London residents will have been seen for care in clinics outside London. Similarly, some London clinics will have provided care to residents of PCTs outside London.

Limitations

Probable route of infection can be hard to determine, but this is only likely to result in negligible misclassification error.

Indicator 2.04 Late HIV diagnoses by PCT of residence, 2005-2006

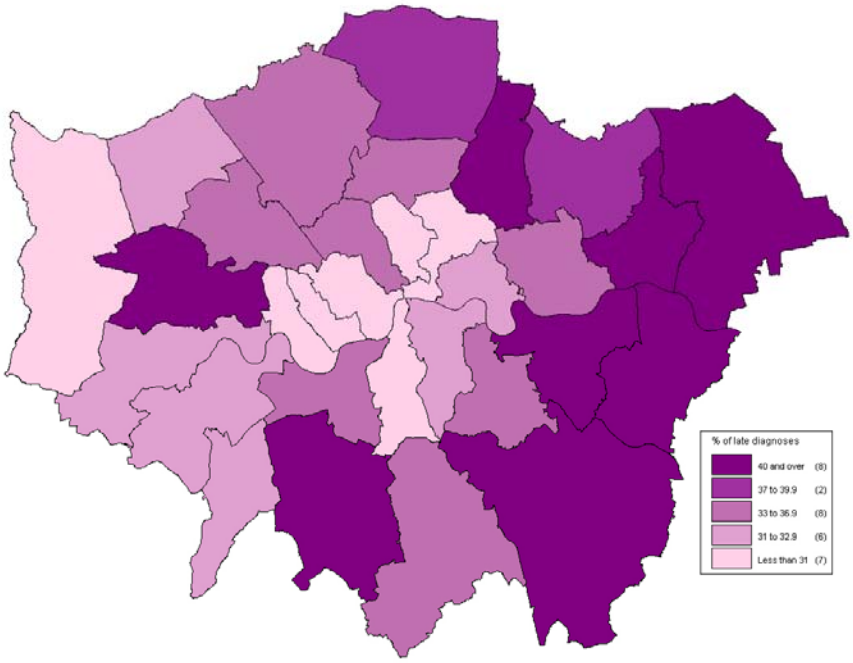
Rationale for inclusion

Earlier diagnosis of HIV can reduce the risk of AIDS and death. It also allows diagnosed people to make behavioural changes to avoid infecting others and can reduce infectivity due to earlier initiation of antiretroviral therapy. Late diagnosis is defined as a CD4 count less than 200 cells per $mm^{3.}$ This is below the recommended threshold for starting therapy and indicates an average of about 8 years of infection prior to diagnosis. CD4 counts are a strong marker of the continuous progression of infection prior to therapy. Late diagnosis for HIV infection has been identified by NHS London as the 'HIV prevention indicator', with a performance managed target of 15% by 2010-11.

What does this indicator show?

- Overall, for the period 2005 and 2006, there were 3,879 people identified as newly diagnosed with a reported PCT of residence in London and a reported CD4 cell count.
- Of these 33% (1,297) were diagnosed late (CD4 count less than 200 cells per mm^3).
- The proportion diagnosed late varied by sector (from 29% in North West London to 36% in North East London and South West London).
- PCTs in East London were disproportionately affected: the proportion diagnosed late ranged from 19% in Westminster PCT to 48% in Havering PCT.

Figure 12: Late diagnoses (CD4<200 cells per mm^3) of HIV infection by PCT of residence, 2005 - 2006



 Source: HPA (SOPHID)

Table 5: **Individuals identified as newly diagnosed in SOPHID and proportion diagnosed with a CD4 count of less than 200 by PCT of residence*, London, 2005-2006**

London Sector of residence	PCT of residence	Overall 2005-2006				
		Persons with CD4 count (n)			% <200	% <200
		<200	>=200	Total		
North Central London	Barnet	31	61	92	34%	32%
	Camden	51	101	152	34%	
	Enfield	50	80	130	38%	
	Haringey Teaching	58	110	168	35%	
	Islington	36	118	154	23%	
North East London	Barking & Dagenham	39	55	94	41%	36%
	City & Hackney Teaching	56	136	192	29%	
	Havering	10	11	21	48%	
	Newham	78	137	215	36%	
	Redbridge	23	40	63	37%	
	Tower Hamlets	45	101	146	31%	
	Waltham Forest	54	63	117	46%	
North West London	Brent Teaching	35	65	100	35%	29%
	Ealing	32	43	75	43%	
	Hammersmith & Fulham	18	51	69	26%	
	Harrow	11	23	34	32%	
	Hillingdon	10	30	40	25%	
	Hounslow	34	72	106	32%	
	Kensington & Chelsea	15	55	70	21%	
	Westminster	27	114	141	19%	
South East London	Bexley	20	28	48	42%	34%
	Bromley	18	22	40	45%	
	Greenwich Teaching	47	64	111	42%	
	Lambeth	109	256	365	30%	
	Lewisham	87	174	261	33%	
	Southwark	116	244	360	32%	
South West London	Croydon	69	122	191	36%	36%
	Kingston	13	28	41	32%	
	Richmond & Twickenham	9	20	29	31%	
	Sutton & Merton	51	78	129	40%	
	Wandsworth	45	80	125	36%	
	London	1,297	2,582	3,879	33%	33%

* PCT of residence is not collected for new diagnoses. These figures are based on experimental data obtained by cross-linking the New Diagnosis database to SOPHID.

Source: HPA (SOPHID / New Diagnosis database)

Metadata

Indicator description	Late diagnosis of HIV infection (CD4 less than 200 cells per mm^3) by PCT. Note: these data are used for performance management by NHS London as the 'HIV prevention indicator'.
Source of data	Residence-based reports of HIV-infected adults accessing care (SOPHID), reports of new HIV diagnoses, and CD4 cell counts collected from 14 London laboratories (CD4 Surveillance).
Numerator definition	The total number of HIV-infected London residents aged 15 years or above who were diagnosed in 2005 or 2006 with PCT of residence and CD4 cell count reported where the CD4 cell count was less than 200 cells per mm^3.
Denominator definition	The total number of HIV-infected London residents aged 15 years or above who were diagnosed in 2005 or 2006 with PCT of residence and CD4 cell count reported. Important note: this does not amount to the total number of new HIV diagnoses among residents in 2005 and 2006 in each PCT.
Geography	The data are presented according to PCT of residence.
Timeliness	Data presented are for 2005/6 although 2004/5 data were used as the baseline for the newly developed HIV prevention indicator. Updated data will be available by the end of August 2008. Data will be more frequently updated in the future.
Disclosure control	No names are collected. No patient-level data are ever released and aggregate data are only published after ensuring that deductive disclosure cannot occur. HIV voluntary reporting systems have approval (renewed each year) under the Section 60 regulations of the Health and Social Care Act (Statutory Instrument 1438, June 2002). In addition, all data are stored on restricted and secure databases at the HPA, with strict adherence to the Data Protection Act and Caldicott Guidelines[8].
Data accuracy and completeness	Data are preliminary and will be updated in the future. CD4 cell counts are subject to natural and measurement variability but these data should still provide a robust measure of late diagnosis. The amount of missing information is expected to improve as data are updated and greater follow-up/integration of the datasets occurs. It is important to note that many HIV-infected individuals were infected abroad and this will reduce the time between infection and diagnosis in the UK. However, the majority of these individuals live with undiagnosed HIV infection in the UK for several years before diagnosis.

Limitations

The reporting of residence information and record linkage to CD4 cell counts is not complete. Some individuals who were infected abroad will not have spent all their time between infection and diagnosis in the UK. This may mean that late diagnosis cannot be reduced to zero per cent. However, the majority of individuals infected abroad live with undiagnosed HIV infection in the UK for several years before diagnosis and many opportunities for earlier HIV diagnosis are missed.

Indicator 2.05 Adults newly diagnosed with HIV in London by major prevention groups and likelihood that the infection was acquired in the UK, 2002-2006

Rationale for inclusion

In London, people from some population groups, particularly men who have sex with men (MSM) and Black Africans, have an increased risk of being diagnosed with HIV. The proportion of infections which were acquired in the UK varies greatly between these key prevention groups. Information about these trends is essential to support prevention initiatives aimed at reducing HIV transmission in the UK.

What does this indicator show?

- In 2006, 2,993 adults were diagnosed with HIV in London, representing around 40% of all new HIV diagnoses in adults in the UK.
- Numbers of new HIV diagnoses among MSM increased continuously between 2002 and 2006 whereas new diagnoses of among Black African heterosexuals peaked in 2003 and have since declined.
- Where infection route was known in 2006, 43.0% (1,145) were MSM and 36.4% (969) were Black African heterosexuals, which is a reversal of the trend seen earlier in the decade.
- Ascertainment of country of infection for MSM increased from 37.6% in 2002 to 65.9% in 2006.
- Where country of infection was known, 76.4% of Black Africans were reported to have been infected abroad while 23.6% were probably or possibly infected in the UK.
- A decline between 2002 and 2006 in the number of new HIV diagnoses of Black African heterosexuals infected abroad accounted for the overall decline among Black African heterosexuals.
- There was no evidence of a fall in the number of new HIV diagnoses of Black African heterosexuals infected in the UK.
- A decline in infections acquired abroad was also seen among black Caribbeans between 2002 and 2006. By contrast, infections probably or acquired in the UK rose by 90% during the same period.

New HIV diagnoses in adults (aged 15 years or older) by major prevention groups and probable country of infection, London, 2002-2006

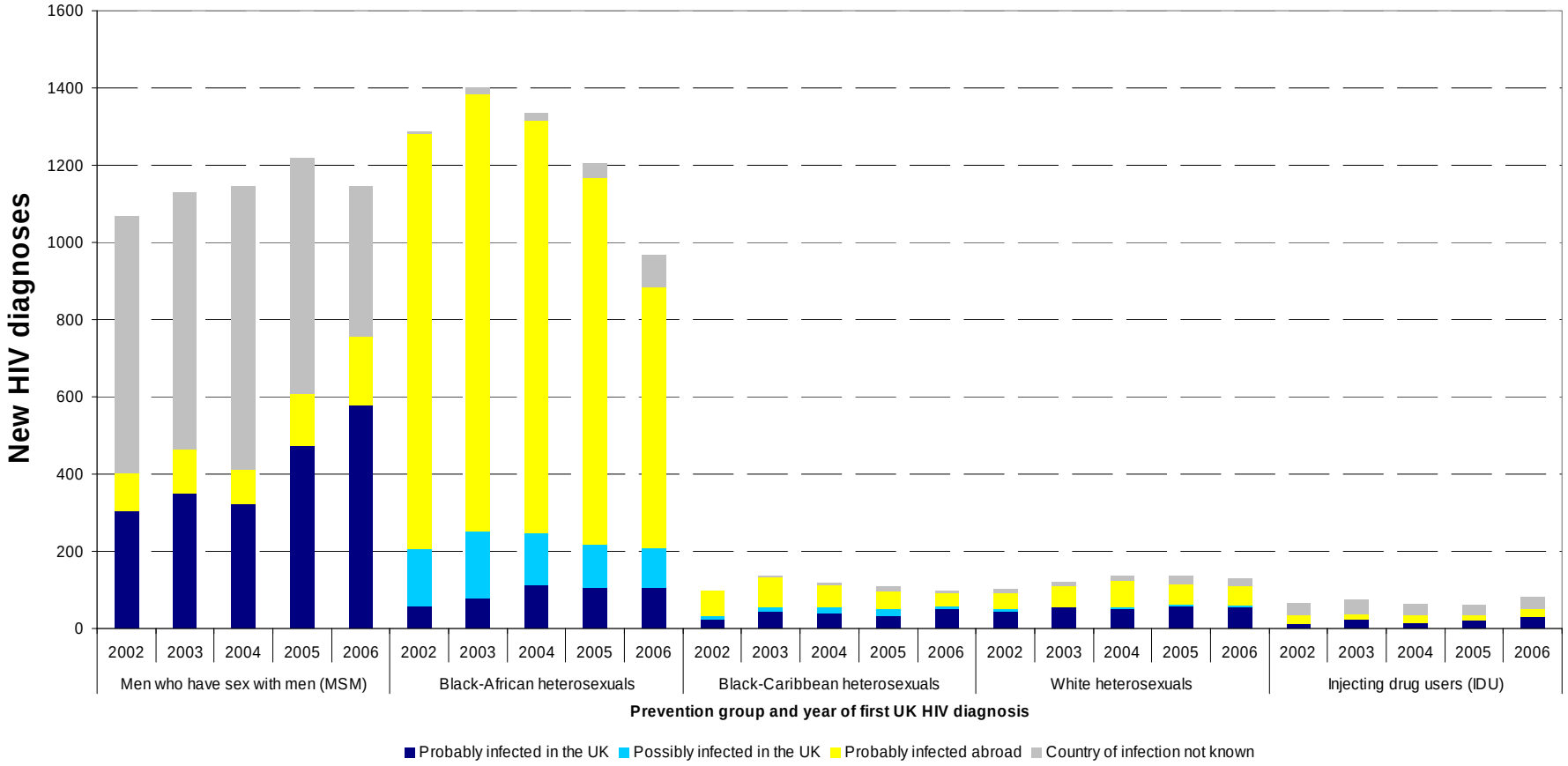


Figure 13: New HIV diagnoses in adults (aged 15 years or older) by major prevention groups and probable country of infection, London 2002-2006.
Source: HPA (HIV New Diagnoses)

Metadata

Indicator description	Numbers of adults belonging to major prevention groups who received a new HIV diagnosis in London in the years 2002 to 2006 and the proportions who were probably or possibly infected in the UK.
Source of data	HIV/AIDS New diagnoses and deaths.
Numerator definition	Not applicable
Denominator definition	Not applicable
Geography	The data are presented for the whole of London.
Timeliness	Reports to the end of December 2007.
Disclosure control	No names are collected. No patient-level data are ever released and aggregate data are only published after ensuring that deductive disclosure cannot occur. HIV voluntary reporting systems have approval (renewed each year) under the Section 60 regulations of the Health and Social Care Act (Statutory Instrument 1438, June 2002). In addition, all data are stored on restricted and secure databases at the HPA, with strict adherence to the Data Protection Act and Caldicott Guidelines[8].
Data accuracy and completeness	HIV new diagnosis reporting is subject to a variable reporting delay. Numbers are likely to rise, especially those for most recent years. Infection route is collected for all diagnoses. For adults diagnosed in 2006 it has been obtained for 89.0% of reports. Country of infection is also collected for all diagnoses. It is not possible however to follow up all reports for this information and priority is given to reports of heterosexually acquired diagnoses as these are most likely to have been acquired abroad.

Limitations

New diagnoses may represent infections that have been acquired years previously. Increases in the number of new diagnoses may reflect increases in testing rather than rising incidence. New diagnosis data are clinic rather than residence-based: some of the diagnoses reported may be in people resident outside London, while conversely some London residents may be diagnosed outside the capital. The most likely country of infection can be difficult to determine for many heterosexually infected individuals who have had exposure to HIV infection both in the UK and abroad and so some individuals are categorised as probably or possibly infected in the UK or abroad.

Indicator 2.06 Offers and acceptances of HIV tests in London GUM clinics, 2003-2006

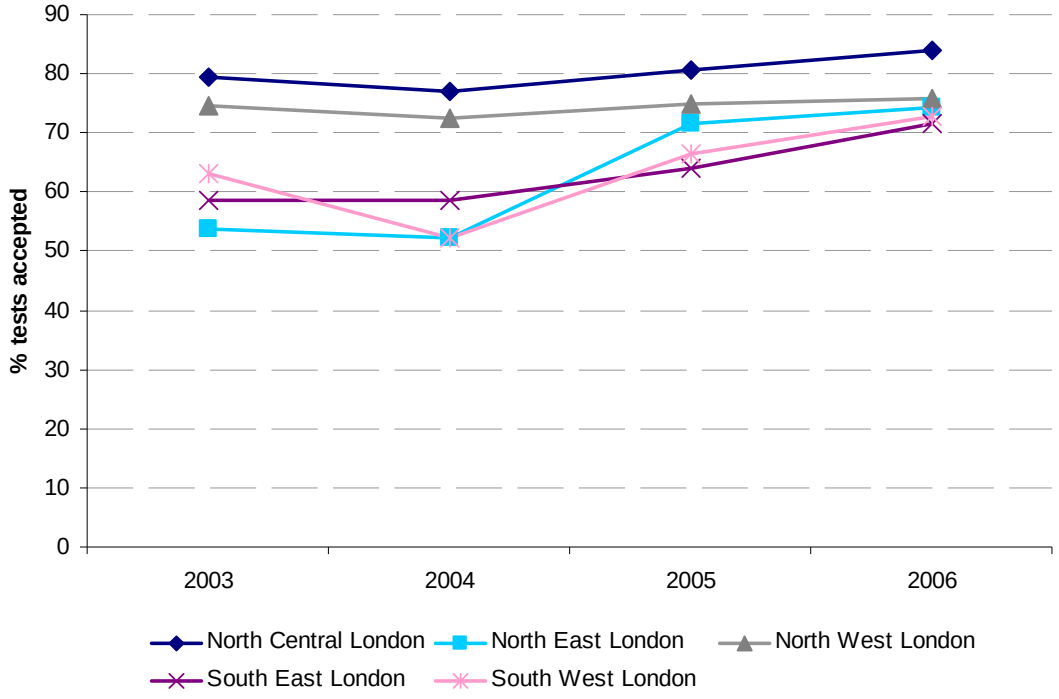
Rationale for inclusion

Whenever an STI is suspected it is important to test for HIV as early as possible. This is so that treatment can be initiated and so that the patient can undergo counselling on safer sex practices which can reduce the likelihood of onward transmission. HIV testing is offered to all patients attending for a sexual health screen in Genitourinary Medicine (GUM) clinics. The guidelines of the British Association for Sexual Health and HIV (BASHH) state that all patients attending a GUM clinic should be offered an HIV test irrespective of symptoms or risk factors. The National Strategy for Sexual Health and HIV set a target of 60% testing uptake by 2007.

What does this indicator show

- In 2006 more than three-quarters of those offered an HIV test in London GUM clinics opted to test.
- Over 192,000 tests were performed in total in 2006.
- Uptake of testing was highest in North Central London at 84.0%.
- Overall, 77.6% of men and 73.6% of women took up the offer of a test.
- MSM were more likely to test than other men: 83.5% accepted the offer of a test.

Figure 14: Uptake of HIV testing in London GUM clinics by sector of clinic, 2003-2006



Source: HPA (KC60)

Table 6: Number of HIV tests offered and taken in London GUM clinics by gender (and male sexual orientation) and sector of clinic, London, 2003-2006

London sector of clinic	Gender	2003		2004		2005		2006	
		Offered	Tested	Offered	Tested	Offered	Tested	Offered	Tested
North Central London	Male	15556	13117	19097	15536	20059	16646	19493	16710
	of which MSM*	4309	3882	4837	4253	4846	4263	4282	3901
	Female	17276	13010	21147	15479	21661	17056	21168	17448
	Total	32832	26127	40244	31015	41720	33702	40661	34158
North East London	Male	15773	8595	18037	9884	21052	15303	22255	16615
	of which MSM*	1496	787	1728	909	2541	1850	2906	2209
	Female	16220	8568	18095	8945	21053	14864	22952	16975
	Total	31993	17163	36132	18829	42105	30167	45207	33590
North West London	Male	29096	22362	35367	26231	37534	28784	41020	32001
	of which MSM*	5459	4593	5894	4888	7152	5906	9025	7537
	Female	28062	20211	34708	24604	37602	27421	40848	29941
	Total	57158	42573	70075	50835	75136	56205	81868	61942
South East London	Male	21945	13331	23905	14485	23810	15757	23611	17371
	of which MSM*	3025	2024	2879	2029	3296	2511	3774	3053
	Female	21750	12336	23231	13101	23812	14783	21420	14923
	Total	43695	25667	47136	27586	47622	30540	45031	32294
South West London	Male	14894	9532	18559	10219	19437	13579	18831	14418
	of which MSM*	1253	928	1236	912	1223	964	1141	948
	Female	18009	11196	22462	11195	23510	14994	22841	15878
	Total	32903	20728	41021	21414	42947	28573	41672	30296
	London Total	198581	132258	234608	149679	249530	179187	254439	192280

*Men who have sex with men (MSM) are a subcategory of Male. Therefore, the number of tests offered or accepted by male patients includes the numbers offered or accepted by MSM.
Source: HPA (KC60)

Metadata

Indicator description	Offers and acceptances of HIV tests in London GUM clinics by sector of clinic, 2003–2006.
Source of data	Data are from the statutory quarterly KC60 returns submitted by Genitourinary Medicine (GUM) clinics in London.
Numerator definition	Number of tests taken from those offered.
Denominator definition	Number of tests offered to patients.
Geography	The data are presented according to the sector of the clinic (which may or may not be the same as the sector of residence for the patient).
Timeliness	KC60 returns are sent to the HPA's Centre for Infections every three months, six weeks after the end of the quarter.
Disclosure control	There is no disclosure control associated with this indicator.
Data accuracy and	Data are reported quarterly and some clinics may not have submitted data. The data have not been adjusted for missing

completeness	data. Not all returns had been submitted (one clinic submitted three returns in 2006). GUM clinics have a statutory duty to make this return.

Limitations

The data available from the KC60 statutory returns are for tests offered in GUM clinics only. Tests offered in other clinical settings, such as general practice, are not recorded in the KC60 dataset. The data available from the KC60 statutory returns are the number of tests offered, not the number of patients offered a test. Individual patients may have been offered more than one test in a year. The information provided has not been adjusted for missing clinic data.

Indicator 2.07 Uptake of HIV testing in sentinel GUM clinics in London by HIV serostatus, 2002-2006

Rationale for Inclusion

The promotion of HIV testing in at risk population groups is a key component of efforts to reduce the proportion of HIV which remains undiagnosed and also the proportion which is diagnosed late. The National Strategy for Sexual Health and HIV for England set a target of 60% HIV test uptake in GUM clinics by 2007 and another target of a reduction of 50% in the proportion of HIV positive individuals remaining undiagnosed after visiting a GUM clinic by 2007. This indicator uses data from the Unlinked Anonymous Survey of Genitourinary Medicine Clinic Attendees (GUM Anon) survey to compare the uptake of HIV testing amongst HIV infected individuals and HIV uninfected individuals attending sentinel participating GUM clinics.

What does this indicator show?

- In 2006, more than 8 in 10 individuals attending sentinel GUM clinics in London for a new sexual health problem received an HIV test.
- HIV test uptake rates are above 8 in 10 regardless of gender and sexual orientation.
- The uptake of HIV testing in 2006 was significantly higher than the 2002 baseline and had surpassed the target.
- Unlinked anonymous testing reveals that the uptake of HIV testing is considerably lower for HIV infected attendees (60% [275/461]) compared to HIV uninfected attendees (85% [38,798/45,481]).
- Less than half of HIV infected men who have sex with men (MSM) and approximately 2/3 of HIV infected heterosexuals attending sentinel GUM clinics received an HIV test.
- Overall, the percentage of individuals who were found to be HIV positive through anonymous testing but who left the clinic unaware of their HIV infection has steadily declined from 53% in 2002 to 40% in 2006. However, it is unlikely to meet the national strategy target of a reduction by 50% of 2002 levels by 2007.

Table 7: Uptake of HIV testing in sentinel GUM clinics by HIV serostatus, London, 2002-2006

		Excludes individuals already diagnosed HIV positive before attendance		
	Year	Proportion of attendees receiving an HIV test[1]	Proportion of HIV negative attendees[2] receiving an HIV test	Proportion of HIV positive attendees[3] receiving an HIV test
MSM	2002	59%	60%	38%
	2003	64%	65%	46%
	2004	75%	76%	54%
	2005	75%	76%	51%
	2006	81%	82%	47%
Heterosexual men	2002	56%	56%	55%
	2003	58%	58%	53%
	2004	75%	75%	59%
	2005	79%	79%	68%
	2006	86%	86%	78%
Heterosexual women	2002	56%	56%	55%
	2003	57%	57%	61%
	2004	74%	74%	63%
	2005	78%	78%	69%
	2006	85%	85%	69%

1 The denominator includes all attendees having a syphilis test apart from those that already know themselves to be HIV positive before attending and those that have already had a syphilis test that calendar quarter. The numerator includes all those receiving an HIV test (those with the KC60 code 'P1A' (HIV antibody test and no sexual health screen) or 'S2' (HIV antibody test and sexual health screen)).
2 This is calculated as per 2. It includes all attendees that were found to be HIV negative through unlinked anonymous HIV testing.
3 This is calculated as per 2. It includes all attendees that were found to be HIV positive through unlinked anonymous HIV testing.

Metadata

Indicator description	The proportion of those attending sentinel GUM clinics who accepted an HIV test, by their HIV serostatus.
Source of data	The Unlinked Anonymous (UA) Genitourinary Medicine (GUM) survey uses residual blood specimens obtained for syphilis serology to measure the HIV prevalence, including undiagnosed HIV prevalence, amongst GUM attendees. The sample is irreversibly unlinked from any patient identifiers. Limited information on risk factors and whether voluntary confidential HIV testing was accepted is retained. This survey is operational in 8 GUM clinics in London (and 16 in total across the UK).
Numerator definition	The numerator includes all GUM clinic attendees in the denominator (see below) who received an HIV test at that visit. This includes those coded with the KC60 code 'P1A' (HIV antibody test and no sexual health screen) or 'S2' (HIV antibody test and sexual health screen).
Denominator definition	The denominator includes all GUM clinic attendees having a syphilis test apart from those that already knew themselves to be HIV positive before attending and those that have already had a syphilis test that calendar quarter.
Geography	The data presented are for London as a whole (based on reports from eight of the 34 GUM clinics in London).
Timeliness	Data are released annually (in autumn, for the previous calendar year).
Disclosure control	It is critically important that it should not be possible to deductively disclose the identity of someone found through unlinked anonymous testing to be HIV positive. To avoid this possibility, limited data are collected. No personally identifying information is collected. Data are attendance based and person based.
Data accuracy and completeness	Clinical and demographic data are collected by clinicians and sent to HPA Centre for Infections (CfI) for double entry. HIV testing is carried out according to national guidelines.

Limitations

The UA GUM clinic survey is a sentinel survey. Eight of the 34 GUM clinics in London participate in the survey. Some of those HIV positive MSM who refused an HIV test may have been aware of their status but chose not to disclose it to the GUM clinic. Nevertheless, the data overall suggest there is scope for further improvement in voluntary HIV testing rates in MSM attending GUM clinics in England.

Indicator 2.08 Prevalence of HIV in women resident in London who gave birth in 2006

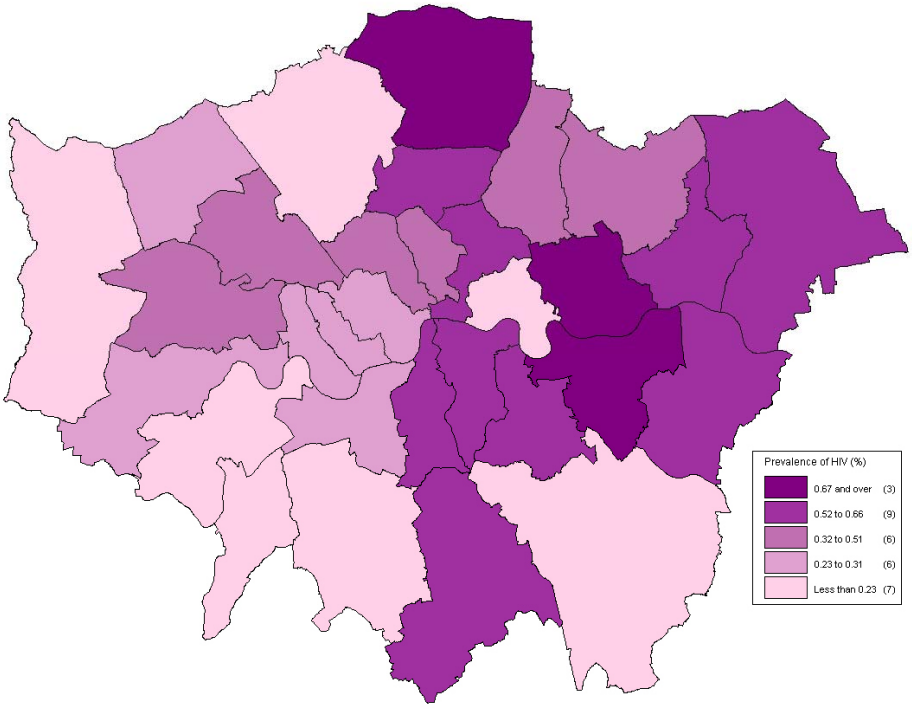
Rationale for inclusion

HIV prevalence in pregnant women provides information about (although not a direct measure of) the prevalence of HIV in the heterosexual population.

What does this indicator show?

- The burden of HIV among pregnant women varies widely between PCTs from about one in every 127 women in Enfield to around one in 899 women in Hillingdon.
- Across London, HIV prevalence in pregnant women has remained stable since 2003 at around 0.4%.
- HIV prevalence is highest among women born in sub-Saharan Africa who are resident in London, and therefore highest in PCTs with large populations of women born in sub-Saharan Africa.

Figure 15: Prevalence of HIV in women resident in London who gave birth in 2006 by PCT of residence



Source: HPA (UA DBS) / GLA (EGPP)

Table 8: Prevalence* of HIV in women giving birth by mother's world region of birth and PCT of residence, London, 2006

Sector	PCTs	UK	Sub-Saharan Africa	Rest of the world	Overall**
North Central London	Barnet	<0.01%	1.31%	0.08%	0.20%
	Camden & Islington	0.06%	1.76%	0.18%	0.33%
	Enfield	<0.01%	3.44%	<0.01%	0.79%
	Haringey	0.18%	2.24%	0.08%	0.58%
North East London	Barking Dagenham & Havering	0.04%	3.17%	0.16%	0.55%
	City & Hackney	0.20%	2.44%	0.24%	0.61%
	Newham	0.20%	2.44%	0.10%	0.70%
	Redbridge	<0.01%	1.86%	0.18%	0.34%
	Tower Hamlets	0.11%	2.50%	<0.01%	0.22%
	Waltham Forest	0.08%	2.44%	<0.01%	0.34%
North West London	Brent	0.52%	1.38%	0.06%	0.40%
	Ealing	<0.01%	2.09%	<0.01%	0.32%
	Hammersmith & Fulham	0.10%	1.25%	0.09%	0.27%
	Harrow	0.12%	0.91%	0.30%	0.30%
	Hillingdon	<0.01%	0.88%	0.12%	0.11%
	Hounslow	<0.01%	2.82%	<0.01%	0.30%
	Kensington & Chelsea	<0.01%	2.55%	0.08%	0.30%
South East London	Bexley	0.07%	3.64%	0.53%	0.52%
	Bromley	<0.01%	2.11%	0.24%	0.17%
	Greenwich	<0.01%	2.40%	0.35%	0.67%
	Lambeth Southwark & Lewisham	0.13%	2.09%	0.37%	0.64%
South West London	Croydon	0.25%	2.59%	0.10%	0.64%
	Richmond, Kingston & Twickenham	0.09%	1.91%	0.10%	0.17%
	Sutton & Merton	0.10%	1.08%	0.11%	0.20%
	Wandsworth	<0.01%	1.21%	0.17%	0.23%
London		0.09%	2.14%	0.13%	0.42%

*Where the observed prevalence is less than 0.01% this is shown as <0.01%.

**The overall prevalence includes data from samples for which mother's country of birth could not be obtained.

Source: HPA (UA DBS)

Metadata

Indicator description	This indicator shows the proportion of women giving birth who are HIV positive according to their area of residence and whether they were born in the UK, sub-Saharan Africa or the rest of the world.
Source of data	Data are derived from unlinked anonymous testing of left over neonatal dried blood spots for maternal HIV infection. All infants have a blood spot taken around one week after birth to test for a variety of conditions including sickle cell and metabolic disorders.
Numerator definition	The number of dried blood spots that test positive for the presence of maternal anti-HIV antibodies. The number of positive women includes women who are diagnosed and undiagnosed. Due to antenatal screening, however, most of these women (>90%) will be

	diagnosed before delivery.
Denominator definition	The total number of dried blood spots tested.
Geography	The data are presented according to area of residence of the mother at the time the dried blood spot was taken. Unfortunately, data are not collected by PCT therefore in some instances it is not possible to map to every PCT and data has to be aggregated e.g. Lambeth, Southwark & Lewisham. In addition, the boundaries used are historic boundaries. The data for Westminster are amalgamated into Hammersmith & Fulham, and Kensington & Chelsea data.
Timeliness	Samples are tested at around six months after they were originally taken. Data presented are complete for that year: there is no reporting delay.
Disclosure control	Data are not shown where the denominator is less than 20. Data are grouped and aggregated to prevent deductive disclosure. Data are unlinked from personally identifying information. Where the observed prevalence is less than 0.01% this is shown as <0.01%.
Data accuracy and completeness	The data presented represent the observed prevalence in the sample tested. Samples from babies whose parents have opted out of the UA survey or where there was insufficient blood to test for HIV are not included in the data (3 opt outs and 14 insufficient samples in 2006). Data from one quarter have been excluded as a high proportion lacked country of birth data for 2006.

Limitations

Prevalence relies on allocation of area of residence by healthcare worker rather than postcode. As a result, not all individual PCTs can be mapped e.g. Lambeth, Southwark and Lewisham (LSL) or Westminster. In addition, the boundaries used are historic boundaries. The data for Westminster are amalgamated into Hammersmith & Fulham, and Kensington & Chelsea, data. Improvements could be made to the data by requiring the usual postcode of the woman to be recorded in the minimum data set.

This is an observed prevalence, and should not be interpreted as exact.

Indicator 2.09 Diagnoses of primary and secondary infectious syphilis in London GUM clinics, 2002-2006

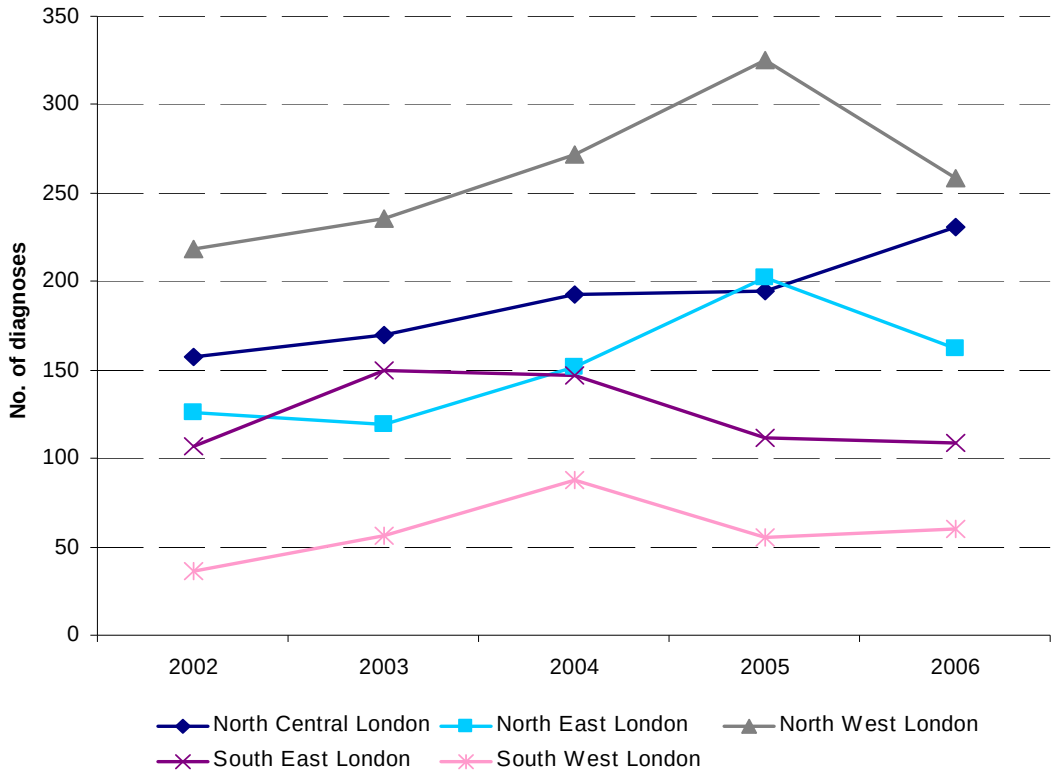
Rationale for inclusion

Syphilis is a bacterial sexually transmitted infection. Untreated syphilis can lead to serious complications including damage to the heart, respiratory tract or central nervous system. Maternal syphilis can result in cases of congenital syphilis as well as stillbirth or abortion, and low birth weight or premature birth.

What does this Indicator show?

- Fluctuations in the number of diagnoses were observed over the years for the five London sectors.
- The majority of primary and secondary syphilis was seen in men (sex ratio: 9:1).
- Two-thirds of men diagnosed at GUM clinics were MSM.
- Syphilis diagnoses increased in all sectors apart from South East London over the period 2002 to 2006. The largest proportional increase was seen in South West London where numbers increased by two-thirds from 36 in 2002 to 60 in 2006. The numbers underlying this increase are extremely small however.
- The largest absolute increase was seen in North Central London where numbers rose from 157 in 2002 to 231 in 2006.
- Overall, London saw the annual number of syphilis diagnoses rise by over a quarter during the period.

Figure 16: Diagnoses of primary and secondary infectious syphilis in GUM clinics by London sector of GUM clinic, 2002-2006



Source: HPA (KC60)

Table 9: Diagnoses of primary and secondary infectious syphilis in GUM clinics by (a) sector of clinic and (b) gender (and male sexual orientation), London, 2002-2006

(a) Sector of clinic	2002	2003	2004	2005	2006
North Central London	157	170	193	195	231
North East London	126	119	152	202	162
North West London	218	236	272	325	258
South East London	107	150	147	112	109
South West London	36	56	88	55	60
(b) Gender/*MSM*					
Male	568	626	738	763	738
*of which MSM**	*324*	*368*	*402*	*534*	*494*
Female	76	105	114	126	82
London total	**644**	**731**	**852**	**889**	**820**

*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)

Metadata

Indicator description	Diagnoses of primary and secondary infectious syphilis in London GUM clinics, by sector of GUM clinic, and gender and age group (and male sexual orientation) 2002 – 2006.
Source of data	Data are from statutory quarterly KC60 returns submitted by GUM clinics in London.
Numerator definition	All London GUM clinic attendees who were diagnosed with primary or secondary infectious syphilis (KC60 codes A1 and A2). See BASHH guidelines (www.bashh.org) for further information.
Denominator definition	Not applicable.
Geography	The data are presented according to the sector of the clinic (which may or may not be the same as the sector of residence for the patient) and for London as a whole.
Timeliness	KC60 returns are to be sent quarterly to the HPA, Colindale, six weeks after the end of the quarter. Reminder letters are sent out before the end of the quarter to all GUM clinics in London.
Disclosure control	Figures have been suppressed where the number observed is between one and four (less than five).
Data accuracy and completeness	Data are reported quarterly and some clinics may not have reported data. The data have not been adjusted for missing data. Not all returns have been submitted (one clinic submitted three returns in 2006).

Limitations

The data available from the KC60 statutory returns are for diagnoses made in GUM clinics only. Diagnoses made in other clinical settings, such as general practice, are not recorded in the KC60 dataset. The data available from the KC60 statutory returns are the number of diagnoses made, not the number of patients diagnosed. Individual patients may have more than one diagnosis in a year. The information provided has not been adjusted for missing clinic data. Patient PCT of residence is not recorded in the KC60 returns, and GUM clinics are open access clinics. They are therefore not restricted to patients residing in the area.

Indicator 2.10 NESS: proportion of those diagnosed with syphilis who were co-infected with HIV, by sector of clinic, 2002-2006

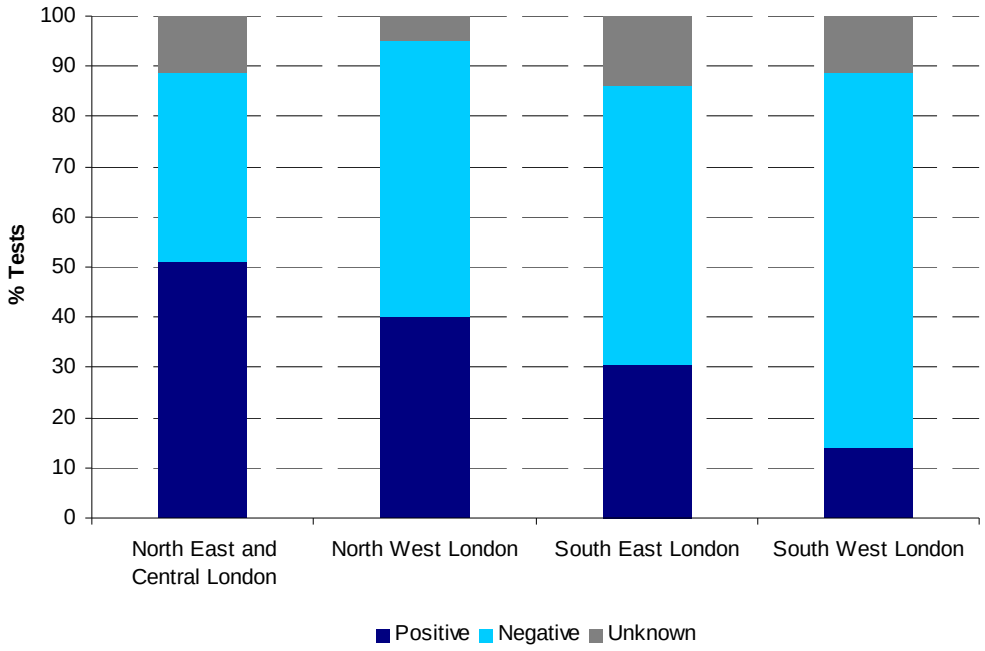
Rationale for inclusion

Syphilis facilitates the transmission of HIV, while immunosuppression caused by HIV can increase the severity of syphilis symptoms. HIV/syphilis co-infection is also an indicator of high risk sexual behaviour. These data are derived from the National Enhanced Surveillance System (NESS).

What does this indicator show?

- A large proportion (almost 40%) of those diagnosed with syphilis also have HIV.
- This proportion varies across London from over 50% in North East and North Central London to around 13% in South West London.

Figure 17: Proportion of those diagnosed with infectious syphilis by HIV serostatus and sector of clinic, London, 2002-2006



Source: HPA (NESS)

Table 10: Proportion of those diagnosed with syphilis who were co-infected with HIV, by sector of clinic, London, 2002-2006

	HIV		2002	2003	2004	2005	2006
London	Positive	Number	168	166	199	179	193
		%	38.7%	29.0%	31.2%	37.8%	39.6%
	Negative	Number	168	266	304	227	247
		%	38.7%	46.4%	47.7%	48.0%	50.7%
	Unknown	Number	98	141	134	67	47
		%	22.6%	24.6%	21.0%	14.2%	9.7%
	Total	Number	434	573	637	473	487
		%	100.0%	100.0%	100.0%	100.0%	100.0%

Source: HPA (NESS)

Metadata

Indicator description	Proportion of those diagnosed with syphilis in London GUM clinics between 2002 and 2006 who were found to be HIV positive and reported to NESS.
Source of data	National Enhanced Syphilis Surveillance (NESS).
Numerator definition	Number of people diagnosed with syphilis in London GUM clinics who were found to be HIV positive. See BASHH guidelines (www.bashh.org).
Denominator definition	Number of people diagnosed with syphilis in London GUM clinics.
Geography	The data are presented for London as a whole.
Timeliness	GUM clinics send their data direct to HPA Centre for Infections (CfI) on a continuous basis.
Disclosure control	Numbers under five have been suppressed.
Data accuracy and completeness	Reporting may vary over time and between clinics. The number of cases reported for each clinic is cross-checked against the clinic's KC60 returns and any discrepancies and coding errors are investigated with the clinic's co-operation.

Limitations

Reporting is voluntary. Some syphilis diagnoses made in London GUM clinics will not have been reported to NESS. Some cases will be asymptomatic and will not therefore be diagnosed.

Indicator 2.11 Diagnoses of uncomplicated gonorrhoea in London GUM clinics, 2002-2006

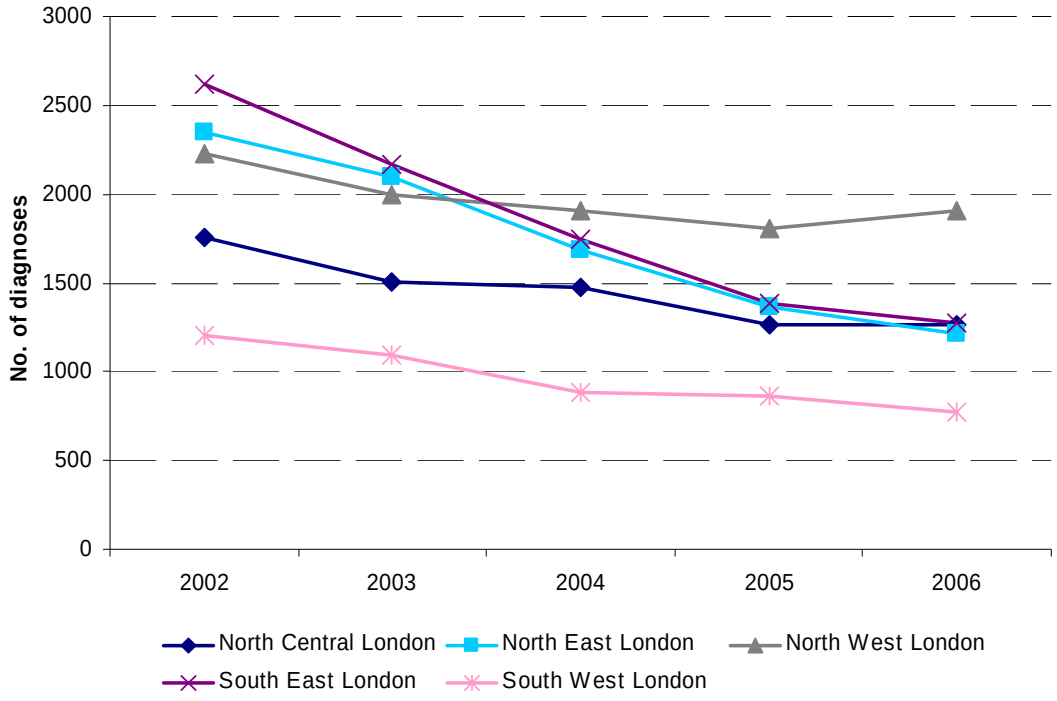
Rationale for inclusion

Gonorrhoea is the second most common bacterial sexually transmitted infection diagnosed in GUM clinics. Untreated infection can lead to serious health problems, particularly for women. Complications include pelvic inflammatory disease, ectopic pregnancy and infertility.

What does the indicator show?

- Although there was a 37% decrease in the number of diagnoses of uncomplicated gonorrhoea made in London GUM clinics between 2002 and 2006, an increase of 34% was seen among MSM: from 1,658 diagnoses in 2002 to 2,221 diagnoses in 2006.
- The proportion of diagnoses made in women declined from around 30% in 2002 to less than a quarter in 2006.
- At a sector level the steepest decline in the annual number of diagnoses of uncomplicated gonorrhoea was seen in South East London: at 1,276 the number of diagnoses in 2006 was around half that seen five years earlier in 2002.

Figure 18: Diagnoses of uncomplicated gonorrhoea in GUM clinics by sector of clinic, London, 2002-2006



Source: HPA (KC60)

Table 11: Diagnoses of uncomplicated gonorrhoea in GUM clinics by (a) sector of clinic and (b) gender (and male sexual orientation), London, 2002-2006

(a) 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*					
Male	7114	6221	5592	5086	4876
*of which MSM**	*1658*	*1800*	*1957*	*2219*	*2221*
Female	3043	2641	2096	1601	1556
London total	**10157**	**8862**	**7688**	**6687**	**6432**

*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.
HPA (KC60)

Metadata

Indicator description	Diagnoses of uncomplicated gonorrhoea in London GUM clinics, by sector of clinic, and gender and age group (and male sexual orientation) 2002-2006.
Source of data	Data are from statutory quarterly KC60 returns submitted by GUM clinics in London.
Numerator definition	All London GUM clinic attendees who were diagnosed with uncomplicated gonorrhoea (KC60 codes B1 and B2). See BASHH guidelines (www.bashh.org) for further information.
Denominator definition	Not applicable.
Geography	The data are presented according to the sector of the clinic (which may or may not be the same as the sector of residence for the patient) and for London as a whole.
Timeliness	KC60 returns are to be sent quarterly to the HPA, Colindale, six weeks after the end of the quarter. Reminder letters are sent out before the end of the quarter to all GUM clinics in London.
Disclosure control	Figures have been suppressed where the number observed is between one and four (less than five).
Data accuracy and completeness	Data are reported quarterly and some clinics may not have reported data. The data have not been adjusted for missing data. Not all returns have been submitted (one clinic submitted three returns in 2006).

Limitations

The data available from the KC60 statutory returns are for diagnoses made in GUM clinics only. Diagnoses made in other clinical settings, such as general practice, are not recorded in the KC60 dataset. The data available from the KC60 statutory returns are the number of diagnoses made, not the number of patients diagnosed. Individual patients may have more than one diagnosis in a year.

The information provided has not been adjusted for missing clinic data.

Patient PCT of residence is not recorded in the KC60 returns. GUM clinics are open access clinics and therefore not restricted to patients residing in the area.

Indicator 2.12 Characteristics of patients reported to the GRASP sentinel system with confirmed gonorrhoea

Rationale for inclusion

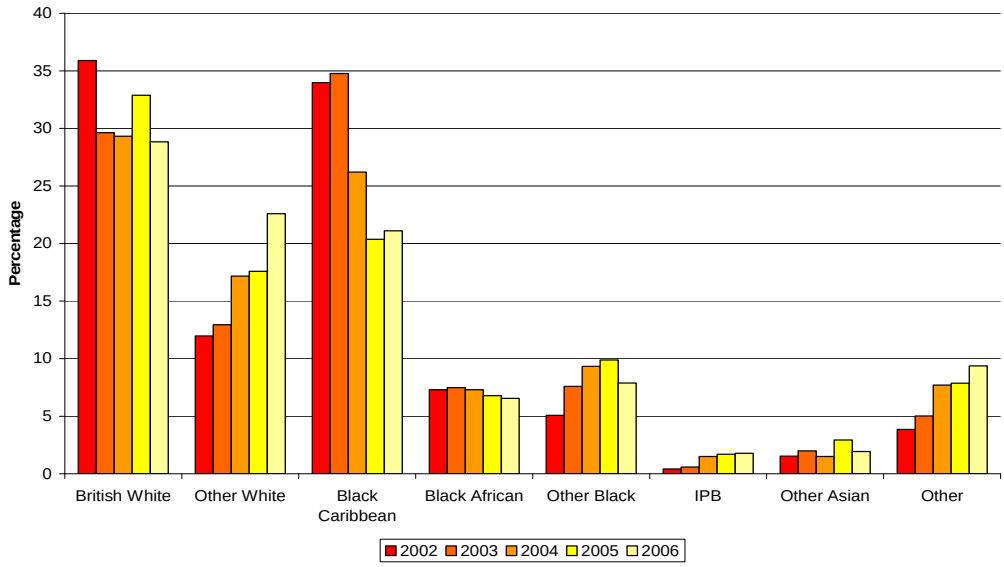
Gonorrhoea tends to be concentrated in core risk groups, including Black ethnic populations and men who have sex with men (MSM). Statutory GUM returns (KC60) for England and Wales have shown a decline in gonorrhoea diagnoses since 2003. This decline has been attributed to heterosexual men and women. The Gonococcal Resistance to Antimicrobial Surveillance Programme (GRASP) can provide additional demographic, clinical and behavioural data. It is also able to provide data on drug resistant gonorrhoea, which is becoming increasingly common.

What does this indicator tell us?

In London:

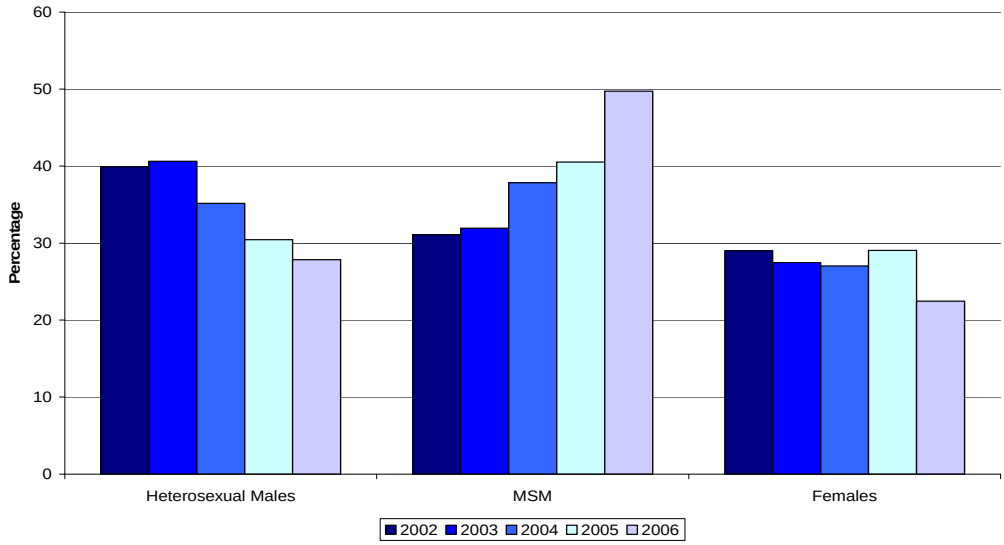
- In 2006 people of white British ethnicity continued to account for 29% of gonorrhoea diagnoses reported to GRASP.
- The proportion of gonorrhoea diagnoses for Black Caribbeans fell sharply between 2002 and 2006 from 34% to 21%. There was also a decrease in the proportion of gonorrhoea diagnoses for Black Africans from 7.3% to 6.5% over the same time period.
- The proportion of gonorrhoea diagnoses for people of other white ethnicity almost doubled from around 12% in 2002 to around 23% in 2006.
- The proportion of diagnoses for heterosexual men declined from around 40% in 2002 to 28% in 2006.
- Conversely, MSM accounted for an increasing proportion of diagnoses, rising from 32% in 2002 to half in 2006.
- The proportion of diagnoses for heterosexual women fluctuated with a peak of around 28% in 2005 before dropping to 22% in 2006.
- Drug resistant gonorrhoea continued to be a problem with tetracycline resistance peaking at about 60% in 2002, although this had fallen to around 43% by 2006.
- The greatest increase in resistance was seen in the proportion of gonococcal isolates resistant to ciprofloxacin: 31.4% in 2006, more than four times that seen in 2002 (7.2%).
- In 2006 the greatest burden of ciprofloxacin resistant gonorrhoea was among MSM: 47% compared with 9.5% among women and 19% among heterosexual men.
- In line with recommended prescribing practice, over 75% of GUM patients were treated with ceftriaxone, cefixime or spectinomycin compared with less than 60% in 2005 when the BASHH guidelines were changed. No isolates have been found with resistance to any of these cephalosporins over the last five years.

Figure 19: Trends in the proportion of patients included in GRASP by ethnicity, London, 2002-2006



Source: HPA (GRASP)

Figure 20: Trends in the proportion of patients included in GRASP by gender and male sexual orientation, London, 2002-2006



Source: HPA (GRASP)

Table 12: Proportion of gonococcal isolates from London patients resistant to specific antimicrobials, 2001-2006

Antimicrobial	Year %					
	2001	2002	2003	2004	2005	2006
Penicillin (MIC*>=1mg/l)	8.2	10.1	8.7	14.4	25.4	10.9
Tetracycline (MIC*>=2mg/l)	45.7	60.3	47.2	52.2	56.4	43
Ciprofloxacin (MIC*>=1mg/l)	1.8	7.2	7.9	16.7	24.7	31.4
Azithromycin (MIC*>=1mg/l)	0.3	0.5	1.3	1.5	2.2	1.1
Spectinomycin (MIC*>=128mg/l)	0.0	0.1	0.0	0.4	0.0	0.0

Source: HPA (GRASP)

* MIC means Minimum Inhibitory Concentration and is defined as the lowest concentration of an antimicrobial that will inhibit the visible growth of a micro-organism after overnight incubation. The MICs shown for the specific antimicrobials define the cut-off for resistance to these antimicrobials.

Metadata

Indicator description	Gonococcal isolates collected from patients attending London GUM clinics analysed by ethnicity, prevention group and drug resistance, 2001 to 2006.
Source of data	The Gonococcal Resistance to Antimicrobial Surveillance Programme (GRASP).
Numerator definition	For antimicrobial resistance: all isolates with resistance to each of the antimicrobials tested. For epidemiological characteristics: all patients for whom epidemiological data were collected and who belonged to the category under investigation.
Denominator definition	For antimicrobial resistance: all gonococcal isolates that were successfully retrieved and tested by STBRL (Sexually Transmitted Bacteria Reference Laboratory). For epidemiological characteristics: all patients included in GRASP data collection.
Geography	The data are presented for London as a whole (based on reports from nine of the 34 GUM clinics in London).
Timeliness	See Accuracy and completeness below.
Disclosure control	None associated with this presentation.
Data accuracy and completeness	The Gonococcal Resistance to Antimicrobial Surveillance Programme (GRASP) monitors gonococcal antimicrobial resistance at 26 sentinel sites in England and Wales. Consecutive gonococcal isolates are collected between June and August of each year and sent to the STBRL at the Health Protection Agency for sensitivity testing. GRASP data constitutes a sample of the total gonorrhoea diagnoses made in Genitourinary Medicine (GUM) clinics in England and Wales.

Limitations

Since GRASP is a sentinel programme, data cannot be provided at the level of PCTs. Due to variations in the retrieval and confirmation of isolates submitted to STBRL in 2005, the data on resistance prevalence are statistically weighted. This is done to avoid resistance estimates being under-representative of sites that have a

low retrieval rate and over-representative of sites that have a high retrieval rate. Consequently, estimates for previous years have been recalculated in this way and so values presented here may differ slightly from the unweighted estimates that have appeared in previous GRASP reports.

The data presented in this section represent specimens collected from GUM clinics only.

Indicator 2.13 Diagnoses of uncomplicated genital chlamydia in London GUM clinics, 2002–2006

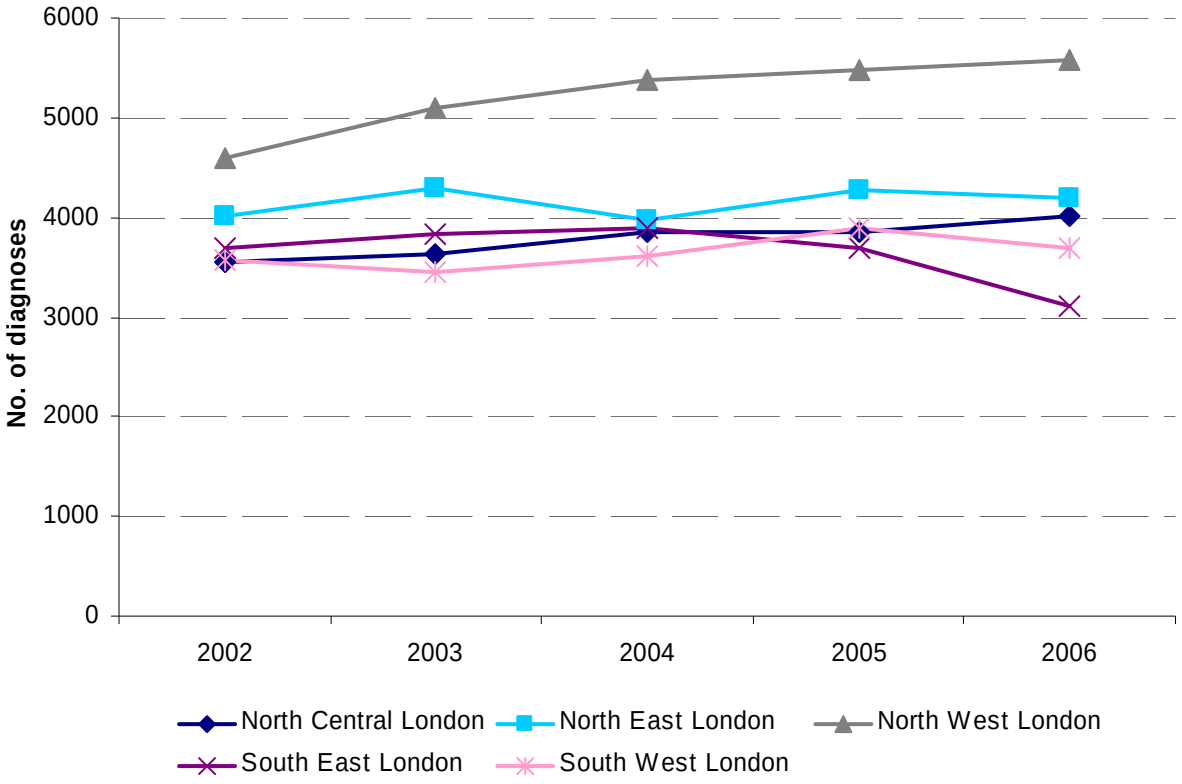
Rationale for inclusion

Genital chlamydia is the most common sexually transmitted infection diagnosed in GUM clinics in the UK. It affects an estimated one in ten sexually active young men. It is asymptomatic in at least 75% of women and 50% of men. Untreated infection can lead to serious health problems, particularly for women, for example pelvic inflammatory disease, ectopic pregnancy and infertility.

What does this indicator show?

- The number of genital chlamydial diagnoses in GUM clinics has reached a plateau at 20,000 in London over the past 4 years.
- Several factors may have impacted on the levelling of the genital chlamydia rates seen in GUM clinics especially among women. These include screening outside GUM clinics, fewer referrals to GUM clinics from primary care, GUM clinics reaching capacity in patient numbers and patients seen within 48 hours of making an appointment, slowing the spread of the infection.
- A 1:1 sex ratio was seen in men and women attending GUM clinics and being diagnosed with genital chlamydia.

Figure 21: Diagnoses of uncomplicated genital chlamydia in GUM clinics by sector of clinic, London, 2002-2006



Source: HPA (KC60)

Table 13: Diagnoses of uncomplicated chlamydia in GUM clinics by (a) sector of clinic and (b) gender (and male sexual orientation), London, 2002-2006

(a) Sector of clinic	2002	2003	2004	2005	2006
North Central London	3559	3632	3848	3858	4020
North East London	4016	4299	3967	4281	4190
North West London	4598	5099	5373	5485	5578
South East London	3685	3840	3894	3688	3109
South West London	3571	3460	3616	3903	3696
(b) Gender/MSM					
Male	9442	9914	10194	10701	10591
of which MSM*	756	855	839	1168	1424
Female	9987	10416	10504	10514	10002
London total	19429	20330	20698	21215	20593

* 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)

Metadata

Indicator description	Diagnoses of uncomplicated genital chlamydia in London GUM clinics, by sector of clinic, and gender and age group (and male sexual orientation), 2002-2006.
Source of data	Data are from statutory quarterly KC60 returns submitted by GUM clinics in London.
Numerator definition	All London GUM clinic attendees who were diagnosed with uncomplicated genital chlamydia (KC60 codes C4A and C4C). 2002-2006.
Denominator definition	Not applicable.
Geography	The data are presented according to the sector of the clinic (which may or may not be the same as the sector of residence for the patient) and for London as a whole.
Timeliness	KC60 returns are to be sent quarterly to the HPA, Colindale, six weeks after the end of the quarter. Reminder letters are sent out before the end of the quarter to all GUM clinics in London.
Disclosure control	Figures have been suppressed where the number observed is between one and four (less than five).
Data accuracy and completeness	Data are reported quarterly and some clinics may not have reported data. The data have not been adjusted for missing data. Not all returns have been submitted (one clinic submitted three returns in 2006).

Limitations

The data available from the KC60 statutory returns are for diagnoses made in GUM clinics only. Diagnoses made in other clinical settings, such as general practice, are not recorded in the KC60 dataset. The data available from the KC60 statutory returns are the number of diagnoses made, not the number of patients diagnosed. Individual patients may have more than one diagnosis in a year. The information provided has not been adjusted for missing clinic data. Patient PCT of residence is not recorded in the KC60 returns. GUM clinics are open access clinics and therefore not restricted to patients residing in the area.

Indicator 2.14 NCSP: Positivity of genital chlamydia amongst asymptomatic young people

Rationale for inclusion

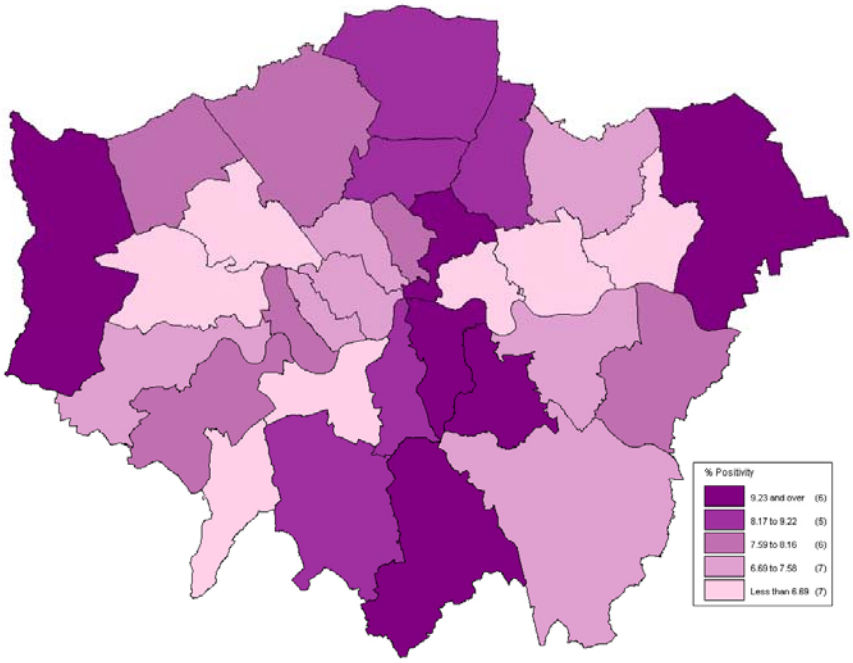
The National Chlamydia Screening Programme (NCSP) provides screening to asymptomatic people aged under 25 years in healthcare and non-healthcare settings across England. The goal of the programme is to control genital chlamydia through the early detection and treatment of asymptomatic infection, to prevent development of sequelae, and to reduce onward disease transmission. The programme receives several datasets including disaggregated electronic data on a quarterly basis from programme areas. Programme areas are responsible for local management of chlamydia screening and may cover one or more PCTs. Eighty-six programme areas (covering 152 PCTs nationally) are screening. About 1 in 10 young people screen positive through the National Chlamydia Screening Programme (NCSP).

Between October 2005 and March 2008 an independent pilot run by Boots Pharmacy and the Department of Health offered chlamydia screening in pharmacies in London. These data are compiled by the NCSP and have been included.

What does this indicator show?

- A total of 51,024 screening tests were done by the NCSP between 1 April 2007 and 31 March 2008.
- Overall positivity among London residents was 7.0% in men and 8.3% in women, which is a little lower than the figures reported nationally for the same period: 7.6% in men and 9.3% in women.
- Positivity was highest among those whose ethnicity was reported as Black or Black British at 10.7% and lowest among those reported to be Asian or Asian British at 2.9%.
- While considerable variation was seen in positivity at PCT level, this is likely to reflect differences in the implementation of screening at the local level rather than local variations in prevalence.

Figure 22: NCSP: Positivity of genital chlamydia by PCT of residence, London, 2007-2008



Source: NCSP

Table 14: NCSP: Positivity of genital chlamydia by ethnicity and age group, London, 2007-08

Ethnicity	Result	< 16 YRS	16-19 YRS	20-24 YRS
White	Positive	71	618	766
	Negative	746	6485	11782
Black or Black British	Positive	82	759	505
	Negative	577	5207	5286
Asian or Asian British	Positive	5	33	50
	Negative	100	1119	1689
Chinese	Positive	<5	10	25
	Negative	<5	133	317
Mixed	Positive	34	199	148
	Negative	262	1640	1391
Other	Positive	5	40	48
	Negative	36	450	733
Unknown/Missing	Positive	24	279	240
	Negative	317	2904	3717
London	Positive	222	1938	1782
	Negative	2042	17938	24915
	Total	2264	19876	26697

1. Total includes all ages & all test results (equivocal, inhibitory & insufficient). Consequently, columns may not add up to total.
2. Data are as of 12/06/08 and may not reflect all screens performed.
3. Numerator used is number of screens and not number of people. Please note that number of screens as collected through the NCSP programme will be used a proxy for the number of people screened.

Source: NCSP

Table 15: NCSP: Positivity of genital chlamydia by PCT of residence, London, 2007-2008

PCT Name	Total Positivity Rate	95% confidence interval
Barking & Dagenham PCT	6.40%	(4.7% - 8.1%)
Barnet PCT	7.90%	(6.3% - 9.5%)
Bexley PCT	7.80%	(6.4% - 9.3%)
Brent Teaching PCT	6.30%	(5.1% - 7.4%)
Bromley PCT	7.00%	(5.7% - 8.3%)
Camden PCT	6.70%	(5.5% - 7.9%)
City & Hackney Teaching PCT	9.20%	(8.3% - 10.2%)
Croydon PCT	9.90%	(8.1% - 11.7%)
Ealing PCT	5.80%	(3.6% - 8.0%)
Enfield PCT	8.20%	(6.7% - 9.6%)
Greenwich Teaching PCT	7.60%	(6.5% - 8.7%)
Hammersmith & Fulham PCT	8.00%	(5.6% - 10.3%)
Haringey Teaching PCT	8.90%	(7.5% - 10.3%)
Harrow PCT	7.80%	(6.1% - 9.6%)
Havering PCT	11.50%	(8.1% - 15.0%)
Hillingdon PCT	9.80%	(7.0% - 12.5%)
Hounslow PCT	7.20%	(5.3% - 9.1%)
Islington PCT	7.70%	(6.5% - 8.9%)
Kensington & Chelsea PCT	6.80%	(4.2% - 9.4%)
Kingston PCT	5.20%	(2.8% - 7.6%)
Lambeth PCT	9.00%	(8.2% - 9.8%)
Lewisham PCT	10.70%	(9.9% - 11.4%)
Newham PCT	5.70%	(4.4% - 7.1%)
Redbridge PCT	7.20%	(5.5% - 9.0%)
Richmond & Twickenham PCT	8.20%	(5.5% - 10.8%)
Southwark PCT	9.80%	(9.0% - 10.7%)
Sutton & Merton PCT	8.40%	(6.3% - 10.6%)
Tower Hamlets PCT	3.10%	(2.6% - 3.6%)
Waltham Forest PCT	9.10%	(7.4% - 10.7%)
Wandsworth PCT	5.50%	(4.1% - 7.0%)
Westminster PCT	7.10%	(5.2% - 8.9%)

Source: NCSP

Metadata

Indicator description	Numbers and results of screening tests done through the NCSP stratified by (i) PCT of residence (ii) gender and ethnic group.
Source of data	National Chlamydia Screening Programme (NCSP).
Numerator definition	Number of confirmed positive screening tests.
Denominator definition	For positivity measures, the denominator was the sum of the number of positive and negative screening tests by PCT of residence/gender/ethnic group as reported to the NCSP.
Geography	The data are presented for London as a whole and by PCT of residence.
Timeliness	Data cover the period 1 April 2007 to 31 March 2008. Reports to 12 June 2008.
Disclosure control	Numbers less than five have been suppressed.
Data accuracy and completeness	Number reported is number of screening tests and not number of people screened. However the number of screening tests collected through the NCSP is used as a proxy measure of the number of people screened. Totals do not include records where sex is unknown or not specified, nor do they include equivocal, inhibitory and insufficient test results.

Limitations

Data are based on postcode of residence: some of those screened may have accessed services outside of London. Conversely, the data may not reflect all screening tests done by services within London.

When interpreting positivity results, it is important to be aware that these may be influenced by a number of factors including: (i) small numbers (and therefore large confidence intervals); (ii) variations in the composition of each PCT's resident population in terms of age groups and ethnic backgrounds (and in the targeting of screening within that population); (iii) variations in deprivation within and between PCTs, (iv) variations in the number of screening tests carried out in each PCT and in the proportion of people who screen in PCTs other than the one in which they are resident.

Indicator 2.15 Coverage of National Chlamydia Screening Programme

Rationale for inclusion

The National Chlamydia Screening Programme (NCSP) provides screening to asymptomatic people aged under 25 years in healthcare and non-healthcare settings across England. The goal of the programme is to control genital chlamydia through the early detection and treatment of asymptomatic infection, to prevent development of sequelae, and to reduce onward disease transmission. Programme areas are responsible for local management of chlamydia screening and may cover one or more PCTs. Eighty-six programme areas (covering 152 PCTs nationally) are screening.

Between October 2005 and March 2008 an independent pilot run by Boots Pharmacy and the Department of Health offered chlamydia screening in Boots pharmacies in London. These data are compiled by the NCSP and have been included.

At the beginning of 2007 the Department of Health set a Local Delivery Plan (LDP) target (LDP PSA11d) for PCTs to screen 15% of their 15-24 year old resident population for chlamydia during 1 April 2007 – 31 March 2008.

In 2008/9 the Department of Health set the chlamydia 'Vital Signs Indicator' which includes a target of achieving 17 per cent for chlamydia screening and testing in young persons between 15 and 24 years of age during 1 April 2008 – 31 March 2009.

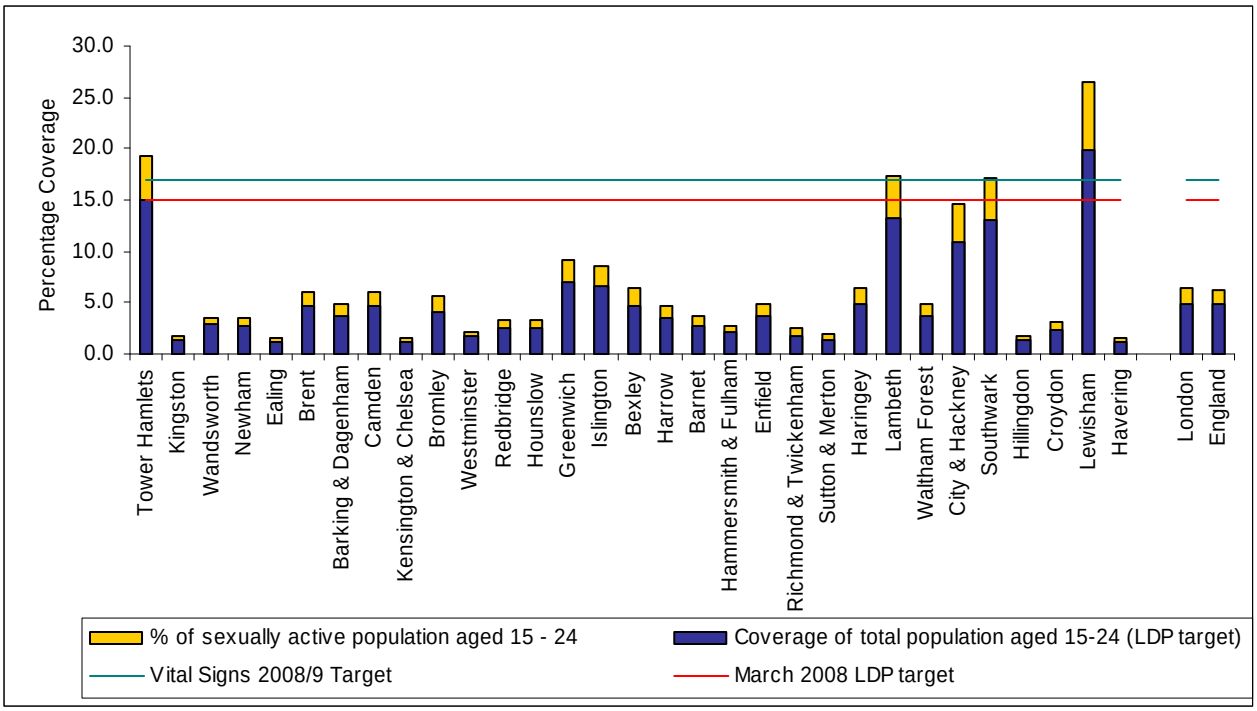
However, coverage alone does not determine how well a programme is being implemented. It is important to consider both coverage and positivity together.

What does this indicator show?

According to LDP criteria for 2007/8:

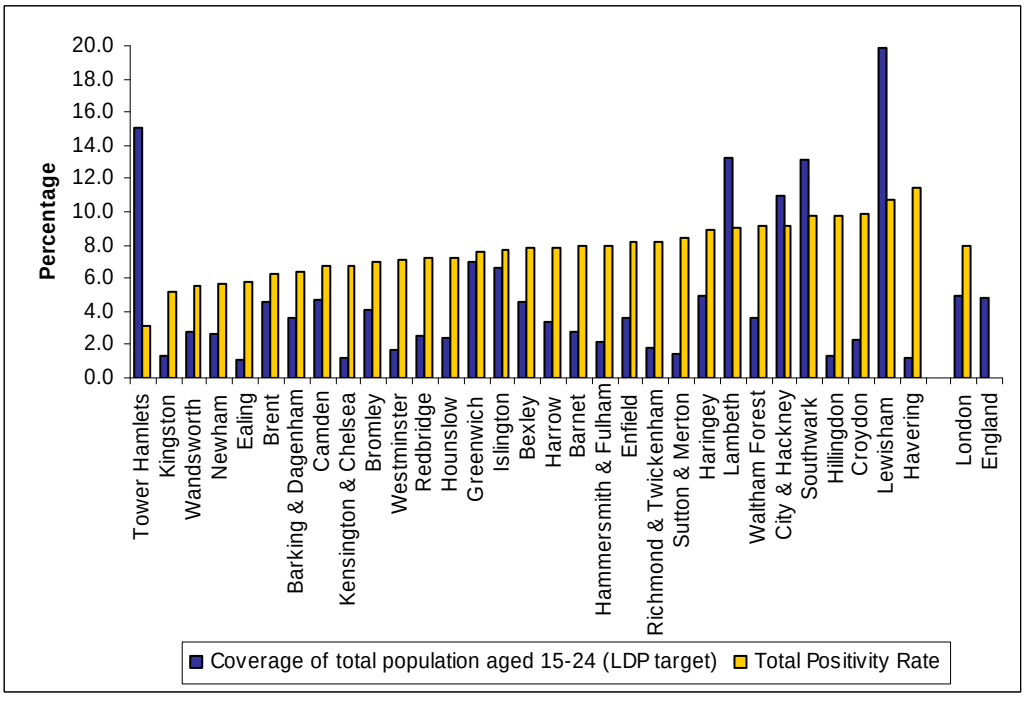
- Both nationally and in London strategic health authority (SHA), NCSP coverage was 4.9%.
- There was wide variation in NCSP coverage across London, ranging from only 1.1% in Ealing to 19.9% in Lewisham.
- Lewisham and Tower Hamlets were two of the three PCTs nationally that reached the LDP target of 15%.
- Comparing coverage and positivity rates shows that some PCTs are being more effective in targeting their programme. Tower Hamlets, while achieving high coverage, had the lowest positivity rates in London, whereas Havering had high positivity but very low coverage. Lambeth, Southwark and Lewisham all had both high coverage and high positivity.
- Test results come from a variety of screening venues reflecting the differences in the way the NCSP has been implemented in different areas. Almost a third of tests across London came from Community Sexual and Reproductive Health (CSRH) Services. This pattern also varied between PCTs with up to 85% of tests in Lewisham coming from CSRH services.

Figure 23: National Chlamydia Screening Programme Coverage, London PCTs, April 2007-March 2008



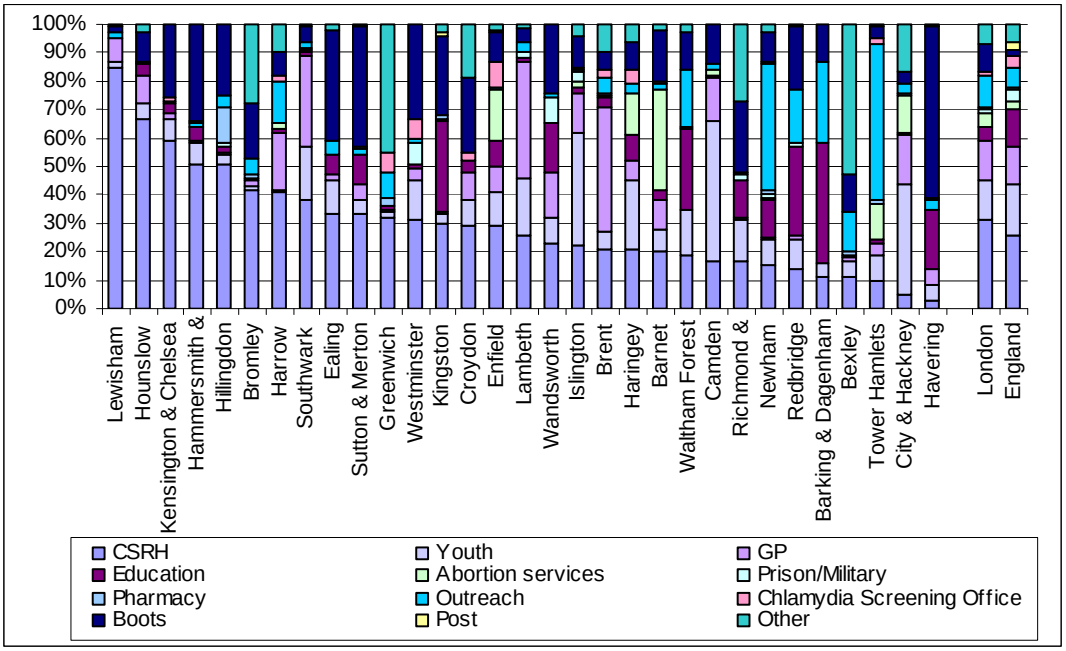
Source: NCSP

Figure 24: NCSP: Positivity compared to coverage in London PCTs, April 2007-March 2008



Source: NCSP

Figure 25: NCSP source of test by London PCT, April 2007-March 2008



Source: NCSP

Metadata

Indicator description	Number of screens and positivity by PCT of residence within London SHA.
Source of data	NCSP and Boots Pathfinder project.
Numerator definition	Numerator used is number of screens and not number of people. Please note that number of screens as collected through the NCSP will be used a proxy for the number of people screened.
Denominator definition	For measures of coverage in 2007/8, the denominator was the total resident population aged 15 to 24 years in each PCT. This was obtained from the mid-2005 figures published by the Office of National Statistics. For measures of positivity, the denominator was the sum of the number of positive and negative screens by PCT of residence as reported to the NCSP.
Geography	The data are presented by PCT of residence.
Timeliness	Data cover the period 1 April 2007 to 31 March 2008. Data were extracted on 3 June 2008.
Disclosure control	None.
Data accuracy and completeness	Number reported is number of screens and not number of people screened. However, the number of screens collected through the NCSP is used as a proxy measure of the number of people screened. Data are as of 03/06/08 and may not reflect all screens performed. Data are by PCT of residence and not PCT where the screen occurred. England total excludes those where the residential postcode is missing/invalid or outside of England.

Indicator 2.16 Diagnoses of genital herpes in London GUM clinics, 2002-2006

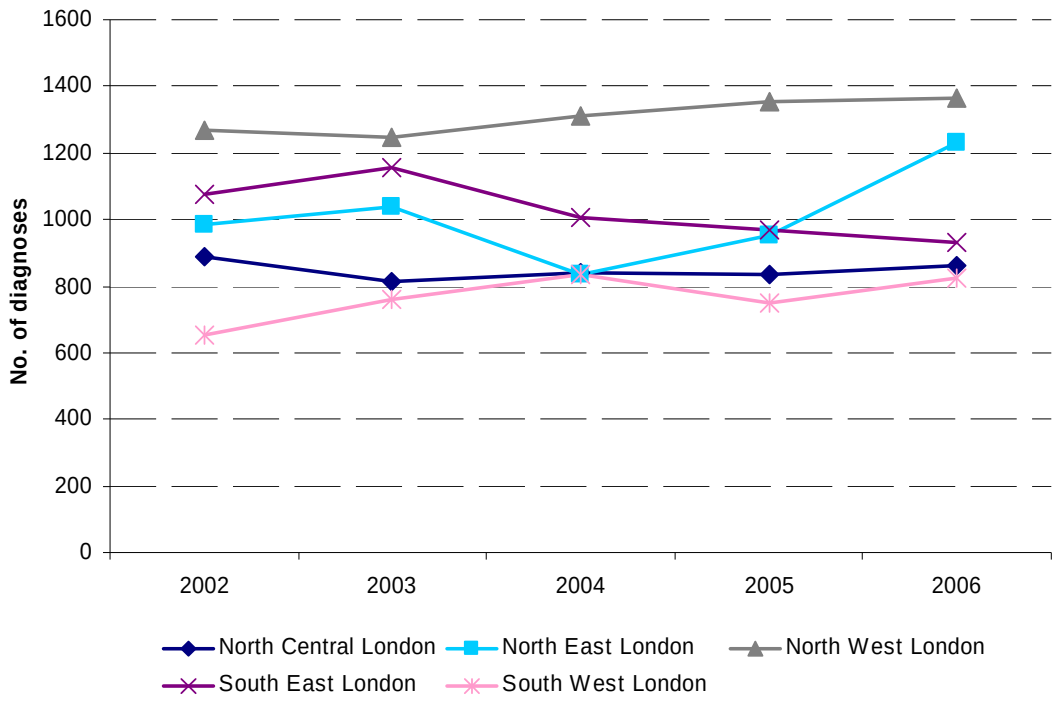
Rationale for inclusion

Genital herpes is a chronic infection and is the most common ulcerative STI in the UK. While some infections are asymptomatic, a substantial number of those infected experience recurrent and often painful attacks.

What does this indicator show?

- Diagnoses of genital herpes (first attack) in GUM clinics are much higher among women than men in London with 3 diagnoses in women for every 2 in males.
- There was a 7% increase in the number of herpes diagnoses (first attack) between 2002 and 2006 in London GUM clinics. The annual number of diagnoses rose from 4,867 to 5,210.

Figure 26: Diagnoses of genital herpes (first attack) by sector of GUM clinic, London, 2002-2006



Source: HPA (KC60)

Table 16: Diagnoses of genital herpes (first attack) in GUM clinics by (a) sector of clinic and (b) gender (and male sexual orientation), London, 2002-2006

(a) Sector of clinic	2002	2003	2004	2005	2006
North Central London	887	812	838	834	859
North East London	984	1038	836	955	1230
North West London	1268	1245	1313	1355	1366
South East London	1074	1158	1004	966	932
South West London	654	761	834	749	823
(b) Gender/MSM					
Male	1995	2059	1962	1997	2095
of which MSM*	282	289	263	303	290

Female	2872	2955	2863	2862	3115
London total	**4867**	**5014**	**4825**	**4859**	**5210**

*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)

Metadata

Indicator description	Diagnoses of genital herpes (first attack) in London GUM clinics, by sector of clinic, and gender (and male sexual orientation), 2002-2006.
Source of data	Data are from statutory quarterly KC60 returns submitted by GUM clinics in London.
Numerator definition	All London GUM clinic attendees who were diagnosed with genital herpes (first attack) (KC60 code: C10A).2002-2006.
Denominator definition	Not applicable.
Geography	The data are presented according to the sector of the clinic (which may or may not be the same as the sector of residence for the patient) and for London as a whole.
Timeliness	KC60 returns are to be sent quarterly to the HPA, Colindale, six weeks after the end of the quarter. Reminder letters are sent out before the end of the quarter to all GUM clinics in London.
Disclosure control	Figures have been suppressed where the number observed is between one and four (less than five).
Data accuracy and completeness	Data are reported quarterly and some clinics may not have reported data. The data have not been adjusted for missing data. Not all returns have been submitted (one clinic submitted three returns in 2006).

Limitations

The data available from the KC60 statutory returns are for diagnoses made in GUM clinics only. Diagnoses made in other clinical settings, such as general practice, are not recorded in the KC60 dataset. The data available from the KC60 statutory returns are the number of diagnoses made, not the number of patients diagnosed. The information provided has not been adjusted for missing clinic data. Patient PCT of residence is not recorded in the KC60 returns. GUM clinics are open access clinics and therefore not restricted to patients residing in the area.

Indicator 2.17 Diagnoses of genital warts in London GUM clinics, 2002-2006

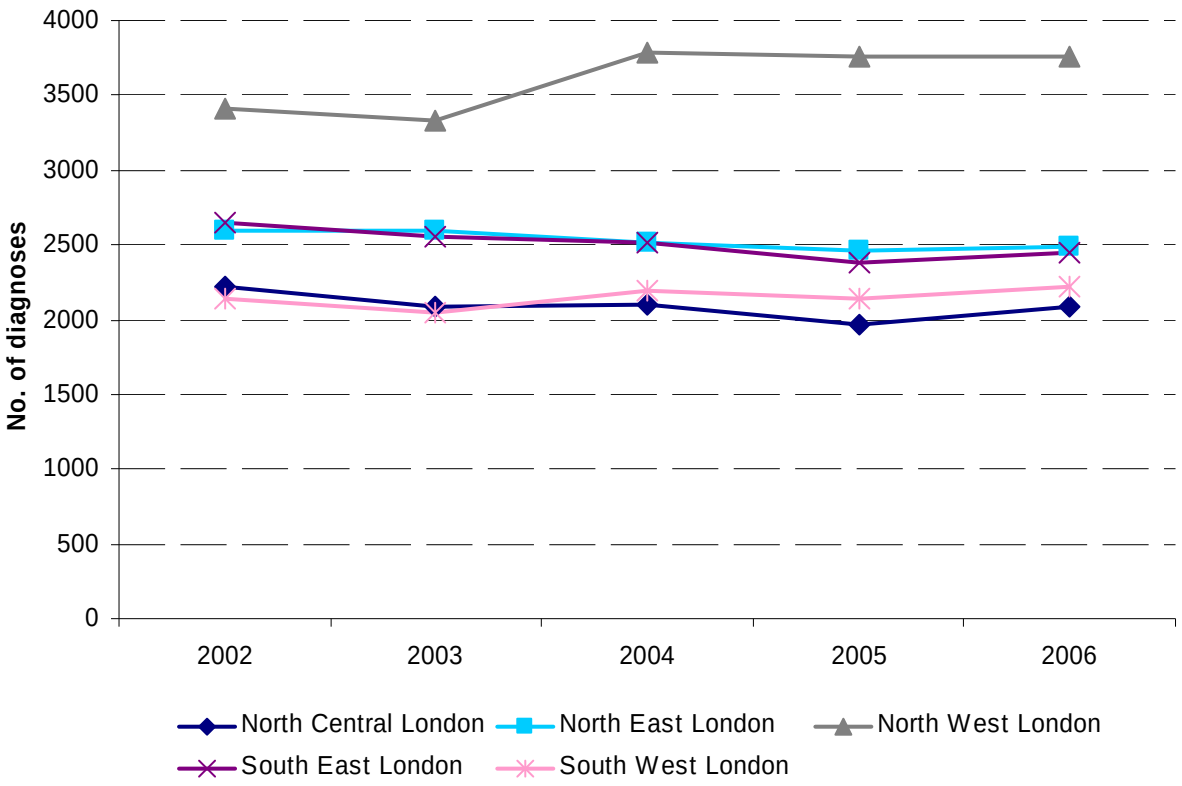
Rationale for inclusion

Genital warts are the second most common STI in the UK and are caused by human papillomavirus (HPV). Some HPV types, especially 16 and 18, are associated with cancers, particularly cervical cancer. There are about 1,000 deaths from cervical cancer in the UK annually. However, most of the HPV types that cause genital warts are types 6 and 11, which are low risk for cervical cancer.

What does this indicator show?

- Annual numbers of diagnoses of genital warts (first attack) in GUM clinics in London have remained stable. The number of diagnoses in 2006 was 12,996.
- Although the diagnoses of genital warts (first attack) in GUM clinics in London were higher among men, the rate of genital wart diagnoses within the 16-19 age group among women was more than double that among men in the same age group.

Figure 27 : Diagnoses of genital warts (first attack) by sector of GUM clinic, London, 2002 - 2006



Source: HPA (KC60)

Table 17: Diagnoses of genital warts (first attack) in (a) GUM clinics by sector of clinic and (b) gender (and male sexual orientation), London, 2002-2006

(a) Sector of clinic	2002	2003	2004	2005	2006
North Central London	2222	2084	2099	1970	2083
North East London	2589	2594	2521	2461	2482
North West London	3418	3330	3786	3759	3753

South East London	2643	2559	2511	2380	2452
South West London	2139	2051	2195	2143	2226
(b) Gender/MSM					
Male	7234	7028	7361	7005	7162
of which MSM*	986	985	911	993	1082
Female	5777	5590	5751	5708	5834
London total	**13011**	**12618**	**13112**	**12713**	**12996**

*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)

Metadata

Indicator description	Diagnoses of genital warts (first attack) in London GUM clinics, by sector of clinic, and gender and age group (and male sexual orientation), 2002 – 2006.
Source of data	Data are from statutory quarterly KC60 returns submitted by GUM clinics in London.
Numerator definition	All London GUM clinic attendees who were diagnosed with genital warts (first attack) (KC60 code: C11A). 2002 – 2006.
Denominator definition	Not applicable.
Geography	The data are presented according to the sector of the clinic (which may or may not be the same as the sector of residence for the patient) and for London as a whole.
Timeliness	KC60 returns are to be sent quarterly to the HPA, Colindale, six weeks after the end of the quarter. Reminder letters are sent out before the end of the quarter to all GUM clinics in London.
Disclosure control	Figures have been suppressed where the number observed is between one and four (less than five).
Data accuracy and completeness	Data are reported quarterly and some clinics may not have reported data. The data have not been adjusted for missing data. Not all returns have been submitted (one clinic submitted three returns in 2006).

Limitations

The data available from the KC60 statutory returns are for diagnoses made in GUM clinics only. Diagnoses made in other clinical settings, such as general practice, are not recorded in the KC60 dataset. The data available from the KC60 statutory returns are the number of diagnoses made, not the number of patients diagnosed. Individual patients may have more than one diagnosis in a year. The information provided has not been adjusted for missing clinic data. Patient PCT of residence is not recorded in the KC60 returns. GUM clinics are open access clinics and therefore not restricted to patients residing in the area.

Section 3. Access to Genitourinary Medicine (GUM) clinics

A number of approaches are required to improve sexual health. These range from sexual health promotion to the provision of effective and accessible diagnostic and treatment services for sexually transmitted infections. A number of one-to-one interventions have been recommended by NICE as effective including assistance with partner notification to ensure that sexual partners can be tested and treated (if necessary)[9]. Poor access to sexual health services has been highlighted as contributing to the continuing increase in sexually transmitted infections (STIs).[10]

Delayed treatment and untreated infections fuel increases in STIs as further individuals become infected. It has been demonstrated that adequate increases in Genitourinary Medicine (GUM) capacity are very likely to lead to cost-savings. Rapid treatment of a majority of new infections limits onward transmission, resulting in low infection rates and low demand for treatment[10].

The white paper, *Choosing health: Making healthier choices easier*[1] included a number of commitments, including improved access to GUM clinics.

The Operating Framework for the NHS in England[11] identified 48-hour access to GUM clinics as a priority in 2006/07 and 2007/08. The targets,[12] which are linked to the local development plans (LDPs) of PCTs, are:

- 100% of patients attending GUM services are offered an appointment to be seen within 48 hours of contacting a service by March 2008 and maintained thereafter.
- 95% of patients to be seen within 48 hours by March 2008 and maintained thereafter.

Previously, there was no national system for the continuous monitoring of GUM waiting times. The national audit of waiting times in GUM clinics in England was developed in the interim until the electronic monitoring system began in 2007.

The national GUM waiting times audits (WTA) were published quarterly. The last audit was in August 2007. These data refer to patients' PCT and Strategic Health Authority (SHA) of residence.

There is a new electronic audit system, GUMAMM (GUM access monthly monitoring), for central reporting to the DH. The first phase commenced in 2006 and was fully rolled out in April 2007.

Indicator 3.01 Percentage of patients attending a GUM clinic who are offered an appointment to be seen in 48 hours

Rationale for inclusion

Poor access to sexual health services has been highlighted as contributing to the continued increase in STIs. This indicator is one of the national targets in the NHS operating frameworks. The data are by PCT of residence or registered GP rather than by clinic.

What does this indicator show?

2007/08 GUMAMM data

- The percentage of patients offered an appointment to be seen in a GUM clinic within 48 hours in London over the year was 95.1% compared to 91.1% for England.
- London did not reach the target of 100% of patients offered an appointment.
- Within London, Newham PCT had the highest proportion of patients offered an appointment (99.6%).
- Kingston PCT had the lowest proportion (78.0%) followed by Haringey (83.0%).
- About half of the PCTs had proportions lower than the London average.
- There have been issues of data quality since the central returns started as some clinics had problems with data capture. The GUM clinic in Kingston Hospital in particular had problems with data capture for most of the year, so the average for Kingston PCT has been based on the last two months of 2007/08 data.

April 2008 GUMAMM data

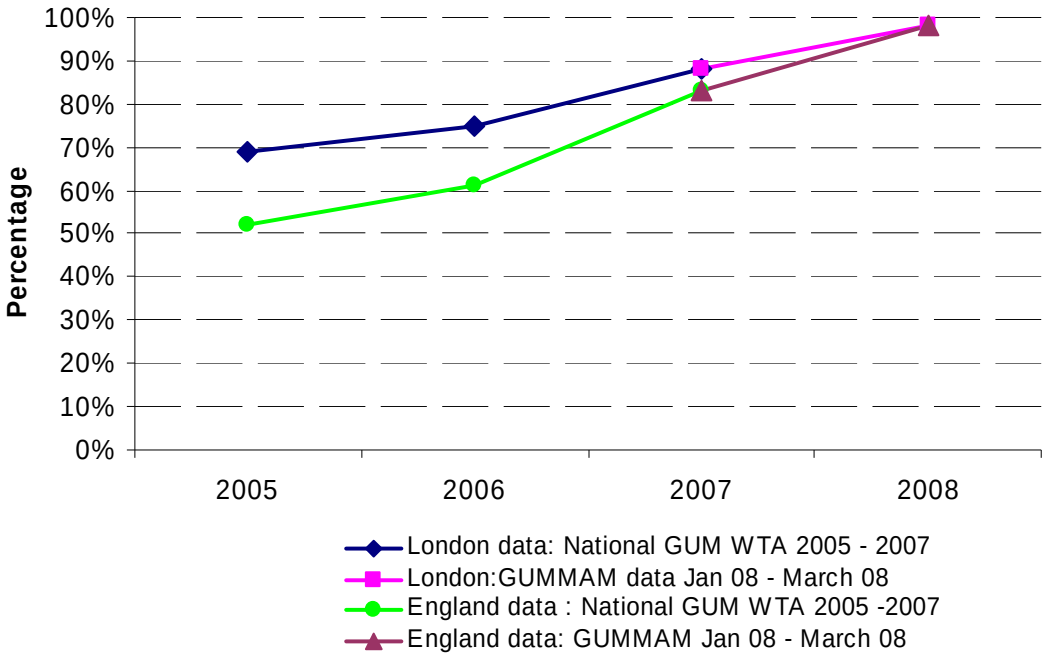
- The percentage offered an appointment in London was 98.1% and 98.5% in England.
- Lambeth and Kensington & Chelsea PCTs had the highest percentage of patients offered an appointment of 99.9% and Barnet PCT had the lowest percentage of patients offered (81.9%)
- Kingston PCT achieved 98.1% of patients offered an appointment.

Trend data

The trend data are from two sources: i) the national GUM waiting time audits which are of people surveyed at points in time and ii) the GUMAMM data which are a continuous capture. The quarterly audits for the available periods 2005 - 2007 have been combined into the corresponding years to give an average to reduce the effect of seasonal variation. The 2008 data reflect the time period January to March 2008 only.

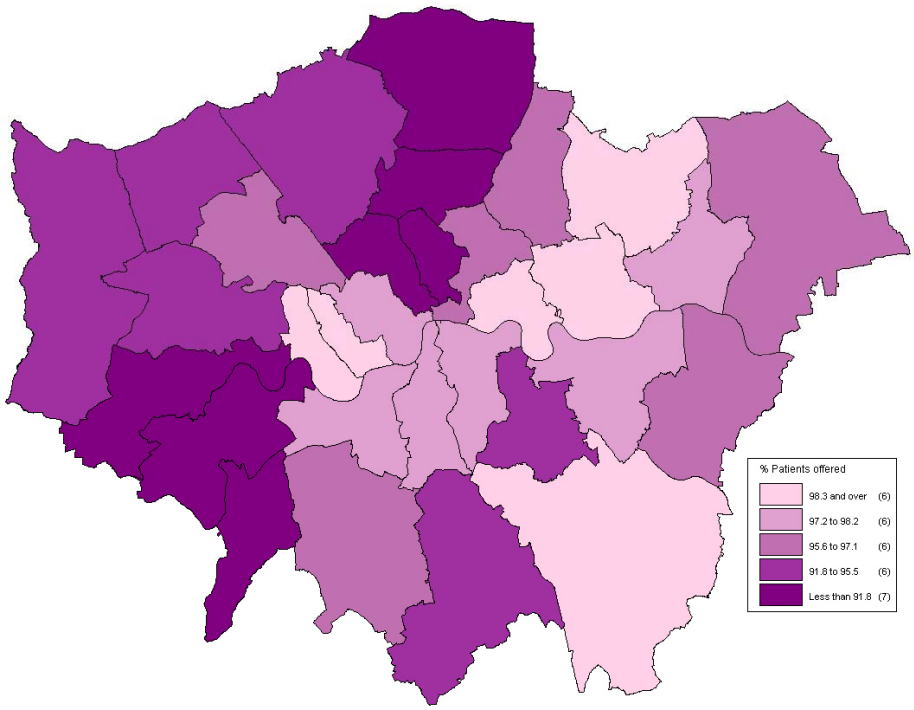
- The percentage of people offered an appointment to be seen at a GUM clinic within 48 hours in London has increased steadily from an average of 68.9% in 2005 to 97.9% in 2008.
- In England the corresponding percentages were 52% and 97.8% respectively.

Figure 28 : Percentage of patients offered an appointment to be seen at a GUM clinic within 48 hours, London and England, August 2005-March 2008



Sources: HPA and GUMAMM

Figure 29: Percentage of patients offered an appointment to be seen at a GUM clinic within 48 hours, by PCT, 2007/08



Source: DH GUMAMM data

Metadata: May 04 – August 07 data

Indicator description	The percentage of patients attending a GUM clinic who were offered an appointment to be seen within 48 hours.
Source of data	National GUM waiting times quarterly audits (WTAs) May 2005 - August 2007 published by the HPA.
Methodology*	The first WTA was conducted in May 2004; there were two audits in 2004, three audits in 2005, four audits in 2006 and three audits in 2007. In May 2005, the survey form was modified to include a question on day of the week so that data could be analysed adjusting for weekends. Any questionnaire where this question was not answered was excluded from analysis from May 2006. The questionnaire was also adjusted to include the output percentage of patients offered an appointment within 48 hours.
Numerator definition	The number of patients attending a GUM clinic who responded to the survey and were offered an appointment to be seen within 48 hours.
Denominator definition	The total number of patients attending a GUM clinic who responded to the survey.
Geography	SHA and PCT data relating to patients' residence; regional and clinic level data referring to clinic and region of attendance.
Timeliness	Audits were carried out for one week every quarter with exact dates being determined by the Steering Group that oversaw the audit. A five-week turnaround period from the start of the audit till the release of the report was adhered to.
Disclosure control	Data were appropriately aggregated to increase the statistical power of analysis and to avoid deductive disclosure of patients' identities due to small numbers.
Data accuracy & completeness	This audit measures waiting times from the perspective of the patient, and does not measure factors that could extend waiting times, for example whether the patient chose a later appointment rather than the first offered. Therefore the results may not directly reflect time to first available appointment from the clinic perspective. Consequently, results should be interpreted with caution and in association with other local information on access to services.

*For more information on the methodology used in waiting times audit see http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1194947355662

Metadata: April 07 – March 08 data

Indicator description	The percentage of patients attending a GUM clinic who were offered an appointment to be seen within 48 hours.
Source of data	The Genitourinary Medicine monthly access monitoring (GUMAMM) April 2007 - March 2008 downloaded from DH Unify system.
Numerator definition	The number of patients attending a GUM clinic who were offered an appointment to be seen within 48 hours.
Denominator definition	The total number of patients attending a GUM clinic.
Geography	PCT of registered GP, SHA and England
Timeliness	Continuous capture reported monthly
Disclosure control	None.
Data accuracy & completeness	There have been issues with data capture, in particular some PCTs did not submit the name of the responsible commissioner. DH has recently introduced a cleaning exercise and some validation measures.

Limitations

At an individual PCT level, the data reflect the number of patients waiting to be seen at any GUM clinic as they are based on PCT of residence (audit data) or PCT of registered GP (GUMAMM data). They do not reflect the performance of individual clinics within each PCT region.

Provider level data can be obtained but were not considered in the context of this report.

Indicator 3.02 Percentage of patients attending a GUM clinic who are seen within 48 hours

Rationale for inclusion

Please see Indicator 3.02

What does this indicator show?

2007/08 GUMAMM data

- In London the proportion of patients seen at a GUM clinic within 48 hours was 87.9% - higher than that of England as a whole (80.3%).
- Newham PCT had the highest proportion seen within 48 hours (98%) while both Kingston and Haringey PCTs recorded only 76% of patients seen within 48 hours.
- There have been issues of data quality since the central returns started as some clinics had problems with data capture. Kingston in particular had problems with data capture for most of the year so its average has been based on the last two months data.

April 2008 GUMAMM data

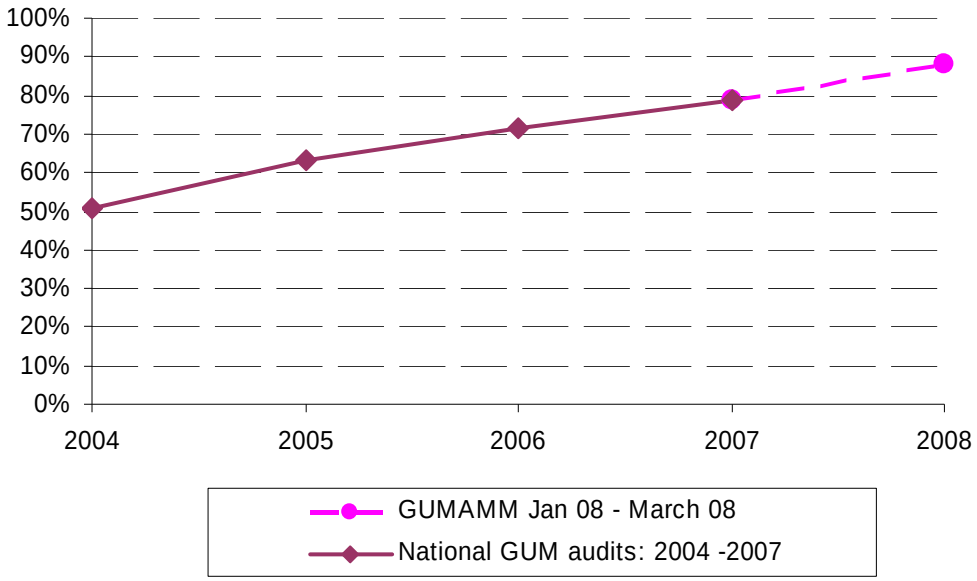
- In London the percentage of patients seen in a GUM clinic within 48 hours was 87.7% compared to 84.2% for England.
- Newham PCT had the highest proportion at 97.5% and Barnet PCT had the lowest at 67.1%.
- Kingston PCT had 94.4% of patients seen within 48 hours
- Only five PCT's in London met the recommended target of 95% of patients to be seen within 48 hours by March 2008.

Trend data

The trend data are from two sources: i) the national audits which are based on surveys at specific points in time and ii) the GUMAMM data which are a continuous capture. The quarterly audits between 2004 and 2007 have been combined into the corresponding years to give an average to reduce the effect of seasonal variation. The 2008 data reflect the time period January to March 2008 from the GUMAMM data.

- The percentage of people seen at a GUM clinic within 48 hours in London has increased steadily from an average of 50.7% in 2004 to 88.4% in 2008.
- Within London, whilst all sectors have seen an increase in the percentage of patients seen, North Central London has had consistently lower percentages and North East London has had consistently higher percentages.

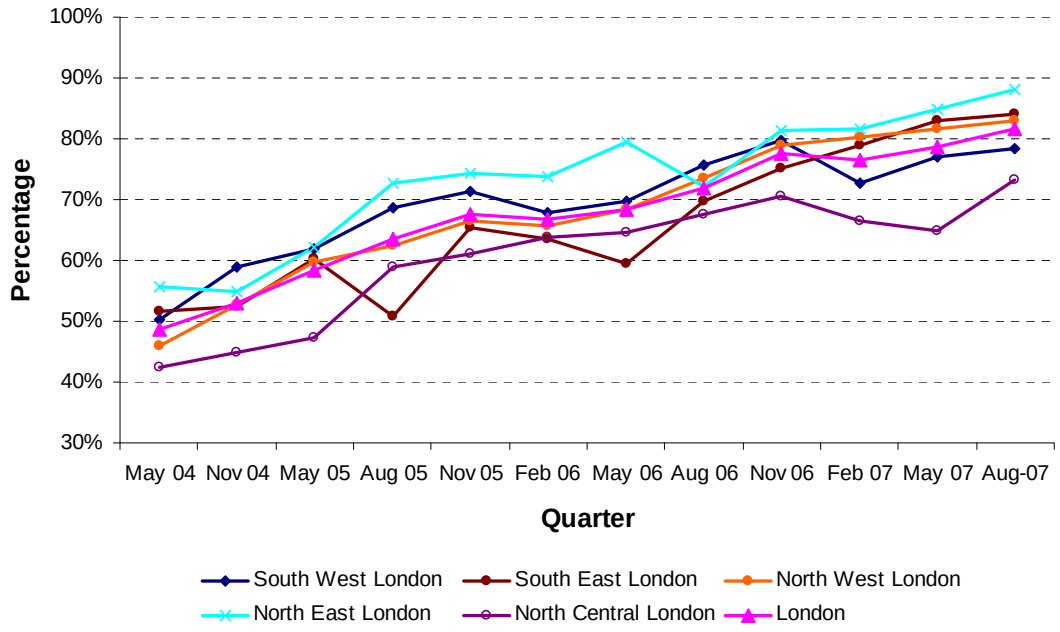
Figure 30: Percentage of patients seen at a GUM clinic within 48 hours, London, August 2004–March 2008



Sources: HPA and GUMAMM

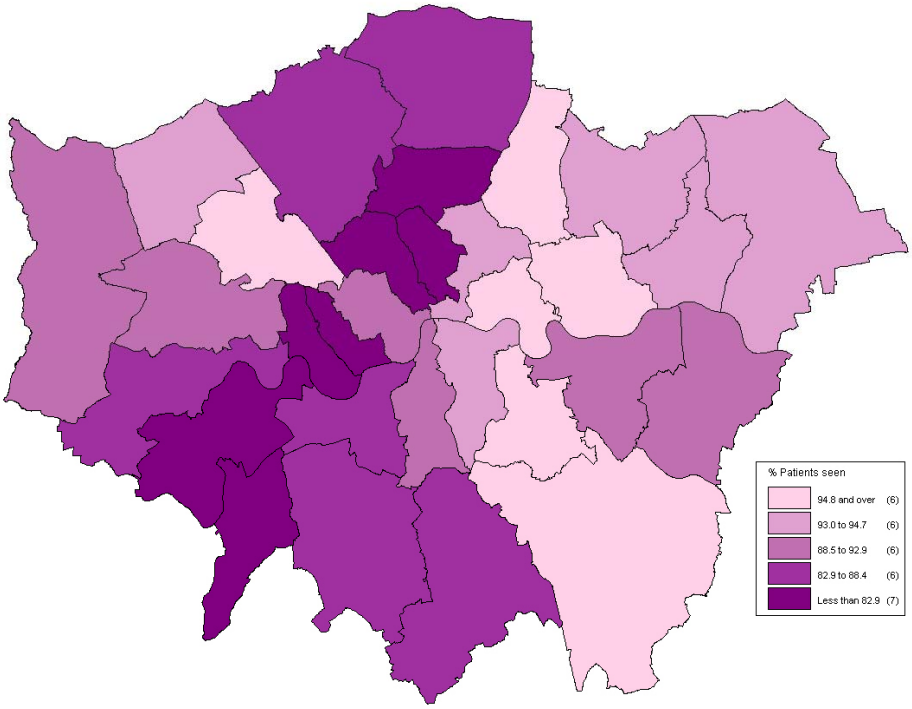
NB: The number of audits done per year varied from 2-4 (see metadata)

Figure 31: Percentage of patients seen at a GUM clinic within 48 hours, London, 2004–2007



Source: HPA

Figure 32: Percentage of patients seen at a GUM clinic within 48 hours, by PCT, 2007/08



Source: DH GUMAMM data

Metadata: May 04 – August 07 data

Indicator description	The percentage of patients attending a GUM clinic who were seen within 48 hours.
Source of data	National GUM waiting times quarterly audits May 2004 - August 2007 published by the HPA.
Methodology*	See Indicator 3.01.
Numerator definition	The number of patients attending a GUM clinic who responded to the survey and were seen within 48 hours.
Denominator definition	The total number of patients attending a GUM clinic who responded to the survey.
Geography	See Indicator 3.01.
Timeliness	See Indicator 3.01.
Disclosure control	See Indicator 3.01.
Data accuracy & completeness	See Indicator 3.01.

*For more information on the methodology used in waiting times audit see http://www.hpa.org.uk/web/HPAwebFile/HPAweb_C/1194947355662

Metadata: April 07 – March 08 data

Indicator description	The percentage of patients attending a GUM clinic who were seen within 48 hours.
Source of data	The Genitourinary Medicine monthly access monitoring (GUMAMM) April 2007 - March 2008 downloaded from DH Unify system.
Numerator definition	The number of patients attending a GUM clinic who were seen within 48 hours.
Denominator definition	The total number of patients attending a GUM clinic.
Geography	PCT of registered GP, SHA and England
Timeliness	Continuous capture reported monthly
Disclosure control	none
Data accuracy & completeness	See Indicator 3.01

Limitations

The limitations of these data are similar to those for the previous indicator 3.01.

Section 4. Cancer and screening

Cervical cancer is the second most common cancer after breast cancer in women aged under 35 years, and is the twelfth most common cancer in women of all ages. Cervical cancer is a recognised rare outcome of a common sexually transmitted infection, caused by the human papilloma viruses (HPVs). Although HPV is recognised as the cause of cervical cancers, there are no routine data on the prevalence of HPV in the community. It is not recorded in the data from laboratories although it may be mentioned on cervical smear reports. The World Health Organisation has summarised the burden of cervical HPV infection based on a number of epidemiological studies[13]. It reports that HPV prevalence in the general population of women with normal cytology is 7.1% but the prevalence of HPV-16 or HPV-18 (types of Human Papilloma Virus) in women with cervical cancer is 82.1%.

The establishment of HPV infection as a cause of cervical precancers and cancers provides a tremendous opportunity for cervical cancer prevention through vaccination. Recently a vaccine for HPV has been developed for use in sexually naïve young girls. This is targeted against HPV-16 and HPV-18, which account for approximately 70% of cancer cases. The *Performing Better?* report[14] suggests that the new vaccine for preventing HPV will have significant implications. It will be important for service providers to monitor access to and uptake of the vaccine by girls from the age of 12. There is a need to ensure that it is not wrongly perceived as a replacement for the cervical cancer screening programme. Women who are invited for cervical screening will still need to attend the screening.

Studies[15,16] have shown that the key risk factors for cervical cancer among women are the sexual behaviour of the woman and her partners. Co-factors that modify the risk of cervical cancer include the use of oral contraceptives (OCs) for five or more years, smoking, high parity (five or more full term pregnancies) and previous exposure to other sexually transmitted diseases, such as Chlamydia trachomatis (CT) and herpes virus type 2. Women exposed to HIV are also at high risk of HPV infection.

In 2000-2004, the cervical cancer incidence rate in the most deprived London group was 9.6 per 100,000 females compared to 5.4 per 100,000 in the most affluent London group[17]. The cervical cancer incidence was highest in North East and South East London Cancer Networks.

Cervical screening

A national NHS cervical screening programme was established in 1988-89. The national target for cervical screening coverage is 80% although, to date, London has fallen below this target. Cervical screening coverage is defined as the percentage of women eligible for screening who have had an adequate test with a recorded result at least once in the previous 5 years.

There are several factors which may contribute to the difference in coverage between London and the rest of the country:

- London's population is much more diverse;
- there is greater deprivation;
- there are well-established structural differences in primary care, with more single handed GPs and more practices without a practice nurse, thus restricting access to a female smear taker.

- London has high levels of population mobility which will also affect the ability of GPs to achieve high population coverage.

A national decrease in screening coverage coincided with the introduction of the new GMS contract in 2004. The Quality and Outcomes Framework (QOF) is a voluntary annual reward and incentive programme for all GP surgeries in England, detailing practice achievement results.[18] This contract gives a reduction in practice income for higher levels of screening compared to the previous target based contract. In addition, under the new GMS contract women who have been invited for a cervical screening test and have failed to attend on three occasions may be excluded from the workload calculation for QOF purposes. This is called exception reporting. Exception reporting by the surgeries may be one of the reasons for the reduction in screening coverage in London. It affects coverage because women that are exception reported will no longer be invited for cervical screening.

In June 2007, liquid based cytology was introduced as a method of taking cervical smear samples in London. This will lead to a reduction in inadequate smear samples.

National targets and Local Delivery Plan (LDP).

The cervical screening indicator contributes to two public service agreement targets:

- PSA03a: Cancer mortality rates
- PSA03b: Cancer: implementation of NICE improving outcomes guidance

The aim of these national targets is to reduce mortality rates from cancer by 2010 by at least 20% in people under 75. There is an inequalities element to the target whereby the inequalities gap should be reduced by at least 6% between the fifth of areas with the worst health and deprivation indicators and the population as a whole.

Indicator 4.01 Incidence of cervical cancer

Rationale for inclusion

HPV infection is a recognised cause of cervical cancer. Women exposed to HIV are at high risk of HPV infection. Exposure studies have shown that the key determinants among women are the number of sexual partners, the age at which sexual intercourse was initiated and the likelihood that at least one of their sexual partners was an HPV carrier as measured by his sexual behaviour traits. The greater the number of sexual partners a woman has without the use of condoms, the greater her risk of coming into contact with this virus and of later developing cervical cancer.

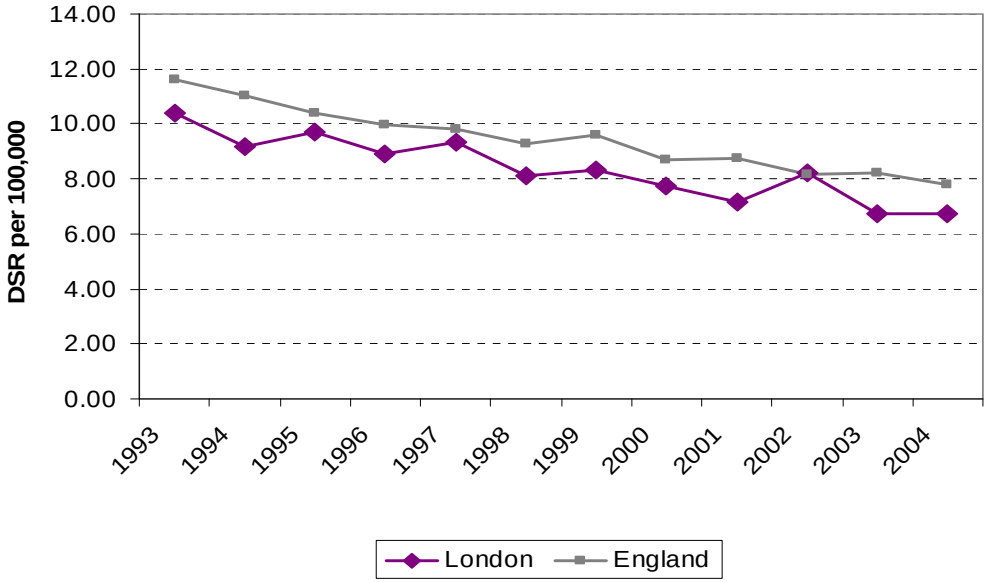
What does this indicator show?

- Between 2000 and 2004, 1,443 females were diagnosed with cancer of the cervix in London.
- According to Thames Cancer Registry data, cancer of the cervix accounted for 2% of all newly diagnosed malignant neoplasms in females in London (2000-2004).
- London's cervical cancer age standardised incidence rate was 7.3 per 100,000 in 2000-2004
- Among London's primary care organisations, City & Hackney, and Barking & Dagenham PCTs had the highest incidence rates with 13.7 per 100,000 and 12.5 per 100,000 respectively in 2000-2004.
- Barnet PCT and Ealing PCT had the lowest incidence of cervical cancer each with rates of 4.8 per 100,000 population.
- Incidence in Barking & Dagenham, City & Hackney and Southwark PCT was significantly higher than London as a whole in 2000-2004

Trend data

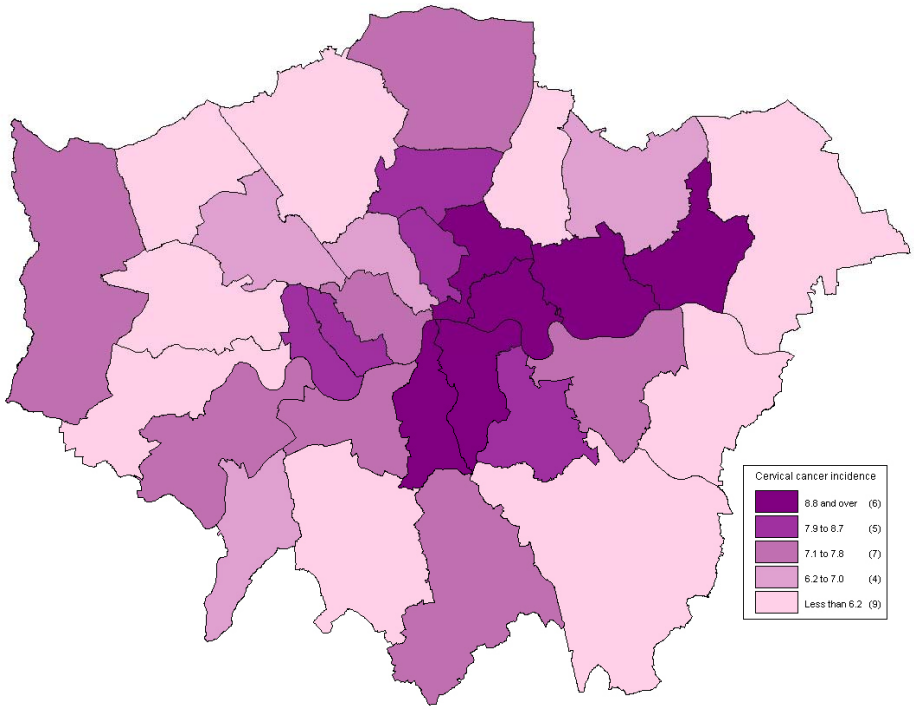
- From 1993 to 2004, London showed a downward trend in cervical cancer incidence rates, from 10.4 to 6.7 per 100,000 population.
- Similarly, there was a fall in cervical cancer incidence rates nationally.

Figure 33: Cervical cancer, directly age standardised incidence rates (DSR) (per 100,000 European population), London and England, 1993-2004



Source National Centre for Health Outcomes Development

Figure 34: Age standardised cervical cancer Incidence rate, by PCT, London, 2000-2004, pooled



Source Thames Cancer Registry

Metadata

Indicator description	Directly age standardised incidence rate of cervical cancer (ICD-10 C53, ICD-9 180) in the respective calendar years, all ages, female.
Source of data	Trend data are from Office of National Statistics analysed by National Compendium of Clinical Indicators. Data by PCT from Thames Cancer Registry.
Numerator definition	Cancer registrations for cervical cancer (ICD-10 C53 ICD-9 180) in the respective calendar years in the respective area from Thames Cancer Registry and the Office for National Statistics (ONS).
Denominator definition	2001 Census based mid-year population estimates for the respective calendar years. Data are based on the latest revisions of ONS mid-year population estimates for the respective years current as at March 2007.
Geography	PCT, SHA, England.
Timeliness	Latest incidence data are from 2004.
Disclosure control	None.
Data accuracy & completeness	Registration data for years 1993-2004 were extracted by ONS in July 2007 with organisational codes assigned using the postcode of usual residence and the November 2006 edition of the National Statistics Postcode Directory. The rates in this report have been taken from the 2008 Compendium and may differ from those of previous issues because of changes in methodology to extract data by area, and also because of data enhancements by ONS. Cancer registrations are also continuously being updated retrospectively and ONS records will have been updated since previous analyses.

Limitations

Data are not timely and 2004 data are the most up to date available. To take into account small numbers and year on year variation, aggregated data from 2000-2004 have been presented for PCT level information. Single year data have been used for regional and England analysis

Data on anal cancers, which are thought to have a similar viral aetiology, have not been presented due to small numbers at regional level.

Indicator 4.02 Mortality from cervical cancer

Rationale for inclusion

Cervical cancer is caused by a sexually transmitted infection. Mortality from cancer of the cervix accounted for 2% of all deaths from malignant neoplasms in females in 2000-2004 in London and nationally. Due to improved cancer detection and treatment, mortality from cervical cancer has been decreasing. However, some London PCTs still have relatively high cervical cancer death rates.

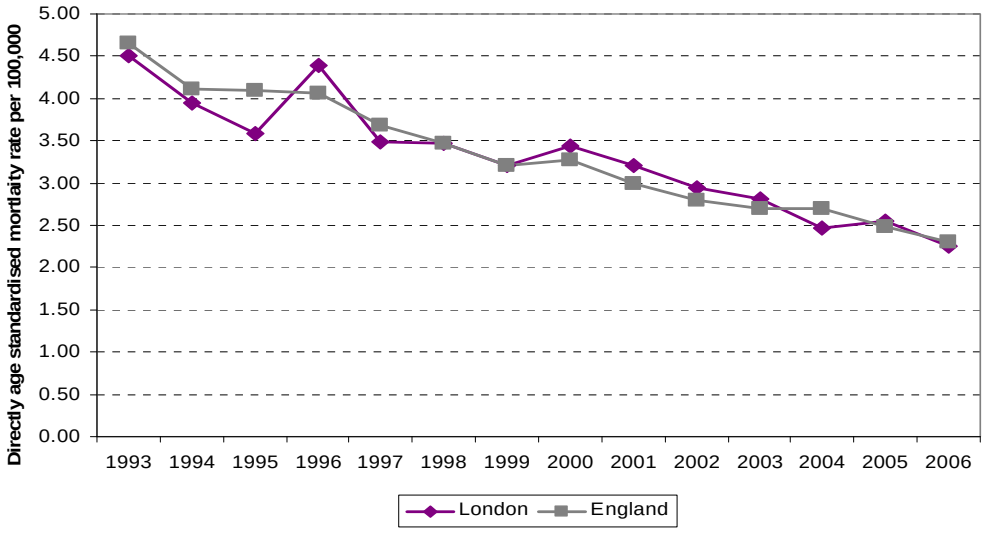
What does indicator show?

- In 2000-2004, there were around 600 deaths (rounded to the nearest 100) from cervical cancer in London.
- The age standardised mortality rate was 3.0 per 100,000 (2000-2004).
- There is a wide variation in mortality rate associated with deprivation. The most deprived group had 4.2 deaths per 100,000 compared to 1.7 per 100,000 in the most affluent group[17].
- Although the numbers are small, there was wide variation in mortality rates between London PCTs.
- In 2000-2004, there were 2 London PCTs with rates significantly higher than the average for London. These were Newham and Tower Hamlets.

Trend data:

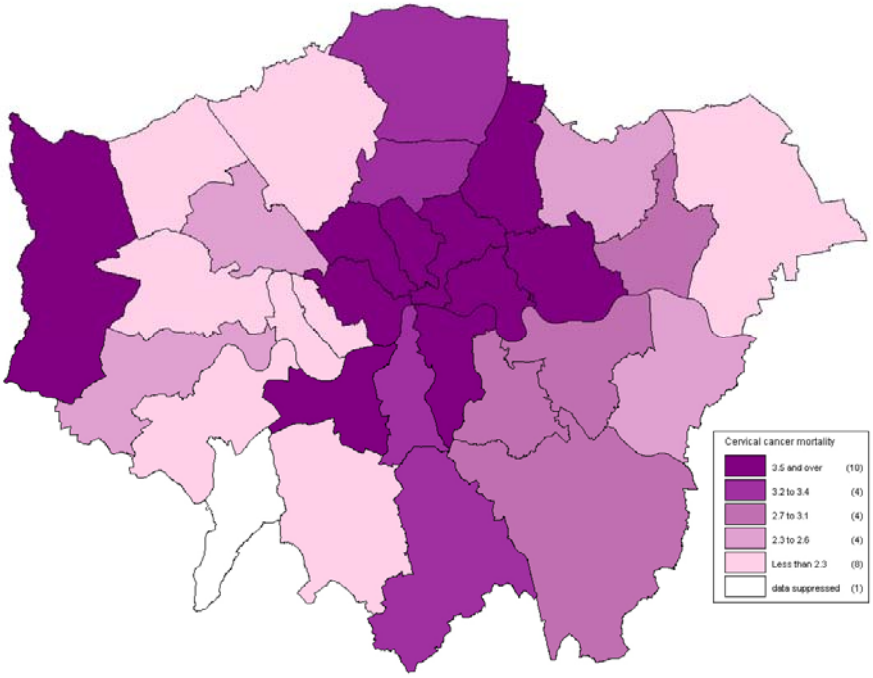
- As with cervical cancer incidence, mortality rates have decreased since the introduction of the national cervical screening programme.
- Rates fell from 4.5 per 100,000 in 1993 to 2.3 in 2006 in London. This is similar to the trend seen nationally.
- PCT trends have not been shown due to small numbers.

Figure 35: Deaths from cervical cancer, all ages, directly age standardised rate per 100,000, London and England, 1993 to 2006



Source National Centre for Health Outcomes Development

Figure 36: Age standardised mortality rates from cervical cancer by PCT, London, 2000-2004, pooled



Source Thames Cancer Registry

Metadata

Indicator description	Directly age standardised mortality rate from cervical cancer (ICD9 180, ICD10 C53, All ages)
Source of data	Trend data are from Office of National Statistics analysed by National Compendium of Clinical Indicators. Data by PCT from Thames Cancer Registry.
Numerator definition	Deaths from cervical cancer, classified by underlying cause of death (ICD-10 C53, ICD-9 180), registered in the respective calendar year(s).
Denominator definition	Data are based on the latest revisions of ONS mid-year population estimates for the respective years, current as at 23 October 2007.
Geography	London PCTs.
Timeliness	1993-2006 (Annual trends). Statutory notification of deaths means that data are timely.
Disclosure control	To protect confidentiality of individuals, numbers less than five have been suppressed.
Data accuracy & completeness	For trend analysis, the numbers of deaths observed in the years 1993-98 and 2000 were adjusted to give "expected" numbers of deaths which would have been coded to this cause in ICD-10. This is done by multiplying the ICD-9 based death counts by the appropriate ICD-10/9 comparability ratio published by the ONS. From the 2003 Compendium onwards, data are based on the original causes of death rather than the final causes used in earlier Compendia.

Limitations

The routinely available data do not allow for examination of correlation with socio-economic deprivation at an individual level. Screening history of individual women is not routinely collected as part of the cancer data set and therefore five year survival rates were not looked at, nor the proportion of deaths from cervical cancer that occurred in women who had cervical screening.

Indicator 4.03 Cervical screening coverage

Rationale for inclusion

The cervical screening programme aims to reduce the number of women who develop invasive cervical cancer (incidence) and the number of women who die from it (mortality). It does this by regularly screening all eligible women so that conditions, which might otherwise develop into invasive cancer, can be identified and treated. Early detection and treatment of precancerous conditions can prevent cervical cancers from developing.

Cervical screening coverage is defined as the percentage of women eligible for screening who have had a test with a recorded result at least once in the previous five years. There is a national cervical screening coverage target of 80% of 25-64 year olds.

What does this indicator show?

In 2006/7

- Coverage amongst 25-64 year olds in London remains below target. London had the lowest cervical screening coverage in England at 74.0%, while coverage in England was 79.2%.
- Only two PCTs in London, Bexley Care Trust and Bromley PCT, had coverage over the national target of 80%. Their rates were higher than that of England.
- The remaining 29 London PCTs had less than the 80% coverage: 10 PCTs had between 75% and 79.9%, and 18 between 70% and 74.9%.
- Coverage in Hammersmith & Fulham is consistently below 70%, the lowest in the country.

Trend data

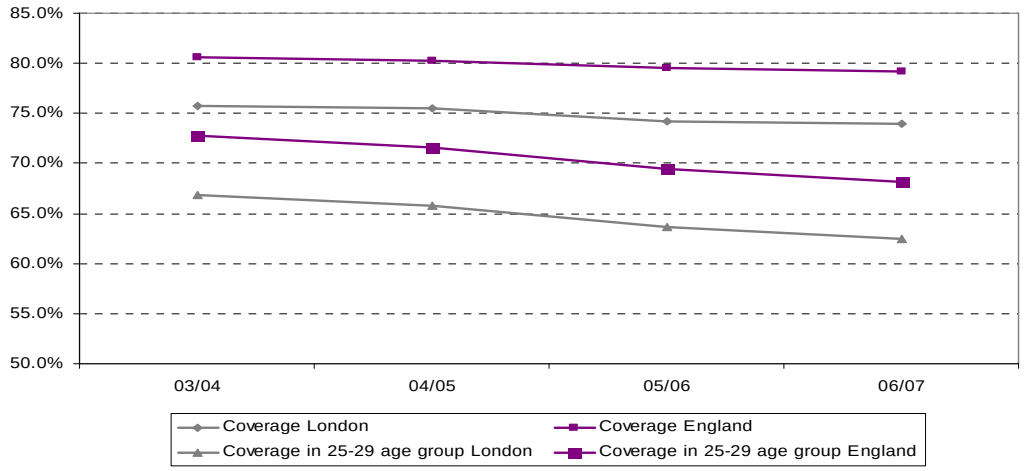
Between 2003/04 and 2006/07

- Cervical screening coverage decreased nationally from 80.6% to 79.2% and in London from 75.7% to 74.0%
- Cervical screening coverage in 25-29 year olds decreased nationally from 72.8% to 68.2% and in London from 66.9% to 62.4%

Between 2005/06 and 2006/07[19, 20]

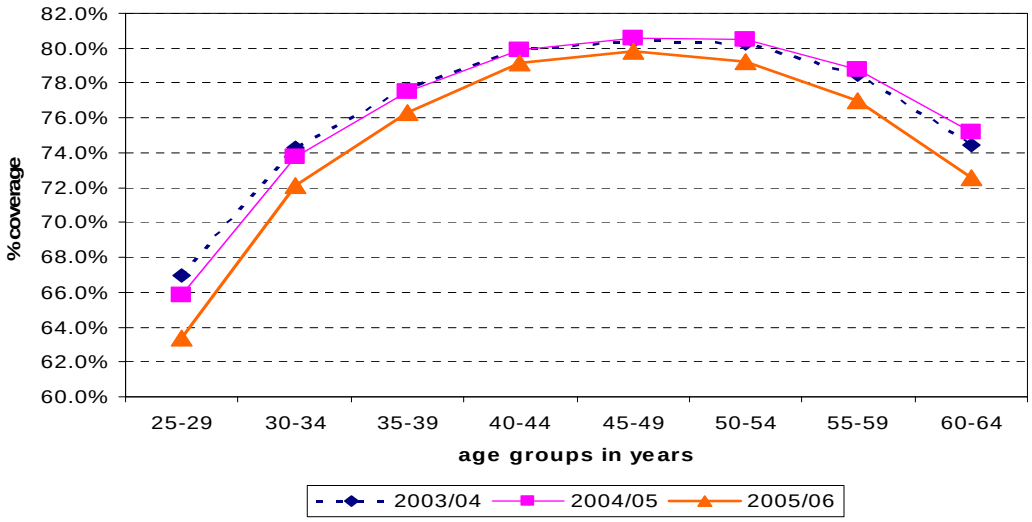
- Cervical screening coverage decreased nationally by 0.3 percentage points from 79.5% to 79.2% and in London by 0.2 percentage points from 74.2% to 74.0%
- However, 12 London PCTs increased their coverage in this time period
- All other London PCTs have seen a fall in coverage
- Barnet and Camden had the largest fall in coverage.
- Cervical screening coverage in 25-29 year olds decreased from 63.6% to 62.4%
- There has also been a drop in women in the older age groups being screened, although this it thought to be partly due to the phasing in of the longer screening intervals for women over the age of 50.

Figure 37: Cervical screening coverage, all ages and 25-29 age group, London, England, 2003/04 to 2006/07



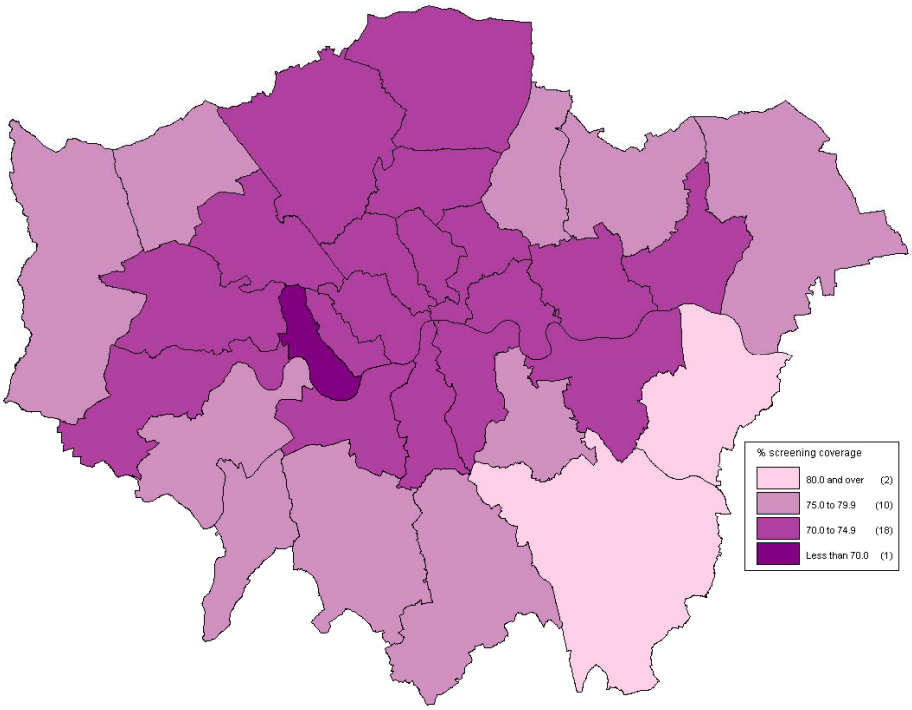
Source London QARC

Figure 38: Cervical screening, percentage coverage in age groups, London, 2003/04 to 2005/06



Source London QARC

Figure 39: Cervical screening coverage, percentage, London PCTs, 2006/07



NHS Cervical screening bulletin statistical bulletin, NHS Information Centre

Metadata

Indicator description	Cervical screening coverage in women aged 25 to 64 years.
Source of data	Further data provided directly by the London cervical screening programme Quality Assurance Reference Centre, (QARC), Statistical bulletin 2006, The Information Centre for Health and Social Care.
Numerator definition	Eligible women aged 25-64 years recorded as having had a test with a recorded result at least once in the previous 5 years at 31 March for the respective year. Data also presented for those aged 25-29 years.
Denominator definition	Eligible women. Responsible population estimates based on Exeter System GP lists as at 31 March for the respective year, less the number of women recorded as ineligible.
Geography	Primary care organisations, Strategic Health Authority, England responsible population. . Although primary care organisations (PCOs) have a defined geographical boundary, the populations used are NOT those of women resident within the PCO boundaries. Instead, the populations of women for whom each of the PCOs is responsible are used. Where women on the call/recall screening register are not registered with a GP at the time coverage is calculated they are allocated to a PCO on a geographical basis. Similarly, the populations used for Strategic Health Authorities and Government Office Regions are NOT those of women resident within their boundaries, but are the aggregates of the responsible populations of their constituent PCOs.
Timeliness	The annual figures for the KC53 from April to March are collated for London by National Health Services Information Authority (NHSIA).
Disclosure control	None.
Data accuracy & completeness	Statistical information is required annually by the Department of Health to monitor the performance of the national cervical Cancer Screening Programme. PCOs report the population coverage of the screening programme on the Department of Health return KC53. To enable statistics to be produced in totality for the individual primary care organisations the NHSIA downloads the resident information from all of the individual systems, collates them by the registered population and then disseminates them to the Department of Health for inclusion in the statistical bulletin. Women ineligible for screening, and therefore excluded from both the numerator and denominator of the coverage calculation, are those whose recall has ceased for clinical reasons (e.g. those who have had a hysterectomy).

Limitations

This report does not include data on screening by ethnicity or social class as this is not routinely collected with screening data. It presents the data on a predominantly geographical area basis which may mask some intra-PCT inequalities. It does not detail screening by five year age groups at PCT level which could also highlight some differences in uptake.

Indicator 4.04 Cervical smear taking in NHS community clinics

Rationale for inclusion

NHS community clinics are an important alternative to cervical screening in the GP surgery. This is arguably more important in London than in the country as a whole, as the proportion of smears taken in a community setting are significantly higher in London. This indicator also gives information on an aspect of the NHS community clinic workload not captured by the KT31.

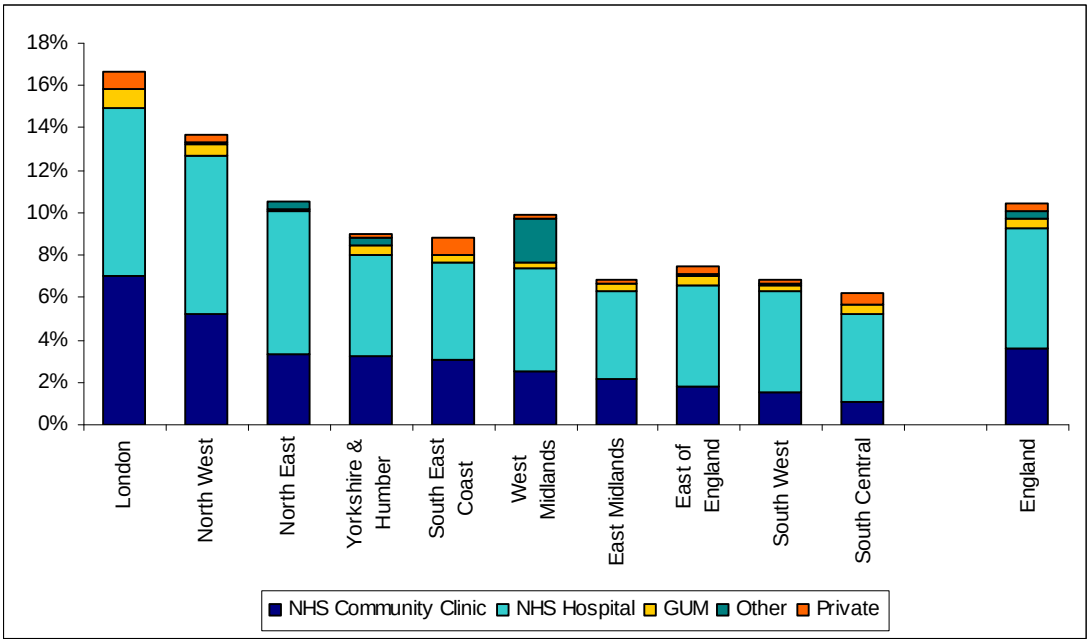
What does the indicator show?

- In London in 2006-07, 7.0% of cervical smears screened in NHS laboratories were taken in NHS community clinics.
- This is double the proportion taken in NHS community clinics in England as a whole (3.6%).

Trend data

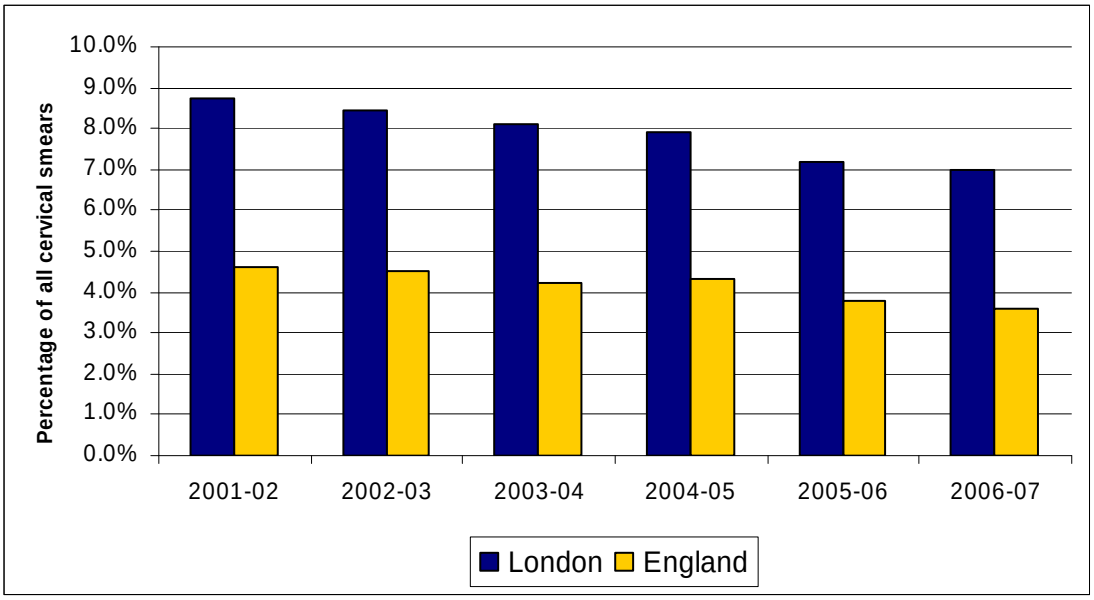
- The proportion of smears taken in NHS community clinics in London has decreased from 8.7% in 2001-02 to 7.0% in 2006-07.
- A similar decrease has been seen in England as a whole, from 4.6% to 3.6% over the same time period.

Figure 40: The proportion of cervical smear tests taken in non-GP practice settings by Region, 2006-07



Source: Cervical screening statistical bulletin 2006-7, The NHS Information Centre

Figure 41: Percentage of all cervical smears taken in NHS community clinics, 2001-2007



Source: Cervical Screening Bulletins, NHS Information Centre and Department of Health

Metadata

Indicator description	Percentage of cervical smears screened in NHS laboratories by source of smear.
Source of data	Cervical screening statistical bulletin 2006-07, 2005-06 and 2004-05, The NHS Information Centre. Cervical screening statistical bulletin 2003-04, 2002-03, and 2001-02, Department of Health.
Numerator definition	The number of cervical smears taken in NHS community clinics in London, other regions and England.
Denominator definition	The total number of smears screened in NHS laboratories in London, other regions and England.
Geography	SHA, England.
Timeliness	Mandatory annual data are provided from all NHS laboratories undertaking cervical screening using KC61 form.
Disclosure control	None.
Data accuracy & completeness	Data are complete.

Limitations

These data are not available at a population level. They are generated at a laboratory level but are published only at a regional level. Women not resident in London may have been screened within London and women resident within London may have been screened outside the capital.

Section 5. Admissions

Introduction

Although there are many possible causes, sexually transmitted infections such as chlamydia and gonorrhoea increase the risk of pelvic inflammatory disease (PID) and ectopic pregnancy.

Rates of admissions of these two conditions may give some idea of the extent of untreated sexually transmitted infections in the population. However, it does not give a complete picture as not all cases of PID are admitted to hospital.

Indicator 5.01 Pelvic inflammatory disease

Rationale for inclusion

Pelvic inflammatory disease (PID) is a generic term for inflammation of the female uterus, fallopian tubes and/or uterus which progresses to scar formation with adhesions to nearby tissues and organs. Many patients with laparoscopic evidence of PID are in fact not aware that they have had it. In the UK, PID accounts for around one in 60 visits to the GP by women under the age of 45.[21] It can cause serious or even life threatening illnesses and can also result in infertility, ectopic pregnancy and chronic pain. This indicator only covers admissions to hospital for PID. Treatment in general practice or in outpatients cannot currently be measured.

What does this indicator show?

- For the years 2002/03 to 2006/07, the London boroughs of Lewisham (271), Bexley (255) and Bromley (245) had the highest rate of admissions for PID per 100,000 females aged 15-44 in London.
- The lowest rates of admissions to be found during this time were in Westminster (103 admissions per 100,000 females aged 15-44), Kensington & Chelsea (106) and Richmond-upon-Thames (109).
- Due to relatively small numbers of admissions, there is no statistically significant difference between any of the London boroughs (apart from between the very largest rate and the very smallest rate).
- At sector level, South East London has by far the highest rate of admissions, at 228 per 100,000 females aged 15-44. This is almost 100 admissions higher than South West London (133 admissions per 100,000 females aged 15-44).
- The rates for Inner London and Outer London are very similar over this period (178 admissions and 176 admissions per 100,000 females aged 15-44 respectively). Both these rates and the rate for London are slightly lower than that of England during this time period (186 admissions per 100,000 females aged 15-44).

Trend data

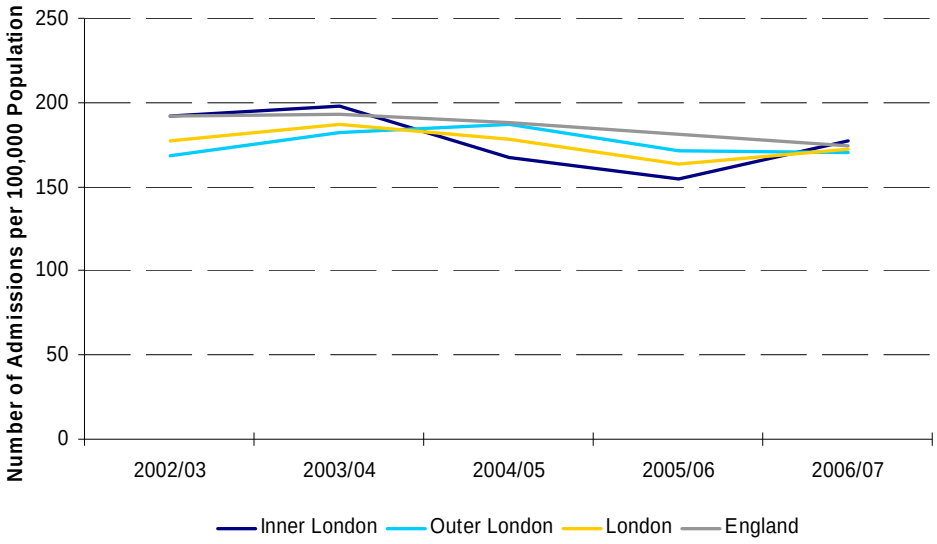
- There does not appear to be any overriding upward or downward trend in the data over the five year period (Figure 42): the rates for Inner London, Outer London, London and England appear to remain fairly constant during this time.

Table 18: Directly age standardised admission rate for PID in females aged 15-44, between 2002/03 and 2006/07

Area	Rate per 100,000	95% Confidence interval Lower level	95% Confidence interval Upper level
North East London	194.9	163.1	226.8
North Central London	152.9	122.0	183.8
North West London	155.8	129.9	181.6
South East London	228.2	193.6	262.8
South West London	133.2	104.5	161.8
Inner London	177.6	155.8	199.5
Outer London	175.7	157.6	193.9
London	175.5	161.7	189.3
England	185.5	179.7	191.4

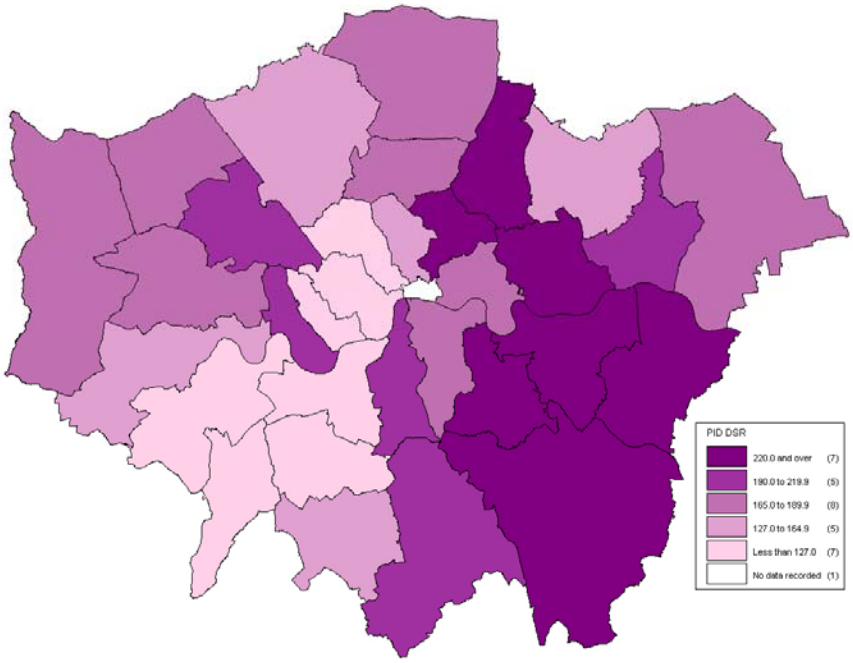
Source: HES, analysis by London Health Observatory

Figure 42: Directly age standardised admission rate for PID in females aged 15-44 between 2002/03 and 2006/07



Source: HES

Figure 43: Directly age standardised admission rate for PID in females aged 15-44 by PCT, 2002/03 to 2006/07



Metadata

Indicator description	Directly age standardised rate of admissions for PID in females aged 15-44 (standardised to the European population).
Source of data	Hospital Episode Statistics (HES).
Numerator definition	Females aged 15-44 admitted to hospital with a primary diagnosis ICD-10 code between N70 and N77 by year.
Denominator definition	Population of females aged 15-44 by year.
Geography	Local Authority, London Sector, Inner London, Outer London, London, England.
Timeliness	HES data are available annually.
Disclosure control	When numbers are five or less, numbers are suppressed.
Data accuracy & completeness	Data for this indicator can be considered accurate and complete.

Limitations

PID admission rates seem relatively unchanged in London. However, the full burden of disease is not captured by hospital admissions data as some cases are managed in primary care or GUM clinics where access to data is poor.

HES data do not include private or NHS work conducted in private hospitals.

Indicator 5.02 Ectopic pregnancy

Introduction

An ectopic pregnancy is a complication of pregnancy in which the fertilised egg is implanted in any tissue apart from the uterine wall. In most cases, this occurs in the fallopian tube. The foetus produces enzymes that allow it to implant in varied types of tissue, and thus an embryo implanted anywhere other than the uterus can cause extensive tissue damage in its efforts to reach a sufficient supply of blood. While there are thought to be numerous possible reasons for an ectopic pregnancy, previous inflammation of the fallopian tubes caused by pelvic inflammatory disease (PID) is known to be a major risk factor.

What does this indicator show?

- For the years 2002/03 to 2006/07, Lewisham had the highest rate of admissions per 100,000 females aged 15-44 at just over 177. The next highest rates in London were found in Hackney (137) and Lambeth (135).
- The lowest rates in London during this period were to be found in Bromley (39 admissions per 100,000 females aged 15-44), Islington (56) and Kensington & Chelsea (58). The rate for Bromley is surprising given that, during the same time period, it had one of the highest rates in London of PID. Due to small numbers however, there is a statistically significant difference between the two lowest of the local authorities and the highest only.
- South East London had the highest rate of admissions looking at the five London sectors (118 admissions per 100,000 females aged 15-44). North Central London had the lowest rate of admissions (80 admissions per 100,000 females aged 15-44).
- During this period, Inner London had a higher rate of admissions than Outer London (107 admissions per 100,000 females aged 15-44 compared to 95 admissions per 100,000 females aged 15-44).
- In 2006/07 the rate was 94 admissions per 100,000 females aged 15-44 in England and 109 admissions in London.

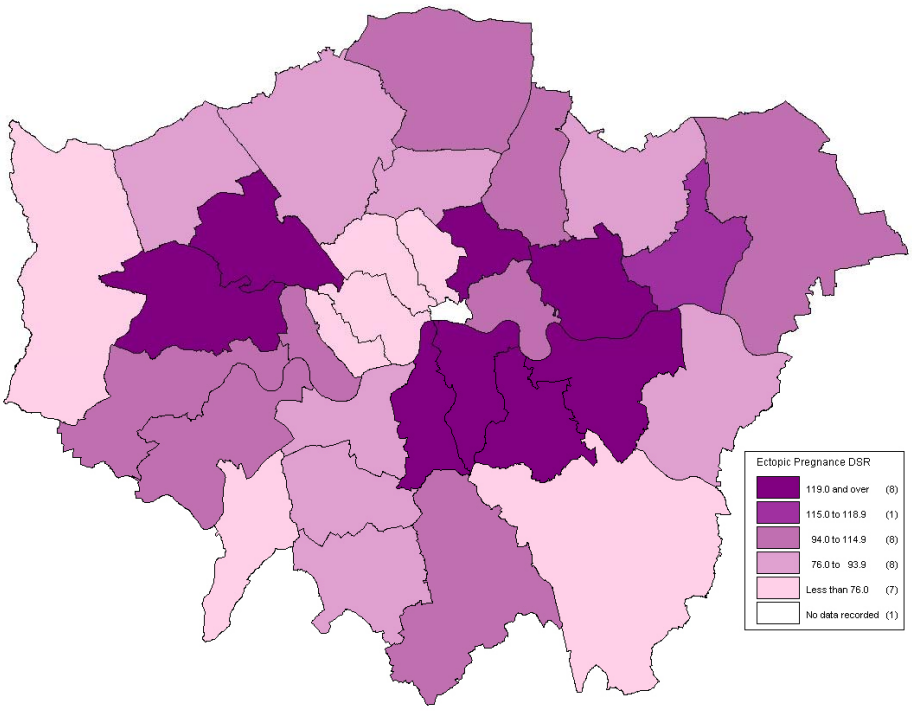
Trend data

- The rate of admissions for ectopic pregnancy in both London and England has risen year on year from 2002/03 to 2006/07.
- In London, the rate was about 86 admissions per 100,000 females aged 15-44 in 2002/03. By 2006/07, this rate had risen to 109 admissions per 100,000 females aged 15-44.
- In the same time period in England, this rate had risen from 80 to 94 admissions per 100,000 females aged 15-44.
- Rates in Inner and Outer London, and the five London sectors also rose during the same time period.

Figure 44: Directly age standardised admission rate for ectopic pregnancy in females aged 15-44 between 2002/03 and 2006/07

Source: HES, analysis by London Health Observatory

Figure 45: Directly age standardised admission rate for ectopic pregnancy in females aged 15-44 by PCT, 2002/03 to 2006/07



 Source: HES, analysis by London Health Observatory

Table 19: Directly age standardised admission rate for ectopic pregnancy in females aged 15-44, between 2002/03 and 2006/07

Area	Rate per 100,000	95% Confidence interval Lower limit	95% Confidence interval Upper limit
North East London	107.8	84.6	131.0
North Central London	80.3	58.6	102.1
North West London	92.2	72.9	111.6
South East London	118.0	93.4	142.5
South West London	92.7	69.6	115.8
Inner London	107.0	90.6	123.3
Outer London	95.2	82.0	108.4
London	99.5	89.3	109.7
England	87.3	83.2	91.3

Source: HES, analysis by London Health Observatory

Metadata

Indicator description	Directly age standardised rate of admissions for ectopic pregnancy in females aged 15-44 (standardised to the European population).
Source of data	Hospital Episode Statistics (HES).
Numerator definition	Females aged 15-44 admitted to hospital with a primary diagnosis ICD-10 code O00.
Denominator definition	Population of females aged 15-44 by year.
Geography	Local Authority, London Sector, Inner London, Outer London, London, England.
Timeliness	HES data are available annually.
Disclosure control	When numbers are five or less, numbers are suppressed.
Data accuracy & completeness	Data for this indicator can be considered accurate and complete.

Limitations

Some patients who present with early ectopic pregnancies can be treated medically with methotrexate. They will not be captured in the admissions data from Hospital Episode Statistics (HES).

As mentioned previously, HES data do not include private or NHS work conducted in private hospitals.

Section 6. Contraception

Introduction

Ensuring wide and appropriate access to reproductive health services for the sexually active population is vital to the successful delivery of any local strategies to improve sexual health, and will in turn help to deliver national objectives for improved sexual health.[22] NHS provision of contraceptive care is complex. It is estimated nationally that three quarters of consultations take place in general practice. Most of the rest take place in Community Sexual & Reproductive Health (CSRH) services (referred to as community contraceptive, or contraception, clinics, or services, in the NHS Contraceptive Services bulletin which publishes the statistics from these services).

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

The Independent Advisory Group on Sexual Health and HIV Annual Report[23] 2004/05 emphasised the need to improve contraceptive services and drew attention to the lack of adequate national performance monitoring. The Healthcare Commission has recognised the lack of an indicator that provides a reliable assessment of access to contraception for primary care trust (PCT) performance monitoring and is therefore relying on more process type indicators. The Commission is currently working with the Department of Health to develop more outcome focused indicators.[22]

1. General practice

There is no routine publication of statistics on contraceptive prescribing or advice from general practice settings. However, the Prescription Pricing Authority database records all medicines prescribed in primary care and this can be used to understand more about prescribing of contraception from general practice. These data are not person-based but, when described as a rate in relation to practice size of women aged 15-44 years, serves as a proxy for availability of the range of contraceptive services directly delivered by the practice. Some PCTs have access to analysis of GP activity in relation to Local or Enhanced service contracts for provision of long-acting reversible contraception (LARC) methods.

2. Community sexual and reproductive health services

Activity data on aspects of the work of CSRH services (largely PCT provider services) are returned by providers to the Information Centre using Korner return KT31.[24] This return collects information on contacts at CSRH clinic sessions only in relation to contraceptive provision and is currently under revision by the DH as it is inadequate for its purposes[5].

Much clinical work currently undertaken by CSRH in provision of holistic services (eg pregnancy testing, abortion referral and follow-up, cervical cytology[25], Chlamydia screening,[26] testing and treatment for STIs, training and level 3 contraceptive service elements) is not collected for KT31. All activity except specific contraceptive care is recorded on KT31 as ‘other’ or ‘none’.

CSRH services are largely open-access (there are age restrictions in some sessions) and self-referring. They are used by many women who are not resident in the PCT in which the service is provided.

Women requiring contraception should be given information about, and offered, a choice of all methods, including long-acting reversible contraception (LARC) methods. The effectiveness of LARC methods does not depend on daily compliance. LARCs consist of intra-uterine devices (copper devices and the medicated device known as an intrauterine system), injectable contraceptives and implants.

NICE has recommended that contraceptive service providers should be aware that all currently available LARC methods are more cost effective than the combined oral contraceptive pill even at one year of use.

For reasons outlined in this section, the uptake of LARC has been examined using the Prescription Pricing Authority data only, as KT31 data do not reliably capture the choice and provision of LARC methods.

Indicator 6.01 First contact attendances at community contraceptive services

Rationale for inclusion

The provision of adequate, clinically safe and confidential contraceptive services that provide a full range of methods is crucial to the prevention of unwanted pregnancies. The KT31 collection of attendances at community contraception services gives an indication of how much services are being used and some measure of the degree of access they provide. Because of the range of contraceptive methods available, CSRH services have been aimed primarily at women. However, services are also available to men. First contacts should therefore be examined for both women and men.

What does this indicator show?

The latest data are from the 2006/07 NHS Contraceptive Services statistical bulletin[24]. A first contact is defined as the first time a client is seen in the year by professional staff at a clinic or domiciliary visit for counselling or to be prescribed contraceptives. Contacts with community contraception services by PCT area is recorded by PCT of the service attended and not place of residence. This means that rates of attendance cannot be obtained at PCT level.

The following findings should be interpreted with caution – in the published KT31 data, returns are included from some providers without clarity as to which PCT(s) has/have commissioned their work. (See Metadata and limitations.)

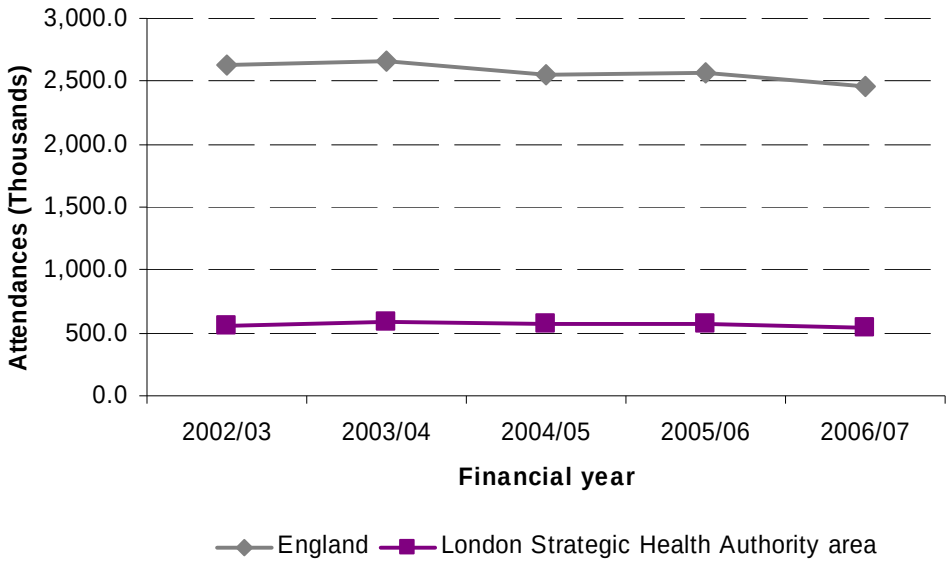
In 2006/07

- In London, 547,500 attendances were made at community contraceptive services. There were 292,000 first contacts by women and 21,400 first contacts by men.
- The number of female first attendees is equivalent to 15% of the female population in London aged 13–44 years, this is more than in any other region. The corresponding percentage for England is 10%.
- Within London, Camden PCT had the highest number of female first contact attendances (29,300) and Kingston PCT had the lowest (1,300). Lewisham PCT had the highest number of male first contact attendances (3,200) and Hammersmith & Fulham PCT had the lowest (less than 50).

Trend data

- Over the last 5 years, total London attendances have varied little whereas there is a small decrease in attendances across England as a whole.
- The number of female first attendances has followed a similar pattern.
- The number of male first attendances has almost doubled in the past 5 years from 11,400 in 2002/03 to 21,400 in 2006/07. England has similarly seen a significant rise in male attendances, mainly young men in the age group 19 years old and under.

Figure 46: Total attendances at community contraceptive services, London and England, 2002/03–2006/07



Source: The Information Centre, KT31 return

Metadata

Indicator description	Number of first contact attendances by females (males) at community contraception clinics.
Source of data	KT31 returns have been published annually since 2004/05 by the Information Centre in the bulletin *Contraceptive Services*. Prior to this they were published by DH.
Numerator definition	Number of people making contact with a health professional at a community contraceptive service for the first time in the financial year.
Denominator definition	n/a
Geography	London, England. As contacts with community contraception services is recorded by PCT of service attended and not place of residence, rates are not available at sub-regional level.
Timeliness	Data for the previous financial year are published annually in October.
Disclosure control	None.
Data accuracy & completeness	Some of the data for 2005/06 have been revised in the 2006/07 bulletin. Where a provider is unable to submit a return, data from the latest available are used. Where parts of a return are missing, the corresponding parts from the latest available year are used, scaled as appropriate. Some organisations include returns from organisations not listed in the tables as they are aggregated prior to submission and impossible to separate. Note, there are no data for Barking & Dagenham PCT or Islington PCT in 2006/07. In previous years, Barking & Dagenham has submitted returns through Havering PCT and Islington has submitted through Camden PCT. Also note, the data for London includes organisations other then PCTs and the Brook centres. See limitations below.

Limitations of the data

There are several issues with source of this indicator

- KT31 is not person-based. Attendances are recorded as a first or subsequent visit in the year to the clinic only, and therefore cannot give an account of the frequency of an individual's attendances. Also, patterns of usage or change of contraception used cannot be tracked.
- KT31 returns are made by some organisations* providing contraceptive care that are not attributed to the PCT commissioning the service (e.g. London Brook, Kings College Hospital). This results in an incomplete picture of PCT commissioned activity in these national data and this will need to be examined further locally.
- There is also a problem with returns being submitted in duplicate e.g. Harrow PCT commissions Northwest London Hospitals Trust to provide its CSRH service. However, both submitted a return in 2006/07.
- Access to most community contraceptive services is by self referral and clients based in several PCTs can access the service. As already mentioned, data are not collected by PCT of residence so it is not possible to attribute activity in a PCT service to the women resident there.

*Tables showing contacts with services by all providers can be found in the Excel workbook available at http://www.lho.org.uk

Indicator 6.02 First contact female attendances at community contraception clinics by age

Rationale for inclusion

Attendance at contraception clinics varies by age. The proportion of women attending community contraception clinics by age helps identify the predominant groups attending the clinics and those age groups where there may be unmet need. The pattern of attendance in the younger age groups is particularly important. As teenage pregnancy rates in the UK are amongst the highest in Europe; access to appropriate contraception is important.

What does this indicator show?

Rate of attendance per 100 population

- In London, the highest rate of attendance at community contraception clinics of the female population was in the age group 18-19 years (26.5 per 100 female population aged 18-19 years).
- In England, the 16-17 year olds had the highest rate (22 per 100 female population aged 16-17 years).
- Under-15 year olds had the lowest rate of attendance per 100 female population in London (4.4 per 100) and in England (4.9 per 100).
- Compared to the other regions in England, London had the highest rates in all the age groups between 18 years and 35 years and over.

Table 20: First contacts with women at community contraception clinics (rate per 100 population), by SHA, 2006/07

	England	North East	North West	Yorks. & Humber	East Midlands	West Midlands	East of England	London	South East Coast	South Central	South West
All ages	10.1	11.8	12.6	10.9	7.4	9.3	7.0	15.2	7.1	7.6	7.3
under 15	4.9	9.7	7.2	6.8	5.7	3.3	2.8	4.4	2.6	3.5	4.3
15	15.4	24.2	21.1	20.9	15.3	13.7	10.6	14.1	10.2	12.0	12.6
16-17	22.0	29.9	28.7	26.0	16.5	19.0	22.6	24.9	15.7	16.3	18.0
18-19	18.9	20.6	22.2	20.8	14.2	16.2	18.5	26.5	15.0	15.9	13.2
20-24	14.7	14.8	17.9	14.3	10.0	13.0	10.8	22.0	11.5	12.7	11.0
25-34	8.9	9.2	10.9	8.7	5.9	8.4	4.8	14.2	5.9	6.6	5.9
35 and over	6.3	7.0	7.3	6.4	4.4	6.2	3.4	11.9	4.5	3.9	4.0

Source: The Information Centre, KT31 return

Age distribution of first contacts by women at community contraception clinics

In London and England:

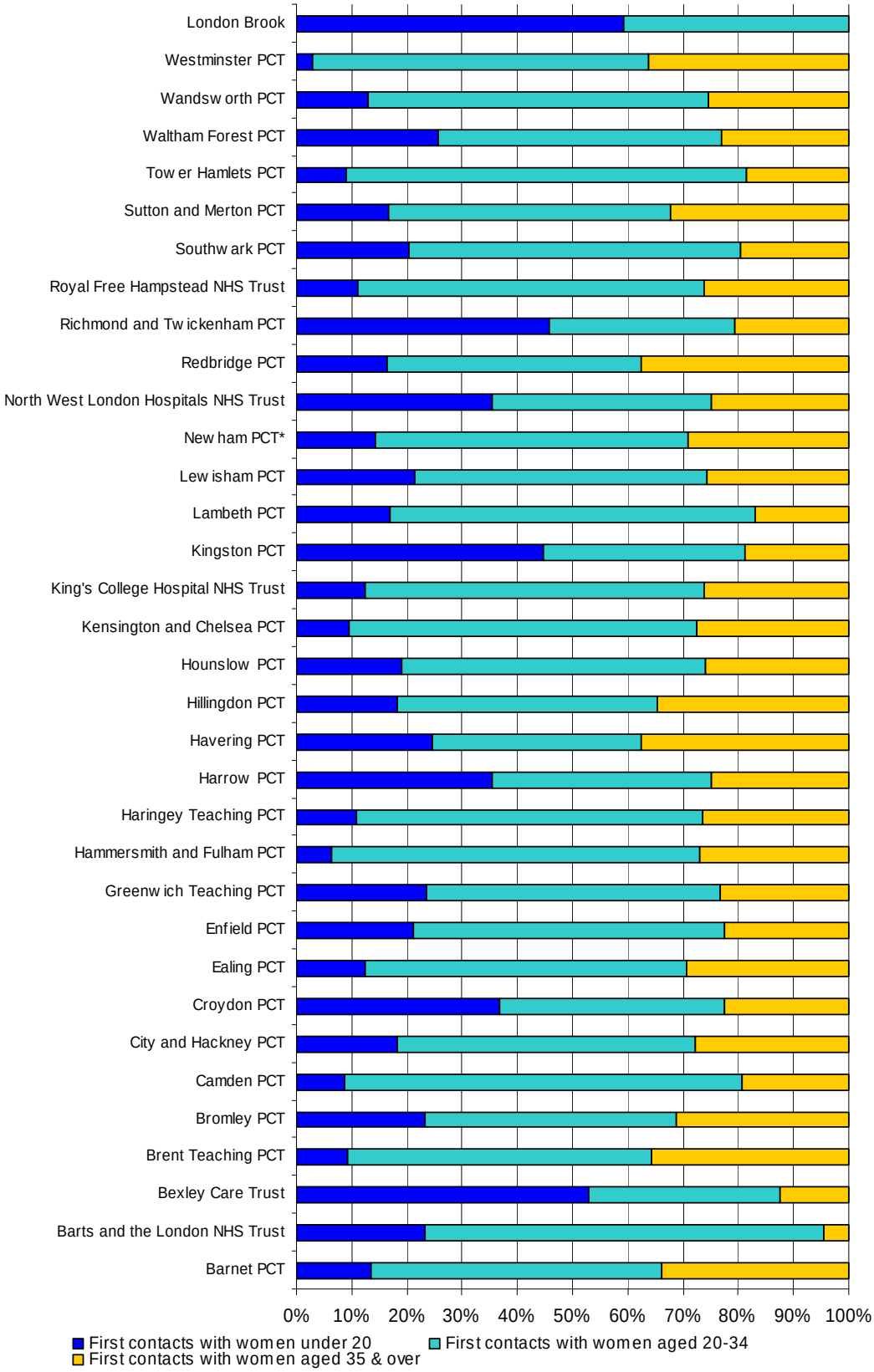
- 56% of first attendances at community contraception clinics were women in the 20-34 year age group, similar to England.
- 25% were in the over 35 year age group.
- 18% were in the under 20 age group, which is lower than England (30%).

Within London (Figure 47)

- In Bexley, over half of attendances were in the under 20s, while in Westminster less than 5% of attendances were in teenagers.

- Almost 40% of attendances in Redbridge and Havering were in women over 35.
- There was no obvious geographical pattern of attendance.

Figure 47: Age distribution of first contacts by women at community contraception clinics, by provider, 2006/07



Source: The Information Centre, KT31 return

Trend data

The proportion of women attending community contraception clinics for the first time in London in under 20, 20-34 and over 35 year age groups remained unchanged between 2002/03 and 2006/07.

Metadata

Indicator description	Rate of first contact attendances by females at community contraception clinics by age.
Source of data	KT31 returns have been published annually since 2004/05 by the Information Centre in the bulletin Contraceptive Services. Prior to this they were published by DH. ONS: mid year population estimates 2006.
Numerator definition	Number of women making contact with a health professional in a community contraceptive clinic for the first time in the financial year in each age group.
Denominator definition	Estimated mid year population for females for each equivalent age group. Under 15 years (13-14years); Over 35 years (35 – 44 years).
Geography	London, England. As contacts with community contraception clinics is recorded by PCT of clinic attended and not place of residence, rates are not available at sub-regional level.
Timeliness	As Indicator 6.01.
Disclosure control	None.
Data accuracy & completeness	As Indicator 6.01.

Metadata

Indicator description	Proportion of first female attendances at community contraception clinics by age.
Source of data	KT31 returns have been published annually since 2004/05 by the Information Centre in the bulletin Contraceptive Services. Prior to this they were published by DH.
Numerator definition	Number of women making contact with a health professional in a community contraceptive clinic for the first time in the financial year in each age group.
Denominator definition	Total number of women making contact with a health professional in a community contraceptive clinic for the first time in the financial year.
Geography	PCT, London, England. Data are not published at regional and sub regional level before 2006/07 and were requested specifically for this report.
Timeliness	As Indicator 6.01.
Disclosure control	None.
Data accuracy & completeness	As Indicator 6.01.

Limitations of the data

The limitations of KT31 data as stated in Indicator 6.01 apply.

Community clinics are not the only source of contraceptive advice and these data need to be considered with data from general practices. These two data sources are however not comparable.

Care must be taken in interpreting these data without reference to the rate of attendances by PCT, and the patterns of provision and client flows between PCTs.

Indicator 6.03 First contact female attendances at community contraception clinics by method of contraception

It would be good to know which methods of contraception are provided at first and subsequent visits from CSRH services. Unfortunately this information cannot be derived with any accuracy from current or historical KT31 returns. A pragmatic decision has therefore been taken not to include this indicator as it has very serious limitations and its use can lead to misleading information.

Limitations of the indicator

The 'method of contraception' recorded against the first contact of an individual in any one year, and the attribution of method at first visit is subject to serious errors.

DH guidance states that "The main method of contraception for new clients is that chosen after counselling; for existing clients it is the principal method in use unless a change is advised. For new clients, the main method should be the substantive method chosen and not any interim method, even if the choice is not made until a subsequent attendance or visit."[24]

However, many contraceptive clinics do not have adequate IT support and rely on paper systems. Once entries are made they cannot be changed retrospectively and hence choice of method at a subsequent visit can not be recorded.

Many services in fact record as main method the method dispensed from the clinic at the first attendance. The implication of this is that a woman first attending for counselling for LARC may have another method in use, e.g. the pill, if it is not appropriate for her to start the LARC until her next visit; her main method of contraception may be recorded as the pill. The initiation of a LARC method at a subsequent visit will not be captured.

There is also no distinction between the initiation of a contraceptive method and an attendance for follow up of the method, e.g. a woman may make first contact with a clinic to check the placement of her intra-uterine device that she has had in place for a while. The main method will often be recorded as an intra-uterine method (LARC) even though this represents continuing use rather than initiation.

These limitations currently preclude the use of this indicator.

Indicator 6.04 Rate of GP prescribing of LARC

Rationale for inclusion

Long acting reversible contraception (LARC) is effective (see introduction) and should be available to all who might choose a LARC method. For many women LARC methods might be most easily and appropriately accessed from General Practice (GP). It is necessary to understand the pattern of provision and access to these methods across a local area in order:
1) to provide support for and encourage development of information and provision of the range of contraceptive care in local practices
2) to build pathways for women choosing LARC methods that are not directly provided by the practice at which they are registered.

This indicator calculates the rate of prescribing of LARC in GP surgeries using the data on prescribing available from the Prescription Pricing Authority (PPA). This approach compares one year's contraceptive prescriptions of LARC at a PCT level in relation to the registered list size[27].

What does the indicator show

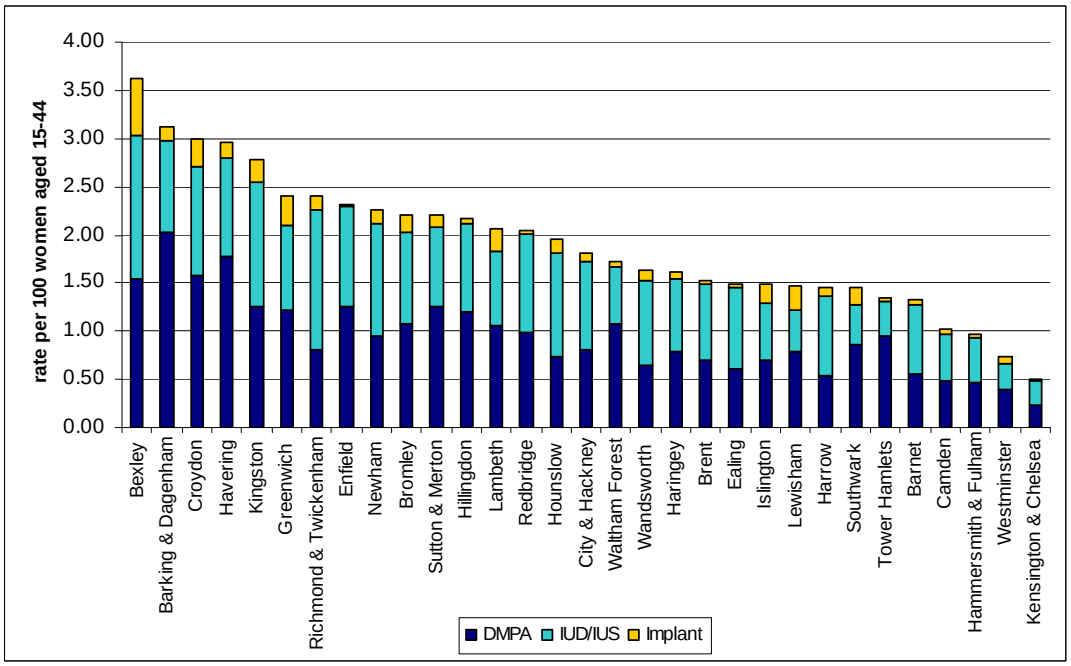
This indicator is composed of three types of LARC: Injectable contraceptives (Depot Medroxyprogesterone Acetate or DMPA); Intrauterine contraceptives (intrauterine devices IUDs and Intrauterine Systems IUS); and implanted contraceptives.

- There was a more than seven fold difference in the prescribing rates of LARC in primary care between PCTs.
- The highest overall LARC prescribing rate (3.6 per 100 registered women aged 15 to 44) was seen in Bexley.
- The lowest LARC prescribing rate was seen in Kensington & Chelsea (0.5 per 100 registered women aged 15 to 44)

There is also a difference in the rates of the different methods prescribed

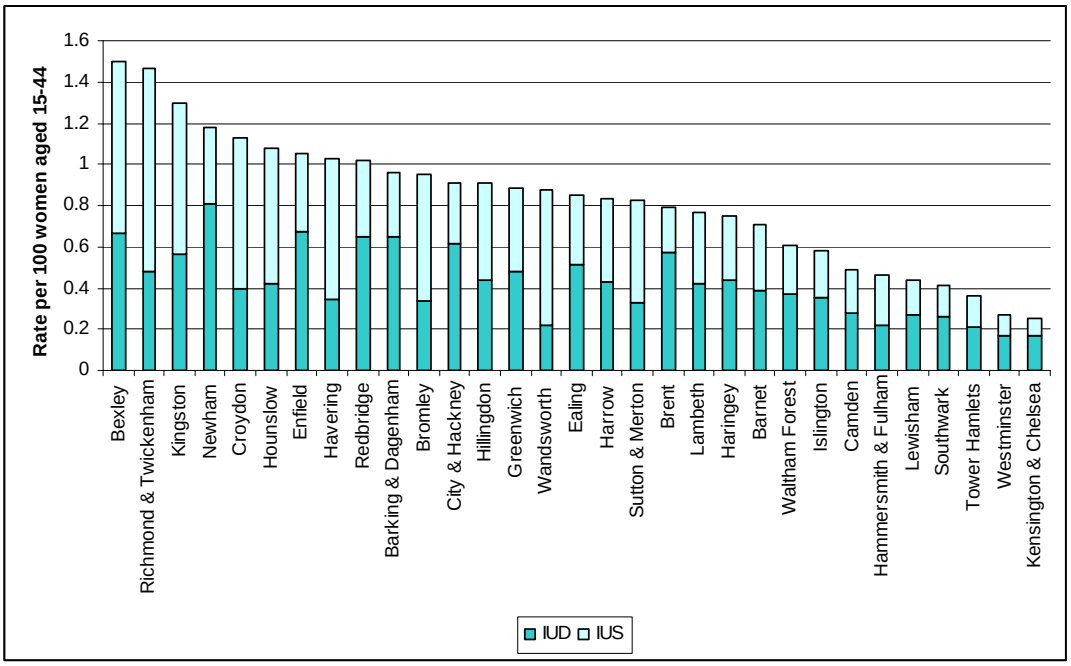
- Bexley had the highest prescribing rate of intrauterine and implantable contraceptives.
- Barking & Dagenham had the highest rate for DMPA prescribing.
- Kensington & Chelsea had the lowest rates for all three methods
- In 10 of the 31 London PCTs, the rate of prescribing intrauterine systems exceeded that of IUD prescribing.

Figure 48: LARC prescribing rate per 100 women aged 15-44 in general practice, 2007/08



Source: Prescription Pricing Authority, Exeter registered population data

Figure 49: Intrauterine device and intrauterine system prescribing rate per 100 women aged 15-44 in general practice, 2007/08



Source: Prescription Pricing Authority, Exeter registered population data

Metadata

Indicator description	Rate per 100 women aged 15-44 prescribed LARC method of contraception in primary care.
Source of data	Prescription Pricing Authority (PPA), Exeter for registered population data.
Numerator definition	Number of items for IUS/IUD and implants. For injectable contraceptives: number of items/4.3 (to supply one woman with DMPA for one year requires 4.3 injections).
Denominator definition	Registered population aged 15 to 44.
Geography	PCT.
Timeliness	Financial year 2007/08.
Disclosure control	None.
Data accuracy & completeness	All primary care prescriptions are logged on the PPA data base and were accessed through the e-PACT system.

Limitations

GP prescribing data are not person based but item based. They can take no account of contraception prescribed but not used. No interpretation of real "woman–years" of contraception should be derived from this calculation.

Not all LARC prescribing is for contraceptive purposes. Intrauterine systems in particular are prescribed for menorrhagia. It is not possible to determine the indication for which the LARC was prescribed.

Indicator 6.05 Contraceptive prescribing costs in general practice

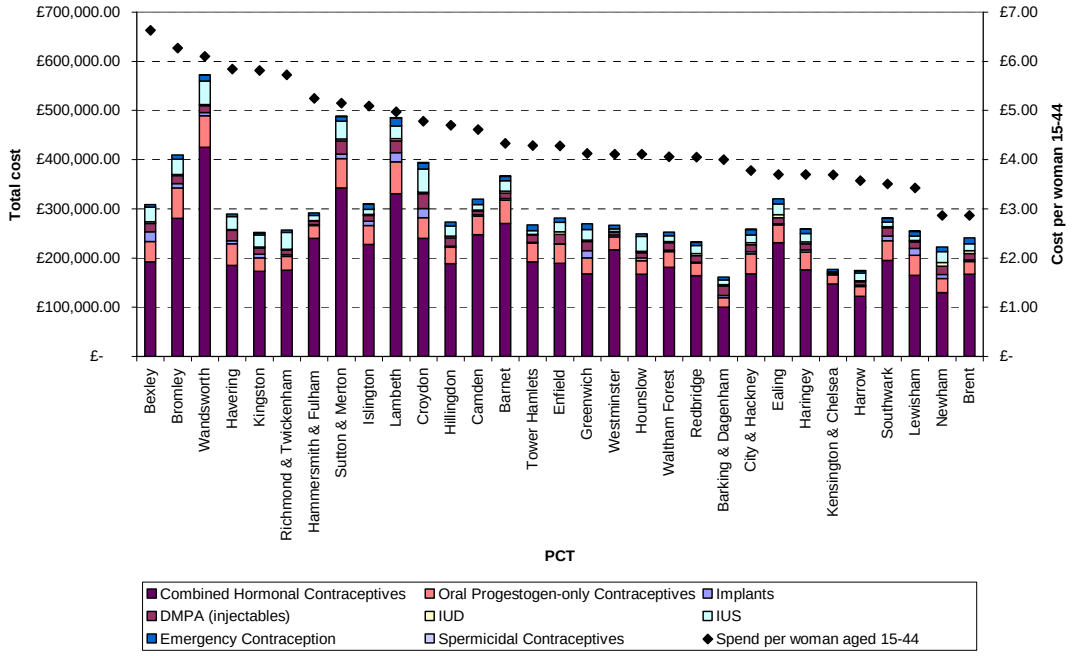
Rationale for inclusion

As previously mentioned, contraceptive advice and provision of a range of methods of contraception are available from general practice. Three quarters of contraceptive consultations take place in general practice. However, not all practices will offer the full range of methods. This indicator is a crude measure of the costs of prescribing in general practice in 2007/08. It only looks at the cost of the contraceptives prescribed and does not take into account the number of times that a woman is seen or surgery time spent on contraceptive services.

What the indicator shows

- In London in 2007/08, over £9million was spent on contraceptive prescribing in GP surgeries.
- The largest spend was on combined hormonal contraceptive pills.
- The total contraceptive prescribing cost varied per PCT. It ranged from nearly £600k in Wandsworth to under £200k in Barking & Dagenham.
- Taking the size of the female population of reproductive age into account, the cost of prescribing per woman aged 15-44 shows an almost twofold difference between the highest (Bexley at £6.63 per head) and the lowest (Brent £2.86). It is not clear from these data whether the rates are different due to greater numbers of prescriptions or due to prescribing more expensive items (see limitations).

Figure 50: Contraception prescribing in general practice, London PCTs, 2007/08



Source: Prescription Pricing Authority, Exeter registered population data

Metadata

Indicator description	Cost of prescribing contraceptives in general practice. Spend per registered female patient aged 15-44.
Source of data	Prescription Pricing Authority e-PACT database.
Numerator definition	Total cost of prescriptions for contraceptives.
Denominator definition	Number of registered female patients aged 15-44.
Geography	PCT.
Timeliness	2007/08.
Disclosure control	None.
Data accuracy & completeness	All prescriptions from GPs are included in the e-PACT database.

Limitations

- Prescribing costs were obtained at a group level rather than for specific drugs. Variations could be due to prescribing of greater volume of lower cost items or lower volume of higher cost items. To illustrate this, combined hormonal contraceptives vary in cost from £2.29 for a 3 month supply to £14.70 for a 3 month supply (British National Formulary March 2008).
- Individual practice level data were not available to us for this report. It is likely that there will be a wide variation in prescribing at a practice level but this would need to be investigated by an individual PCT.
- Data are for prescriptions issued and give no information about compliance or continued use.

Section 7. Conceptions and abortions

Introduction

Rates of abortion and teenage conceptions are important sexual health indicators as both provide a measure of the levels of unprotected sex (or failure of contraception) in the community.

Teenage pregnancy is now a key public health issue in the UK, with research from the late 1990s suggesting that the UK has one of the highest teenage pregnancy rates in Western Europe. Teenage mothers and their children are prone to poorer outcomes including lower birth weight babies and higher infant mortality rates. Postnatal health and long term emotional health are worse than in older mothers and teenage mothers and their children are more likely to end up living in poverty[28].

The Government's teenage pregnancy strategy includes a target of halving the under–18 rate of conceptions by 2010 and establishing a firm downward trend in the under–16 rate. This target is included in Department of Health (DH) and Department for Education and Skills (DfES) Public Service Agreements, and in primary care trust (PCT) Local Delivery Plans and performance indicators. To undertake this, all local areas have a 10-year strategy in place, with local under-18 conception rate reduction targets of between 40 and 60%. These local targets underpin the national 50% reduction target.

The *National Strategy for Sexual Health and HIV* highlighted wide variations in access to abortion services and in method of termination. The earlier in pregnancy an abortion is performed the lower the risk of complications. Delays in access to abortion services will seriously impact on pregnant teenagers who tend to seek professional advice later than older women.

Patterns of sexual health are strongly linked to "fertility" – the reproductive behaviour of women at population level. It is important to monitor the rate at which children are being born in order to direct resources appropriately.

Indicator 7.01 Fertility rate

Rationale for inclusion

At its most simplistic, the fertility rate shows how many children are being born. Rates of abortion and teenage conception are the more important sexual health indicators in showing levels of unprotected sex (or failure of contraception). However, in the community, the overall fertility rate is an important indicator to help determine where resources need to be used most strategically in terms of information, education and also all maternity services. The latter is of particular relevance in the case of London as maternity services and the way they are provided are under close scrutiny in the recent *Healthcare for London: A Framework for Action* report[29].

What does this indicator show?

- In 2006, the fertility rate was approximately 60 births per 1,000 females aged 15-44 in England. In London, this rate was slightly higher at just under 66 births. Outer London had a higher fertility rate than Inner London: around 67.5 births per 1,000 females aged 15-44 compared to around 63.5 births per 1,000 females aged 15-44.

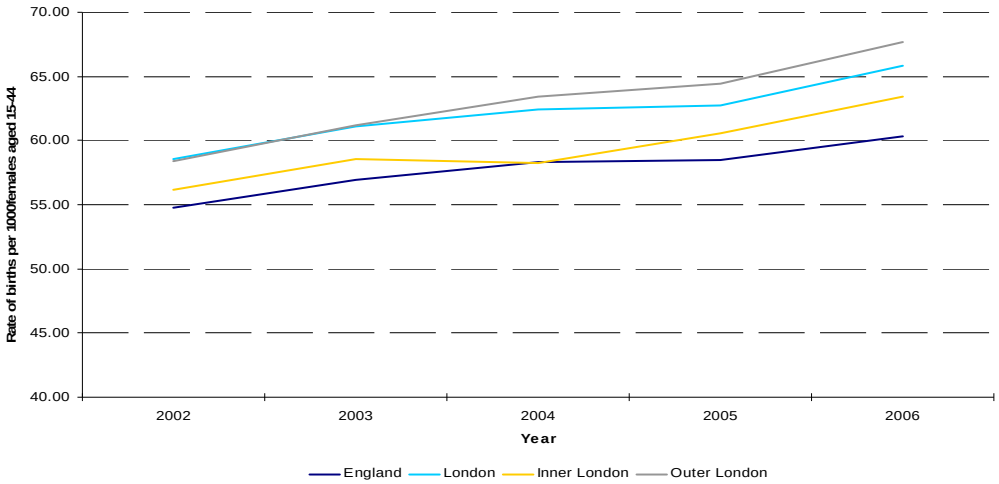
Of the London sectors:

- North East London had the highest fertility rate with approximately 75.5 births per 1,000 females aged 15-44.
- North Central London had the lowest with around 61 births.
- The London boroughs of Newham and Barking & Dagenham had the highest fertility rate at around 89 births and 84 births per 1,000 females aged 15-44 respectively.
- City, Westminster and Camden all had fertility rates below 50 births per 1,000 females aged 15-44 (40 births, 44 births and 45 births respectively).

Trend data

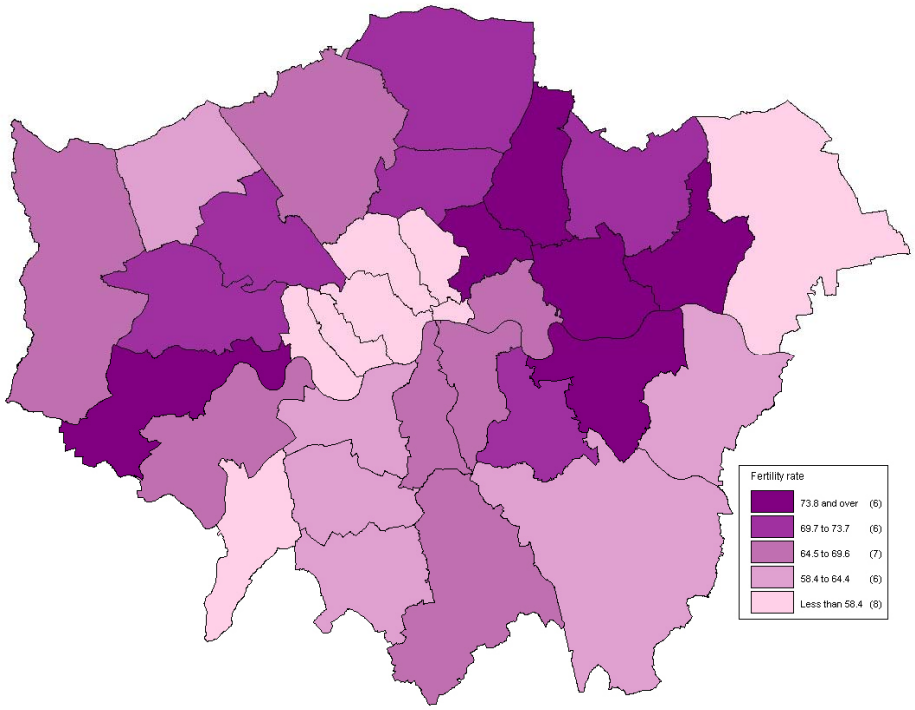
- Between the years of 2002 and 2006, the fertility rate increased every year in both England and London.
- In 2002, the fertility rate in England was 54.78 births per 1,000 females aged 15-44 compared to 60.34 in 2006; an increase of around 10%.
- In London, the figure was 58.55 births per 1,000 females aged 15-44 in 2002, compared to 65.82 in 2006; an increase of around 12%.
- The fact that more children are being born will have a great impact on services and access to them not only now, but in the future. This will need careful planning, and also careful targeting, given that different sub-groups of the population have different needs.

Figure 51: Fertility rate - number of births per 1,000 females aged 15-44, 2002-2006



Source: NCHOD

Figure 52: Fertility rate – number of births per 1,000 females aged 15-44, by borough, 2006



Source: NCHOD

Table 21: Number of births per 1,000 females aged 15-44, by area of London, 2002-2006

Area	2002	2003	2004	2005	2006
England	54.78	56.90	58.36	58.51	60.34
London	58.55	61.10	62.46	62.74	65.82
Inner London	56.19	58.54	58.27	60.59	63.43
Outer London	58.39	61.15	63.44	64.43	67.71
North East London	66.84	69.63	72.13	66.52	75.69
North Central London	56.32	58.28	59.65	60.33	61.05
North West London	55.82	57.57	58.42	58.14	62.37
South East London	59.05	62.65	63.97	65.24	67.27
South West London	54.43	57.26	58.18	58.34	62.33

Source: NCHOD

Metadata

Indicator description	Number of births per 1,000 females aged 15-44.
Source of data	The National Centre for Health Outcomes Development (NCHOD).
Numerator definition	Number of births to females aged 15-44 resident in particular area in a year.
Denominator definition	Number of females aged 15-44 resident in particular area in a year.
Geography	London borough, London sector, Inner London, Outer London, London, England.
Timeliness	Data are produced by NCHOD yearly.
Disclosure control	There is no disclosure control associated with this indicator.
Data accuracy & completeness	Data are from ONS data sources so can be considered to be accurate and complete.

Limitations

The Greater London Authority (GLA) produces forecasts as to the number of births each London borough may experience in the future. These data have not been included, partly because they are outside the scope of this sexual health needs assessment. The data are also not particularly robust and do not take into account such things as recent migration patterns. However, the LHO is currently working on a new methodology to assess the impact of recent migration on birth rates in London.

Indicator 7.02 Total period fertility rate

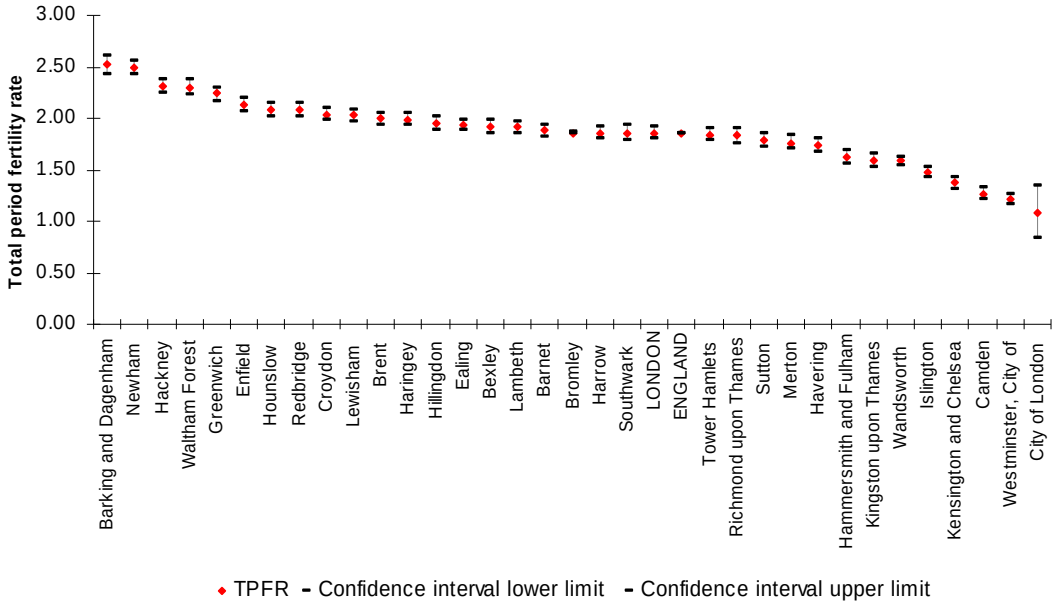
Rationale for inclusion

The total period fertility rate (TPFR) shows the average number of children a woman would have were she to experience the current fertility rate. The TPFR can show where resources need to be used most strategically in terms of information, education and maternity services. The latter is of particular relevance in the case of London as maternity services and the way they are provided are under close scrutiny in the recent *Healthcare for London: A Framework for Action* report[29].

What does this indicator show?

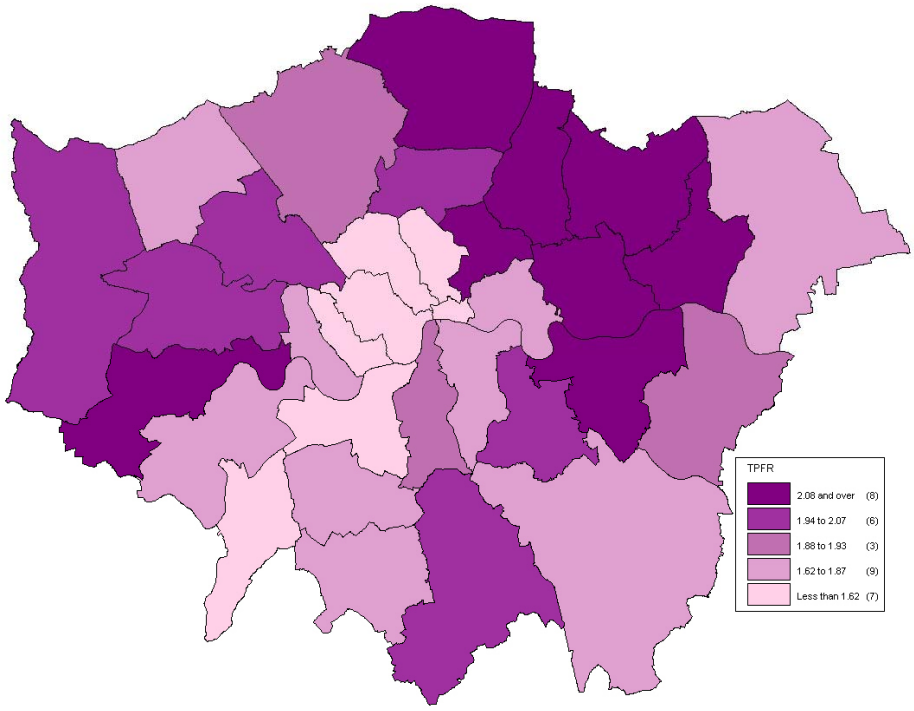
- In 2006, the TPFR for London was 1.86 births. This was very similar to that of England as a whole, which had a TPFR of 1.85 births.
- There was large variation within London however. The TPFR ranged from 2.52 births in Barking & Dagenham and 2.49 births in Newham, to 1.21 births in Westminster.

Figure 53: Total period fertility rate (TPFR) by London borough, 2006



Source: NCHOD

Figure 54: Total period fertility rate, by London borough, 2006



Source: NCHOD

Metadata

Indicator description	Total period fertility rate.
Source of data	The National Centre for Health Outcomes Development (NCHOD).
Numerator definition	Live births occurring to females aged 11 and over in the particular area in the respective calendar year.
Denominator definition	Number of females aged 15-44 resident in particular area in respective calendar year.
Geography	London borough, London, England.
Timeliness	Data are produced by NCHOD yearly.
Disclosure control	There is no disclosure control associated with this indicator.
Data accuracy & completeness	Data are from ONS data sources so can be considered to be accurate and complete.

Limitations

The total period fertility rate is a synthetic rate and not something that is actually counted. The total period fertility rate does not necessarily predict how many children a woman will eventually have as the fertility rates may change over time.

Indicator 7.03 Total period abortion rate as a percentage of potential fertility rate

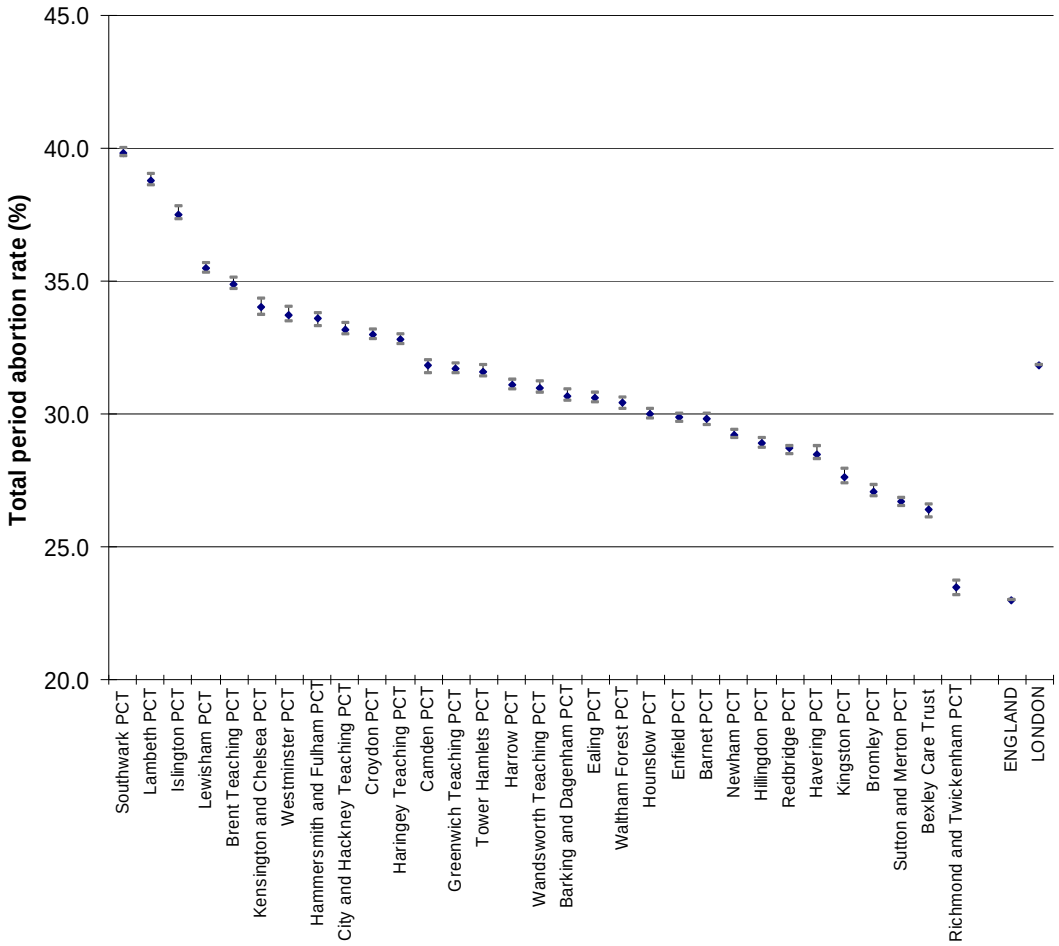
Rationale for inclusion

This indicator shows the number of abortions per woman (TPAR) as a percentage of the total number of conceptions per woman (TPFR). This indicator provides a focus for where information on safer sex and abortion could best be targeted if women experienced the current age specific abortion and fertility rates.

What does this indicator show?

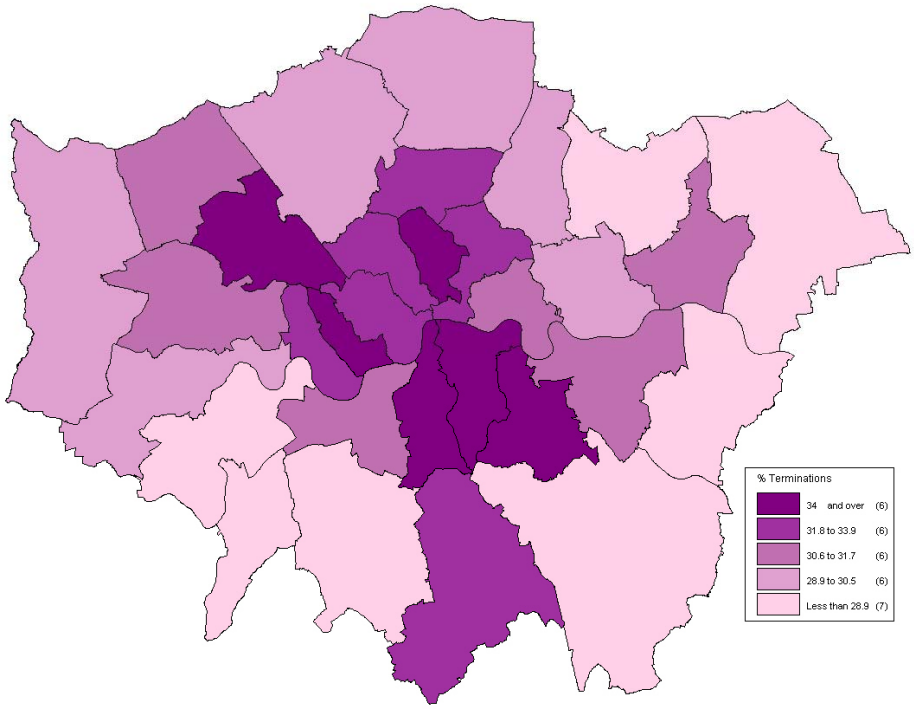
- In London in 2006, the TPAR as a percentage of TPFR was approximately 32%.
- The London percentage is higher than that of England, which had a percentage of around 23%.
- Within London, there was wide variation. Rates ranged from almost 40% in Southwark down to around 24% in Richmond & Twickenham.

Figure 55: Total period abortion rate as a percentage of potential fertility rate, 2006



Source: NCHOD

Figure 56: Total period abortion rate as a percentage of potential fertility rate, London PCTs, 2006



Source: NCHOD

Metadata

Indicator description	Total period abortion rate as a percentage of potential fertility rate.
Source of data	The National Centre for Health Outcomes Development (NCHOD).
Numerator definition	Total period abortion rate in the respective calendar year.
Denominator definition	Total period abortion rate added to the total period fertility rate in the respective calendar year.
Geography	London PCT, London, England.
Timeliness	Data are produced by NCHOD yearly.
Disclosure control	There is no disclosure control associated with this indicator.
Data accuracy & completeness	Data are from ONS data sources so can be considered to be accurate and complete.

Limitations

Illegal abortions are not counted in these data and therefore they may not reflect the complete picture. However, this is not thought to impact on the numbers significantly.

Indicator 7.04 Teenage conceptions in girls aged under 18 years

Rationale for inclusion

Teenage pregnancy is a health inequality and social exclusion issue and leads to poor health and social outcomes for the mother and baby. Teenage pregnancy is defined as conception in a female aged less than 18 years.

A key factor in reducing teenage pregnancies is the provision of effective, young person centred sexual health advice services[30]. These services include:

- Sex and relationships education (SRE) delivery with high priority given to Personal, Social and Health Education (PSHE) in schools;
- A strong focus on targeted interventions with young people at greatest risk of teenage pregnancy, in particular with looked-after children;
- The availability and consistent take-up of SRE training for professionals in organisations working with the most vulnerable young people.

Risky behaviours such as early onset of sexual activity, poor contraceptive use, alcohol and substance misuse, teenage motherhood and repeat abortions are associated with high rates of teenage conception. An unplanned teenage conception gives an indication that there was unprotected sex and high risk of sexually transmitted infections.

The UK has one of the highest rates of teenage conceptions in Western Europe. There is a 10 year government national teenage pregnancy strategy to tackle the issue.

The targets are:

- To halve the under-18 conception rate by 2010 (from 46.6 per 1,000 in 1998, with an interim target of a 15% reduction by 2004), and establish a firm downward trend in the under-16 rate.
- To increase the proportion of teenage parents in education, training or employment to 60% by 2010, to reduce their risk of long-term social exclusion.

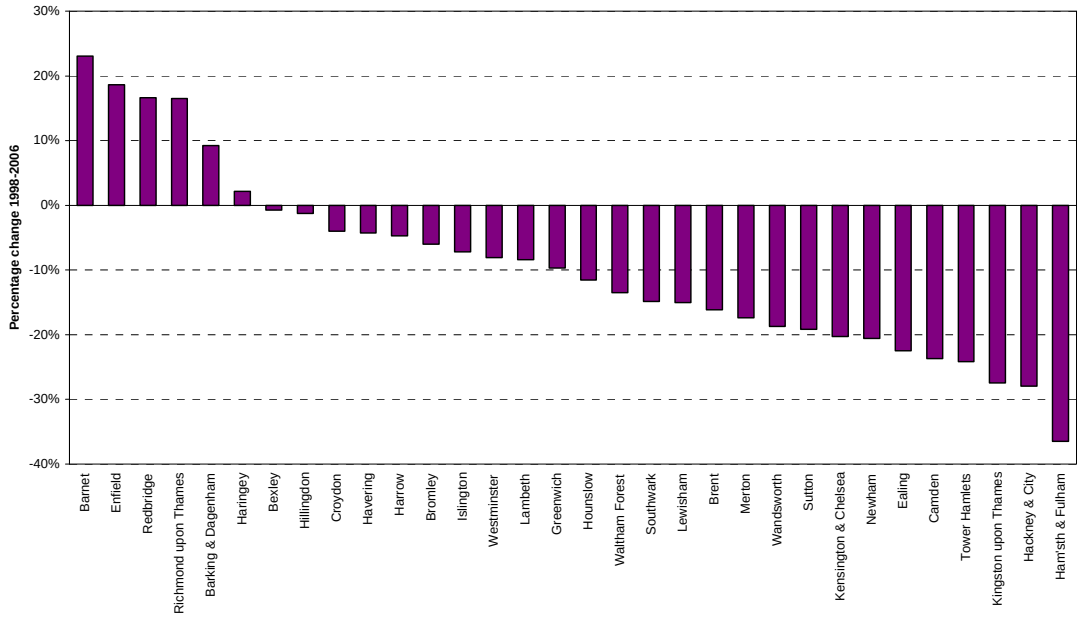
To undertake this all local areas have a 10-year strategy in place, with local under-18 conception rate reduction targets of between 40% and 60%. These local targets underpin the national 50% reduction target.

What does this indicator show?

Teenage pregnancy rates have fallen both nationally and in London since 1998.
In 2006:

- There were 5,680 conceptions in girls aged under 18 years in London.
- 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.
- The Inner London rate was 55.7 per 1,000 and the rate in Outer London was 40.1 per 1,000.
- The highest teenage conception rate was in Lambeth, 78.1 per 1000.
- Hammersmith & Fulham, Hackney and City of London, Kingston, and Tower Hamlets had the largest declines in the teenage conception rate between 1998 and 2006 out of all boroughs in London.

Figure 57: Conception rate in girls aged under 18, percentage change from 1998 baseline, London, 2006



Source: Teenage Pregnancy Unit

Trend data

Annual trend

- Between 1998 and 2006 the national teenage conception rate in under-18s has been falling every year.
- There has been a narrowing of the gap between London and England since 2002. The gap in teenage conception rates between Outer London and Inner London remains wide but there has been a narrowing since 1998.
- London's reduction in under 18 teenage conceptions was less than the 2004 national interim target of a 15% reduction. It achieved a 3.6% reduction from the 1998 baseline while England had a 10.9% reduction.

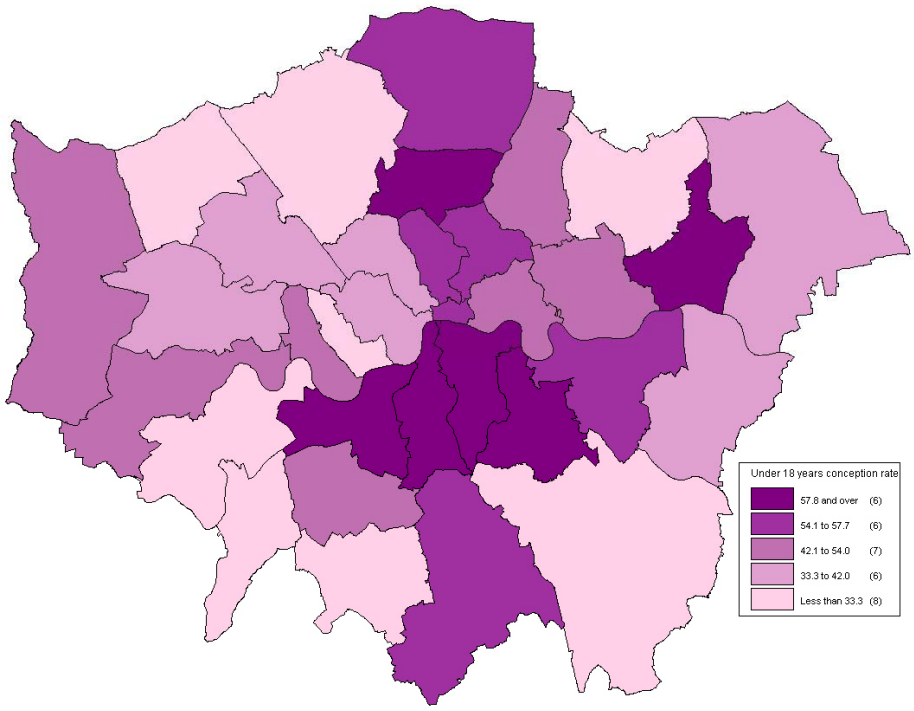
Percentage change from 1998 baseline (annual data)

- Between 1998 and 2006, 89% of local authorities in England, including 82% of London boroughs, achieved an overall reduction in their under 18 conception rate.
- The teenage conception rate fell by 13.3% in England and by 11.1% in London between 1998 and 2006. London as a whole is not on track meet the national 2010 target of halving the teenage conception rate by 2010.
- In Inner London the teenage conception rate fell by 16.6% compared to a fall of 4.9 % in Outer London by 2006.
- The four Inner London areas with the historically highest rates (Southwark, Lambeth, Lewisham, Hackney and City of London) have seen a reduction from the baseline and show a downward trend in conception rate. Southwark has seen a higher percentage reduction than London in its conception rate from the baseline.

Figure 58: Annual trend, conception rate per 1000 girls aged 15-17 years, Inner London, Outer London, London and England, 1998-2006

Source: Teenage Pregnancy Unit

Figure 59: Conception rate per 1000 girls aged 15-17 years, London boroughs, 2006



Source: Teenage Pregnancy Unit

Metadata

Indicator description	Under 18 conception rate, females aged 15-17 years.
Source of data	Birth registrations are processed by ONS and abortion notifications by the Department of Health (DH). DH sends abortion statistics to ONS who produce the teenage conception rates. Teenage conception statistics are published by the Teenage Pregnancy Unit.
Numerator definition	All conceptions in girls aged under 18 years in the respective year. Conception statistics include pregnancies that result in one or more live or still births, or a legal abortion under the Abortion Act 1967. Miscarriages and illegal abortions are not included.
Denominator definition	Population of girls aged 15-17 years old. The three-year age group (15-17) is used as the denominator as including younger age groups in the base population may produce misleading results.
Geography	Top tier local authorities, London, and England. The postcode of the woman's address at time of birth or abortion is used to determine local authority of residence at time of conception.
Timeliness	The 2006 analyses in this report are based on 'provisional' data released in April 2008. There is a time lag in the release of conceptions data due to the need to base calculations on births and abortions data. The Office for National Statistics (ONS) is responsible for these calculations and usually provides the first round of year-based conceptions data about 14 months after the end of the year to which they relate.
Disclosure control	Counts for City of London have been combined with those for Hackney.
Data accuracy & completeness	The date of conception is estimated using recorded gestation for abortions and stillbirths, and assuming 38 weeks gestation for live births. A woman's age at conception is calculated as the number of complete years between her date of birth and the date she conceived.

Limitations

Yearly increases in teenage conception rates should be interpreted with caution as they are based on a small number of events. In addition, not all conceptions will be included as the data exclude miscarriages and illegal abortions.

It should be noted that not all teenage pregnancy is unplanned - this may account for the relatively low uptake of termination in some London boroughs and the consistently high conception rates in some boroughs.

Indicator 7.05 Percentage of teenage conceptions in girls aged under 18 years resulting in abortion

Rationale for inclusion

A conception resulting in an abortion suggests that the conception was unintended. This indicator contributes an understanding of teenage conception. It indicates that either the sex and relationships education messages to young people may not be hitting their mark or that young people have limited access to effective contraceptive advice and contraception. Young women living in socially disadvantaged areas are less likely to opt for an abortion if they get pregnant.

What does this indicator show?

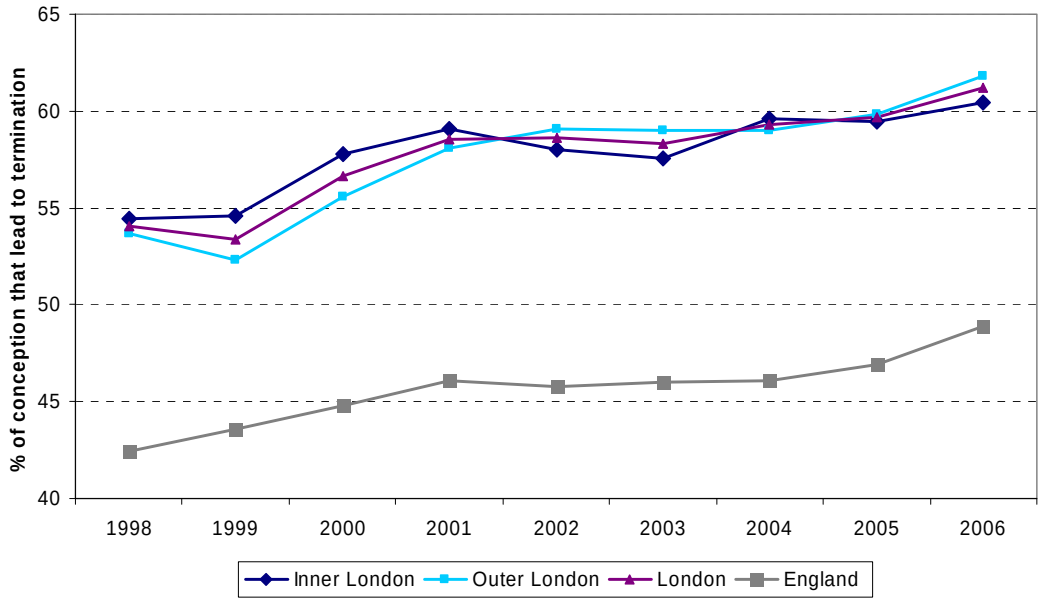
In 2006

- 61% of all under 18 conceptions in London lead to an abortion.
- London had a higher proportion of conceptions in girls aged under 18 years that resulted in an abortion than England (49%).
- Inner and Outer London had a similar percentage of teenage conceptions that result in an abortion despite the higher teenage conception rate in Inner London: 62% in Outer London and 60% in Inner London.
- The percentage of teenage conceptions that lead to abortion ranges from 51% in Hounslow and Newham, to 78% in Richmond upon Thames.

Trend

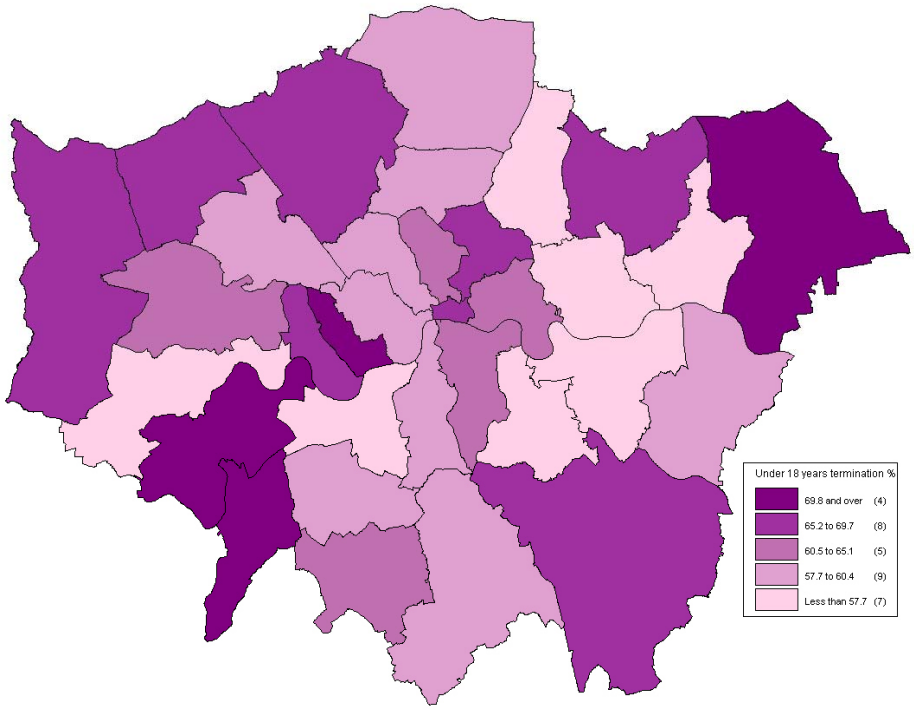
- Since 1998 the proportion of teenage conceptions that lead to abortion has increased in London and England.

Figure 60: Percentage of under 18 conceptions that lead to abortion, London and England, 1998-2006



Source: Teenage Pregnancy Unit

Figure 61: Percentage of conceptions leading to abortion in girls aged under 18, London, 2006



City of London data are combined with Hackney

Source: Teenage Pregnancy Unit

Metadata

Indicator description	Percentage of under 18 conceptions that result in abortion, females aged 15-17 years.
Source of data	Birth registrations are processed by ONS and abortion notifications by the Department of Health (DH). DH sends abortion statistics to ONS who produce the teenage conception rates. Teenage conception statistics are published by the Teenage Pregnancy Unit at http://www.everychildmatters.gov.uk/health/teenagepregnancy/statistics/
Numerator definition	All legal abortions under the Abortion Act 1967 in teenagers aged under 18.
Denominator definition	All conceptions in those aged under-18. Conceptions include pregnancies that result in one or more live or still births, or a legal abortion under the Abortion Act 1967. Miscarriages and illegal abortions are not included. However, as only 5% of under-18 conceptions are to girls under 15 a three-year age group (15-17) is used as the denominator as including younger age groups in the base population may produce misleading results.
Geography	Top tier local authorities, London, and England. The postcode of the woman's address at time of birth or abortion is used to determine local authority of residence at time of conception.
Timeliness	The 2006 analyses in this report are based on 'provisional' data released in April 2008. There is a time lag in the release of conceptions data due to the need to base calculations on births and abortions data. The Office for National Statistics (ONS) is responsible for these calculations and usually provides the first round of year-based conceptions data about 14 months after the end of the year to which they relate.
Disclosure control	Counts for City of London have been combined with those for Hackney.
Data accuracy & completeness	The date of conception is estimated using recorded gestation for abortions and stillbirths, and assuming 38 weeks gestation for live births. A woman's age at conception is calculated as the number of complete years between her date of birth and the date she conceived.

Limitations

Yearly changes in the percentage of conceptions leading to abortion should be interpreted with caution as they are based on a small number of events. In addition, not all conceptions will be included as the data exclude miscarriages and illegal abortions.

It should be noted that not all teenage pregnancy is unplanned - this may account for the relatively low uptake of termination in some London boroughs and the consistently high conception rates in some boroughs.

Indicator 7.06 Teenage conceptions in girls aged under 16 years

Rationale for inclusion

Females aged under 16 years are a vulnerable group. The age of onset of sexual activity has fallen and this age group is at most risk of sexually transmitted Infections and teenage pregnancy. Girls under 16 are five times more likely to die during or immediately after pregnancy than women aged 20 to 24.[31]

What does this indicator show?

- In the under 16s about 7 in 10 conceptions result in an abortion in London compared to 6 in10 for England.
- The under-16 conception rate in London in 2003-05 was 9.1 per 1000 girls aged 13-15, compared with 7.7 in England.
- Within London, Lambeth, Southwark, Lewisham and Barking & Dagenham had the highest teenage conception rates in 2003-05.
- There is wide variation in the percentage of conceptions leading to abortion in girls under 16 across the London boroughs. In 2003-2005 the percentage of conceptions ending in abortion ranged from 50% in Wandsworth to 81.1% in Westminster.

Trend data

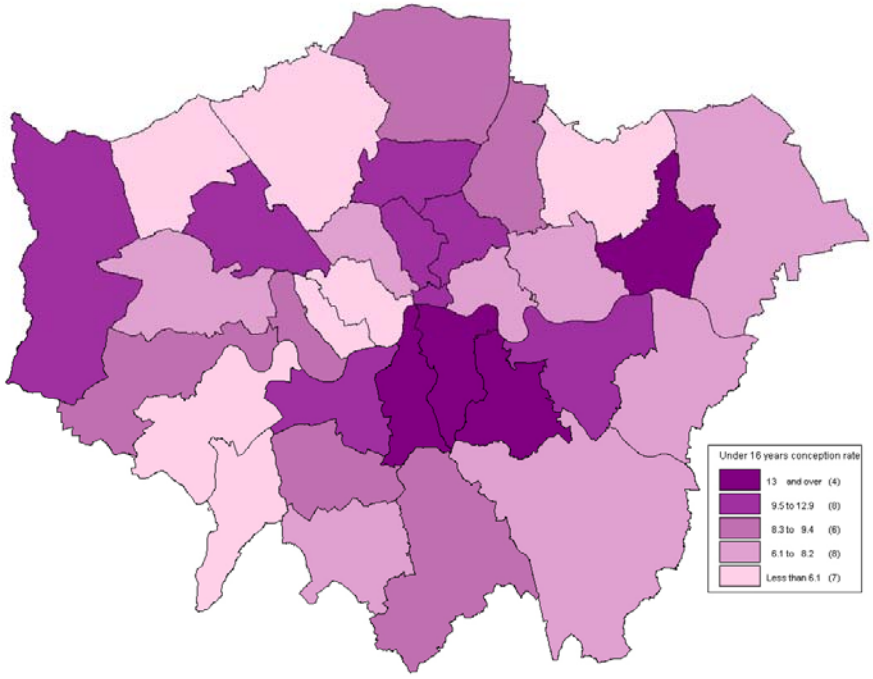
- From 2001-03 to 2003-05 there was a fall in the number of under 16 teenage conceptions and a downward trend in the under 16 conception rate in both London and England.

Table 22: Under 16 conception rates and proportion leading to abortion, 2001-2005

	2001-2003			2002-2004			2003-2005		
	Number	Rates	% leading to abortion	Number	Rates	% leading to abortion	Number	Rates	% leading to abortion
London	3,728	9.9	65.4	3,603	9.5	66.3	3,435	9.1	65.9
England	22,360	7.9	56.5	22,132	7.8	57.0	22,201	7.7	57.6

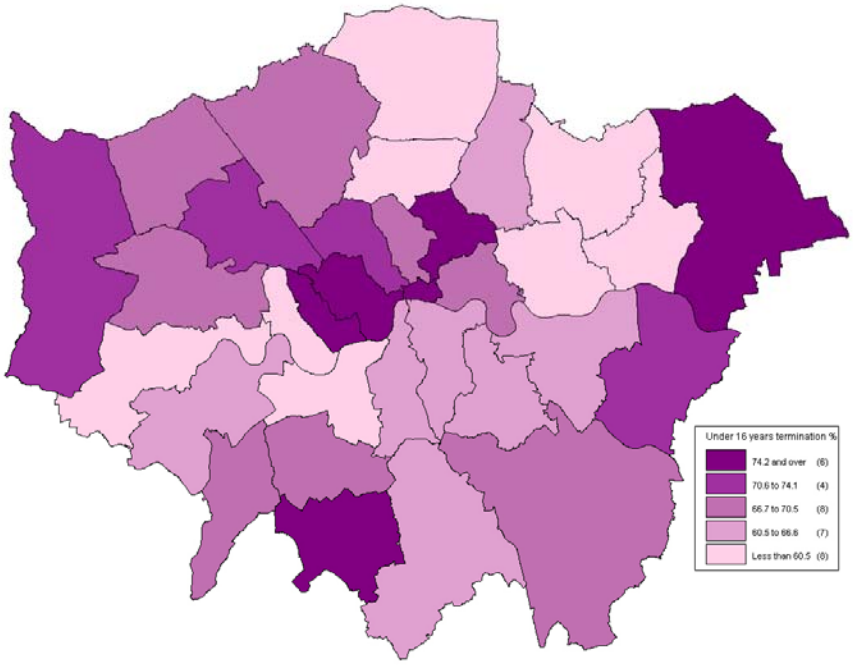
Source: Teenage Pregnancy Unit

Figure 62: Conceptions to girls aged under 16 years, London boroughs, 2003 to 2005



Source: Teenage Pregnancy Unit

Figure 63: Percentage of conceptions leading to abortion in females aged under 16 years, London boroughs, 2003-2005



Source Teenage Pregnancy Unit

Metadata

Indicator description	Under 16 conception rates, females aged 13-15 years. Percentage of under 16 conceptions leading to abortion.
Source of data	Birth registrations are processed by ONS and abortion notifications by the Department of Health (DH). DH sends abortion statistics to ONS who produce the teenage conception rates. Teenage conception statistics are published by the Teenage Pregnancy Unit.
Numerator definition	Conception statistics include pregnancies that result in one or more live or still births, or a legal abortion under the Abortion Act 1967 Miscarriages and illegal abortions are not included. For under 16 conception rates, conceptions in those under 16 are used as the numerator. For the percentage of conceptions leading to abortion, all legal abortions are included in the numerator.
Denominator definition.	The population aged 13-15 is used as the denominator for under 16 conception rates. For the percentage of conceptions leading to abortion, conceptions in those under-16 are used as the denominator.
Geography	Top tier local authorities, London, and England. The postcode of the woman's address at time of birth or abortion is used to determine local authority/ward of residence at time of conception.
Timeliness	Data for 2003-05 are provisional. There is a time lag in the release of conceptions data due to the need to base calculations on births and abortions data. The Office for National Statistics (ONS) is responsible for these calculations and usually provides the first round of year-based conceptions data about 14 months after the end of the year to which they relate.
Disclosure control	Counts for City of London have been combined with those for Hackney. For conceptions leading to abortions, percentages based on fewer than 10 events would be suppressed.
Data accuracy & completeness	The date of conception is estimated using recorded gestation for abortions and stillbirths, and assuming 38 weeks gestation for live births. A woman's age at conception is calculated as the number of complete years between her date of birth and the date she conceived.

Limitations

The Teenage Pregnancy Unit TPU provides under 16 conception data averaged over three years because of the low number of events in this age group. In addition, not all conceptions will be included as the data exclude miscarriages and illegal abortions.

Indicator 7.07 Abortion rate

Rationale for inclusion

Unintended pregnancies can be associated with poor sexual health outcomes. They are a reflection of poor access to effective contraception and are associated with the consequences of unprotected sex including sexually transmitted infections. The level of abortions is an indicator of the degree of failure to use contraception or failure of the contraception itself. The abortion procedure can be complicated by infection although this is most likely to be due to pre-existing infection and is less likely, the earlier the abortion is carried out.

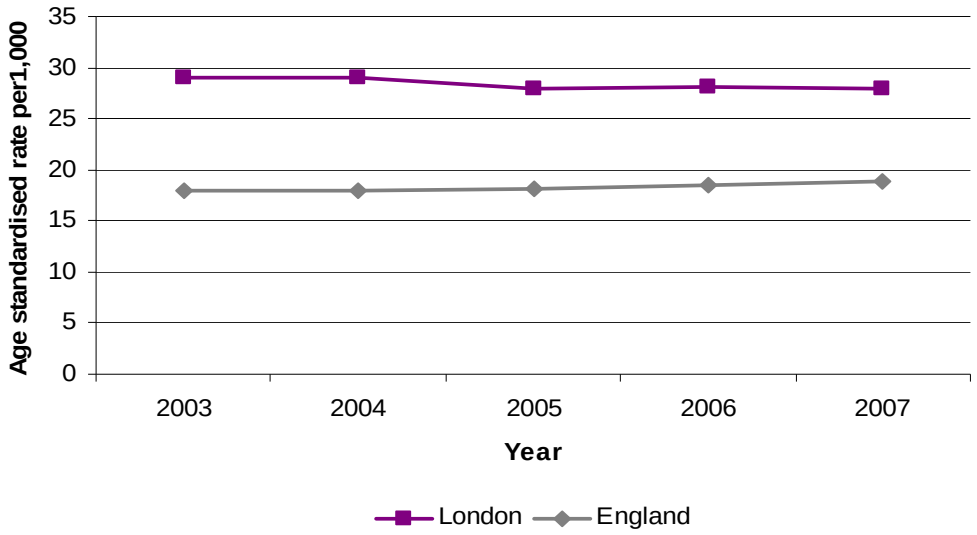
What does this indicator show?

- There was a total of 50,213 abortions (NHS funded and private) to women resident in London in 2007, which represents an age standardised rate of 28 per 1,000 resident women aged 15-44.
- This is significantly higher than England which is 18.8 per 1,000 resident women aged 15–44.
- Twenty-eight out of thirty-one PCTs in London have higher rates than England.
- Four PCTs have rates which are about double or more than the England rate. Southwark PCT has the highest abortion rate of 41 per 1,000 followed by Barking & Dagenham 40 per 1,000, Lambeth 39 per 1,000 and Lewisham 37 per 1000.
- Richmond & Twickenham PCT has the lowest rate of 16 per 1,000

Trend data

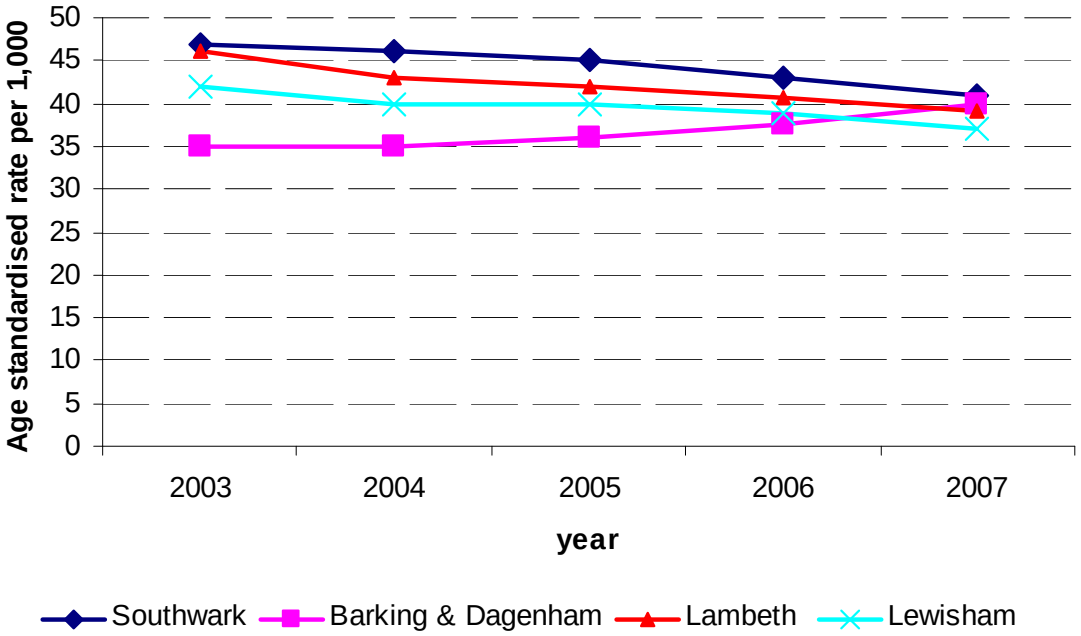
- London has seen a gradual fall in the abortion rate from 2003 to 2005, but since then it has stayed at the same level.
- England on the other hand has seen a gradual rise.
- Amongst the PCTs with the highest abortion rates in 2007, three of them are on a downward trend whereas Barking & Dagenham has been increasing since 2005.

Figure 64: Age standardised abortion rate per 1,000 women aged 15-44 years, London and England, 2003 – 2007



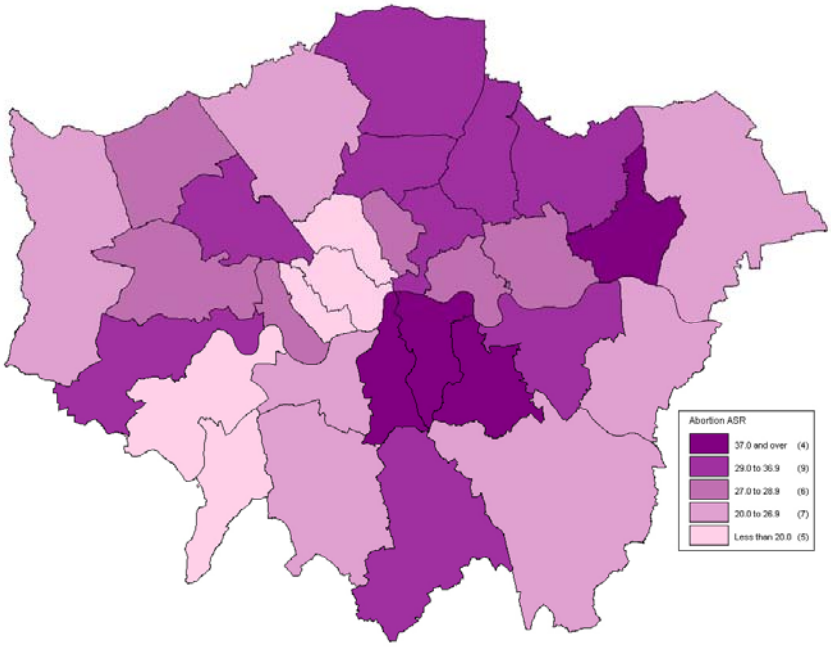
Source: DH Statistical Bulletin Abortions 2003, 2004, 2005, 2006 and 2007

Figure 65: Age standardised abortion rate per 1,000 women aged 15-44 years, selected PCTs, London, 2003 – 2007



Source: DH Statistical Bulletin Abortions 2003, 2004, 2005, 2006 and 2007

Figure 66: Age standardised abortion rate per 1,000 women aged 15-44 years, by PCT, 2007



Source: DH Statistical Bulletin Abortions 2007

Metadata

Indicator description	Age standardised rate of abortion per 1,000 females aged 15-44 years (NHS funded and private).
Source of data	Abortion notification forms returned to Chief Medical Officers of England and Wales and summarised in the annual Abortion Statistics Bulletin published by the DH. Note that similar data are published by NCHOD, which includes confidence intervals; however they produce crude rates rather than age standardised. ONS – for population estimates.
Numerator definition	Number of women aged 15 - 44 years who had an abortion in that year.
Denominator definition	Estimated mid year population for females aged 15 – 44 years.
Geography	PCT, London, England, England and Wales.
Timeliness	Data for the previous calendar year are published annually in June.
Disclosure control	The ONS guidance on disclosure review was used which provides details on how to identify cells within tabulated statistics where the risks of a breach of confidentiality are unacceptable. Suppression was applied to cells with fewer than five cases at national level or fewer than 10 cases at sub-national level. The same principles were also applied to tables showing rates and percentages.
Data accuracy &	Incomplete and incorrectly completed forms are returned to

completeness	practitioners for completion and clarification. In a very small number of cases (about one-quarter of one percent), the information remains unavailable at the time of publication.

Indicator 7.08 Percentage of abortions by gestation

Rationale for inclusion

Department of Health policy is that women who are legally entitled to an abortion should have access to the procedure as soon as possible. Evidence shows that the risk of complications increases the later the gestation. In 2001, the Government set a standard of a maximum waiting time of 3 weeks. Since 2002/03 the government has invested £8 million to improve early access to abortion services.

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 abortions undertaken within this time frame.[32]

What does this indicator show?

In London

- The majority of all abortions (NHS funded and private) were carried out under 13 weeks in 2007.
- This comprised 74% under 10 weeks and 16% at 10-12 weeks; a further 10% were carried out above 13 weeks gestation.
- The pattern was similar to England with 70% performed under 10 weeks, 20% at 10-12 weeks and 10% above 13 weeks.
- London achieved the recommended level of 70% of NHS funded abortions performed under 10 weeks, compared with England (68.3%).

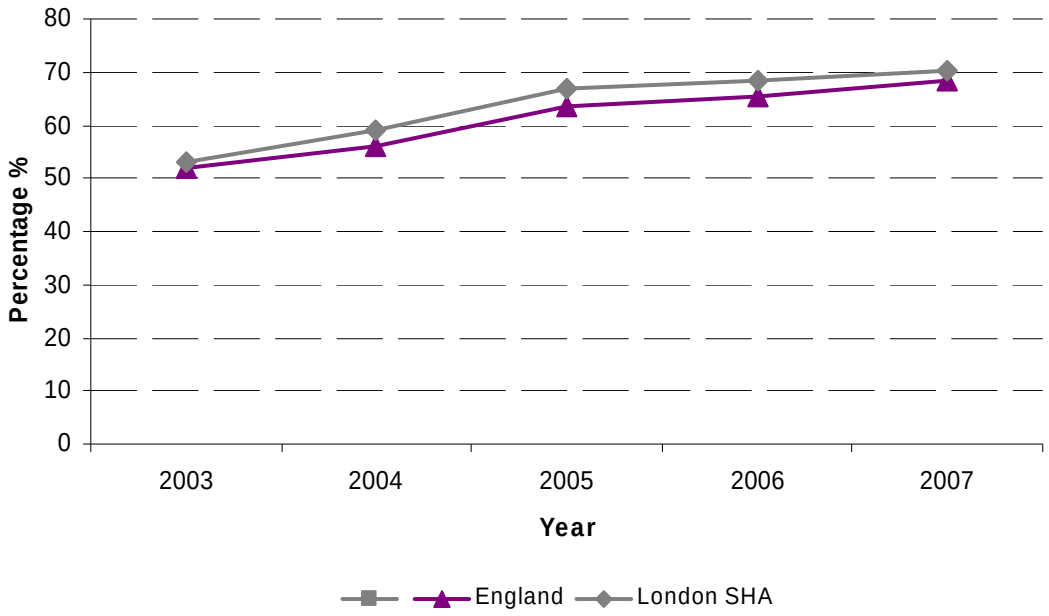
Within London, there is considerable variation:

- Nineteen PCTs have reached the recommended level of 70% NHS funded abortions performed under 10 weeks.
- Havering PCT had the highest percentage (85%) of NHS funded abortions performed under 10 weeks.
- 12 PCTs were below the recommended level with Newham being the lowest (43%).

Trend data

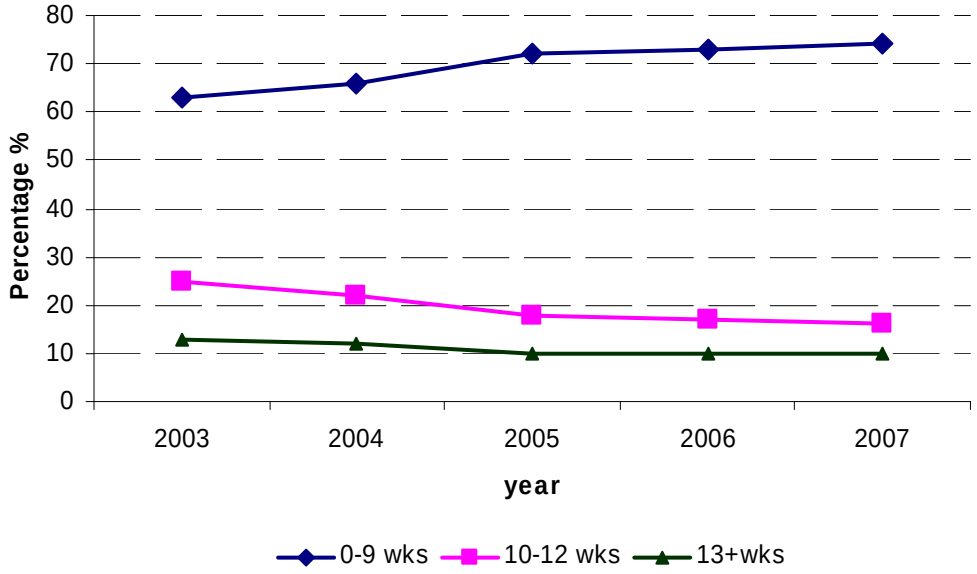
- The proportion of NHS funded abortions performed under 10 weeks in London has risen steadily since 2002 which is similar to England although London has consistently performed better.
- The proportion of all abortions performed under 10 weeks in London also continues to rise.

Figure 67: Percentage of NHS funded abortions performed under 10 weeks gestation, London, England, 2002-2007



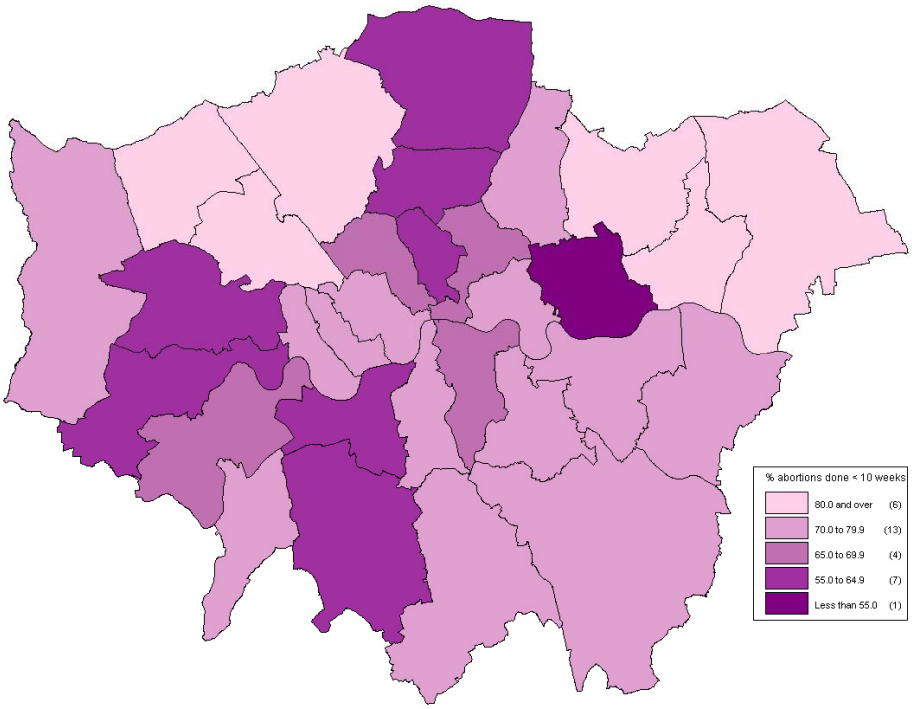
Source: DH Statistical Bulletin Abortions 2003, 2004, 2005, 2006 and 2007

Figure 68: Percentage of abortions performed (NHS and non NHS) by gestation, London, 2002-2007



Source: DH Statistical Bulletin Abortions 2003, 2004, 2005, 2006 and 2007

Figure 69: Percentage of all NHS funded abortions done under 10 weeks gestation in London by PCT, 2007



Source: DH Statistical Bulletin Abortions 2007

Metadata

Indicator description	Percentage of abortions by gestation (All purchasers or NHS funded only).
Source of data	Abortion notification forms returned to Chief Medical Officers of England and Wales and summarised in the annual Abortion Statistics Bulletin published by the DH. Note that similar data are published by NCHOD, which includes confidence intervals but they are not broken down by purchaser.
Numerator definition	Number of abortions performed in women aged 15 – 44 years in each gestation band for purchaser specified.
Denominator definition	Total number of abortions performed in women aged 15 – 44 years for purchaser specified.
Geography	PCT, London, England, England and Wales.
Timeliness	As Indicator 7.07.
Disclosure control	As Indicator 7.07.
Data accuracy & completeness	As Indicator 7.07.

Limitations

It is unclear whether this target is achieved by easing access to early procedures or by restricting access to later abortions. It is generally recognised as a problem by

providers that no targets exist regarding second trimester abortions. Concerns have been raised that some PCTs do not commission services for abortions above 20 weeks gestation.

In addition to access issues, it is possible that a low proportion of abortions under 10 weeks could also be due to late presentation to services. Even if women present late, they still require rapid referral to abortion services. Although it was beyond the scope of this report it would be useful to look at waiting times for referral to the service.

Indicator 7.09 Abortion by age

Rationale for inclusion

The abortion rate varies with age. It is important to know which age groups have high abortion rates to help direct suitable resources. The health and social impacts of being a teenage mother have been discussed earlier and it is therefore important that this group has access to abortion services.

What does this indicator show?

- Like England, the age standardised abortion rate in London in 2007 was highest in age group 18-19 years (51 per 1000 women aged 18-19 years) and was much higher than England (34.5 per 1000 women).
- This was followed closely by the 20-24 year age group which had an abortion rate of 50 per 1000 in London compared to 32.9 per 1000 in England.
- The age standardised abortion rate for the under-18 age group was 27 per 1000 women in London compared to 20 per 1000 women in England.
- The under-16 year crude abortion rate is pooled (2003-2005) and was 4.7 per 1000 female population aged 13-15 years compared to 3.8 for England.

Within London

- Lambeth PCT had the highest rate in the 18-19 year age group (79 per 1000 women)
- Barking & Dagenham had the highest rate in the 20-24 age group (75 per 1000 women)
- Southwark PCT had the highest under-18 year rate of 47 per 1000 women which is more than double that of England.
- Lambeth PCT had the highest under-16 year abortion rate of 11.5 per 1000 followed by Southwark PCT of 9.4 per 1000. Both are significantly higher than London and England.
- Richmond & Twickenham PCT has the lowest under–16 year rate of 1.9 per 1000.

Table 23: Age standardised abortion rate per 1,000, by age groups, selected PCTs, London, England, 2007

Place	Total abortions	Rate 15-44	Rate Under-18	Rate 18-19	Rate 20-24	Rate 25-29	Rate 30-34	Rate 35+
Southwark PCT	2,877	41	47	77	68	46	37	19
Barking & Dagenham PCT	1,491	40	32	65	75	58	38	13
Lambeth PCT	2,664	39	44	79	72	38	29	18
Lewisham PCT	2,293	37	40	69	69	47	30	14
London SHA	50,213	28	27	51	50	34	23	12
England	189,734	18.8	20.0	34.5	32.9	24.5	15.2	7.0

Source: DH Statistical Bulletin Abortions 2007

NB: See metadata for population ranges that the rates have been based on

Table 24: Under 16 years old crude abortion rate per 1,000 female population aged 13-15 years, selected PCTs, London and England, pooled years 2003-2005

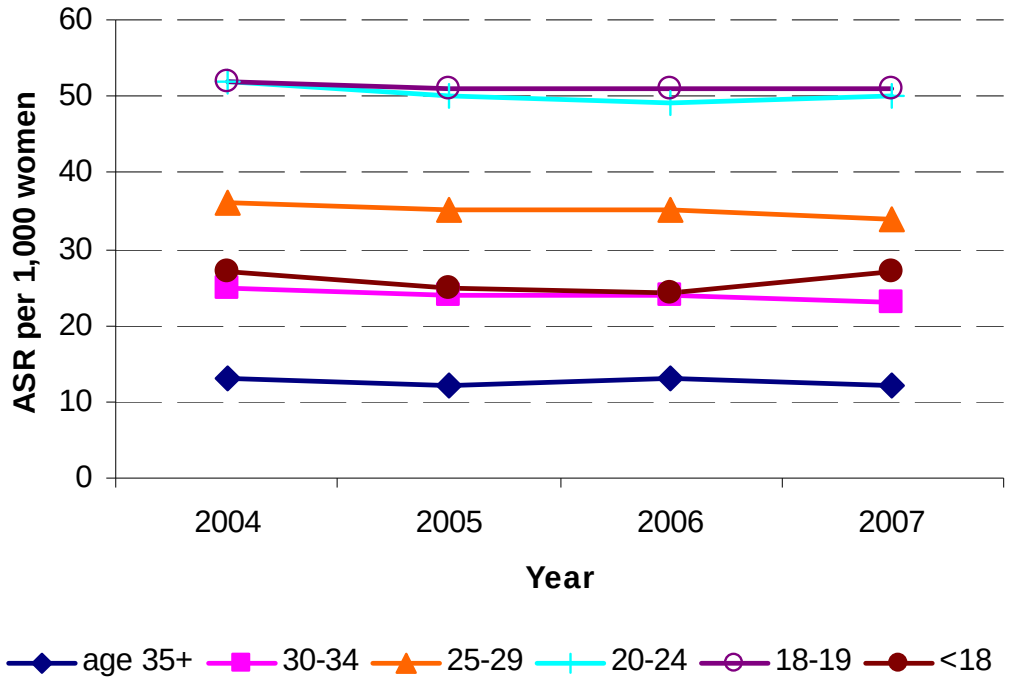
	Number of abortions	Rate per 1,000 female population	95% confidence interval
England	10906	3.8	3.7-3.9
London	1785	4.7	4.5-5.0
Islington PCT	62	7.9	6.2-10.1
Lewisham PCT	114	8.7	7.2-10.4
Southwark PCT	112	9.4	7.8-11.3
Lambeth PCT	136	11.5	9.7-13.6

Source: NCHOD, December 2006 release

Trend data

Across most of the age groups in London, the abortion rate has remained about the same or fallen slightly since 2004.

Figure 70: Age specific abortion rate (ASR) per 1,000 women aged 15-44 years, selected age bands, London, 2004-2007



Source: DH Statistical Bulletin Abortions 2004, 2005, 2006 and 2007

Metadata

Indicator description	Age standardised rate of abortion per 1,000 females by age group.
Source of data	Abortion notification forms returned to Chief Medical Officers of England and Wales and summarised in the annual Abortion Statistics Bulletin published by the DH. Note that similar data are published by NCHOD, however, they produce crude rates rather than age standardised. ONS – for population estimates.
Numerator definition	Number of women who had an abortion in that year per age group.
Denominator definition	Estimated mid year population for females for each equivalent age group. Rates for under 18 years and over 35 years are based on populations 15-17 years and 35–44 years respectively.
Geography	PCT, London, England, England and Wales.
Timeliness	As Indicator 7.07.
Disclosure control	As Indicator 7.07.
Data accuracy & completeness	As Indicator 7.07.

Indicator 7.10 Abortion by method

Rationale for inclusion

At all gestations women may be offered medical or 'surgical' procedures (suction termination or dilatation and evacuation). There are advantages and disadvantages with both and these may change with the gestation of the pregnancy. At gestations below 7 weeks, the medical method is most effective and conventional suction termination should be avoided. [33] At gestations above 12 weeks, the use of surgical methods is dependent on the operator and the medical method may be more appropriate.

What does this indicator show?

- In England and Wales, 35% of all abortions were performed medically in 2007.

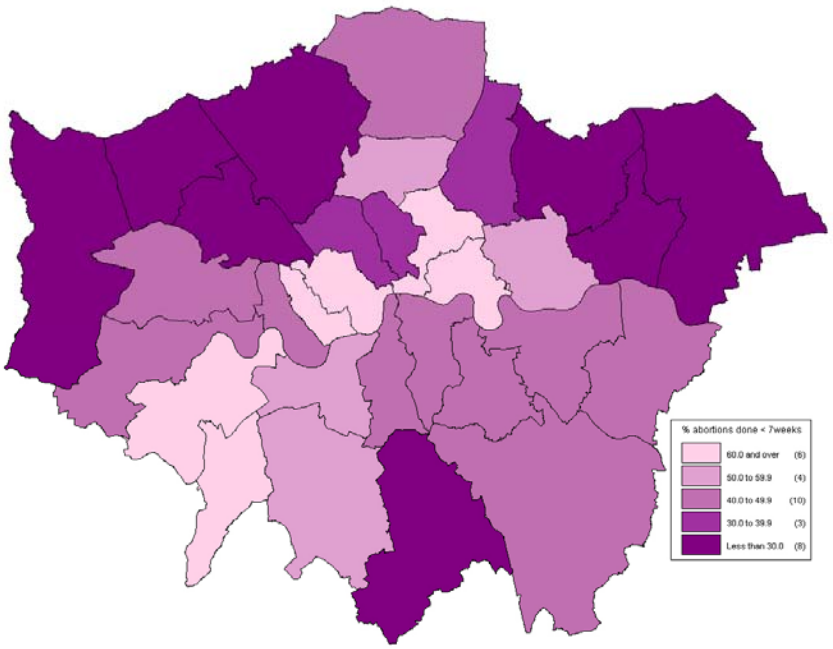
Data obtained for London showed that in 2006

- 19% of abortions were performed medically compared to 30% in England and Wales.
- 40% of all abortions done under seven weeks were by the medical route.
- Barking & Dagenham had the smallest proportion of terminations under seven weeks performed medically (17%) followed by Havering (18%). Richmond & Twickenham had the highest proportion at 69%.

Trend data

- In England and Wales, the proportion of medical abortions has more than doubled in the last five years. There are no other trend data available.

Figure 71: Percentage of abortions done under seven weeks gestation by the medical route, London PCTs, 2006



Source: Abortion notification forms 2006, analyzed by DH

Metadata

Indicator description	Percentage of abortions performed by the medical route.
Source of data	Abortion notification forms returned to Chief Medical Officers of England and Wales and summarised in the annual Abortion Statistics Bulletin published by the DH.
Numerator definition	Number of abortions performed to women aged15 – 44 years by the medical route specified by gestation.
Denominator definition	Total number of abortions performed to women aged 15 – 44 years.
Geography	England, England and Wales. (Data are not published routinely at regional and sub-regional levels and were obtained specifically for this report.)
Timeliness	As Indicator 7.07.
Disclosure control	As Indicator 7.07.
Data accuracy & completeness	As Indicator 7.07.

Limitations

The percentage of abortions performed medically for all gestations is much lower in London than England. We are not able to tell from the data if this reflects clinician preference or patient choice. Also, this may be influenced by access to surgical methods at late gestations (beyond 15 weeks) i.e dilatation and evacuation which can only be performed by specialist practitioners. London provides good access to this procedure and therefore medical methods may be used less.

Indicator 7.11 Percentage of abortions that are repeat in women aged under 25 years

Rationale for inclusion

Repeat unintended pregnancy and subsequent abortion are associated with increased pregnancy risks.

What does this indicator show?

- 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%.

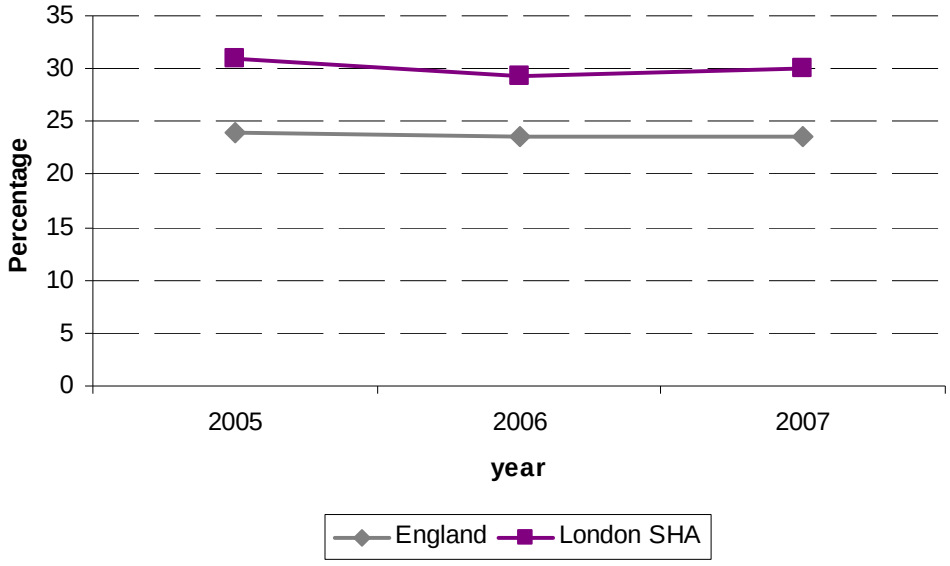
Within London

- All the PCTs had rates above the England average.
- Barking & Dagenham and Redbridge PCTs had the highest proportion at 35%.
- Wandsworth PCT had the lowest proportion at 25%.

Trend data

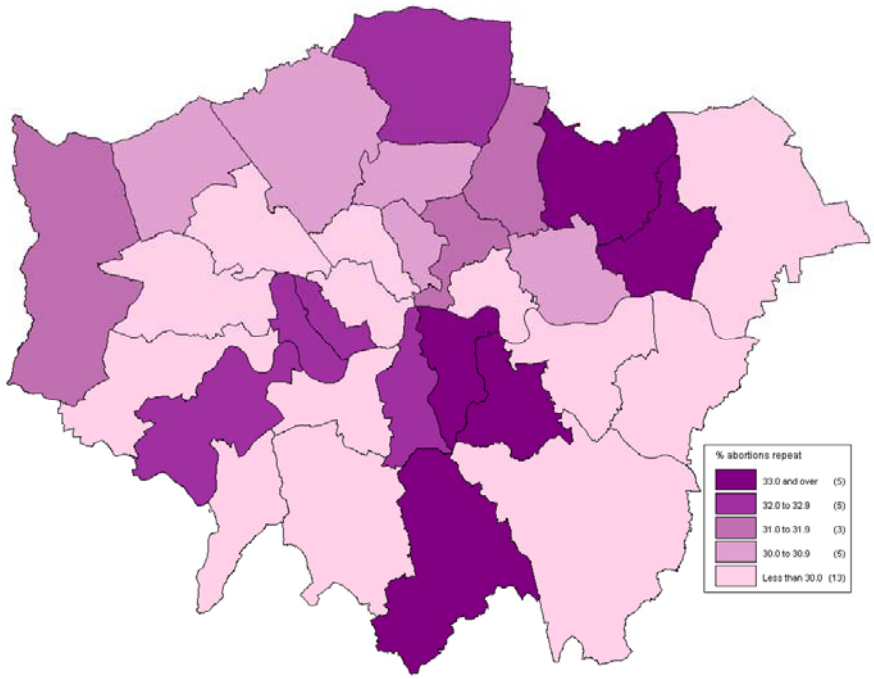
- Trend data are only available for the last three years. The proportion of abortions performed to women under 25 years that were repeat abortions has fallen slightly in London, as is the case in England.

Figure 72: Percentage of abortions that are repeat in women under 25 years, London and England, 2005-2007



Source: DH Statistical Bulletin Abortions 2005, 2006 and 2007

Figure 73: Percentage of abortions that are repeat in women under 25 years, London PCTs, 2007



Source: DH Statistical Bulletin Abortions 2007

Metadata

Indicator description	Percentage of abortions that are repeat in women under 25 years.
Source of data	Abortion notification forms returned to Chief Medical Officers of England and Wales and summarised in the annual Abortion Statistics Bulletin published by the DH.
Numerator definition	Number of abortions performed to women aged 15 - 44 years who had had a previous abortion in addition to the one recorded for that year.
Denominator definition	Total number of abortions performed to women aged 15 - 44 years.
Geography	PCT, London, England, England and Wales. Data at regional and sub-regional level are available from 2003.
Timeliness	As Indicator 7.07.
Disclosure control	As Indicator 7.07.
Data accuracy & completeness	As Indicator 7.07.

Section 8. Sexual attitudes and behaviours

In addition to data on health services and patterns of disease, sexual health needs can also be determined through the perceptions and expectations of the profiled population. Qualitative data on attitudes, experiences and behaviour of different elements of the population can be gathered quantitatively though surveys. These surveys may provide an explanation of, or perspective for, certain sexual behaviours or help to identify high risk populations. They may also be useful in targeting social marketing of sexual health services.

Some surveys involve repeated interviews with the same individuals or groups in the form of a panel to enable changes in behaviour and attitudes to be measured over time. Other studies involve a specially selected sample of individuals who are interviewed at a specific time, for example during participation in an employment programme. User and potential user involvement information has been collected by using national surveys as a proxy.

Findings from the following surveys are reported in this report:

- Tell Us 2 survey
- Schools' Health Education Unit's Health Related Behaviour Questionnaire
- National Survey of Sexual Attitudes and Lifestyles (NATSAL)
- UK Gay Men's Sex Survey
- BASS line: The African Health and Sex Survey
- Omnibus Contraception and Sexual Health Survey

National targets

The data will contribute understanding to meeting the following sexual health targets:

Public Service Agreement (PSA) targets

- Reduction in under-18 conception rate by 50% from 1998 baseline by 2010
- as part of a broader strategy to improve sexual health

Vital signs framework

- Under-18 conception rate per 1,000 females aged 15-17
- Prevalence of chlamydia
- Guaranteed access to a GUM clinic within 48 hours of contacting a service

National Indicator Set

- NI 112: Under-18 conception rate
- NI 113: Prevalence of chlamydia in under-25s

Indicator 8.01 TellUs2 Survey 2007

TellUs2 is an annual survey of children and young people in England. It is a qualitative, user perception survey designed to gather comparable data on children and young people's views of their lives, their schools and their local areas across the country. The 2007 survey was conducted among children in years six, eight and 10 (aged 10-15 years) in maintained schools. TellUs2 is carried out by Ofsted (Office for Standards in Education, Children's Services and Skills) with questions devised jointly by Ofsted, Department for Children, Schools and Families (DCSF) and Ipsos MORI. London data were extracted from the national survey.

Rationale for inclusion

This survey provides information on a borough's progress towards the five Every Child Matters[34] outcomes:

- Be healthy
- Stay safe
- Enjoy and achieve
- Make a positive contribution
- Achieve economic well-being.

The outcomes are mutually reinforcing. For example, children and young people learn and thrive when they are healthy, safe and engaged; and the evidence shows clearly that educational achievement is the most effective route out of poverty.

In this survey, emotional and sexual health is covered in two questions in the secondary school questionnaire. The questions were:

- "What do you think of the information and advice you get on the following things?" (where sexual health and relationships was one of the topics)
- "Which of the following things, if any, do you worry about the most?" (where girlfriends/boyfriends/sex was one of the options)

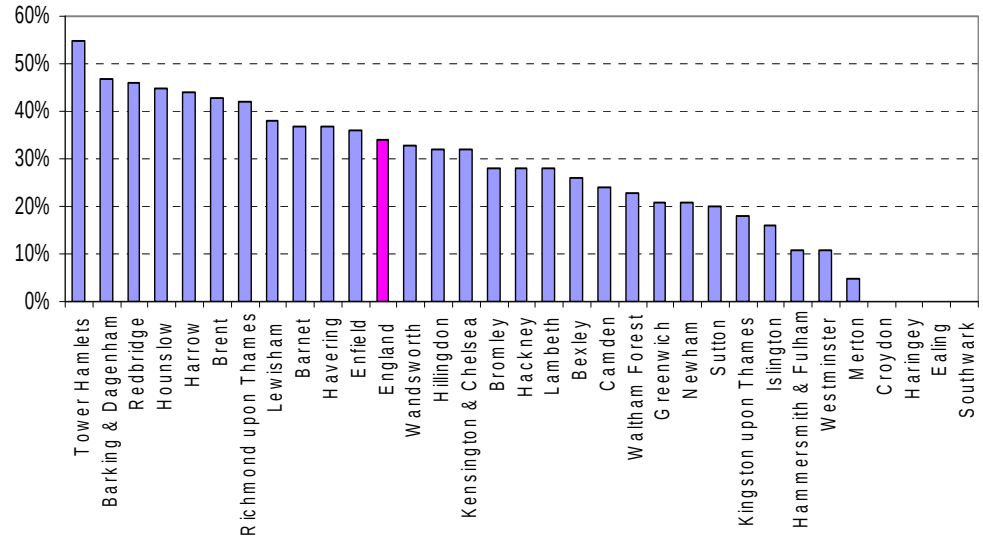
What does survey show?

- Response rates from schools varied widely, ranging from 5% in Merton to 55% in Tower Hamlets. The national school response rate was 34%.
- Between 54% and 73% of children and young people in London borough schools surveyed in 2007 thought that the information they received on Sex and Relationships (SR) was good enough.
- Compared to the national average significantly fewer school pupils in Richmond upon Thames, Havering and Waltham Forest thought that the information on SR was good enough compared to the national average.
- The proportion of young people who said that sex/boyfriends/girlfriends was the thing they worried about most was higher in eight London local authorities than the national average of 18%.
- This was highest in Barking & Dagenham (32%) and lowest in Tower Hamlets (11%).

Trend

The TellUs 1 survey was carried out in 2006 and it is planned that the survey will be repeated annually. It is too early to present trend data.

Figure 74: TellUs2 Response rate from London boroughs, 2007



Source: Tellus 2 Survey 2007

Table 25: Results from specific questions in TellUs2 survey, London boroughs, 2007

Borough	% of school children that think they need better information & advice on S&R? (year 8 & 10 only)	% of school children that think they receive good enough info on SR (year 8 & 10 only)	% of school children that worry about -Girlfriends/ boyfriends/ sex
Hillingdon	46	54	16
Newham	46	54	18
Richmond upon Thames	**46**	54	21
Sutton	46	54	26
Waltham Forest	**46**	54	18
Enfield	45	55	14
Havering	**45**	55	21
Redbridge	45	55	17
Tower Hamlets	43	57	**11**
Hackney	42	58	12
Islington	42	58	13
Harrow	41	59	15
Lewisham	41	59	19
Barnet	38	62	16
Brent	38	62	**14**
Kingston upon Thames	38	62	13
Bexley	37	63	19
Camden	37	63	19
Hounslow	34	66	19
Lambeth	34	66	14
Barking & Dagenham	31	69	32
Greenwich	27	73	12
Kensington & Chelsea	27	73	17
England	37	63	18

Note: The following boroughs: Haringey, Southwark, and Croydon and Ealing and City of London did not provide enough data and their results were added to national estimates; in Bromley, Hammersmith & Fulham, Merton, Wandsworth and Westminster, only year 6 pupils took part and therefore were not asked these questions.

The London average was not calculated and each borough's data were compared to national data and reported as statistically different (red being higher and green being lower). The difference is considered significant when we are 95% sure that the difference would not have occurred by chance. It is important to remember that local authorities have different confidence intervals based on the factors above. Therefore limitations exist when comparing local authority figures. For example, for a particular question a local authority may have a 'better' result than another local authority, but the figure may not be coloured green indicating a positive significant difference. This may be explained by the first local authority having a small sample or one that is not representative enough of the local authority to make confident assumptions about the significance. For this type of sample, a larger design effect has been applied from the calculations provided by MORI.

Metadata

Source of data	Ofsted.
Numerator definition	Questions which were asked of all children and young people used the total number of responses from the local authority or nationally. Likewise, questions asked only of year eight and year 10 children used all responses in the local authority or nationally from pupils aged between 12 and 15.
Denominator definition	Years six, eight, and 10 children of both sexes in maintained schools and pupil referral units. Population data for 2006 from the Pupil Level Annual School Census (PLASC) were used to derive the weights and the number of children. Number of pupils attending Pupil Referral Units is obtained from the 2006 School Level Annual School Census (SLASC).
Geography	London boroughs, England.
Timeliness	Children and young people were asked to complete the online survey over a 7 week period from 24 April 2007 to 14 June 2007.
Disclosure control	School data are not identifiable. Data at local authority level are only given in local authority reports where there are at least 100 responses and at least two schools taking part per year group.
Data accuracy & completeness	Where insufficient numbers of pupils or schools took part in a local authority, their results are not presented at local authority level. Where there are insufficient responses in one age group, the local authority summary report excludes this age group only.
Sample size	Subject to assumptions about levels of response that the survey will achieve, the sampling method being used for a 'typical' local authority is estimated to deliver about 1,300 responses from children and young people. MORI estimate that this will provide headline local authority data reliable to within three to five percentage points for a 50% survey measure at the 95% confidence level. This is in line with other surveys of this type.
Response rate	School response rate is given by the number of schools which participated in each local authority and were included in the local authority report, divided by the number of schools approached in the local authority for the relevant year groups. A limit of 40 primary schools, 15 secondary schools and two pupil referral units (PRUs) was set for each local authority. Sampling for the survey involved children from randomly selected classes.

Limitations

Not all London schools took part in the survey. The responses from the survey were weighted to ensure that the summary data at local authority and national level were representative of the population of years six, eight and 10 children within that area in terms of the following characteristics: gender, age, proportion of children eligible for free school meals in the school (as a proxy for deprivation) and type of school.

Indicator 8.02 SHEU Health Related Behaviour Questionnaire (HRBQ) Studies

Survey description

The Health Related Behaviour Questionnaire (HRBQ) was first developed by John Balding in the 1970s. Since then it has been used in thousands of surveys in secondary schools in the UK. It is carried out by the School's Health Education Unit (SHEU), an independent research and publishing unit which works with local authorities, primary care trusts, and other voluntary and statutory bodies working with children and young people.

The HRBQ contains the following sections:

- Personal background: age, family structure, ethnicity, home background, self-esteem, locus of control, personal safety, height and weight;
- Nutrition: lunch and breakfast, frequency of consumption of listed foods;
- Drugs: smoking, alcohol, other drugs;
- Hygiene, medication, dental: frequency of use of medication, relationship with GP, dental hygiene, health problems;
- Relationships: mental health, sexual health: 'important others', problems and sources of support, contraceptive knowledge, awareness of sexually transmitted infections, value of contraceptive methods for infection control;
- Leisure and money: leisure activities, income, money spent, National Lottery, Instant scratch cards, money saved;
- Exercise: frequency of involvement, feelings about fitness & exercise, cycling training & safety, accidents.

There is both a primary school and a secondary school version of the questionnaire. Many of the questions in the primary version are directly compatible with those in the secondary school version, thus providing a longitudinal study across the under 16s. The SHEU secondary school surveys between 2001 and 2006 involved over 221,000 young people aged 13-15 years (years eight and 10) from secondary schools and 12,482 children from primary schools (years five and six). Data for London schools were extracted from the results.

Rationale for inclusion

Several important health-related issues (such as diet, physical activity, self-esteem, drinking and smoking) have their foundations in the early years. Teenage pregnancy and early onset of sexual behaviour is associated with low levels of self esteem, while high self esteem motivates positive behaviours. Many health educators believe self esteem may motivate positive behaviour change and enable pupils to refuse or otherwise avoid health-risky situations. The Government's Every Child Matters and National Healthy Schools programme require that information on relationships should be provided to school children. SRE also forms part of the school curriculum. The survey provides a picture of self esteem in boys and girls. The survey asked questions about knowledge of family planning and specialist young people services, and knowledge of HIV prevention from years eight and 10. Having an understanding of how school children and young people feel should allow targeting of services and health improvement initiatives.

Primary school survey findings

Children were asked about who had talked to them about how their body changes as they grow up.

- 76% of children said that their parents had; this was similar in Inner and Outer London.
- Inner London pupils were more likely to report discussing puberty in the school setting (with teachers, school nurses or other visitors) than Outer London pupils (73%, 20% and 25% compared to 58%, 13% and 17%).

A number of questions were asked relating to self esteem allowing a rating to be given.

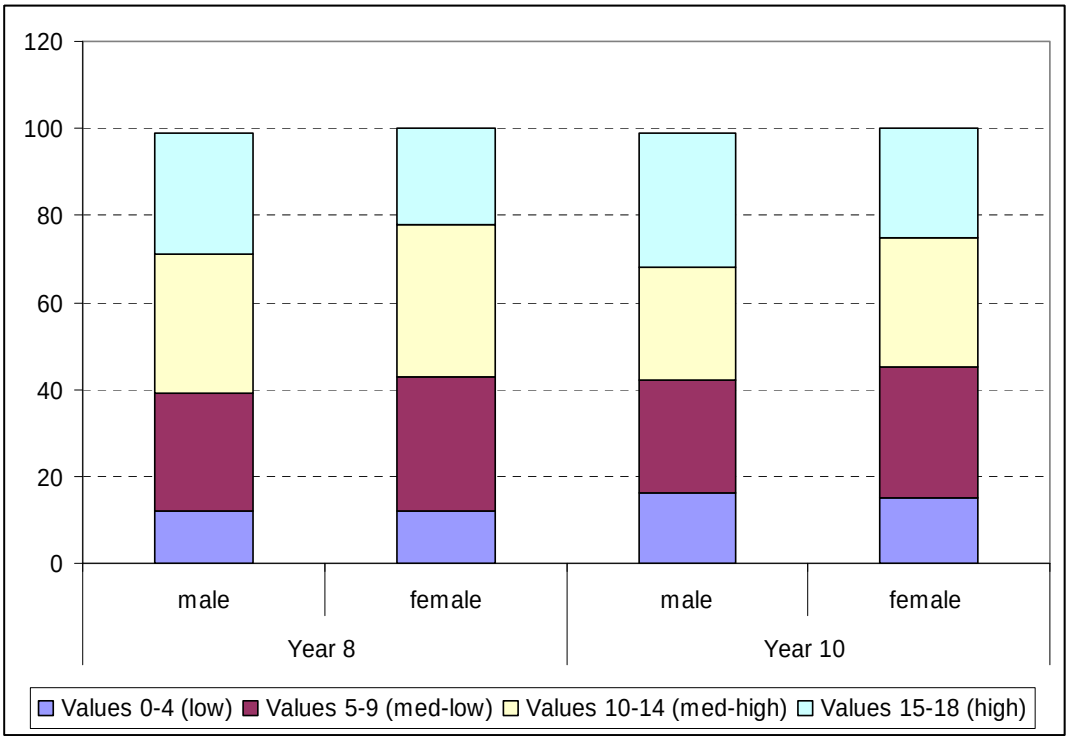
- 81% of school children had high or medium-high self esteem
- Only 4 % had low self esteem and the figures were similar in Inner and Outer London.
- More girls had low self esteem than boys in both school years.

Secondary school

Self esteem

- A greater percentage of Inner London pupils (31%) had high self esteem compared to Outer London (25%).
- A lower percentage of Inner London pupils (12%) had low self esteem compared to pupils in Outer London.
- A lower percentage of girls in both school years had high self esteem scores compared to boys (22% of year 8 girls and 25% of year 10 girls compared to 28% and 31% in boys respectively).

Figure 75: Levels of self esteem in secondary school aged children, 2001-2006



Source: SHEU Health Related Behaviour Questionnaire (HRBQ) Studies 2001-6

Knowledge of sexually transmitted infections

- 52% of pupils surveyed had never heard of gonorrhoea.
- 50% had never heard of chlamydia, genital herpes or genital warts.
- A third had never heard of pubic lice.
- Most of the pupils had heard of HIV although 15% claimed they had never heard of it.
- About a quarter said they knew nothing about STIs.
- Young people who had heard of these infections were often not clear about what could be treated or cured. Less than 20% correctly identified which STIs can be treated and cured and 10% thought most of the STIs can be treated but not cured.
- 64% knew that HIV was treatable but incurable.

Preventing pregnancy - knowledge of services

- 39% of young people in the survey said they knew where they could get condoms free of charge, family planning or other clinics being most commonly identified (18%)
- Overall, 59% of the young people said that they did not know where to get free condoms; this figure fell from about 75% in year eight who did not know to 44% in year 10. 36% of year 10 females knew about the family planning or other clinic compared with 19% of males.
- 47% of Inner London pupils knew of a local special contraception and advice service for young people compared to 34% in Outer London.

Knowledge of birth control/family planning

- 61% of school children felt that condoms were reliable to stop pregnancy while 14 % thought they were not.
- Only 4% claimed to have never heard of a condom.
- 13% had never heard of the pill.
- 18% had never heard of the morning after pill.
- 29% had never heard of the safe period.
- When asked which contraceptive method was effective in stopping infections like HIV, 52% did not respond to the question or felt that none of the available contraceptive methods was reliable.
- 44% felt condoms and 23% felt that female condoms were reliable for preventing pregnancy.
- Some young people thought that other methods such as the diaphragm (8%), pill (8%), sex without penetration (8%), morning after pill (4%) and safe period (2%) were reliable methods to prevent HIV.

Trends

It was not possible to look at trend data for London but the wider databanks from which these results are extracted show that over the last 10-20 years (SHEU, forthcoming publication):

- Older pupils are now slightly more likely to say that schools should be their main source of sex information than they are to say parents; 20 years ago the figures were 3 or 4 to 1 in favour of parents.
- Parents are more likely now than previously to be identified as the adults with which young people get on best.
- Young people expressed decreasing anxiety about HIV between 1992 and 2003.
- Awareness of local sexual health services increased from 1993 to 2004.

- Similarly, awareness of a local source of free condoms increased over the same time period.

Metadata

Source of data	SHEU, Exeter.
Numerator definition	All young people in year group answering the question.
Geography	Inner /Outer London.
Denominator definition	All young people taking part in the survey.
Timeliness	Specially commissioned results from an aggregate of local surveys between 2001 and 2006.
Sample size	33,747 school children from years five and six in primary schools and from years eight and 10 in secondary schools.
Disclosure control	Aggregated data.
Data accuracy & completeness	Paper questionnaire survey. Thirty of the 33 London local authorities took part in the survey.

Limitations

Not all London boroughs took part in the survey.

Indicator 8.03 National Survey of Sexual Attitudes and Lifestyles (NATSAL)

The National Centre for Social Research (NatCen) has carried out two major surveys of British sexual attitudes, and it is anticipated that a similar survey will be commissioned once every 10 years. Findings have been used to help policy makers draw up health education plans, particularly in the areas of teenage pregnancy and sexually transmitted infections.

The first survey of 19,000 adults in 1990 took place in a new climate of sexual openness after the spread of AIDS and HIV. It shed light on patterns of sexual behaviour and the prevalence and distribution of at-risk groups.

In a second survey in 2000, 12,000 people aged between 16 and 44 were interviewed, including a boosted sample of ethnic minorities. Interviewees were questioned about their first sexual experiences, their use of contraceptives and their cohabitation.

Survey findings in 2000[35]

- The survey showed that the behaviour trend towards multiple sexual partners and unprotected sex was more common in London than the rest of Britain.
- The average number of heterosexual sex partners in the past five years was higher in both men (4.5 partners) and women (2.7 partners) in London than elsewhere in Britain (3.7 and 2.3 partners respectively).
- Individuals with concurrent partnerships in the past year (two or more relationships at the same time) were also more common in London.
- National data showed that concurrent relationships are most common amongst those aged 16-24.
- The proportion of men who had a homosexual partner in the last five years was higher in London (5.5%) compared with the rest of Britain (2.1%).
- Although the London data are not available at an ethnic group level, national survey information shows that Black Caribbean and Black African men report the highest number of lifetime sexual partners of all ethnic groups. Just over a quarter and a third respectively, had concurrent partners.
- Nationally, condom use on all occasions in the four weeks prior to being interviewed in those with two or more partners in the past year was low at 33% and 24% in men and women respectively.
- National findings show that parents and schools are the preferred source of sex education and further information[36].

Metadata

Data collection	Interviews were conducted with 16 to 44 year olds living in private households in England, Scotland and Wales. The survey included urine sampling to test for Chlamydia trachomatis. An ethnic minority boost was carried out to increase the number of respondents from four ethnic minority groups, and a total of 950 interviews were achieved. Data were collected by a combination of computer assisted face to face and self interviewing.
Response rate	The main survey response rate was 63.1%. Because response rates were lower in London, an adjustment taking account of the over-sampling of London gave a better estimate of a national response rate at 65.4%.
Sample	A stratified sample of addresses was selected from the small user Postcode Address File (PAF), using a multistage, probability cluster design with over-sampling in Greater London. At each household, eligible residents were enumerated, and one was randomly selected to take part.

Limitations

NATSAL is a decennial survey and is due to be repeated in 2010. The most recent data from the survey undertaken in 2000, which is reported here, may not therefore reflect the current attitudes.

Indicator 8.04 Gay Men's Sex Survey

This survey, undertaken by Sigma Research, is carried out to inform health professionals involved in the planning and delivery of programmes to address HIV prevention needs of men who have sex with men[37]. The survey's concept of need is based on the individual's service knowledge, skills and ability as opposed to the traditional concept .It provides a social context on the HIV epidemic among gay men. A sub analysis of the national survey has been undertaken for London-resident gay men.

Rationale for inclusion

Gay men are disproportionately affected and infected by HIV. This survey describes the distribution of behaviours which may lead either to acquiring or transmitting infection. It describes unmet prevention needs and HIV test patterns of men who have HIV, and men who do not. It allows sexual health intervention profiling. It contributes to *Making it Count*[38], a collaborative planning framework to reduce the incidence of HIV infection during sex between men.

What does the survey show?

Survey findings based on 2004, 2005 2006 and 2007 surveys

- There is more unmet need in young gay men with the median age of diagnosis as 35 years and age at infection of 30 years.
- About 10% of sexually active men who took part in the survey have female sexual partners.
- The ethnic breakdown of the sample is about 86% white and 14% BME/other.
- About a quarter of men sampled had never taken an HIV test.

Specifically in London in 2007

- 22.3% of London's gay men had never had an HIV test. This ranged from 4.8% who had never had a test in Richmond to 45% in Bexley.
- 78.5% were not in a serodiscordant regular relationship but 10.5% were unaware of their or their partner's HIV status.
- 56.8% had had five or more male sexual partners in the past year.
- 27.5% of men had, in the past year, had unprotected anal sex with a partner who was serodiscordant or of unknown HIV status.
- In response to the statement "I would sometimes rather risk HIV transmission than use a condom", 13.5% either agreed or strongly agreed.

Trend data:

Although the survey has been conducted since 1987, it is not possible to comment on trends or on longitudinal patterns due to:

- changes in the questions and definitions used in the survey
- changes in recruitment
- different demographics and
- a change in survey method (initially the survey was only by questionnaires given out at the Gay Pride event but surveys are now also web based and postal).

All of these changes mean that the samples are not comparable.

Table 26: London findings from selected years of UK Gay Men's Sex Survey

Year of survey		2004	2005	2006	2007
Proportion with local authority of residence unknown %		15.4	15	25	12.2
Sample sizes numbers- males		3975	4356	3589	2715
Age groups in years		14-84	14-85	15-80	14-87
Average age in years		35	35	36	35
Years of formal education after the age of 16 years of age %	None	9.8	9.7	9	
	1-2 years	16.7	15.1	14	
	3-5 years	35.6	34.4	34.7	
	6 + years	38	40.8	42.3	
Sexual identity%	Gay	87		86.6	87.2
	Bisexual	7.5		6.8	7.4
	Don't use labels	5		5.9	5.5
Ethnicity %	white	86.1	86.5	86.6	79.7
	BME	7.3	7.3	5.5	10.4
	mixed and other	6.6	6.2	8	8.8
Living arrangements %	alone			36.8	
	male partner			29.1	
HIV testing %	never tested	27.8	28.2	23.4	22.3
	negative test in >1 year	24.5	26.2	27.4	61.9
	negative in last year	34.7	33.5	36.4	
	tested positive	13	12.2	12.8	15.8
Number of male sexual partners in the last year %	1	12.9	15.8	16.2	15.4
	2 to 4	24.7	22.6	22.5	21.7
	5 to 12	26.6	26.8	26.3	23.2
	13 to 29	17.3	17.2	17	15.9
	30+	18.6	17.6	18	17.7
Gender of sexual partners%	men only	90.4	87.9	89.7	89
	men and women	6	9.1	6.9	6.2

Source: Vital Statistics 2005, 2006, 2007. The UK Gay Men's Sex Survey Area Sub-samples Data Report April 2006, February 2008, and August 2008.

Limitations

There is a paradox in HIV prevention planning for gay men as unmet need, as defined by this survey, does not necessarily lead to "harm". The men who do not practice safer sex are not necessarily ill informed. HIV positive gay men are often better informed than those who are unaware of their HIV status.

Indicator 8.05 BASS line survey 2007: African Health and Sex Survey

BASS line was a survey of people aged 16 and over, living in England, who identified themselves as African. It was on the topic of HIV sexual behaviour, knowledge and attitudes[39]. BASS line 2007 used two data collection methods: a self sealing freepost address booklet distributed by health promotion agencies and online via a dedicated website. Of all people responding in London, the majority were from South London PCTs. Data from 8 PCTs were combined into an "all other London" category because fewer than 20 residents in each borough completed the questionnaire. This "all other London" category also includes those where the PCT of residence was unknown. The survey questions are grouped into three main themes: HIV and STI testing and diagnosis; sexual HIV risk behaviours; and HIV prevention needs.

Rationale for inclusion

Black minority ethnic groups are consistently identified as those who are most affected by STIs. They are referred to as a key prevention group in this report.

HIV and STI testing

- Across London, almost one in five Africans surveyed were known to be HIV positive and almost half had never been tested.
- Kingston and Hounslow had the highest percentage of those surveyed that were known to be HIV positive.
- Camden and Southwark had the lowest percentage of those surveyed who had been tested for HIV.
- Across London, 9% wanted an HIV test but did not know where to get one, although the rate was 20% in Ealing.
- Almost 9% had been diagnosed with an STI other than HIV in the past 12 months, with the highest rates being in Wandsworth and Hounslow.

Sexual HIV risk behaviours

- 8.5% had 5 or more sexual partners in the past year. The highest rates were seen in Lambeth and City & Hackney at 19.4% and 14.9% respectively.
- Almost one in five Africans in London said they never used a condom.
- Of those that had used a condom, one in five reported that they had experienced condom breakage or slippage in the last year.
- One in twelve reported having a definite or probable serodiscordant (one partner HIV positive) sexual relationship in the past year.

HIV prevention needs

- Although most people knew that AIDS is caused by the virus, HIV, and that the infection is incurable, 6.5% thought that they could tell someone had the virus by looking at them and 7.7% did not know that people could have the virus without knowing it.
- 40% of those surveyed did not know that at least one in twenty Africans in the UK has HIV infection. Nearly 20% thought that Africans were deported from the UK for being HIV positive.
- Although 85.7% knew that there was HIV medicine, over 21% did not know that the medicine works better if taken before the person becomes ill.

- The majority (over 78%) knew about the availability of free condoms but almost 20% reported difficulty in getting hold of condoms.
- Almost a quarter of those surveyed said they would worry about what people would think of them if they carried a condom and one in eight said they would not find it easy to talk about safer sex and HIV with new sexual partners.

Table 27: BASS line survey 2007: the African Health and Sex Survey, London PCT results, percentages

	HIV testing history			Wants HIV test but doesn't know where to get one	Had STI (other than HIV) in past 12 months	Sexual HIV risk behaviour			
	Never tested	Last tested negative	Tested positive			Had 5 or more sexual partners in the last year	Never use a condom	Condom breakage or slippage in last year	Definite or probable serodiscordant relationship in the past year
Barnet	42.9	42.9	14.3	7.1	3.6	0	14.3	10.7	10.7
Enfield	35.9	35.9	28.1	14.3	4.9	7.7	14.5	14.3	11.7
Haringey	45.5	35.1	19.5	5.3	6.5	10.4	14.3	14.5	5.4
Waltham Forest	55.2	34.5	10.3	18.5	3.4	3.3	20.0	16.7	6.9
Redbridge	47.6	28.6	23.8	9.5	8.65	4.5	34.8	17.4	4.3
Ealing	40.0	56.0	4.0	20.0	16	7.7	16.7	20.8	3.8
Brent	38.1	38.1	23.8	10.0	9.6	4.8	14.3	19.0	10
Camden	59.4	37.5	3.1	10.0	0	6.3	19.4	19.4	6.8
Islington	31.6	52.6	15.8	5.0	5.0	10.5	31.6	5.3	0
City & Hackney	55.3	27.7	17.0	6.4	6.5	14.9	26.7	17.8	6.8
Newham	47.8	36.2	15.9	15.2	4.4	3	16.2	20.6	7.6
Barking & Dagenham	52.7	40.0	7.3	14.0	5.4	11.4	19.2	19.2	11.8
Kensington & Chelsea	33.3	57.1	9.5		0	4.8	9.5	15.0	9.5
Hounslow	29.2	37.5	33.3	8.7	16.7	0	30.4	13.0	4.2
Wandsworth	56.1	22.8	21.1	8.9	20	8.5	18.3	35.6	9
Lambeth	46.1	35.9	18.0	4.8	9.4	19.4	16.9	28.1	10.9
Southwark	61.8	28.2	10.0	16.4	8.1	9	17.3	19.3	11.1
Lewisham	35.6	44.1	20.3	13.6	15.3	8.1	24.2	14.5	9.7
Greenwich	40.3	32.3	27.4	3.4	9.8	11.1	15.6	26.6	9.6
Bexley	52.4	38.1	9.5	9.5	4.8	4.8	23.8	25.0	15
Kingston	43.6	15.4	41.0	5.1	12.9	10.5	25.6	43.2	0
Sutton & Merton	55.6	16.7	27.8	14.4	10.8	6.6	23.3	22.5	3.8
Croydon	35.4	35.4	29.3	6.0	15.9	3.5	21.7	28.0	8.8
Westminster	34.6	50.0	15.4	4.0	3.8	7.6	19.2	16.0	7.6
All other London	49.4	37.8	12.8	4.9	4.8	7.8	16.9	13.4	8.8
London	46.8	34.5	18.7	9.1	8.7	8.5	19.1	20.5	8.3

Source: BASS line survey. http://www.sigmaresearch.org.uk/files/local/London_BL_2007.pdf

Limitations

BASS line 2007 used two data collection methods: a self sealing freepost address booklet distributed by health promotion agencies and online via a dedicated website. Therefore, those that decided to respond to the questionnaire are a self motivated group and so the findings may not be generalisable to the rest of the African population.

Indicator 8.06 Omnibus Contraception and Sexual health Survey

The Omnibus survey is a multipurpose survey. The contraceptive module includes questions on contraceptive use, sexual health and knowledge of sexually transmitted infections. London data were extracted from the main survey from 2001 to 5. The sample size was 3019 respondents of which there were 1347 males aged 15-69 and 1647 females aged 15-49 years. National findings of the survey suggest that there has been an increase in the use of the contraceptive pill over the years of the survey

Rationale for inclusion

The General Household Survey looks at trends since 1986 in the use of contraceptive methods by women aged 16-49 when questions about contraception were first addressed to all women aged 16 years. The survey is carried out nationally across England.

What the survey showed

Contraception

- In 2001-5, nearly two-thirds of women in London aged 16-49 (66.9%) used at least one form of contraception.
- The contraceptive pill and the male condom have remained the most commonly used methods of contraception.
- The majority (88.1%) of all women in the survey had heard of hormonal emergency contraception (the morning after pill).
- Only 44% were aware of the emergency Intrauterine Device (IUD).
- The women obtained the emergency pill from a chemist or pharmacy (30%), their own GP /practitioner (25%), family planning clinic (15%) and accident and emergency (2.5%).

Services for contraception/advice

When asked which service they visited for contraception /advice:

- 14.9% said family planning service,
- 20% visited their practice nurse/GP,
- 6.5% visited chemist or pharmacy.

Sexual behaviour

- In London, between 2001 and 2005, 85.6% of men aged 16-69 responded that they only had sex with women compared to 94% nationally.
- Four percent said they only had sex with men, compared to 1% nationally. Five percent had not yet had a sexual relationship and the remaining 4% were reportedly bisexual.
- In the year prior to the interview, a greater proportion of women than men had had only one sexual partner (86% and 76% respectively).

- Nine percent of women had had two or three partners compared to 14% of men.
- Fifty-four percent of men aged 16-69 years and 52% of women aged 16-49 years who were in a sexual relationship said what they had heard about STIs, HIV or AIDs had not influenced their behaviour.
- Where behaviour had changed, the main difference was a reported increase in condom use (36% of women and men in London and 37% nationally); fewer one night stands (5% of both men and women); and having a test for STI when they changed partners (7% of women and 4% of men).

Condom use

- Of those in a sexual relationship, either currently or in the year before the interview, only 37% of women and 48% of men had used a condom in the past year.
- The most common reason given for condom use was prevention of pregnancy (51% of females and 46% of males). Only 6% of females and 13% of males said they used it to prevent infection. About a third of males and females said they use condoms for preventing pregnancy and infection.
- Of those who had used a condom in the past year, 60% of females and 50% of males said they always used one when having sexual intercourse.
- 18% of women and 24% of men reported being regular condom users.
- 23% of females and 24% of males reported sometimes using condoms.

Sources of information about sexually transmitted infections

- The main source of information on STIs was television, with 17% stating TV adverts and 29% TV programmes.
- Newspapers, books and magazines accounted for 28.9%.
- Schools or colleges were a source of information for 6.5%.
- Only 5.1% said from GP, family planning and GUM clinics.

Limitations

The small sample size for London may not wholly reflect the diversity of the population.

Indicator 8.07 Other surveys

1. From a positive perspective: Key issues for people living with HIV in the UK, 2007[40].

Currently there is limited information on the key issues for people living with HIV in the UK and in the capital. Following work by the UK Coalition of People Living with HIV and AIDS (UKC), the National AIDS Trust produced a report, analysing outcomes from regional focus groups/meetings and drawing on the UKC questionnaire. The report provides information on the concerns of people living with HIV. It involved 65 focus groups of which 12 were with London residents. The main concerns for people living with HIV in the UK were:

- the ability to have children
- availability of sperm washing
- support for young people and people living with HIV who are in prisons
- a need for more work to be done with the heterosexual white population
- the need for HIV medication to be delivered to mothers post partum
- serodiscordant relationships.

International travel restrictions were also of particular concern to Londoners living with HIV.

2. Mayisha II 2004 Study - community based survey of sexual attitudes and lifestyles among Black African communities[41]

The survey was made up of 1359 Black African respondents: 872 from London, 252 from Luton and 235 from the West Midlands. The survey found that

- In both men and women the older age groups were more likely to test positive for HIV. The HIV positive rates were 26.8 % in men 40-44 years, 25.5% in women aged 35 to 39 years
- HIV rates were lowest in those aged under 25 years.
- 20% of men reported two or more sexual partners compared to 7.9% of women
- Over half (51%) of the females had never had an HIV test compared to 42.9% of males.

HIV awareness raising events and one to one outreach were the main factors that motivated them to take an HIV test.

3. Sexual health knowledge, attitudes and behaviours among Black and Minority ethnic youth in London, 2006

Among 16-18 year olds surveyed in London, non-use of contraception at first intercourse was most frequently reported among Black African males (32%), Asian females (25%), Black African females (24%) and Black Caribbean males (23%)[42]. 65% of Black Caribbean males reported experience of sexual intercourse, and 48% reported first intercourse under the age of 16.

Section 9. Crime: Sexual Violence

Introduction

Sexual assault and domestic violence are both criminal justice and public health problems. In the last decade, the Government has implemented a range of policy interventions that aim to tackle domestic and sexual violence both nationally and locally. These measures focus on early intervention and prevention, improving the criminal justice process and providing support for victims.

The Domestic Violence, Crime and Victims Act 2004 introduced new powers for the criminal justice system to deal with offenders, while increasing the protection of victims and witnesses. The Sexual Offences Act 2003, which was introduced in May 2004, has clarified the law in relation to sexual assault. It has established a legal definition of 'consent'. It also created new offences and strengthened sentences. The existing network of sexual assault referral centres has been extended since 2004, together with other voluntary sector counselling and support services for victims of sexual crime.

More recently, the Home Office has classified 'reducing the most serious violence' as Priority Action 1 within Public Service Agreement (PSA) Target 23 published in October 2007. This includes tackling serious sexual offences and domestic violence. There is also a greater focus on more serious crime within the Home Office's 2008/2011 crime strategy published in July 2007.

There are two major action plans to tackle domestic violence and sexual violence. The National Domestic Violence Delivery Plan (2005) [43] aims to:

- reduce the prevalence of domestic violence,
- increase the rate of reporting,
- increase the rate of offences brought to justice and
- improve support and protection for victims.

The Action Plan on Sexual Violence (2007)[44], a cross governmental plan aims to:

- introduce a range of measures aimed at improving the criminal justice response to sexual violence,
- strengthen support and health services to enable specialised support to be provided to victims,
- introduce preventive measures aimed at those at risk of victimisation or re-victimisation, and
- introduce preventive measures aimed at those at risk of offending or re-offending.

Sexual violence and domestic violence are under-reported crimes. Domestic violence is not a formal category of crime and therefore reported crime statistics are not able to identify it specifically. To understand the complexity of under-reporting and domestic crime, the British Crime Survey provides useful information. The sampling frame for the survey is such that it is not possible to extract data for London due to small numbers.

British Crime Survey (BCS)

The British Crime Survey (BCS) is a large, nationally representative victimisation survey of approximately 47,000 adults living in private households in England and Wales. The BCS provides a generally more reliable trend measure of violent crime as it is not affected by changes in reporting, police recording and local policing activity. It

has been measured in a consistent way since the survey began in 1982. BCS includes a self-completion module relating to experiences of intimate violence.

The term intimate violence is used to describe domestic violence, sexual assaults and stalking and is asked of people aged 16 to 59. The figures from the BCS are not affected by levels of reporting to the police, which is particularly important for these crime types. Prevalence rates for domestic violence from the self-completion module are around five times higher than rates obtained from face-to-face interviews on the BCS. Based on the 2005/06 BCS self-completion module on intimate violence, approximately three per cent of women and one per cent of men had experienced a sexual assault in the previous 12 months[45]. The majority of this was accounted for by less serious sexual assaults. Less than one per cent of both women and men had been a victim of a serious sexual assault.

Information used in this report

Data for this chapter are from the Home Office Statistical Bulletin[45], 31 January 2008 and all supplementary tables.

Indicator 9.01 Recorded Sexual Offences 2007

Rationale for inclusion

Sexual offences include sexual assault, rape, abuse of position of trust, trafficking and prostitution offences. These offences have an impact on the individuals and their families and friends. In some instances they may result in transmission of sexually transmitted infections or an unwanted pregnancy.

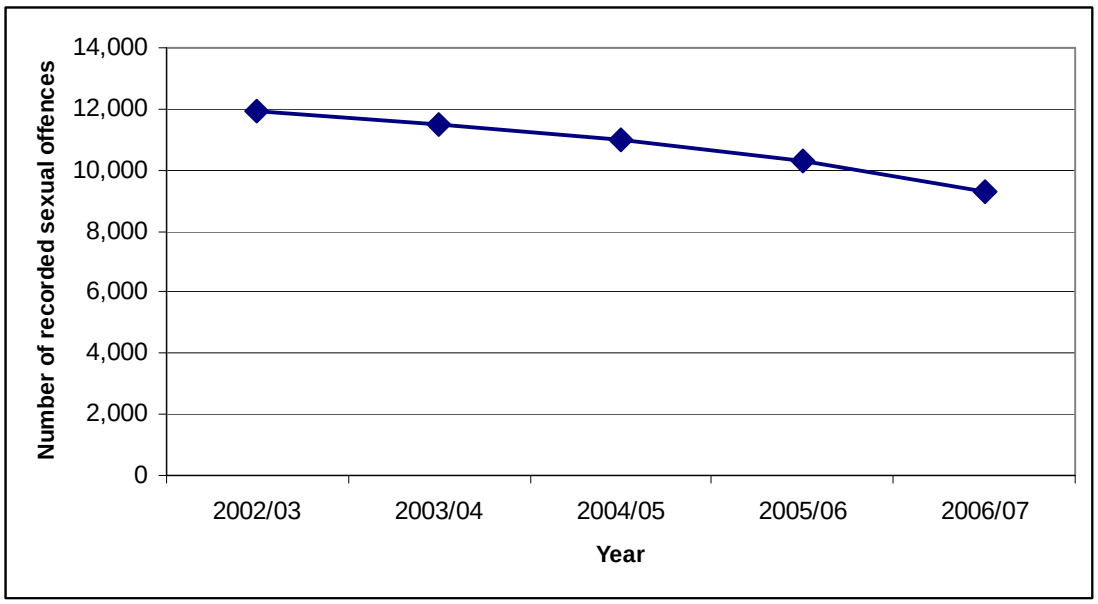
What does the indicator show?

- In 2006/07, there were 9,294 sexual offences in London – a rate of 1.24 per 1,000 population, and in England the rate was 1.07 per 1,000 population.
- The London figure hides wide variation in rates across London.
- The highest rate of offences occurred in the City of London at 4.90 per 1,000 and the lowest rate was in Havering at 0.65 per 1,000.

Trend

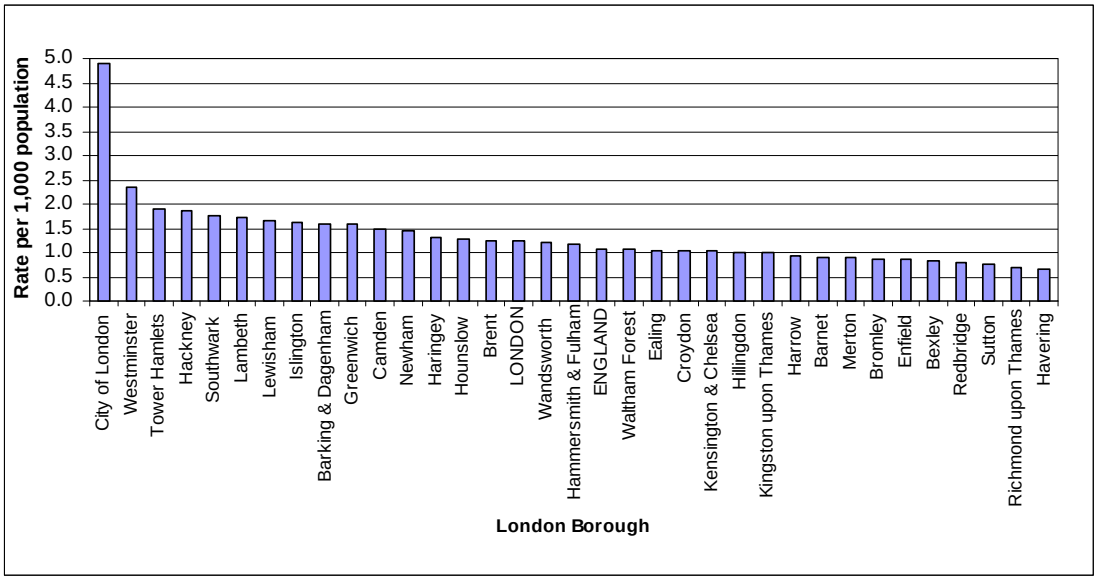
- From 2005/06 to 2006/07, there was a 9.7% reduction in sexual offences in London compared to 7.4% in England.
- Havering had the highest decrease with a 31% fall from the previous year.
- Seven London areas had an increase in sexual offences between 2005/06 and 2006/07. Harrow, although it has relatively low rates, had the greatest percentage increase in sexual offences from the previous year (28%).
- The trend from 2002/03 shows a steady decline in the numbers of recorded sexual offences.

Figure 76: Number of sexual offences, London, 2002/03 to 2006/07



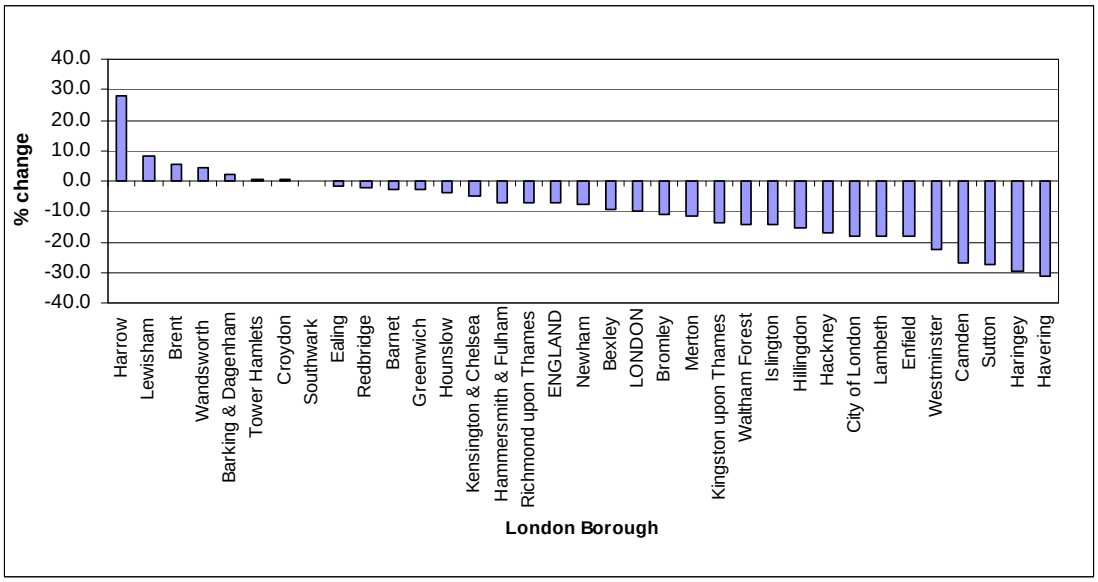
Source: Home Office, Crime in England and Wales 2006/2007
(http://www.homeoffice.gov.uk/rds/pdfs08/cdrpog1.xls)

Figure 77: Sexual offences per 1,000 population, London boroughs, England, 2006/07



Source: Home Office, Crime in England and Wales 2006/2007
(http://www.homeoffice.gov.uk/rds/pdfs07/cdrptabs.xls)

Figure 78: Percentage change in recorded sexual offences, London boroughs, 2005/06 to 2006/07



Source: Home Office, Crime in England and Wales 2006/2007
(http://www.homeoffice.gov.uk/rds/pdfs07/cdrptabs.xls)

Nationally recorded crime by offence from 2005/06 to 2006/07 shows that rapes of a female fell by five per cent to 12,630, but rapes of a male rose by three per cent to 1,150 offences. Sexual assaults on a female fell by seven per cent to 21,403 offences, and sexual assaults on a male fell by 13 per cent to 2,763[46].

Metadata

Indicator description	Indicator 1. Number of recorded sexual offences per 1,000 population Indicator 2. Percentage change in number of recorded sexual offences
Source of data	Data for this chapter are from the Home Office Statistical Bulletin[44], 31 January 2008 and all supplementary tables. The data in this section are collected for Crime and Disorder Reduction Partnership and published in (http://www.homeoffice.gov.uk/rds/pdfs07/cdrptabs.xls and http://www.homeoffice.gov.uk/rds/pdfs08/cdrpog1.xls)
Numerator	Indicator 1. Number of recorded sexual offences 2006/07 Indicator 2. Change in the number of recorded sexual offences 2005/06 to 2006/07
Denominator	Indicator 1. ONS mid year population estimates 2005 Indicator 2. Number of recorded sexual offences 2005/06
Geography	London boroughs, London
Timeliness	Data are released annually by the Home Office
Disclosure control	There is no disclosure control for this indicator.
Data accuracy and completeness	Police recorded sexual offences cover different types of unlawful sexual activity, including rape and sexual assault. Some of the offences do not necessarily involve violence: unlawful sexual intercourse with a person under 16 or with a mental disorder, for example. The range of seriousness is addressed by creating two sub-categories: • Most serious sexual crime (including rapes, sexual assaults, and sexual activity with children) • Other sexual offences (including soliciting, exploitation of prostitution, and other unlawful sexual activity between consenting adults). Data in this report cover all sexual offences recorded by the Police. London data are from City of London Police and London Metropolitan Police. Sexual violence and domestic violence are under-reported crimes, therefore these data may not include all offences. Police recorded crime data are recorded where the offence occurs and may not represent offences committed on the resident population.

Limitations

Sexual violence and domestic violence are under-reported crimes. The British Crime Survey data are not available at a regional level and thus not included in this indicator set.

The BCS provides a measure of the level of crime committed against the private household population in England and Wales; recorded crime is a measure of those crimes reported to the police and then recorded by them. Only a subset of these measures is comparable.

Police recorded crime data offences are recorded where the offence occurs and may not represent offences committed on the resident population.

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