NHS Bromley
Sexual Health Needs
Assessment 2009
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EXECUTIVE SUMMARY

1. National picture, policy and guidance

The incidence of sexually transmitted diseases is steadily rising in the UK, and the teenage conception rate, though falling, is still the highest in western Europe. In response to this situation, a number of national and regional policy documents have been produced over the last ten years, aimed at improving sexual health through prevention and better services. These include the National Strategy for Sexual Health and HIV (2001), Sex and our City (a review of sexual health services in London), Choosing Health (2004), You’re Welcome (2007), and two sets of NICE (National Institute of Clinical Excellence) guidance, the first on reducing Sexually Transmitted Infections (STIs) and under-age conceptions, and the second on changing behaviour.

In summary, policy and guidance has centred around:

- Identifying groups and individuals who are at particular risk of poor sexual health, and providing preventive and supportive services to these.
- A national public information campaign aimed at preventing STI and Human Immunodeficiency Virus (HIV) transmission and unintended pregnancies.
- Local stakeholders to review sexual health and HIV provision in each area
- Providing STI, contraceptive and other sexual health services via an integrated service, rather than separately. Ideally patients should be able to attend a ‘one stop’ clinic where all their sexual health needs can be met.
- A broader role for nurses and other primary care staff in the delivery of sexual health services.
- Providing sexual health services that are young people-friendly.
- Increasing the use of Long Acting Reversible Contraception (LARC).
- Increasing routine testing for HIV, so reducing late diagnosis rates.
- Increasing access to Genitourinary Medicine (GUM) clinics within 48 hours
- Decreasing rates of new diagnoses of Gonorrhoea and HIV
- Increasing rates of Chlamydia screening

2. Improving sexual health in Bromley: work to date

In Bromley, the Primary Care Trust (PCT) produced its own Sexual Health Strategy in 2006, followed by an in depth needs assessment in 2008. A report following a visit by the Department of Health’s National Support Team in January 09 commended the needs assessment, but suggested that it could be updated, and expanded to include information on vulnerable groups and user views. The result is this document.

3. Aims and Objectives of the Needs Assessment

Aims:

1. To understand the sexual health needs of Bromley residents.
2. To review the provision of Sexual Health and HIV services in Bromley, to assess the need for these services in the local population, and to identify any gaps between provision and need, and between provision and national guidance.
3. To inform a sexual health strategy for Bromley that describes a high quality, evidence-based and cost effective service that is in line with national guidance.

Objectives:

1. Quantify the levels of STIs and HIV infection in Bromley, and to identify trends and at-risk groups.
2. Assess the current performance of local contraceptive services by analysing rates of teenage conceptions, abortions, and uptake of long acting reversible contraceptives (LARC).
3. Quantify and evaluate current service provision in terms of capacity, geographical cover and ability to provide services that users need.
4. Gather views of local stakeholders on current and future provision.
5. Gather views of service users on current and future provision.
6. Identify population groups who may not be accessing the services they need, and why.
7. Identify gaps between current service provision and need.
8. Identify gaps between current service provision and national standards.
9. Make recommendations as to how those gaps could be filled.

4. The population of Bromley

The estimated population of under 25s is approximately 35,000, and is expected to rise slightly by 2013, and to fall off again by 2018. While the number of people under 19 is expected to fall overall by 2026, increased numbers are expected in the Crays, Penge and Cator, and Plaistow and Sundridge. The proportion of ethnic minorities in the population is expected to rise, in particular Black Africans.

Although Bromley is a relatively affluent borough, there are pockets of very low income, with unemployment levels similar to inner London. Similarly, there is a wide range of educational attainment among schools in Bromley.

5. High risk and vulnerable groups

Certain groups are at particular risk of poor sexual health. In Bromley these include young people who live in deprived areas, those not in education, employment or training (NEET), looked after children, people who misuse drugs and/or alcohol, certain ethnic groups, men who have sex with men, and youth offenders.

The highest numbers and proportions of children and young people in Bromley are located in: Cray Valley West, Cray Valley East, Penge & Cator, Clock House and Kesley & Eden Park. Deprivation is also highest in these wards.

In terms of specific groups in the population:

- Bromley has higher numbers of young people not in education, employment or training (NEET) than comparable boroughs
- There were 250 looked after children in 2008, and 117 care leavers.
- There are around 250 youth offenders, with equal numbers of males and females
- Young parenthood is common among Gypsies and travellers, and religious beliefs are often opposed to the use of contraception;
• A high proportion of newly diagnosed HIV infections occur among Black Africans, of whom 41% are diagnosed late. Twice as many women as men are affected.
• There are an estimated 12,000 gay men living in Bromley, who are hard to reach, probably due to homophobic attitudes and consequent fear of openness.

6. Sexual Health in the UK, South East London and Bromley

A. Sexually Transmitted Infections

In the UK there have been consistent increases in the incidence of Chlamydia and genital warts, while gonorrhoea has decreased. In South East London (SEL) STIs have been slowly falling overall, until 2007 when there was an increase.

In the Beckenham clinic in Bromley in 2007 there was a marked increase in diagnoses of Chlamydia, Gonorrhoea, Herpes and Warts, more so than in SEL as a whole, with women and the younger age group of 20-24 significantly more at risk.

B. HIV/AIDS

In the UK, 55% of all HIV diagnoses are in heterosexuals, and 41% in MSM. 36% of diagnoses are in Black Africans, of whom 41% are diagnosed late. Twice as many black African women are affected as men. The proportions are similar in Bromley. Prevalence of HIV in people aged 15-59 is lower than in central London, but rising faster, with a rate of 1.75 per 1000 in 2007, with 331 people accessing HIV care (compared with 288 in 2006). Higher rates of HIV are to be found in the north west of the borough.

C. Teenage conceptions

The teenage conception rate is relatively low in Bromley, but has been increasing slightly over the last 10 years. Bromley's teenage conception rate, 34 per 1000 women, is well short of its target, which is to reduce to 17.7 or less by 2010. Teenage conception rates are as high as inner London rates in certain areas of the borough.

D. Terminations of pregnancy/abortion

Abortion rates in the UK are rising steadily, year on year. The proportion of all conceptions ending in abortion is now 23% for England & Wales (E&W) and 32% for London. The abortion rate is higher in Bromley among 18-44 year olds than in E&W (23 v 18.8 per 1000 women), and the repeat abortion rate is similar to central London, at 29%, compared to 25% in England. There were high numbers of abortions in SE20 during 2008/09, and clusters in Bromley Town, the Crays and Biggin Hill.

The percentage of abortions done before 10 weeks gestation is 79% in Bromley, higher than for E&W, and the percentage of NHS funded abortions is also higher than average, at 89%. Just under a third of funded abortions are medical, as opposed to surgical. Abortion providers for Bromley residents are all outside Bromley.

It has only recently been made possible for abortion providers to provide all types of contraception to Bromley clients. A new specialist contraception nurse is now working in the abortion service, who will provide a follow up service for self-referrers and under 18s.
E. Contraception and contraceptive services

First attendances at the Contraception and Reproductive Health Service (C&RH) for Long Acting Reversible Contraceptives (LARCs) in 2007/8 is only 10% in Bromley, compared with 14% in London and 15% in England. However, the clinical lead reports that a concerted effort by the service during 2009 is resulting in increased uptake. 8% of first attendances in 2008/9 were for emergency contraception, compared to 11% in London.

7. Services for Sexually Transmitted Infections (STIs), contraception, and other aspects of sexual health

Service provision for sexual health in Bromley includes preventive as well as diagnostic/treatment services, and comprises:

A. Sexual Health Service (GUM clinic),
B. Contraception & Reproductive Health service
C. GP practices, including Locally Enhanced Service (LES) practices
D. Termination of Pregnancy (TOP) service.
E. Chlamydia Screening
F. Health Improvement
G. HIV Specialist Nursing Service
H. Community Pharmacy
I. School health (Nursing) service
J. Voluntary organisations

A. Sexual health service (GUM)

There is one GUM clinic in Bromley, based at Beckenham Beacon in the north west of the borough, providing 8 mixed walk-in clinics per week, including one YP clinic. Contraception advice, emergency contraception and condoms are provided. A full STI screen is offered, with results available in 2-3 weeks. (Metro, a voluntary agency, does point of care testing for HIV (POCT), with results in 20 minutes. This is a new technology that would require additional funding for GUM services). 61% of people seen at Beckenham Beacon are Bromley residents, and 39% of Bromley GUM patients are seen outside the borough.

B/C. Contraception & Reproductive Health service (C&RH)

Currently, contraception services are provided by C&RH and by General Practices. C&RH run nine general contraception clinics a week at seven different sites. All the clinics are run as a ‘drop-in’/’walk-in’ service. Seven of the clinics are open-access to all ages; the other two are restricted to those aged under 24 (there is also an under-24 clinic within one of the other general clinics). Currently, there is a doctor present in three of the clinics and one session a month at Biggin Hill, who mainly sees clients by appointment, for LARC procedures and specialist advice and follow-up. The other clinics are nurse led, and can usually access doctor advice by telephone if required. Three of the clinics are held at the Beckenham Beacon and the others at six different sites throughout the borough. Contraception clinics are also provided on one day a week during term time for the students at Bromley and Orpington colleges. These are ‘drop-in’ sessions and can provide advice, user dependent contraception supplies, pregnancy testing and Chlamydia screening. In addition, there are specialist, appointment-only clinics for LARC procedures,
vasectomy, and psychosexual counselling, which are all based at the Beckenham Beacon. LARC procedures are currently only carried out in the clinics with a doctor present and in the specialist LARC clinics. About 50% of these procedures are done within a month of being requested, and at first visit where possible and appropriate. Women who wait longer for their procedure are usually unable to be flexible on time of day or venue.

The C&RH service is led by a Lead Nurse and an Associate Specialist. None of the staff are full time, and most of the C&RH nurses are sessional. Staff are well trained and dedicated, but there are not enough to meet service needs. A new post has recently been created, for two days per week, to develop outreach work and domiciliary visits to vulnerable and hard-to-reach groups.

Uptake of community contraception services in Bromley is 30% lower than the national average (possibly because of the limited capacity of C&RH services). Prescription rates for contraceptives, including LARCs, vary widely between GP practices, and are not related to LES status.

**Service limitations that concern both STI and contraception services**

Although C&RH clinics offer Chlamydia screening, advice and signposting on STIs, and IUD/IUS-related STI screening, and contraception advice is offered by the GUM service, in practice both types of clinic are already stretched with their main service and the other service is neither comprehensive nor routinely offered.

While patients can call the C&RH service during office hours, and patients arriving early can take a ticket and a seat, GUM patients can only call during clinic hours, and have to wait outside at Beckenham Beacon until the clinic starts. In both clinics people are turned away if available slots have been filled, or if the service they require is not available. Patients are not turned away if their needs are urgent.

**D. Services for abortion**

Bromley contracts with private providers for these services. The service includes counselling, choice of medical or surgical abortion, contraception advice and, recently, provision of all types of contraception. 68% of patients attend an appointment within one week of their call, and 96% within two weeks. The patient is then offered the procedure usually within one week of the first visit and never longer than 2 weeks.

The PCT aims to reduce the repeat abortion rate (29%) to national levels (23%) by introducing a follow-up service run by a specialist contraception nurse for all self-referrers and under 18s. In addition, C&RH has a policy of making future contraception plans with any clients they refer for TOP. This involves either arranging for Depo-Provera or an IUD/IUS or Implanon to be fitted at the time of a surgical procedure, or booking them an appointment at the C&RH clinic, or providing an oral method to commence immediately after their procedure. Follow-up at C&RH about 3 weeks after the procedure is also encouraged to review their future contraception plans.

**E. Chlamydia Screening Programme**

Chlamydia screening is offered to all young people aged 15-24 via a variety of outlets, including online testing by post. 15% of young people have been screened,
just 2% short of the target for 2009. Recent months have seen an expansion of testing sites, including the TOP service and maternity services.

F. Health Improvement
A wide range of activities are taking place in the borough, to reduce STIs and teenage conceptions, and train staff in contact with young people. Some evaluation of projects is happening, although this is not routine, and data collected for evaluation is not always processed. The Health Improvement directorate is concerned with the population and groups aspects of sexual health promotion, and does not work closely with service providers on individual interventions. Black Africans are at high risk of HIV, but are hard to reach, and there is no current programme directed specifically at this group.

G. HIV Specialist Nursing Service
Two specialist nurses run this service, which is based in the GUM department at Beckenham Beacon, and provides support and advice to people with HIV.

H. Community Pharmacy
While many pharmacies are trained to provide Chlamydia screening, only 6 are providing free emergency contraception to under 16s. The cost of over-the-counter emergency hormonal contraception is otherwise £26.50.

I. School Health
Several school nurses working in the area have specialist training and do sessions as Bromley C&RH nurses. The contraception sessions provided at Bromley and Orpington colleges are staffed by school nurses who also work for C&RH. While all school nurses have some training in sexual health and are well-placed to provide advice and signposting to young people in school, the level of input varies from school to school, and they have other activities to fit in. Most schools have counsellors, but these are not necessarily trained to give advice in sexual health matters.

J. Voluntary organisations
Three organisations that are highly relevant to sexual health of young people in Bromley are:

- The Metro Centre, which is a charity working in partnership with statutory and voluntary organisations providing sexual health services and support to lesbians, gay men, bisexual and transgendered (LGBT) people and those questioning their sexuality. It is based in Greenwich, but has outreach teams working in Bromley, including the Chlamydia Screening outreach team. A lot of gay men from Bromley use the Greenwich service.
- The Junction is a centre in Bromley for people who are living with HIV, and provides a range of services including information and support, counselling, men’s and women’s groups and drop-in sessions.
- Connexions works to link up services in Bromley which support young people.
8. Stakeholder and User views

An important part of any needs assessment is gathering the views of the people who run the services, the people who use them, and the people who need them but don’t use them. Using a combination of questionnaires, workshops and interviews, in a range of settings, we gathered views from staff who work at/with GUM, C&RH services, the young parents midwives service, the youth offending team (YOT), the drugs and alcohol team (DAT), the Health Improvement Service, the Looked After Children team, and the school nurse service. We used questionnaires and interviews to gather views from users and potential users at GUM and C&RH, pregnant teenagers, people with HIV and students at Bromley College.

It is important to remember that the views and comments that are presented here are those of individuals or groups of individuals that are reporting things that they have heard from friends as well as their own personal experiences. An individual’s experience will be affected by many factors, including how often they have used a service, the circumstances in which they used it, and how they were feeling at the time. Comments therefore need to be viewed in that light, and the expertise and experience of staff providing the services will be invaluable in interpreting them.

A summary of views expressed:

1. Attitudes in Bromley towards sexual health and young people
   Staff at several different agencies reported that there is a high level of denial among adults in Bromley about teenage sex, leading to parents opting their children out of sex education, and authorities unwilling to encourage sex education and services in schools. This means that sexually active teenagers, including young gay men, are at high risk of STI, HIV and unplanned pregnancy.

2. Lack of knowledge about existing services and how to access them
   Interviews and questionnaires from young people in the borough revealed that: although many had good knowledge of sexual health matters, via sex education, the level of knowledge around services available was generally low, and there was a lack of clarity about how to access them. The commonest source of information on sexual health services is word of mouth, mostly friends. Young people did not gain much information from school nurses, but would like to. Most young people have heard of the emergency contraception pill, but knowledge about where to get it is patchy, and the cost of obtaining it from pharmacies (£26.50) deters people from getting it this way. Clinics/advice services in or near schools and colleges are used and valued.

3. Certain groups of young people are missing out on sexual health education
   Information gathered also showed that there are certain groups of young people in Bromley who are likely to have missed out on sex education in schools. Their social circumstances (eg being in care, youth offending, school exclusion, teenage pregnancy) both create and perpetuate this lack of contact with mainstream sources of information and support. As a result, these young people have low awareness of the risks of unprotected sex. Very young female youth offenders, for example, are at high risk of pregnancy. Because of their youth and lack of family support, it is too daunting for these girls to attend contraceptive clinics alone. Staff argue that thoughts need to be given as to
other ways of providing these services. On occasion these young women are brought to C&RH clinics by their youth or support worker, usually to a pre-arranged doctor’s appointment. Links are currently being developed by the new specialist C&RH outreach nurse with the various agencies (e.g. YOT and DAT), to facilitate fast-tracked, one-to-one appointments with her, for these vulnerable young people.

4. **Services need to be sensitive and young people friendly**
Young people repeatedly told us that going to a sexual health or contraception clinic for the first time is very daunting, so it needs to be made easy, and staff need to be aware of how embarrassed they may feel. Information on what actually happens in the clinics could help to dispel unrealistic fears, and it is also important that once people do attend, they are not turned away or have wait for long periods. The most important attributes of a service for users were that it was informal, friendly and confidential, and treated them with respect.

5. **Clients would like a choice of times, locations, appointment and drop in clinics, and clinics which provide a full range of sexual health services**
In terms of clinic times, there is a demand for services during the day, early morning, evenings and Saturday afternoons. Some people like young people clinics, others are more concerned with having a choice of clinic days and times.

Generally people felt there were not enough contraception clinics in each locality, and that Beckenham Beacon was too far to go for many parts of the borough, especially if there is no guarantee of being seen. Walk in clinics involve long waits, and people are sometimes turned away. However, an appointment system was used in the past, and abandoned due to the large number of people who did not attend (DNA). Because not all contraception clinics provide all forms of contraception or STI screening, and because the GUM clinic does not provide contraception, people may be told to go elsewhere. Several users reported using services outside the borough, where all services are available and they can be sure of being seen that day.

7. **Not enough information and publicity about services**
In terms of advertising, it was felt that more is needed. The internet, posters and leaflets are favoured forms of advertising. Currently it is not easy to find information on the internet. Young people seemed consistently to know more about STIs and the risk of pregnancy then they did about where to access services.

8. **Communication between services could be better**
Staff members at several services reported that communication between different parts of the service is poor, with changes in clinic times and other details not always communicated to other clinics, Health Improvement, the Chlamydia screening team.

9. **Other suggestions and comments**
Suggestions by patients at the GUM clinic included: an ‘express service’ for condoms and repeat prescriptions; more literature in the waiting areas, and a television. Women in particular would value being able to get contraception provision and STI screening in the same place. Users do not like having to
wait outside the Beckenham clinic until it opens. Most users are satisfied with Beckenham, however, two gay men reported that Metro provided a more pleasant experience. Metro provide specialised services for gay people.

9. Summary of current service provision; achievements and areas for development.

A great deal of information has been collected in this needs assessment, and individual services will wish to examine this in detail in order to inform future developments of their service. To summarise, four key themes have emerged that are of importance to all services:

A. Vulnerable groups
Bromley as a whole has better sexual health than the national average, but there are pockets of deprivation and certain at risk groups where the incidence of STIs and unwanted pregnancy are as high as areas in inner London. This means that efforts at educating young people in sexual health have a high success factor for some parts of the population, but are failing to reach others. Some steps have been taken to address the problems presented by at risk groups, for example the appointment of a dedicated outreach C&RH nurse for two days a week; active promotion of LARC by C&RH, and certain campaigns run by the Health Improvement Service (HIS), but indicators suggest that they may not be enough.

Research has shown that providing education to groups of vulnerable people is not effective, so the focus needs to be on interventions for individuals.

B. Good services, but fragmented and not enough of them
There are many dedicated staff in Bromley, who work very hard to provide good sexual health services and to care for vulnerable groups. The service, however, is fragmented and over-stretched, and there are not enough clinics with enough choice of times and contraceptive methods in each locality, and not enough staff to cope with demand at individual clinics. In addition, a combination of not having the right kinds of staff and historical separation of services means that patients cannot access everything they need at one site. A lack of shared information systems and poor communication between services is also a problem. As a result of these factors, patients who have made the effort to attend may be turned away or referred elsewhere, and often have to wait for long periods.

C. Cultural attitudes and beliefs
Efforts by the Health Improvement Service to improve sexual health in Bromley are hindered by three key factors: the attitudes and beliefs of adults in Bromley that teenagers are too young to have sex, the attitudes and beliefs of young people that all teenagers are having sex, and the fact that an extremely important part of improving sexual health, that of identifying and counselling at risk individuals, is outside their remit.

D. Informing young people about services
Whereas young people in mainstream education are well-informed about sexual health, they are less well informed about sexual health services on offer in their area, and how to access them.
10. Recommendations, Conclusions and Next Steps

There are therefore four main areas that need to be addressed.

A. Vulnerable groups and individuals
In order to address current inequalities in sexual health in Bromley, both prevention and service provision needs to be tailored to specific groups who are at high risk of poor sexual health. This should include the development of tailored services for vulnerable individuals, and identifying and counseling vulnerable young people when they attend mainstream services.

B. Service provision
An integrated service is needed which provides STI diagnosis and treatment, contraception advice and provision, and health promotion. These new services need to be provided equitably across the borough, at times that local people can access them, and with sufficient capacity to avoid the current problem whereby people are turned away or have to wait for long periods.

C. Cultural attitudes and beliefs
The obstacles to sexual health posed by attitudes and beliefs of both young and older people need to be addressed in the health improvement strategy.

D. Information and publicity
The ways in which services are publicised needs to be reviewed and improved.

Recommendations for specific services:

Genito-urinary medicine services
- Provide full STI screens at clinics throughout the borough.
- Incorporate rapid HIV testing and other new technologies which can provide quicker and easier tests.
- Identify which clinics people are turned away from most regularly, and increase provision accordingly.
- Introduce flexibility in clinic length, so that nobody is turned away.
- Review staffing, so that skills and training are matched with demand. In particular more nurses/sexual health advisers are needed who are able to prescribe and to counsel at risk individuals, and who are able to insert implants and IUDs.
- Internal cover is needed to avoid staff absences at clinics.
- Provide an indoor waiting area for patients, with a ticketing system.
- Provide partial appointment clinics, and explore ways of reducing the DNA rate, eg texting appointments the day before. Liaise with clinics outside the borough that have with shorter waiting times to see how they achieve this.
- Provide a full contraception service.
- Patients would like to be able to choose whether they see a male or female, and the possibility of providing this should be explored.
- Plan ahead for increasing numbers of people with HIV, especially staffing levels of HIV specialist nursing team.
- Develop regular communications to ensure other SH services are kept aware of changes in the service and temporary clinic closures.
• Review all clinics in terms of young people friendliness, presence of volunteer youth workers, television, coffee etc. Visit metro and other successful clinics to observe.

• Provide more literature in waiting rooms

**Contraception and Reproductive Health Service**

• Review staffing and training, with the aim of increasing the numbers of staff who are able to administer LARCs, and having permanent staff who work longer hours.

• Increase the number of clinics which provide all forms of contraception, thereby reducing waits for LARCs.

• Increase uptake of LARCs, especially implants and IUD/IUS methods.

• Increase awareness of IUD as a form of emergency contraception, as it is more effective than the hormonal method and can be used long term.

• Address the problem of people being turned away from clinics, and provide appointment as well as walk-in clinics.

• Aim to provide, for all users, a daytime and an out of hours clinic within reasonable reach on every day of the week.

• Review all clinics in terms of young people friendliness, television, coffee etc. Visit metro and other successful clinics to observe.

• Conduct a special review of service provision in areas of high teenage pregnancy and abortion rates, including the Crays, Penge, Annerley, SE20, BR5 and Biggin Hill.

• Establish C&RH services at or close to schools and colleges where these rates are high.

• Provide STI screens as a standard part of the service.

• Ensure that all areas of the service are kept informed about developments and changes in the service, including school nurses and the Chlamydia Screening Team.

• Provide over the counter emergency contraception free or at the cost of a prescription, at all pharmacies if possible, and to all ages. Also explore ways in which EHC may be accessed discreetly, for example vending machines, via the internet, or provided routinely with other forms of contraception.

• Evaluate the new outreach C&RH post for vulnerable groups, to assess uptake and adequacy.

• Increase input on contraception with teenage mothers, liaising with the Young Parents’ Midwives.

• Investigate the feasibility of providing, in addition to the outreach nurse, contraception services for specific vulnerable groups at places where they attend. Eg youth offenders, looked after children, travellers, black Africans, possibly via mobile clinics, or by using voluntary agencies.

• Ensure that nurses and advisers for vulnerable groups know where to refer people at high risk.

• Develop peer support schemes within vulnerable groups, with friends who can accompany young people to clinics.

• Monitor the success of the new C&RH nurse in TOP service.

• Review the possibility of having TOP services within the borough, especially medical abortions.
Primary Care
- Work with primary care to increase consistency of sexual health care provision and ability to provide LARCs.
- Monitor the provision of sexual health services in General Practice, especially smears and LARCs.
- Review training needs in primary care.
- Increase provision of nurse training in contraception by including clinical placements as part of the LES review.
- Investigate the perception of C&RH staff that general practices are not doing enough smears.
- Review the provision of sexual health publicity materials in waiting areas.
- Introduce routine testing for HIV in the north east of the borough, where prevalence is higher.

Health education and prevention
- Review and evaluate current activities in the light of the needs assessment.
- Plan and evaluate health improvement activities using NICE guidance on behaviour change, and preventing STIs and teenage conceptions, including the setting of local targets.
- Work with local services to ensure that NICE guidance on identifying and counselling individuals at risk is implemented.
- Review current advertising of services in light of user views.
- Make information about local services, including details of times of clinics, an integral part of sex education in schools and colleges, so that every young person knows where to go for help for both preventive care and help when they need help.
- Increase publicity of the telephone and email information service, which is greatly under-used at present.
- Work with services to develop a more comprehensive, and more easily accessible, website on sexual health services, which is well advertised.
- Work with drugs and alcohol team to look at ways of reducing the effects of substance misuse on sexual health.
- Introduce regular education for parents, as part of sex education in schools, including awareness raising about sexual orientation. Part of this should include enabling parents to express their concerns about sex education. This should be especially encouraged, or even mandated, for parents who choose to withdraw their children from sex education lessons.
- Plan a campaign to raise awareness of HIV in Black Africans, both men and women, and to increase testing and reduce late diagnosis rates. Consider working with surrounding boroughs that have larger populations of Black Africans.
- Monitor late diagnosis rates of HIV, and identify at risk groups.
- Increase routine testing for HIV in general practice, community and hospital settings, especially in areas of high prevalence (a pilot project to raise awareness in GP practices in high risk areas is being planned).
- Build on young people’s tendency to consult friends for advice by setting up peer mentoring programmes (recommended in ‘Going All the Way’).
- Increase provision of one to one guidance in schools, either through school nurses, or training counsellors and making sexual health part of their remit.
Chlamydia Screening
• Continue recruiting core services to undertake Chlamydia screening.
• Enable outreach nurses to offer Chlamydia screening to under 16s.
• Use Metro to access hard to reach groups, rather than easy to reach young people who are at low risk of infection.

Communication, Information and Publicity (all services need to work together on this)
• Increase access to telephone advice. Clinic phones could be forwarded to the central phone number when clinics/offices are closed.
• The information line should have an option to speak to someone and should also direct callers to the PCT web-site.
• The information line number and website address need to be advertised more widely, including schools, colleges, clubs and other venues that attract young people.
• There should be a web-page for local sexual health services, which cover all areas, including contraception advice, where to get free condoms, emergency contraception, STI advice, Chlamydia screening, pregnancy testing and advice, TOP services (including where they can self-refer), location of pharmacies, and which provide free emergency contraception to under 16s, where to get emergency contraception out of hours. The website should contain a map of where services are based, preferably a facility to enter a post code for ‘find your nearest clinic’. It should also contain up to date information on clinic closures and other changes. This should be a resource for both staff and the public.
• The website address and information line number need to be widely advertised, and new ways that young people can obtain information about sexual health services should also be considered, eg by text.
• Engage with school counsellors and nurses to increase their ability to provide sexual health advice and signposting in schools and colleges.
• Make existing information cards and leaflets available at schools
• Set up regular communication channels between services, to ensure they keep each other informed about changes in clinics.

Other recommendations
• Establish an integrated IT system for all sexual health services.
• In Oxleas contract, include a specification for the provision of psychological services for people with HIV.
• Investigate the need for interpreter services, and how these could be provided.

In implementing these recommendations, the PCT should work closely with schools and colleges, voluntary organisations that support sexual health, and the local authority. The sexual health strategy should be included in all the main strategy documents for the borough, including the local area agreement and Building a Better Bromley.

Conclusions and next steps
There are many good features of the sexual health services in Bromley, including dedicated and enthusiastic staff, a well-functioning GUM service, a choice of C&RH services and a number of special services. This needs assessment has highlighted the need to build on these successes and move towards a more integrated and better publicised service. It provides the basis for a new strategy for an integrated
sexual health service in Bromley, which focuses not only on a high quality, accessible service to those who need it, but also an integrated approach to preventing sexually transmitted diseases, reducing the numbers of unwanted pregnancies, and enhancing sexual health in our population.

The National Strategy for Sexual Health and HIV (DOH 2001) defined sexual health as:
“the capacity and freedom to enjoy and express sexuality without exploitation, oppression, physical or emotional harm with equitable access to services to maintain and improve well-being.”.

To that end, our sexual health strategy will aim to move our local service towards one which:
• Has a welcoming culture that is confidential, respectful and recognises the diversity of relationships.
• Is accessible to all who need it, including those who find it difficult to access mainstream services
• Promotes safer sex and the importance of good sexual health.
• Encourages self care by providing appropriate information and support.
• Is provided by a range of professionals and agencies which work together to improve the sexual health of the population.

Implementation will be achieved through a strong commissioning framework and a programme management approach.
AN ASSESSMENT OF SEXUAL HEALTH NEEDS IN BROMLEY

CONTENTS

1. National picture, policy and guidance 21
2. Improving sexual health in Bromley: work to date 23
3. Aims and Objectives of the Needs Assessment 24
4. Population profile 25
5. High risk and vulnerable groups 30
6. Sexual Health in the UK, South East London and Bromley 36
   - Sexually Transmitted Diseases
   - HIV/AIDS
   - Teenage conceptions
   - Terminations of Pregnancy
   - Contraception
7. Services for STIs, contraception and other areas of sexual health 53
   A. Sexual Health Service (GUM clinic),
   B. Contraception & Reproductive Health service
   C. GP Locally Enhanced Service (LES) practices
   D. Termination of Pregnancy (TOP) service.
   E. Chlamydia Screening
   F. Health Improvement
   G. HIV Specialist nursing service
   H. Community Pharmacy
   I. School health (Nursing) service
8. Stakeholder and user views 84
9. Summary of current service provision; achievements and areas for development. 110
10. Recommendations, Conclusions and Next Steps 114
11. Glossary 119
1. National picture, policy and guidance

Main Points:

- The incidence of sexually transmitted diseases is steadily rising in the UK.
- The teenage conception rate, though falling, is still the highest in Western Europe.
- A number of national and regional policy documents have been produced over the last ten years, aimed at improving sexual health through prevention and better services.
- People most at risk of STI are men who have sex with men (MSM) and those associated with geographical areas of high HIV prevalence. Risk increases with alcohol and substance misuse, early sex, unprotected sex and multiple partners.
- People most at risk of teenage pregnancy are those from disadvantaged backgrounds, in or leaving care, and/or of low educational attainment.
- In London there are high rates of repeat abortions and relatively low use of Long Acting Reversible Contraception (LARC).
- In London, especially the outer boroughs, there is a problem with late diagnosis of HIV infection.
- National guidance on service improvements has included: ‘one stop’ sexual health clinics, providing services that are young-people friendly, increased routine HIV testing, and targeting high risk groups.
- NICE have produced guidance on
  a) how to change behaviour and
  b) reducing STIs and teenage conceptions.

Sexual Health in the UK has been deteriorating over the last twelve years with large increases in sexually transmitted diseases, including a 300% increase in Chlamydia diagnoses (at least in part due to increases in testing), and a 200% increase in Gonorrhoea. The incidence of HIV infection more than trebled in the ten years between 1995 – 2005, and continues to increase. Since the Teenage Pregnancy Strategy of 1998, teenage conceptions have fallen by up to 15%, but the UK still has the highest rate in Western Europe.

In response to these trends, several policy documents and sets of guidance have been produced, the first of which was the National Strategy for Sexual Health and
HIV in 2001, backed by an investment of nearly £50 million to support the range of initiatives set out in the strategy.

The key elements of the strategy included:

- A national public information campaign aimed at preventing STI and HIV transmission and unintended pregnancies.
- New ‘one stop’ sexual health services that provide STI diagnosis and treatment, contraception, and advice and services on other sexual health related issues such as pregnancy counselling, abortion, partner notification.
- A broader role for nurses and other primary care staff in the delivery of sexual health services.
- Routine HIV testing in all sexual health clinics.
- Targets for reducing new infections of Gonorrhoea and HIV.
- More people offered Hepatitis B immunisation in sexual health clinics.
- Local stakeholders to review sexual health and HIV provision in each area.

Sexual health was also one of the six key priority areas in the government’s white paper *Choosing Health*¹ (2004), which focussed on:

- Reducing under 18 conception rates
- Increasing access to GUM clinics within 48 hours
- Decreasing rates of new diagnoses of Gonorrhoea and HIV
- Increasing rates of Chlamydia screening

Recognising that services which aimed at young people needed to pay special attention to being approachable and acceptable to this group, in 2007 the DoH produced guidance, in their report ‘You’re Welcome’, on how to make services young people-friendly. Quality criteria concerned accessibility of services, publicity, and the importance of the training, attitudes and values of staff.

In the same year NICE produced guidance on ‘*One to one interventions for reducing the transmission of STIs including HIV, and to reduce the rate of under 18 conceptions, especially among vulnerable and at risk groups*’.

The guidance emphasised the need to make information and advice on contraception (including emergency contraception) and avoiding STIs available in multiple settings, recognised that risky sexual behaviour was affected by a variety of factors, including low self esteem, peer pressure and lack of skills, and that sexual health problems disproportionately affect: certain groups of people. These include deprived communities, young people in or leaving care and men who have sex with men.

Another important piece of NICE guidance that is relevant to sexual health, *Behaviour change at population, community and individual levels* was published in October 2007. This guidance was produced on the basis of a review of the evidence of what works in changing behaviour at these three levels. The main points were that those planning interventions should:

¹ Choosing health White Paper. Department of Health. 2004
• Be specific about the behaviour they are trying to change, and the results they are seeking
• Be specific about the intervention itself
• Be specific about how and where it will be used
• Be explicit about the underlying theory
• Evaluate the intervention in terms of measurable outcomes

It also makes the points that ‘Effective interventions target specific groups and are tailored to meet their needs’ and ‘Service user views may be helpful in planning interventions’. In particular health professionals need to understand the pay off to individuals of apparently damaging behaviour, and any intervention needs to be culturally sensitive to the group at which it is aimed.

In October 2008 a report which reviewed progress on improving sexual health services in different areas of London, ‘Sex and Our City’, reported that:
• There is wide variation in service provision and expenditure by PCTs which cannot be justified in terms of variations in need
• Commissioning best practice is not consistently taking place in PCTs, particularly with regard to developing and monitoring service specifications
• There is a wide range in access times to GUM services
• There are high rates of late diagnosis of HIV, especially in outer London boroughs.
• There is poor IT support for sexual health services.
• There are high rates of repeat abortions, and a need for increased use of Long Acting Reversible Contraceptives (LARC s).

The most recent report on sexual health to have been published is ‘Going all the Way, Further Education Sexual Health Needs Assessment’, prepared for the London Sexual Health Commissioning Network in July 09. This report recommends that colleges and PCTs work together to provide full sexual health services in or near colleges of further education, and that doing so would provide short term savings in terms of reduced incidence of STIs and unwanted pregnancies. It also recommends that all colleges should provide details of the ways in which they plan to support the health of its students. Peer mentoring schemes were also recommended as a way of helping students to look after their own sexual health. It says that sexual health strategies should be part of all local planning documents, such as the Local Area Agreement and Sustained Community Strategy.

2. Improving sexual health in Bromley: work to date

In response to the National Strategy, Bromley PCT produced its own Sexual Health Strategy in 2006 ² with the overall aims of:
• Reducing unintended pregnancies and ensuring safe pregnancy and childbirth
• Reducing levels of STIs, including HIV, and promoting avoidance of infection
• Ensuring that sexual health services are provided in an integrated way that meet patients’ needs
• Enabling those living, working and visiting Bromley to enjoy sexual relations without exploitation, oppression or abuse

² Modernising Sexual health in Bromley. A strategy to improve Sexual Health and Sexual Health services. June 2006
The PCT also established a Sexual Health Strategy Group which works in partnership with all key stakeholders to improve sexual health and deliver comprehensive sexual health services. A needs assessment was conducted in 2008 in order to identify any current service gaps or unmet needs in the population, and to assess the extent to which the Sexual health strategy action plans and other national/local guidelines had been implemented.

In early 2009 the National Support Team visited the PCT to assess progress in developing local sexual health services. In doing so, they identified some areas where information could be improved or expanded, specifically the need to:

- Consult more with local stakeholders
- Update certain datasets
- Gather and include user views
- Identify vulnerable groups in the population who may not be accessing the services they need.

As a result of this report, the sexual health needs assessment was reviewed and updated into this document.

3. Aims and Objectives of the Needs Assessment

Aims

The aims of the needs assessment were:

- To understand the sexual health needs of Bromley residents
- To review the provision of Sexual Health and HIV services in Bromley, to assess the need for these services in the local population, and to identify any gaps between provision and need, and between provision and national guidance.
- To inform a sexual health strategy for Bromley that describes a high quality, evidence-based and cost effective service that is in line with national guidance.

Objectives

The objectives of the needs assessment were to:

1. Quantify the levels of STIs and HIV infection in Bromley, and to identify trends and at-risk groups.
2. Assess the current performance of local contraceptive services by analysing rates of teenage conceptions, TOPs, and uptake of long acting reversible contraceptives (LARC).
3. Quantify and evaluate current service provision in terms of capacity, geographical cover and ability to provide services that users need.
4. Gather views of local stakeholders on current and future provision.
5. Gather views of service users on current and future provision.
6. Identify population groups who may not be accessing the services they need, and why.
7. Identify gaps between current service provision and need.
8. Identify gaps between current service provision and national standards.
9. Make recommendations as to how those gaps could be filled.
4. Population profile

Main points

- The estimated population of under 25s is approximately 35,000, and is expected to rise slightly by 2013, and to fall off again by 2018.
- While the number of people under 19 is expected to fall overall by 2026, increased numbers are expected in the Crays, Penge and Cator, and Plaistow and Sundridge.
- The proportion of ethnic minorities in the population is expected to rise, in particular Black Africans.
- Bromley is a relatively affluent borough, but there are pockets of very low income, with unemployment levels similar to inner London.

There is a wide range of educational attainment among schools in Bromley.

4.1 Bromley population Profile

The population of Bromley is projected to rise to 299,791 in 2011, and to 303,100 by 2026. This represents a rise of 0.8% between 2006 and 2011, and a rise of 1.92% between 2011 and 2026.

The initial rise is expected to be predominantly among people of working age and the newly retired, and later among people over 75 (see Fig 1). Although the birth rate is currently rising in Bromley, as it is across London, a fall in the number of children and teenagers is expected over the next twenty years. However, these changes are expected to vary from ward to ward, and increases in the numbers of children and young people are expected in Bromley Town, the Crays, Penge and Cator, and Plaistow and Sundridge. Based on the number of pupils school nurses have on their case loads, Bromley’s school age population is estimated to be around 46,000.
It is anticipated that representation from ethnic groups in Bromley is going to increase over the next 20 years. The Black Caribbean ethnic group were the largest ethnic group in 2006 but in 2026, the Black African ethnic group will be the largest single ethnic group in Bromley.\(^3\) (Fig 2).

Bromley Borough contains the largest group of settled Gypsies and Travellers in England, which is estimated to be around 1,000 families. Some of the Travellers are settled on caravan sites but the vast majority live in social housing in The Crays, Penge, Bromley and Biggin Hill wards. Furthermore, it is estimated that there are between 2200 - 2400 refugee households.\(^4\)

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\(^3\) GLA 2006 Demographic Projections

\(^4\) Annual Public Health Report 2007, Bromley PCT
The local economy

Bromley has the fourth highest economy in South London, with a large economically active population compared to other South London Boroughs. Nearly a quarter of Bromley’s jobs are located in Bromley Town Centre, and nearly two thirds (62%) of the jobs in the borough are taken by residents of the borough. 55% of the working population work outside the borough.

Although Bromley is a relatively affluent borough, with incomes generally high and unemployment low, this masks marked geographical variations. These include pockets of very low income, and unemployment levels similar to inner London (Fig 3). Deprivation is a well established risk factor for poor sexual health.
The increase in house prices has led to a steady decline in the supply of affordable social housing available to let, and reported unmet homeless demand is rising. While homelessness is clearly a direct result of an inadequate supply of social housing, it often reflects wider issues, such as migration, repossession and other problems that make it difficult for people to sustain their accommodation. Homelessness is another risk factor for poor sexual health.

**Children and Young People**

As with most indicators of health and well-being in Bromley, there is a wide variation across the borough in terms of deprivation. Deprivation is known to affect sexual and physical health, likelihood of mental health problems, and educational achievement in children and young people. The following graphs (Figs 4 and 5) show wide variation in attainment in eleven year olds in Bromley, with the proportion of children attaining levels 3 and 4 at the appropriate age ranging from 30% – 100%.
We also know that children in vulnerable groups, for example children in care, perform less well and are more likely to have mental health problems. Looked after children leave care at the age of sixteen, and within a year one in four of the girls are pregnant. Absence rates in Bromley are above the national average, and while the number of young people not in employment, education or training (NEET) in Bromley is relatively low, it is still too high for local standards.
5. High risk and vulnerable groups

Main Points:

- Certain groups are at particular risk of poor sexual health. In Bromley these include young people who live in deprived areas, NEET, looked after children, people who misuse drugs and/or alcohol, certain ethnic groups, men who have sex with men, and youth offenders.
- The highest numbers and proportions of children and young people in Bromley are located in: Cray Valley West, Cray Valley East, Penge & Cator, Clock House and Kesley & Eden Park. Deprivation is also highest in these wards.
- Bromley has higher numbers of young people not in education, employment or training (NEET) than comparable boroughs.
- There were 250 looked after children in 2008, and 117 care leavers.
- An estimated 7000 people aged 16-24 have tried drugs, with men and regular club-goers more likely to have taken drugs.
- 63% of children in years 6,8 and 10 reported having been drunk at least once.
- Young parenthood is common among Gypsies and travellers, and religious beliefs are often opposed to the use of contraception.
- A high proportion of newly diagnosed HIV infections occur among Black Africans, of whom 41% are diagnosed late. Twice as many women as men are affected.
- There are approximately 12,000 gay men in Bromley, but they are hard to reach, due to prevailing attitudes and fear of openness.
- There are around 250 youth offenders in Bromley, of whom 13-15 year old girls are at special risk of unplanned pregnancy.

Sexual health is affected by a range of demographic characteristics and social conditions. As a result there are certain groups within the population who are at particular risk of poor sexual health. Because many social conditions are associated with each other, for example deprivation, low educational attainment and substance misuse, young people rarely fall neatly into one category, often overlapping with two or more.
This section of the report identifies groups of young people who are at risk of poor sexual health. These include:

A. Young people in deprived areas, especially those with low educational attainment
B. Young people aged 16-18 who are not in employment, education or training (NEET), and/or are excluded from school
C. Looked after children (LAC)
D. People who misuse drugs or alcohol
E. Gypsies and Travellers
F. Black Africans
G. Men who have sex with men (MSM)
H. Youth offenders

A. Young people in deprived areas

The highest numbers and proportions of children and young people are located in the following wards: Cray Valley West, Cray Valley East, Penge & Cator, Clock House and Kesley & Eden Park. The lowest proportions are found in Darwin, Biggin Hill, Mottingham and Chislehurst North (Fig 6).

These areas are also the areas in which deprivation is highest. Here, multiple risk factors for poor sexual health are at play, including poverty, unemployment, low educational attainment, and drug and alcohol abuse.

Figure 6
Population size of young people in Bromley by ward

Source: ONS
B. Young people aged 16 – 18 who are not in employment, education or training (NEET)

While Bromley represents one of the lower NEET figures compared to other boroughs in London, the proportion of young people in this category is higher than in similar boroughs, such as Kingston and Richmond. As with most indicators in Bromley, it masks large variations between the most and least affluent wards. Reducing the numbers of young people in this group is a key priority for children’s services in Bromley (Fig 7).

Figure 7

Percentage of NEET in Bromley and comparative boroughs

![NEET Percentages Per Borough](http://www.dcsf.gov.uk/rsgateway/DB/SFR)

C. Looked After Children (LAC) and children excluded from school

Looked after children are known to be at high risk of mental health problems that stem from growing up in dysfunctional families, traumatic experiences and living in deprivation (CAMHS Needs Analysis 2008/10).

As of December 1st 2008, there were
- Approximately 250 Looked After Children in Bromley
- 117 care leavers

Children typically leave care at the age of sixteen, and one in four girls leaving care are reported to become pregnant within a year. LAC are also known to have low educational attainment when compared to other children, and low educational attainment is another risk factor for poor sexual health.

It can be seen in the graph below that less than 10% of children in care in Bromley achieve five or more GCSEs. This compares with 55% of all children in Bromley (Fig 8).
Figure 8
Educational attainment in Looked After Children

![Educational attainment in Looked After Children in KS4](http://www.dcsf.gov.uk/rsgateway/DB/SFR)

Source: http://www.dcsf.gov.uk/rsgateway/DB/SFR

Children excluded from school
Table 1 shows the permanent exclusions from schools due to behavioural problems, there being just under 50 of such children in 2007.

Table 1
Permanent Exclusions from Schools in Bromley

<table>
<thead>
<tr>
<th></th>
<th>2004/05</th>
<th>2005/06</th>
<th>2006/07</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>4</td>
<td>8</td>
<td>2</td>
</tr>
<tr>
<td>Secondary</td>
<td>52</td>
<td>74</td>
<td>46</td>
</tr>
<tr>
<td>Total</td>
<td>56</td>
<td>82</td>
<td>48</td>
</tr>
</tbody>
</table>

Source: The London Borough of Bromley, 2007

D. People who misuse drugs or alcohol
People who abuse drugs or alcohol are at higher risk of poor sexual health. The British Crime Survey 2007/08 reported that among 16-24 years olds 21.3% have used one or more illicit drugs (compared to 24.1% in 06/07) and 17.9% have used cannabis. 6.8% of young people had used Class A drugs (compared to 8% in 06/07) and frequent use of any drug has fallen to 7.3% (compared to 11.6% in 02/03). Overall the report concluded that there was a decline in the level of any illicit drug use from (10.0%) to (9.3%).

In terms of who is most likely to use drugs, men were twice as likely to have used any drug as women (12.6% vs 6.2%), and more likely to have used a Class A drug
Drug use in 2007/08 was twice as high for young people visiting nightclubs four or more times a week (33.4%) compared with those not visiting a nightclub at all in the last month (15.5%). Young people going to a nightclub at least once a week on average were over 3 times as likely (13.4%) to have taken any Class A drug in the last year, compared with those not visiting a nightclub at all (4.3%).

Applying this data to the Bromley population aged 16-24 gives an estimated number of drug users in Bromley in 2008 as 7,000 (Table 2).

Table 2
Prevalence and estimated numbers of young people using drugs 2007/08

<table>
<thead>
<tr>
<th>Substance</th>
<th>07/08 prevalence figures</th>
<th>Bromley population 15-24</th>
<th>Estimated number of young people using in last year</th>
</tr>
</thead>
<tbody>
<tr>
<td>All drugs</td>
<td>21.3</td>
<td>32,700</td>
<td>7,000</td>
</tr>
<tr>
<td>Cannabis</td>
<td>17.9</td>
<td>32,700</td>
<td>5,900</td>
</tr>
<tr>
<td>Class A drug</td>
<td>6.8</td>
<td>32,700</td>
<td>2,200</td>
</tr>
<tr>
<td>Frequent drug users</td>
<td>7.3</td>
<td>32,700</td>
<td>2,400</td>
</tr>
</tbody>
</table>

Source: NDTMS

The youth cohort study published in 2008 identified that young people in years 9, 10, and 11 chose to misuse cannabis and alcohol, with use rising with age, and that young people who are Not in Education Employment and Training (NEET) 9% were more likely to have tried alcohol and cannabis.

Alcohol
A biannual survey of schoolchildren in Bromley collected information from youngsters in some Bromley schools and reported that
- up to 14% of 14-15 year olds have mixed alcohol and drugs on the same occasion.
- 23% of 14-15 year old females compared with 20% of the same age males had been drunk during the previous 7 days.

Local data from Accident and Emergency services shows an increasing trend of alcohol misuse in young people. 30% of drug/alcohol attendance in A&E are in young people aged 18 and under. 56% of under 18s are female with an average age of 14 years and 10 months (equivalent in boys is 15 years and 5 months)

The Tellus3 survey, which is a survey of children in years 6, 8 and 10 in selected schools in Bromley, last done in spring 2008, found that 62% of children had been drunk at least once, and of those, nearly 87% had been drunk more than once (Table 3).
Table 3
Responses to Tellus survey 2008: Have you ever had alcohol?

<table>
<thead>
<tr>
<th>Never had alcohol</th>
<th>never been drunk</th>
<th>Once or twice</th>
<th>Once in the last 4 weeks</th>
<th>Twice in the last 4 weeks</th>
<th>3 or more in the last 4 weeks</th>
</tr>
</thead>
<tbody>
<tr>
<td>28%</td>
<td>36%</td>
<td>13%</td>
<td>4%</td>
<td>4%</td>
<td>7%</td>
</tr>
</tbody>
</table>

Source: TellUs Survey 2008

E. Gypsies and Travellers

There are over 11,000 children and young people living in Bromley whose backgrounds and ethnicities are other than White British. A particular group within the Borough is the settled Traveller community, estimated to be at least 2000 and concentrated in two wards: Cray Valley East/West and West Wickham. Those who work with young people in this group report that young parenthood is common and that religious beliefs are often opposed to the use of contraception. The subject of sex is not one that is freely discussed. Any support in terms of sexual health services therefore needs to take these cultural aspects into account, and services need to be provided that are sensitive, confidential, and located in places that are accessible but discreet.

F. Black Africans

Black ethnic minority groups are growing at a faster rate than others, in particular Black Africans. This is of special importance in sexual health services because of the high proportion of newly diagnosed HIV infections occurring in this group, of whom 41% are diagnosed late. Twice as many women as men are affected. Services tailored to this group need to find ways of helping people who are at risk of STIs to be tested for HIV and to access services earlier.

G. Men who have Sex with Men (MSM)

The population of Bromley in the 2001 census was estimated at 295,532, of whom 141,785 were men. In a survey carried out in 1990 and then again in 2000 of people between the ages of 16-24 years (NATSAL. 2000) it was estimated that 8.1% of men have felt sexual attraction towards the same sex at least once in their lives. This would give a total of between eleven and twelve thousand gay or bisexual men in Bromley.

A local health needs assessment of lesbian, gay, bisexual and transsexual people (LBGT) in Bromley was carried out in 2006 to explore their social and health needs. Research in other areas had highlighted that LGBT people experience inequality in health, accessing services and dealing with prejudice.

Questionnaires were distributed and promoted to partner agencies across the borough, and made available online, and a total of 104 respondents completed the questionnaire over a three month period. The main themes which emerged were:

- GP surgeries were highly used but not necessarily for issues due to sexual orientation;
- Very few accessed local sexual health services such as the local GUM clinic;
- Around a 1/3 of male and female respondents had not accessed any sexual health services in the last 12 months;
• Nearly 40% of males had never had an HIV test;
• The majority of male and female respondents were open about their sexuality to family, friends and work colleagues.
• A gay pub/nightclub was the preferred place to access information, advice or support with regard to sexuality;
• Male and female respondents were least likely to get their sexual health knowledge in education;
• Around 60% males and 40% of females would report hate crime to the police;
• Nearly 100% of respondents smoked, but had very little interest in giving up;
• over 80% of males and over 70% of females drank alcohol;

These findings suggest that gay men and women do not access either education or services in the same way as heterosexual people. Most gay men go to GUM services outside the borough, where there are services that are more tailored to their needs. As they do not tend to learn about sexual health at school, young gay men are at particular risk of poor sexual health.

H. Young offenders
There are around 250 youth offenders in Bromley, with roughly equal numbers of males and females. Youth offenders are more likely to be low achievers, excluded from school, and use drugs and alcohol. All these are associated with poor sexual health. The younger female offenders, aged 13-15, are most at risk of becoming pregnant, and often go ahead with the pregnancy rather than have an abortion. The YOT nurse believes this to be mainly because they are against the idea of abortion.

6. Sexual Health in the UK, South East London and Bromley

<table>
<thead>
<tr>
<th>Main points</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Sexually Transmitted Infections</strong></td>
</tr>
<tr>
<td>• In the UK there have been consistent increases in the incidence of Chlamydia and genital warts, while gonorrhoea has decreased.</td>
</tr>
<tr>
<td>• In South East London STIs have been slowly falling overall, until 2007 when there was an increase.</td>
</tr>
<tr>
<td>• In the Beckenham Beacon clinic in Bromley in 2007 there was a marked increase in diagnoses of Chlamydia, Gonorrhoea, Herpes and Warts, more so than in SEL as a whole, with women and the younger age group of 20-24 significantly more at risk.</td>
</tr>
<tr>
<td><strong>B. HIV/AIDS</strong></td>
</tr>
<tr>
<td>• In the UK, 55% of all HIV diagnoses are in heterosexuals, and 41% in MSM. 36% of diagnoses are in Black Africans, of whom 41% are diagnosed late.</td>
</tr>
</tbody>
</table>
• Prevalence of HIV in people aged 15-59 in Bromley is lower than in central London, but rising faster, with a rate of 1.75 per 1000 in 2007, with 331 people accessing HIV care (compared with 288 in 2006).
• Higher rates of HIV are to be found in the north west of the borough
• Twice as many Black African females are affected than males, and their late diagnosis rate is higher.

C. Teenage conceptions
• The teenage conception rate is relatively low in Bromley, but has been slightly increasing over the last 10 years. Bromley is well short of its target for reducing the rate, which is 17.7 by 2010.
• Teenage conception rates are as high as inner London rates in certain areas of the borough

D. Terminations of pregnancy/abortion
• Abortion rates are rising steadily, year on year. The proportion of all conceptions ending in abortion is now 23% for E&W and 32% for London
• The abortion rate is higher in Bromley among 18-24 year olds than in E&W (23 v 18.8 per 1000 women 15-44), and the repeat abortion rate is similar to central London, at 29%. There were high numbers of abortions in SE20 during 2008/09, and clusters in Bromley Town, the Crays and Biggin Hill.
• The % of abortions done before 10 weeks gestation is 79% in Bromley, higher than for E&W.
• The % of NHS funded abortions is also higher than average, at 89%
• Just under a third of funded abortions are medical, as opposed to surgical
• Abortion providers for Bromley residents are all outside Bromley
• The repeat abortion rate for Bromley residents is 29%, similar to that for London, compared to 25% in England
• It has only recently been made possible for abortion providers to provide all types of contraception to Bromley clients
• A new specialist C&RH nurse is now working in the abortion service

E. Contraception and contraceptive services
• First attendances at C&RH clinics for Long Acting Reversible Contraceptives (LARCs) have been 10% in Bromley, compared with 14% in London and 15% in England, but the numbers are now increasing.
• 8% of attendances were for emergency contraception, compared to 11% in London.

A. Sexually Transmitted Diseases

In the UK as a whole there have been consistent increases in the incidence of Chlamydia and genital warts between 2003 – 2007, while diagnoses of Gonorrhoea have consistently decreased. The numbers of diagnoses of syphilis are relatively low and almost entirely in males, but have been increasing gradually during the same period, with a plateau reached in the last two years. Since 2004 the incidence of Herpes has been rising, with a sudden large increase in 2007. While diagnoses of STIs are generally higher in men, Chlamydia and Herpes are the only STIs where there are significantly more diagnoses in women.

In South East London there is a different picture in that rates of diagnosis of all STIs have been falling slightly, year on year, since 2003, but increased in 2007. This increase occurred equally in both males and females, apart from warts, where the increase has been predominantly in males. (Figs 9, 10)

At the Beckenham clinic in Bromley the increase in diagnosis rates in 2007 have been more marked, proportionally, than in SE London as a whole (Fig 12). Interestingly, increases in diagnoses of Herpes and Warts have been markedly higher for females than for males (Fig 13). Another marked difference between Beckenham and SE London as a whole is the age distribution. While in Beckenham more diagnoses are made in 20 – 24 year olds (Fig 14), the largest age group in which STIs are diagnosed in SEL is the 25 – 34 year olds (Fig 11).

Figure 9

![Diagnoses of selected STIs, SE London GUM clinics, 2003-2007](source: HPA)
Figure 10

Diagnoses of selected STIs in males and females, SE London GUM clinics, 2003-2007

Figure 11

Diagnoses of selected STIs by age, SE London GUM clinics, 2007

Source: HPA
Figure 12

Diagnoses of selected STIs, Beckenham Hospital, 2003-2007

Figure 13

Diagnoses of selected STIs in males and females, Beckenham Hospital, 2003-2007

Source: HPA
B. HIV/AIDS in the UK, London and Bromley
The prevalence of HIV in the UK in 2007 was estimated at 77,400, of whom approximately 28% were thought to be unaware of their infection. In 2007 there were 7734 new diagnoses of HIV infection (similar number to previous years), 4887 men, and 2846 women. Of these, 41% were in MSM and 55% in heterosexuals. 65% of heterosexuals infected were Black Africans (Table 4).

Table 4
HIV diagnoses in the UK in 2007.

<table>
<thead>
<tr>
<th></th>
<th>Proportion of new diagnoses</th>
<th>% diagnosed late</th>
<th>UK acquired</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSM</td>
<td>41%</td>
<td>19%</td>
<td>82%</td>
</tr>
<tr>
<td>Heterosexual</td>
<td>55%</td>
<td>36% M</td>
<td>23%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>42% F</td>
<td></td>
</tr>
<tr>
<td>Black African</td>
<td>36%</td>
<td>41%</td>
<td></td>
</tr>
</tbody>
</table>

Source: HPA
Table 5 shows diagnoses of HIV by route, gender and ethnic origin in South East London in 2008, and the data on route of infection is summarised in Table 6.

**Table 5**  
Numbers of diagnosed HIV-infected patients by route of infection, ethnic group and gender in South East London in 2008

<table>
<thead>
<tr>
<th>Probable route of infection**</th>
<th>White</th>
<th>Black-Caribbean</th>
<th>Black-African</th>
<th>Black-Other</th>
<th>Indian/Pakistani/ Bangladeshi</th>
<th>Other/ Mixed</th>
<th>Other Asian/Oriental</th>
<th>Not known</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ethnic Group</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>M</strong></td>
<td><strong>F</strong></td>
<td><strong>M</strong></td>
<td><strong>F</strong></td>
<td><strong>M</strong></td>
<td><strong>F</strong></td>
<td><strong>M</strong></td>
<td><strong>F</strong></td>
<td><strong>M</strong></td>
<td><strong>F</strong></td>
</tr>
<tr>
<td>Sex between men</td>
<td>2752</td>
<td>0</td>
<td>151</td>
<td>0</td>
<td>54</td>
<td>0</td>
<td>23</td>
<td>0</td>
<td>197</td>
</tr>
<tr>
<td>Injecting drug use</td>
<td>75</td>
<td>30</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Sex between men &amp; women</td>
<td>137</td>
<td>157</td>
<td>95</td>
<td>133</td>
<td>4</td>
<td>6</td>
<td>36</td>
<td>47</td>
<td>9</td>
</tr>
<tr>
<td>Blood/blood products recipient</td>
<td>7</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>6</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Mother-to-child transmission</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>72</td>
<td>61</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Other/Not known</td>
<td>93</td>
<td>5</td>
<td>10</td>
<td>1</td>
<td>28</td>
<td>28</td>
<td>11</td>
<td>1</td>
<td>12</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>3065</td>
<td>195</td>
<td>253</td>
<td>148</td>
<td>880</td>
<td>1556</td>
<td>129</td>
<td>105</td>
<td>253</td>
</tr>
</tbody>
</table>

Source: HPA
Table 6
Route of infection for HIV diagnoses in South East London in 2008

<table>
<thead>
<tr>
<th>Total HIV diagnoses</th>
<th>Route of infection</th>
</tr>
</thead>
<tbody>
<tr>
<td>3249</td>
<td>MSM (50%)</td>
</tr>
<tr>
<td>121</td>
<td>Drug users (&lt;2%)</td>
</tr>
<tr>
<td>2938</td>
<td>Heterosexuals (45%)</td>
</tr>
<tr>
<td>23</td>
<td>People receiving blood products (&lt;1%)</td>
</tr>
<tr>
<td>148</td>
<td>Children of HIV infected mothers (2.3%)</td>
</tr>
<tr>
<td>6479</td>
<td>All groups, excluding unknown</td>
</tr>
</tbody>
</table>

Source: HPA

Thus, in SE London, the proportion of infections in MSM is higher than in the UK as a whole, and the proportion in heterosexuals correspondingly lower. Of heterosexuals who were infected, 83% were Black Africans. Among this group, there were twice as many females infected as males, and the UK data shows that the late diagnosis rate is higher in females. Figure 15 shows the pattern of infection in Bromley. The proportion of MSM has decreased over recent years, and is now around 40%, while the proportion of Black Africans affected has increased, with again, twice as many women affected as men.

Figure 15

Geographical variations and changes
In 1998 63% of all diagnoses of HIV were in London, as compared with 48% in 2007. HIV is therefore spreading geographically, outwards from the inner cities. This is reflected locally, with still much smaller numbers of diagnoses in Bromley than in Inner London PCTs, but much greater increases in those numbers, year on
year. In Bromley, the number of people with HIV accessing care rose by nearly 15% between 2006 -7, from 288 in 2006 to 331 in 2007. Numbers have been increasing each year, but this is the largest increase yet.

Even within the borough there is wide variation in the number of diagnoses of HIV, as can be seen in Figure 16, with the highest rates in the north west of the borough.

Testing for HIV

It is recommended, in order to reduce delays in diagnosis, that HIV testing is offered routinely in GUM and antenatal clinics. Uptake of these services in the UK during 2007, was 75% in GUM and 94% in antenatal clinics. It is recommended that where prevalence of HIV in 15-59 year olds is more than 2 per 1000, it should be offered routinely in general practice and in all general medical admissions. Prevalence in this age group in Bromley was 1.75 in 2007, but it is known that rates are higher in the north east of the borough, and routine testing in primary care should be implemented in these areas, together with routine testing of acute medical admissions from those areas..

Figure 16

Numbers of diagnosed HIV-infected patients by postal district of residence 2006.
C. Teenage conceptions

In England
In 1999 the under 18 conception rate in England was 45 conceptions per 1,000 women aged 15 to 17 years. Although rates have steadily decreased over the last ten years, as a result of the Teenage Pregnancy Strategy (1998), the rate has at no point dropped below 40, and for the first time 2007 saw a reversal of the trend, with an increase in conception rate in both under 18s and under 16s.

Table 7
Teenage conception rate in England, by year (conceptions per 1000 women)

<table>
<thead>
<tr>
<th></th>
<th>1999</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 18s</td>
<td>45</td>
<td>40.9</td>
<td>41.9 (N= 42,918)</td>
</tr>
<tr>
<td>Under 16s</td>
<td>7.8</td>
<td>8.3</td>
<td>(N= 8,196)</td>
</tr>
</tbody>
</table>

Source: Teenage Pregnancy Unit

The proportion of conceptions to under 18s resulting in abortion has steadily risen, from under 40% in 1999, to over 50% in 2007. This does not reflect an overall trend in the decisions of women of all ages to have abortions, the proportion having remained static at around 22% for the last decade.

In Bromley
Teenage conception rates in Bromley have always been well below those for London (32.1 in 1999 v 51.1 respectively), but the trend in Bromley has been slightly upwards during the last ten years, while in inner London it has been falling (Fig 17 Table 8). Figures for the first quarter of 2008 show no improvement (Table 9). Bromley is consequently well short of its target of reducing the teenage conception rate to 17.7 by 2010. Also, the relatively low rate in Bromley masks wide variations within the borough, with the most deprived wards having rates comparable to those for inner London (Fig 18).

Figure 17
Under 18 conception rate in England, London and Bromley 2001 - 07

Source: Teenage Pregnancy Unit www.everychildmatters.gov.uk
Table 8
Conception rates in under 18s, per 1000 women, by year and area

<table>
<thead>
<tr>
<th></th>
<th>2001</th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>42.5</td>
<td>42.7</td>
<td>42.2</td>
<td>41.6</td>
<td>41.3</td>
<td>40.6</td>
<td>41.7</td>
</tr>
<tr>
<td>Inner London</td>
<td>65.5</td>
<td>68.7</td>
<td>65.3</td>
<td>60.3</td>
<td>55.7</td>
<td>56.0</td>
<td>56.3</td>
</tr>
<tr>
<td>Outer London</td>
<td>41.9</td>
<td>44.1</td>
<td>44.5</td>
<td>43.1</td>
<td>40.8</td>
<td>40.3</td>
<td>40.3</td>
</tr>
<tr>
<td>Bromley</td>
<td>33.5</td>
<td>35.3</td>
<td>39.3</td>
<td>31.1</td>
<td>36.1</td>
<td>30.9</td>
<td>34.0</td>
</tr>
</tbody>
</table>

Source: Teenage pregnancy unit

Figure 18

Under 18 Conception Rate per 1000 2002 - 2004

NB Data only up to 2004, although demographics are unlikely to have changed substantially.
Table 9
Number of conceptions in under 18s, by quarter and area.

<table>
<thead>
<tr>
<th>Quarter</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>England</td>
<td>10,844</td>
<td>10,927</td>
</tr>
<tr>
<td>Inner</td>
<td>589</td>
<td>616</td>
</tr>
<tr>
<td>London</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outer</td>
<td>858</td>
<td>838</td>
</tr>
<tr>
<td>London</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bromley</td>
<td>44</td>
<td>52</td>
</tr>
</tbody>
</table>

Source: Teenage pregnancy unit

In Bromley in 2007, the most recent year for which we have full statistics, there were 194 conceptions, and 127 abortions. The abortion rate of 65% is a reduction on the rate of 70% in 2006. Abortion rates in this group have been increasing in all areas, but the proportion of under 18 conceptions ending in abortion in Bromley is higher than for London (61%), probably reflecting the relative affluence of Bromley residents. The overall abortion rate, however, is consistently lower than for London, and similar to the UK (Tables 10,11).

Table 10
Number of abortions in under 18s, by quarter and area.

<table>
<thead>
<tr>
<th>Quarter</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>England</td>
<td>5305</td>
<td>4733</td>
</tr>
<tr>
<td>London</td>
<td>923</td>
<td>841</td>
</tr>
<tr>
<td>Bromley</td>
<td>37</td>
<td>24</td>
</tr>
</tbody>
</table>

Table 11
Abortion rate per 1000 women, in under 18s, by quarter and area.

<table>
<thead>
<tr>
<th>Quarter</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>England</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>London</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Bromley</td>
<td>6</td>
<td>4</td>
</tr>
</tbody>
</table>
Table 12
Percentage of abortions in 2008, in under 19s, that were repeat abortions

<table>
<thead>
<tr>
<th></th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>10.7</td>
<td>10.4</td>
<td>11</td>
</tr>
<tr>
<td>London</td>
<td>19%</td>
<td>16.1</td>
<td></td>
</tr>
<tr>
<td>Bromley</td>
<td>13.6</td>
<td>16%</td>
<td>13.5</td>
</tr>
</tbody>
</table>

Source:/www.dcsf.gov.uk/everychildmatters/healthandwellbeing/teenagepregnancy/statistics

Repeat abortion rates in under 19s for Bromley fall between rates in London and England, and fell from an unusually high rate in 2007 down to previous levels.

D. Terminations of Pregnancy/abortions
In England & Wales, the abortion rate was 5.2 per 1000 women aged 15 – 44 in 19695, rising to 18.8 in 2008. The proportion of all conceptions ending in abortion has been rising steadily over the last decade, and is now 23% in England and Wales, and 32% in London. The abortion rate is increasing at a higher rate in teenagers.

Table 13.
Abortions in England, London and Bromley in 2008

<table>
<thead>
<tr>
<th>Geographical Area</th>
<th>Rate per 1000 women 15-44</th>
<th>Total number of abortions</th>
<th>% abortions &lt; 9 weeks Gestation</th>
<th>% repeat abortions in women &lt;25</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>18.8</td>
<td>189,734</td>
<td>70</td>
<td>23.6</td>
</tr>
<tr>
<td>London</td>
<td>28</td>
<td>50,213</td>
<td>74</td>
<td>30</td>
</tr>
<tr>
<td>Bromley</td>
<td>23</td>
<td>1,229</td>
<td>78</td>
<td>29</td>
</tr>
</tbody>
</table>

Source: NCHOD

Fig 19 shows the 2007 TOP rate, by age, in England and Wales and Bromley. Rates are highest in 18 – 24 year olds, but while rates in Bromley are similar to E&W in other age groups, in this age group the rates are significantly higher.

Abortions in London
In London 20% of abortions are self-paid, which is almost double the proportion in the other English SHAs (Sex in the City). 74% of all abortions (NHS funded and private) and 70% of NHS-funded abortions were carried out under 10 weeks in 2007. The latter is similar to England as a whole (68.3%). In 2006, 40% of all abortions done under seven weeks were early medical abortions, with Barking & Dagenham PCT (17%) followed by Havering PCT (18%) having the lowest proportion, and Richmond & Twickenham PCT (69%) the highest. 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%.

Abortions in Bromley
Table 14 shows the increase in numbers of abortions in Bromley each year since 2002. In 2007 there were 1229 TOPs as compared with 3956 live births, giving a proportion of pregnancies going to termination as 24%, close to that for England and Wales.

Table 14

<table>
<thead>
<tr>
<th>Year</th>
<th>Total no of abortions</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>1115</td>
</tr>
<tr>
<td>2003</td>
<td>1103</td>
</tr>
<tr>
<td>2004</td>
<td>1117</td>
</tr>
<tr>
<td>2005</td>
<td>1148</td>
</tr>
<tr>
<td>2006</td>
<td>1246</td>
</tr>
<tr>
<td>2007</td>
<td>1229</td>
</tr>
<tr>
<td>2008</td>
<td>1256</td>
</tr>
</tbody>
</table>

Source: local data
The proportion of abortions funded by the NHS has also been increasing steadily, and in 2008 87% of all abortions on Bromley residents were funded, as compared with the national target of 70%. Table 16 shows how provision in Bromley moved from the NHS hospital to independent providers in 2006.

Figure 20 shows all abortions in 2008 – 09, plotted by postcode of residence. The numbers are very high in SE20, and there are also more abortions in Bromley Town and the Crays. There is a marked cluster in Biggin Hill. These clusters reflect the numbers of young people who live in these areas, and also the levels of deprivation.

### Table 15
#### Percentage of abortions by gestation

<table>
<thead>
<tr>
<th>Year</th>
<th>0-9</th>
<th>10 to 12</th>
<th>13 plus</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>55</td>
<td>33</td>
<td>9</td>
</tr>
<tr>
<td>2003</td>
<td>59</td>
<td>30</td>
<td>11</td>
</tr>
<tr>
<td>2004</td>
<td>64</td>
<td>25</td>
<td>10</td>
</tr>
<tr>
<td>2005</td>
<td>66</td>
<td>23</td>
<td>11</td>
</tr>
<tr>
<td>2006</td>
<td>77</td>
<td>16</td>
<td>7</td>
</tr>
<tr>
<td>2007</td>
<td>78</td>
<td>12</td>
<td>9</td>
</tr>
<tr>
<td>2008</td>
<td>79</td>
<td>12</td>
<td>9</td>
</tr>
</tbody>
</table>

Source: Local data

### Table 16
#### Provision of abortions in Bromley

<table>
<thead>
<tr>
<th>Year</th>
<th>NHS Hospital</th>
<th>Independent Hospital, NHS funded</th>
<th>Privately funded</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002</td>
<td>39</td>
<td>30</td>
<td>31</td>
</tr>
<tr>
<td>2003</td>
<td>33</td>
<td>37</td>
<td>30</td>
</tr>
<tr>
<td>2004</td>
<td>36</td>
<td>36</td>
<td>29</td>
</tr>
<tr>
<td>2005</td>
<td>25</td>
<td>54</td>
<td>21</td>
</tr>
<tr>
<td>2006</td>
<td>9</td>
<td>70</td>
<td>21</td>
</tr>
<tr>
<td>2007</td>
<td>4</td>
<td>82</td>
<td>14</td>
</tr>
<tr>
<td>2008</td>
<td>2</td>
<td>87</td>
<td>10</td>
</tr>
</tbody>
</table>

Source: Local data

### Repeat abortions
One of the most important indicators of the adequacy of sexual health services is the repeat abortion rate. Table 17 shows repeat abortion rates for 2007, and it can be seen that around a quarter of all abortions done in England are in women who have had at least one previous abortion, and that rate is higher in London. Whereas a lower repeat abortion rate might be expected in Bromley, due to its relative affluence, Bromley rates are very similar those for to London.

### Table 17
#### Percentage of Repeat Abortion Rates in 2007

<table>
<thead>
<tr>
<th>% repeat abortions</th>
</tr>
</thead>
<tbody>
<tr>
<td>England and Wales</td>
</tr>
<tr>
<td>London</td>
</tr>
<tr>
<td>Bromley</td>
</tr>
</tbody>
</table>

Source: NCHOD
E. Contraception and contraceptive services

In England, in 2007/8 there were around 2.5 million attendances by 1.1 million different women and 100,000 men. This is unchanged from the previous year. The majority of the attendances (about 90%) are by women, although the proportion of males has increased for two consecutive years, especially in the 16-17 year age groups where it reached 20% in 2007. 20% of women aged 16-19 attended a clinic, and this was the largest age group of attendees. The equivalent figure for 15 year olds and under was 8%.

Table 18a
Contacts with contraceptive services in England, London and Bromley in 2007/08

<table>
<thead>
<tr>
<th>(In thousands)</th>
<th>Clinic attendances</th>
<th>Domiciliary visits</th>
<th>Number of first contacts - Female</th>
<th>Emergency contraceptives</th>
<th>Number of first contacts – Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>2465.1</td>
<td>12.6</td>
<td>1,110.3</td>
<td>135.9</td>
<td>122.7</td>
</tr>
<tr>
<td>London</td>
<td>540</td>
<td>4.3</td>
<td>273.2</td>
<td>27.6</td>
<td>17.8</td>
</tr>
<tr>
<td>Bromley</td>
<td>10.2</td>
<td>0.0</td>
<td>5.4</td>
<td>0.4</td>
<td>0.5</td>
</tr>
</tbody>
</table>

Source: NCHOD

KT31 data, National Information Centre, Leeds
In Bromley in 2007/8 there were just over 10,000 clinic attendances. Although no domiciliary visits are documented in KT31 data, local data reports that 19 took place in 2007/8. About half of attendances (5,400) were first contacts by women, of which the majority were aged 20-34 years. First contact with women under the age of 20 was higher in Bromley (26%) than London (16%), whereas the figure in England was higher than both at 30%.

Oral contraceptives are the most popular methods of contraception among women, accounting for 46% of female contraceptive use, while Long Acting Reversible Contraceptives (LARCs) continue to increase in popularity, accounting for 23% of all primary methods of contraception. Because emergency contraception became available over the counter in 2002, it was issued by clinics on 13,000 occasions in 2007, a fall of 7% from the previous year.

For first contacts in Bromley in 2007/8 (Table 19), only 9% were for LARCs which was significantly lower than London & England, where the proportions were 15% & 16% respectively. However, a higher proportion of contacts in Bromley (31% v 28% and 29% in London & England), were for reasons other than contraception, many of which will be smears, and this will decrease the proportion of LARCs. Also, rates for LARCS are known to have increased substantially in 2009, due to a concerted effort by the local C&RH service.

Table 19
Analysis of first contacts with contraceptive services for women in England, London and Bromley 2007/08

<table>
<thead>
<tr>
<th>Region</th>
<th>Total 1st contacts 1000s</th>
<th>% age &lt;20</th>
<th>% age 20 – 35</th>
<th>% age 35+</th>
<th>% LARCS</th>
<th>% user dependent</th>
<th>Contacts for other reasons</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>1110.3</td>
<td>30</td>
<td>48</td>
<td>22</td>
<td>16</td>
<td>51</td>
<td>29</td>
</tr>
<tr>
<td>London</td>
<td>273.2</td>
<td>16</td>
<td>57</td>
<td>27</td>
<td>15</td>
<td>52</td>
<td>28</td>
</tr>
<tr>
<td>Bromley</td>
<td>5.4</td>
<td>26</td>
<td>43</td>
<td>31</td>
<td>9</td>
<td>58</td>
<td>31</td>
</tr>
</tbody>
</table>

The ONS survey of contraception and sexual health in 2007/8, in women aged 16-19 and men aged 16-69, showed that just under three quarters of women were using contraception, of whom a quarter used the pill. Over 90% of women had heard of the emergency contraceptive pill, and 46% had heard of emergency IUD. Television programmes are the main source of information on STIs (31%), followed by television adverts (22%) and newspapers, magazines and books (20%). There is a difference in the 16-24 age group where 31% of information is from school or college, the overall average for this source being 9%.

Awareness of Chlamydia as a sexually transmitted infection has increasing since 2001, from 65% to 93% for women and from 35% to 85% for men.
7. Services for Sexual Health in Bromley

Main points:

Services for STIs
- There is one GUM clinic, based at Beckenham Beacon in the north west of the borough, providing 8 mixed walk-in clinics per week, including one YP clinic. Contraceptive advice, emergency contraception and condoms are provided.
- A full STI screen is offered, with results available in 2-3 weeks.
- Metro, a voluntary agency, uses a new technology that enables HIV tests to be reported in 20 mins.
- 61% of people seen at BB are Bromley residents, and 39% of Bromley GUM patients are seen outside the borough.

Services for contraception
- The C&RH service is led by a lead nurse and an associate specialist. Staff are all part time, and most of the nurses are sessional. Staff are well trained and dedicated, but there are not enough to meet service needs.
- Contraception services are provided in 9 walk-in clinics per week at 7 different sites. There are also three specialist clinics at Beckenham Beacon. Contraceptive services are also provided by general practices.
- Three clinics have a doctor, plus one a month at Biggin Hill. Implants and IUDs cannot be provided in nurse-led clinics at present.
- 50% of women wait up to a month for LARCs appointments, but may wait up to two months if they cannot be flexible in terms of time and venue.
- Contraceptive advice sessions are provided once a week during term time at Bromley and Orpington colleges.
- A new post has been created, for two days per week, to enable outreach work and domiciliary visits to vulnerable and hard to reach groups.
- Uptake of community contraceptive services in Bromley is 30% lower than the national average, which may be due to lack of capacity.
- Prescription rates for contraceptives, including LARCs, vary widely between GP practices, and are not related to LES status.

Issues affecting both STI and contraceptive services
- Although some STI screens are offered by C&RH clinics, and contraceptive advice is offered by the GUM service, in practice this is not a full service.
- Patients can only call GUM clinics during clinic hours
- GUM patients have to wait outside at BB until the clinic starts
- People are turned away from clinics if available slots have been filled, or if the service they require is not available

**Services for abortion**
- Bromley contracts with private providers for these services
- The service includes counselling, choice of medical or surgical abortion, contraceptive advice and, recently, provision of all types of contraception.
- 68% of patients attend an appointment within one week of their call, and 96% within two weeks. The patient is then offered the procedure within one week of the first visit and never longer than 2 weeks.
- The PCT aims to reduce the repeat abortion rate (29%) to national levels (23%) by introducing a follow up service by a specialist contraception nurse for all self-referrers and under 18s.

**Chlamydia Screening Programme**
- Chlamydia screening is offered to all young people aged 15-24 via a variety of outlets, including online testing by post.
- 15% of young people have been screened, just 2% short of the target for 2009.

**Health Improvement**
- A wide range of activities are taking place in the borough, to reduce STIs and teenage conceptions, and train staff in contact with young people
- There needs to be more collaboration with services, to ensure measures recommended by NICE are implemented both at population and individual level.
- Evaluation of projects against planned outcomes is not routine
- Black Africans are at high risk of HIV, especially women, but there are no current campaigns directed at this group, as they are hard to reach.

**Community Pharmacy**
- While many pharmacies are trained to provide Chlamydia screening, only six are providing free emergency contraception to under 16s

**School Health**
- While all school nurses have some training in sexual health and are well-placed to provide advice and signposting to young people in school, not all schools have a school nurse, and those that do are busy with other activities
• Most schools have counsellors, but these are not necessarily trained to give advice in sexual health matters.

Summary of service provision

Service provision for sexual health in Bromley includes preventive as well as diagnostic/treatment services (see Fig 21), and comprises:

A  Sexual Health Service (GUM clinic),
B  Contraception & Reproductive Health service
C  GP Locally Enhanced Service (LES) practices
D  Termination of Pregnancy (TOP) service.
E  Chlamydia Screening
F  Health Improvement
G  HIV Specialist Nursing service
H  Community Pharmacy
I  School health (Nursing) service
J  Voluntary organisations

Figure 21 Distribution of Sexual health services in Bromley

NOTE: Settings where Health Improvement service is provided and the settings at which the School Health (Nursing) Team work were not included in the mapping process.
A. Genitourinary Medicine

Bromley’s Sexual Health & HIV Service is based at Beckenham Hospital and delivers a range of diagnostic and therapeutic services for people with genitourinary disease and HIV/AIDS including:

- Testing for all STIs & treatment
- Partner notification
- Family Planning advice and provision of emergency contraception
- Free condoms
- Dedicated Young person’s clinic
- Care and treatment for people who are HIV positive
- Post Exposure Prophylaxis for HIV – for both occupational and sexual exposures
- Inpatient HIV care using beds at medical wards at PRUH
- Health Advice Service including advice for sexual assault & advice on infections

All clinics are mixed male & female clinics and operate as a walk in service. Once all the appointment slots are taken up, clients are advised to attend the clinic another day. The majority of the clients are self referrals, and only about 15-20% of patients are referred by a GP. The clinic operates an Open access policy and accepts patients from outside of Bromley PCT boundaries.

There are 8 clinic sessions per week of which one session is a dedicated young person’s clinic. During each session, 20 to 30 new or rebooked patients are seen on a walk-in basis and about 10 follow up patients are also seen by appointment. Patients do not have access to the clinic area until the clinic starts.

Screening/ Testing and results

- All new patients are offered screening for: Syphilis, HIV, Gonorrhoea, Chlamydia, Candida, Trichomonas and for Bacterial Vaginosis
- High risk patients are also offered testing for Hepatitis B & C.
- Pregnancy testing is offered, as appropriate, as well as opportunistic cervical screening. Microscopy of samples taken is done on site by the nursing staff, whereas other laboratory requests are processed at Princess Royal University Hospital.
- Patients ring the clinic on a Wednesday afternoon when all negative and positive results are given over the phone, except results for HIV in patients who are at high risk of HIV. These patients are advised to come in person so that the patient is counselled before the results are shared, whether positive or negative.
- It takes 2-3 weeks to get the result in most cases; if a positive result is obtained beforehand, this is given to the patient immediately without waiting for the patient to call back.
Staff Composition

Medical

Consultants  1.65  
Clinical Assistant  1.00  

Nursing

Band 7  1.0

Administrative

Band 6  0.8

Band 5  3.83

At present, the nurses do not prescribe treatment but training is currently taking place, and it is hoped that nurse prescribing will start by the end of July 09. One of the nurses also works as a Health advisor.

Provision of training

The GUM clinic staff members have in the past provided STIFF courses to primary care staff with a variable attendance. The course lasts 2 days and needs to have at least 20 attendants to make it cost effective. Training is also provided to nurses, midwives and FY2 doctors. More training days can be organised by the GUM clinic staff in the future if there are sufficient numbers of attendants and resources.

Advertisement/Publicity

The service is advertised online (PRUH Website and BASHH) and via leaflets/posters circulated to GPs, contraceptive clinics and School Nurses.

Clinic Activity 2008/09

During 2008/9, 61% of Bromley GUM patients were seen at Beckenham Beacon (Table 20). The most popular clinics outside the borough were Guy’s, Mayday, King’s, Mortimer Market, Westminster Centre, St Thomas’s and Queen Elizabeth. Activity data for 2007/08 shows that about a third of clinic appointments were for people outside the borough, mainly from Lewisham, Croydon and West Kent.

Table 20

New Patient Visits by Bromley residents in 2008/09

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>To Beckenham Beacon clinic</td>
<td>4156 (61% of all new patient visits)</td>
</tr>
<tr>
<td>To non-Bromley clinics</td>
<td>2645 (39% of all Bromley residents)</td>
</tr>
<tr>
<td>Total new patient visits</td>
<td>6801</td>
</tr>
<tr>
<td>Total DNAs at Beckenham</td>
<td>678</td>
</tr>
</tbody>
</table>

Main clinics attended by Bromley residents outside the borough are as follows, in order of popularity:
### Clinic/hospital

<table>
<thead>
<tr>
<th>Clinic/hospital</th>
<th>Number of new patient visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guy’s</td>
<td>374</td>
</tr>
<tr>
<td>Mayday</td>
<td>285</td>
</tr>
<tr>
<td>King’s</td>
<td>271</td>
</tr>
<tr>
<td>Mortimer Market</td>
<td>223</td>
</tr>
<tr>
<td>Westminster Centre</td>
<td>215</td>
</tr>
<tr>
<td>St Thomas’s</td>
<td>207</td>
</tr>
<tr>
<td>Queen Elizabeth</td>
<td>199</td>
</tr>
<tr>
<td>Darent Valley</td>
<td>119</td>
</tr>
<tr>
<td>St George’s</td>
<td>97</td>
</tr>
<tr>
<td>John Hunter, Westminster</td>
<td>86</td>
</tr>
<tr>
<td>St Mary’s</td>
<td>66</td>
</tr>
<tr>
<td>Kent and Sussex</td>
<td>26</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>2168</strong></td>
</tr>
</tbody>
</table>

*(82% of all non-Bromley visits)*

*Source: KC60*

Metro is a voluntary sector service based in Greenwich, but which provides services in Bromley. An HIV test can be done by their Greenwich service in twenty minutes.

### B. Contraception & Reproductive Health services (C&RH)

Currently, contraception services are provided by C&RH and also by General Practices. C&RH run nine general contraception clinics a week at seven different sites. All the clinics are run as a ‘drop-in’/’walk-in’ service. Seven of the clinics are open-access to all ages; the other two are restricted to those aged under 24 (there is also an under-24 clinic within one of the other general clinics). Currently, there is a doctor present in three of the clinics (and one session a month at Biggin Hill), who mainly sees clients by appointment for LARC procedures and specialist advice and follow-up. The other clinics can usually access doctor advice by telephone. Three of the clinics are held at the Beckenham Beacon and the others at 6 different sites throughout the borough. Contraception clinics are also provided one day a week during term time for the students at Bromley and Orpington colleges (these are ‘drop-in’ sessions and can provide advice, non-interventional contraceptive supplies, pregnancy testing and Chlamydia screening). In addition, there are specialist, appointment-only clinics for LARC procedures, vasectomy, and psychosexual counselling, which are all based at the Beckenham Beacon. LARC procedures are currently only carried out in the clinics with a doctor present and in the specialist LARC clinics. However, about 50% of these procedures are done within a month of being requested and at first visit where possible and appropriate. Women who wait longer for their procedure are usually unable to be flexible on time of day or venue.

The service is led by a Lead Nurse and an Associate Specialist. None of the staff are full time, and most of the C&RH nurses are sessional. Staff are well trained and dedicated, but there are not enough to meet service needs. A new post has recently been created, for two days per week, to develop outreach work and domiciliary visits to vulnerable and hard-to-reach groups.
Uptake of community contraceptive services in Bromley is 30% lower than the national average (possibly because of the low capacity of C&RH, due to staffing levels), prescription rates for contraceptives, including LARCs, vary widely between GP practices, and are not related to LES status.

Factors concerning both STI and contraceptive services
Although C&RH clinics offer Chlamydia screening as part of the National Chlamydia Screening Programme (NCSP), advice on STIs (‘signposting’ when necessary) and IUD/IUS-related STI screening, and contraceptive advice is offered by the GUM service, in practice both types of clinic are already stretched with their main service. (i.e. C&RH don’t offer routine STI screening currently)

While patients can call the CR&H service during office hours, and patients arriving early can take a ticket and a seat, GUM patients can only call during clinic hours, and have to wait outside at BB until the clinic starts. In both clinics people are turned away if all available slots have been filled, or if the service they require is not available. Patients are not turned away if their needs are urgent.

Services are classified at three levels:

Level 1
- Sexual history taking, risk assessment and sign-posting
- Pregnancy testing and counselling
- Referral for termination of pregnancy
- Provision of emergency hormonal contraception
- Contraceptive information
- Health promotion
- Condom distribution
- Hormonal contraception / Depo-Provera
- Cervical screening and referral
- Chlamydia screening as part of the NCSP

Level 2
- IUD insertion and removal (including emergency IUD fitting)
- Contraceptive implant insertion and removal
- Counselling and referral for vasectomy

Level 3
- Specialist responsibility for provider quality, teaching and training and clinical governance
- 3 dedicated Young Persons clinics weekly, at 3 different sites
- Highly specialised contraception
- Difficult IUD insertion and removal
- Difficult implant removal
- Psychosexual / erectile dysfunction services
- Vasectomy surgery
Current Clinics:

Mottingham Clinic  (does not offer full range of services, as there is no longer a doctor working there)

Wednesday – 7 – 9 p.m.
Currently no doctor present at this clinic.

Beckenham Beacon Contraception Clinics

- Monday 7-9 p.m. (doctor present)
- Tuesday 7-9 p.m. (young peoples clinic)
- Tuesday LARC 3-5 pm clinic (currently occasional, but planned to be regular when funding available)
- Thursday LARC 1-3 pm, only in term-time for 30 sessions a year
- Thursday 7-9 pm (does not offer full range of services)

Biggin Hill Clinic  (does offer full range of services, but doctor only present one session a month)

Monday 2-4 pm (currently unable to staff monthly evening clinic)

Penge Clinic
Thursday 9.30 – 11.30 a.m. (includes procedures, doctor present)

Eldred Clinic (does not offer full range of services, no doctor)
Tuesday 7 – 9 p.m.

Orpington Hospital Clinic
Thursday 7 – 9 p.m. (procedures, doctor present)

Orpington College
The school nurse runs 2 young person drop in sessions, on Tuesday and Thursday afternoons.

Bromley College
The school nurse runs a young person drop in clinic on a Thursday afternoon

Bromley Y young persons clinic (does not offer full range of services, not suitable for procedures and no doctor)
Saturday 12 – 2 pm
Staff Composition

<table>
<thead>
<tr>
<th>STAFF</th>
<th>WTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Lead Nurse</td>
<td>32 hours per week (0.86 WTE)</td>
</tr>
<tr>
<td>1 Associate Specialist (Clinical Lead /Lead Doctor)</td>
<td>28 hour per week (0.73 WTE)</td>
</tr>
<tr>
<td>No Staff Grade doctor currently</td>
<td>Hoping to appoint to 2 sessions - 8 hours per week</td>
</tr>
<tr>
<td>1 sessional contraception doctor</td>
<td>30 two and half hour sessions per year (specialist clinic for LARC procedures)</td>
</tr>
<tr>
<td>1 Staff Grade doctor (Psychosexual counselling)</td>
<td>One 4-hour session per week</td>
</tr>
<tr>
<td>No Nurse Team Leader post, since April 08 -</td>
<td></td>
</tr>
<tr>
<td>Specialist Nurse Outreach post</td>
<td>16 hours per week</td>
</tr>
<tr>
<td>Vasectomy service:</td>
<td></td>
</tr>
<tr>
<td>2 Registered Nurses – band 5 not C&amp;RH trained</td>
<td>0.18 WTE</td>
</tr>
<tr>
<td>1 Nurse – C&amp;RH trained, band 6 for counselling</td>
<td>Not currently funded</td>
</tr>
<tr>
<td>15 nurses – band 6 and C&amp;RH trained, contracted on a sessional basis</td>
<td>1.76 WTE</td>
</tr>
<tr>
<td>Two part time Secretaries (25 hours in total)</td>
<td></td>
</tr>
<tr>
<td>1 Administrator (due to retire November 2009)</td>
<td>0.78 WTE</td>
</tr>
<tr>
<td>7 band 3 admin &amp; clerical staff contracted sessionally</td>
<td>1.57 WTE</td>
</tr>
<tr>
<td>4 band 2 admin &amp; clerical staff contracted sessionally</td>
<td></td>
</tr>
</tbody>
</table>

*Locum doctors providing on-call cover to nurse-led clinics are paid £35 per session to provide telephone advice as needed*

* Surgeons (1 Staff Grade and 1 Associate specialist) are provided by PRUH for the Vasectomy clinic*
Specific sessions provided by C&RH

1) Vasectomy service
The surgeons for this clinic are provided by Princess Royal University Hospital and the nursing and administration staff by the C & RH service. There is a weekly clinic, during which, an average of 4 operations are carried out and 4 patients counselled. Appointment is provided by GP referral only.

2) Psychosexual service
The Psychosexual Counselling clinic is led by a Staff grade doctor and has a waiting list of about 6 months. Macmillan cancer support have recently highlighted the need for providing this kind of support for people whose sex lives have been affected by cancer.

3) Emergency Contraception service provision
All C&RH clinics provide progesterone-only emergency contraception (POEC), but only clinics with a doctor have the capacity to provide emergency copper intrauterine devices (Cu IUCD). However, appropriate clients attending other clinics are directed to one of the 5 clinics a week (on two different days) that provide this service. There are no appointment slots for this method, the IUCD being fitted when clinically indicated.

4) LARCs service provision
Currently, C&RH provides all methods of LARC (injectable contraception, Implanon subdermal implants, intrauterine devices and intrauterine systems). These are usually provided by appointment (2-8 week wait), but are administered at walk-in where possible.

5) Cervical screening
This is provided in all relevant clinics, but there are plans to confine it to specialist clinic.

6) Contraception and Reproductive Health outreach nurse
A new post has been created, for two days per week, to enable outreach work and domiciliary visits to vulnerable and hard to reach groups. These include:

- Pregnant teenagers, including the Nightingale education unit for pregnant teenagers and teenage mothers
- Youth offenders team (act as bridge to contraceptive services)
- Looked after children and children leaving care
- Gypsies and travellers
- Young people not in education, employment or training (NEET)

Training
The service provides the following medical training:

- FSRH letter of Competence (LoC) in Intra Uterine Techniques (IUT) (for doctors working in Bromley)
- FSRH letter of Competence (LoC) in Sub-dermal implants (SdI) (for doctors working in Bromley)
- GP updating and VTS training in sexual health – if requested and time permitting
The service provides the following nursing training:

- Practical training for Specialist Contraception courses run by Kings College and Greenwich Universities
- RCN recognised training to the standard of FSRH LoC IUT and SdI (for nurses working in Bromley PCT)
- Theoretical updates for Practice and School Nurses working for Bromley PCT

FSRH diploma practical training is not currently offered, but discussions are planned to develop a scheme with several local GPs who are Faculty accredited trainers.

The service also provides training for pharmacists on Patient Group Directives for emergency contraception and Chlamydia treatment (as part of NCSP), and leadership and training for the shared Bromley-wide PGDs in use in community pharmacies.

Advertisement/Publicity
Information on C&RH services are provided by
- Bromley PCT website, and others websites (NHS direct, FPA, SexWise and NCSP)
- E-mail enquiry site, via Bromley pct, called askfp@bromleypct.nhs.uk. The mailbox is opened daily by administrative staff, who deal with it if it’s not a clinical query, and pass it on to a clinician if it is. There are two to three queries per week.
- Leaflets, available to local pharmacies, GP practices, GUM and other agencies
- 24 hour information line which gives a recorded message of clinic opening times
- Weekly advert in Bromley New Shopper newspaper
- Yellow pages

Activity data
Based on KT31 returns for 2007/08, the uptake of community contraceptive services in Bromley is 30% lower than the national average, at 7.3% of the population aged 15-44, compared with 10% national average and 12.9% London average. The 10,180 clinical attendances during this year were 4% down on the year before, and while the number of sessions allocated to young people under 25 remained the same (153 sessions per year), the total contacts by young people had gone down by 6% in 2007/08 to 988.

The majority of the contacts for contraceptive were by women in their twenties or above. Teenagers, on the whole made their first contact with the services for oral contraceptives or condoms, although a small proportion were also for LARCs, mainly implants or injectable contraceptives. The commonest reason for contact in those aged 25 and above was for LARCs, and all of the contacts for IUS were by women aged 25 or above (Fig 22).

While IUS was the commonest reason for contact by those aged 35 and above, injectable contraceptives were the most frequent reason for contact in those aged between 25 and 34 years. Out of the 5098 contacts in 2006/07, 512 (10%) were for LARCs. In comparison, in 2007/08, 506 contacts were for LARCs which was 9% of the total. The numbers have since been rising.

---

6 KT 31 data, IT team, Bromley PCT
**Figure 22**

*Popularity of contraceptive methods for female first C & RH service attendances in Bromley during 06/07*

KT31 data, National Information Centre, Leeds

**Post-coital contraception**

There were 432 contacts for post coital contraception in 2007/08 compared to 391 in 2006/07 for all females. The majority of the females were in the 20-24 and 25 - 34 year age group in 2006/07; with a significant increase in the numbers aged 16-17 in 2007/08. The vast majority of prescriptions were for the hormonal method, rather than IUD.

**Table 21**

*Post-coital contraception prescriptions by type and age*

<table>
<thead>
<tr>
<th>2006/07</th>
<th>Age</th>
<th>2007/08</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type</td>
<td>&lt;15</td>
<td>15</td>
<td>16-17</td>
</tr>
<tr>
<td>Hormonal</td>
<td>6</td>
<td>16</td>
<td>75</td>
</tr>
<tr>
<td>IUD</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>TOTAL</td>
<td>6</td>
<td>16</td>
<td>77</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2007/08</th>
<th>Age</th>
<th>2007/08</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type</td>
<td>&lt;15</td>
<td>15</td>
<td>16-17</td>
</tr>
<tr>
<td>Hormonal</td>
<td>7</td>
<td>33</td>
<td>107</td>
</tr>
<tr>
<td>IUD</td>
<td>0</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL</td>
<td>7</td>
<td>33</td>
<td>108</td>
</tr>
</tbody>
</table>

KT31 data, National Information Centre, Leeds
Male attendances
There were 490 male attendances during 2007/8, a 1% increase from the year before. This represented 4.8% of all attendances, a lower proportion than nationally (10%). The commonest reason for contact in those under 24 was for condoms, and for those over 25, vasectomy. 80% of the latter were over 35.

Activity data from individual clinics
The graph below (Fig 23) shows attendances at individual clinics in 2008/09. The average number of attendances per clinic, based on 52 clinics per year, ranges from 6 per clinic in Biggin Hill to 16 per clinic at one of the Beckenham clinics. Mottingham clinic was closed for a period and patients referred to Bromley North, which explains the difference in attendance rates at these clinics.

Figure 23
Number of attendances at Bromley CR&H clinics, April 08 – April 09

![Graph showing attendances at individual clinics](image)

Source: local data

Long acting reversible contraception (LARC)
LARCs include injectable contraception, contraceptive implants and intrauterine contraceptive devices (IUCDs), and are both clinically effective and cost effective in reducing unplanned pregnancy. Consequently NICE guidelines (2005) and government policy recommend increasing promotion of and access to LARC (including training potential providers to supply it).
The NICE Guidelines on LARC (2005)
- Women requiring contraception should be given information about, and offered a choice of, all methods, including long-acting reversible contraception (LARC) methods.
- Women should be provided with the method of contraception that is most acceptable to them, provided it is not contraindicated.
- Contraceptive service providers who do not provide LARC within their own practice or service should have an agreed mechanism in place for referring women for LARC.
- Healthcare professionals providing intrauterine or sub-dermal implants should receive training to develop and maintain the relevant skills to provide these methods.

The use of LARCs in Bromley is lower than in London as a whole (9% of first attendances in 2008 v 15%). However, a significant proportion of women visit the clinic for other reasons, eg smears, and this will artificially reduce the percentage. Also there are plans to increase the uptake of these methods, and early figures for 2009 show substantial increases.

One reason for a relatively low uptake is that only half the clinics are able to provide all forms of LARC. While all current clinics are able to provide Depo-Provera injections as part of the drop-in service, implants and IUCD insertion need to be done in doctor or trained nurse clinics, of which there are only about 4 a week. These clinics do two to three booked LARC procedures (including implant removals) a session, i.e. about ten a week overall. The waiting list for a procedure at each doctor-led clinic used to be about 3 months two and a half years ago, but is now about a month, except at Orpington clinic, where it is still about 3 months (some clients do not proceed because of the wait and the DNA (did not attend) rate can be high.

There is also a LARC clinic (including training of other providers in LARC techniques) for 30 sessions a year, on a Thursday afternoon at Beckenham Beacon. However, it is becoming difficult to maintain and continue this clinic, as only 30 doctor sessions a year are funded. There is no Administrator during the session, which has caused some problems in the Outpatient’s Department, with some clients not knowing if they have come to the correct place. There is also no administrative support to book the appointments and inform the clients or coordinate the training programme, which is usually done by a doctor (a poor use of resources). The clinic doctor needs a Nurse or Healthcare Assistant to assist them, which is not currently funded. Currently bank staff are used to cover this need, but it is difficult to get someone for just 2-3 hours a week. The clinic sometimes has to be cancelled due to lack of staff. The attendance rate at the LARC/training clinic is very good and the waiting list is a month or less. A proposal has been made for improving LARCs provision in the borough.

C. Sexual health service provision in Primary Care
Since the introduction of the new GP contract in 2004, all GPs have agreed to provide standard contraceptive services. The 51 general practices in Bromley all provide some level of sexual health service, generally contraception, basic sexual health advice and some management of sexual health problems. The new contract also provided new guidance on fitting IUCD which resulted in many GPs not taking
part in this activity. This has led to an increased demand for this service from CRH service, resulting in a waiting list.

Specialist locally enhanced services (LES) are also delivered in some general practices. This has facilitated 13 practices to provide specialist sexual health services (levels 1 & 2) in addition to core services. The level of service provided by GP practices, whether core providers or LES, is variable. Some do test and treat STIs and some refer on. GPs mainly tend to give contraceptive patches, whereas most of the depot injections are given by practice nurses.

The LES practices are:

1. Pickhurst Surgery 8. Crofton Surgery
2. Southborough Lane Surgery 9. The Woodlands Practice
3. Eden Park Surgery 10. The Surgery (Dr Sahi)
4. Addington Road Health centre 11. Links Medical Practice
5. Poverest Road Medical Centre 12. Dysart Surgery
6. Cross Hall Surgery 13. Elm House Practice
7. Biggin Hill Surgery

A survey of eight LES practices, done in April/May 2007, found that 1885 patients had been seen that year for sexual health reasons. The lowest number of patients seen was 49 at Cross Hall Surgery and the highest was 665 at Eden Park. Patients were seen for management of complex sexual health problems, counselling & testing, management of STIs, complex contraception and emergency contraception. Half (50%) of the LES practices were seeing non-practice patients. A number of practices stated that space in the practice was a reason for not providing more clinics and services to non-registered patients.

All of the 8 practices that participated with the survey indicated their need for further training, including STIFF courses (or an update of), training for receptionists for giving out condoms, IUCD insertion training and training for GPs to insert implants.

**Prescribing data for contraceptives**

Fig 24 shows total expenditure on prescribed contraceptives for 2007/08 by practice. There is a wide variation in expenditure, from a few hundred pounds to over £25,000 during this period. Of the top 12 spending practices, just five are LES practices. The high spending practices are based in:

- West Wickham (2)
- Bickley (2)
- Bromley Common
- Beckenham (3)
- Chislehurst (2)
- Biggin Hill
- Orpington

Apart from Orpington, these practices are based in the more affluent areas, with none of the high spending practices being based in the most deprived areas of the borough. However, there is a strong correlation between expenditure on contraception and numbers of women having abortions by practice.
**Figure 24**

[Graph showing the total cost of contraceptive prescribing expenditure by GP practice for 2007/08.]

Source: Bromley prescribing data

**Figure 25**

Fig 25 shows the proportion of expenditure that was on LARCs, and again there is wide variation, with half of the practices where the proportion is over the average of 4%, being LES practices.

[Graph showing the proportion of contraceptive prescribing expenditure on LARCs by GP practice for 2007/08.]

Source: Bromley prescribing data
Three new indicators for the provision of contraceptive services provision in primary care will be introduced in to QoF as of September 2009. These should both stimulate improvements and increase consistency of provision of LARC. They will offer GPs a total of 10 points:

- 4 points for having a register of women on contraception.
- 3 points for offering information about LARC to women on other forms of contraception.
- 3 points for providing LARC information within a month to women prescribed emergency contraception.

**Training**

A new London-wide project started in early 2009 that aims to increase the contraceptive choices available to women across London through offering in-practice training for doctors and nurses. Both professional groups will undergo theoretical and practical training before a final assessment of competency. Support will be offered to surgeries in the form of posters and information booklets so that patients can be made aware of the opportunity to discuss different methods of contraception. The project is expected to run initially for one year, with a review to assess the achievement of the objective to increase contraceptive choice.

Within the borough, the PCT has a Service Level agreement with nine Nurse Training Practices who receive funding to provide training placements for nurses who wish to access particular clinical experience which is not available in their own practice. However none of these practices are currently able to offer a contraception placement. Provision of such placements needs to be considered as part of the LES review. If Practices are not able to provide appropriate contraception placements for their nurses in future there is a risk that nurses in General Practice will not be able to access courses in contraception and develop the necessary skills in order to provide a safe service for clients seeking contraceptive advice. It is therefore important that there is at least one practice in each geographical hub able to provide a clinical placement for nurses taking a course in contraception.

**D. Services for Termination of Pregnancy/abortion**

Women seeking termination of pregnancy may approach the C&RHH service, a GP or self refer. Since April ’08, Bromley PCT has commissioned a Central Booking Service (CBS) provided by the British Pregnancy Advisory Service (BPAS). This service provides the patient with one number to call to make an appointment with one of the providers that are commissioned by Bromley PCT. Due to the fact that the CBS accepts self referral calls from patients, there is no requirement for referral documentation to be completed, although this is still provided by some GPs and contraception clinics. The telephone service is available 7 days a week, 8.00 am – 9.00 pm (Mon-Fri), Saturday 8.30 – 18.00, Sunday 9.30 – 14.30, 363 days a year (Xmas Day and Boxing day closed). Outside of these hours an answer phone is available to take calls.

Bromley PCT currently commissions Marie Stopes International and BPAS as the main providers for the consultations/assessments and TOP procedures. They have services based in Streatham, Brixton and Central London. Agreement has been reached with CBS that patients who cannot be accommodated by Marie Stopes or BPAS due to medical complications or late gestation will be referred to alternative NHS providers – mainly Kings. A ‘named’ contact at CBS has been allocated to deal
with such cases and has close links with the Lead Commissioner at the PCT to ensure that funding problems do not arise.

Outside of the CBS service, the Lead Commissioner also has an arrangement with Queen Mary Sidcup Hospital. Referrals to QMS are offered to patients when there are queries from health professionals or patients who request an NHS acute setting for their TOP and are unhappy with the current providers (for whatever reason). Any bookings are arranged by the Lead Commissioner. The reason why Queen Mary’s Sidcup has not been included in the CBS booking is because of capacity and waiting times.

A little over 100 calls per month are made to CBS by Bromley residents. Table 22 below shows a breakdown by age. 88% of abortions are done by two providers, Marie Stopes in Brixton and BPAS in Streatham, the two closest clinics.

68% of patients attend an appointment within one week of their call, and 96% within two weeks A patient is usually offered an assessment appointment within 5 days, depending on their needs, and never longer than 14 days. The patient is then offered the procedure within one week of the first visit and never longer than 2 weeks.

**Calls to CBS from April to December 2008, by age**

<table>
<thead>
<tr>
<th>No of patients</th>
<th>1006 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 18s</td>
<td>89</td>
</tr>
<tr>
<td>18 – 25</td>
<td>455</td>
</tr>
<tr>
<td>26 – 30</td>
<td>176</td>
</tr>
<tr>
<td>31-35</td>
<td>144</td>
</tr>
<tr>
<td>36-40</td>
<td>98</td>
</tr>
<tr>
<td>41+</td>
<td>43</td>
</tr>
<tr>
<td>not advised</td>
<td>1</td>
</tr>
<tr>
<td><strong>1006</strong></td>
<td><strong>100.00%</strong></td>
</tr>
</tbody>
</table>

Source: Bromley PCT

The service provided includes:
- Counselling
- Consultation which includes discussion around choice of procedures i.e. whether surgical or medical
- Discussion of future contraceptive options. The PCT has recently made a contract with the TOP service providers to offer IUD, IUS, contraceptive depot injection and sterilisation (on a case by case basis).
- Risk assessment for STIs, Chlamydia screening or leaflet on screening
- Follow-up service for teenagers and self-referrers to prevent further unwanted pregnancies

**Medical v surgical terminations**

Medical terminations using RU 486 require two visits, one to be counselled and given the medication, and a second to ensure that abortion has taken place. Surgical terminations, on the other hand, can be completed in a single visit. The
advantage of medical termination for the patient is that it is safer, less invasive, and
does not require an anaesthetic. Some women feel that it is more natural and gives
them more control over their bodies. The down side is that it tends to be more
painful, takes longer, and the patient may feel less supported as they are at home
when it happens. A small number may also haemorrhage and require a blood
transfusion and/or emergency surgical evacuation of their uterus. A few others may
have a failed procedure and need to have a surgical TOP subsequently (this is also
true of surgical procedures that can fail and need to be repeated). The amount
charged by contracted providers is similar for medical and surgical terminations.

In 2008, Bromley’s private providers carried out 1153 abortions, of which 275 (31%)
were medical. This figure cannot be compared with percentages given in Sex and
Our City because the latter are based on abortions done in women of less than 7
weeks gestation, whereas the Bromley figure is based on all abortions done by
those providers.

It is possible that medical terminations could be provided locally, by specialist C and
RH services, although this would need to be on licensed premises (currently only
the PRUH in Bromley) and with support services for complications.

Contraception advice and provision
An important part of any prevention strategy for repeat abortions is to ensure that
women having abortions are offered contraception at the time of their abortion.
Although contraceptive advice has been part of the contract with the private
providers, not all methods of contraception have been funded. The result is that only
about 10% of patients were being given contraception in 2007 and 2008. Funding
has now been specified for the provision of all forms of contraception, and numbers
of patients receiving contraception is now rising. That the use of LARCs should be
recommended, as per NICE guidance, has also been made explicit.

From April 2008 to March 2009 the PCT funded a series of follow-up calls to women
who had called the CBS. Only a third of these consented to provide follow-up
information. Of the 83 under 18s who participated, 71 had had either a TOP or had
miscarried, of whom 53 (64%) were using contraception a month later. 30 (51%) of
these were using an oral contraceptive, 15 (28%) were using a LARC, and 8 were
using condoms. None reported using the diaphragm. 33% were not using any
contraception.

The PCT aims to reduce the repeat abortion rate to national levels by introducing a
specialist contraception nurse to the TOP service, and including funding for all types
of contraception in the TOP contract, as below.

Training
To help ensure that their services are Young People friendly, confidentiality toolkit
training is provided to primary care staff.

E. The Chlamydia Screening Programme

Epidemiology
Chlamydia trachomatis is now the most commonly diagnosed sexually transmitted
infection (STI) in the world, and the most commonly diagnosed STI in the UK. The
number of diagnoses in the UK trebled between 1995 and 2004, following a period
of declining incidence of all sexually transmitted diseases, presumed to be due to
safer sex campaigns to reduce transmission of HIV. Increasing rates of risky sexual behaviour is thought to be the cause of recent increases in diagnoses. Chlamydia now represents 46% of all diagnoses of sexually transmitted diseases.

Rates of infection are associated with ethnic origin, living in an inner city, and indicators of poor sexual health such as high rates of unwanted pregnancy, other STIs etc. The prevalence of infection in Bromley is likely to vary widely between poorer and more affluent areas.

**Clinical features**
Infection with Chlamydia Trachomatis is primarily through penetrative sexual intercourse. Infection is asymptomatic in 70% of women and over 50% of men, and may persist, or resolve spontaneously. Two thirds of sexual partners of Chlamydia-positive individuals are also Chlamydia positive. In the absence of treatment, 10-40% of infected women will develop pelvic inflammatory disease with a significant proportion of these being asymptomatic or having mild, atypical symptoms. PID can result in tubal factor infertility, ectopic pregnancy and chronic pelvic pain. The risk of PID, and its complications, increase with each recurrence of infection.

**Introducing screening**
Tackling the prevalence of Chlamydia through the National Chlamydia Screening Programme [NCSP] is a key commitment of the public health white paper ‘Choosing Health’. In January 2008 Bromley implemented this programme, the aim being to offer screening to all residents between 15 and 24 years of age. For reasons of economy and efficiency, Bromley teamed up with Bexley and Greenwich Primary Care Trusts in order to deliver the programme, with Greenwich PCT taking the lead role. In November 2008, however, responsibility for the programme in Bromley and Bexley transferred to a local team.

By September 2008, a total of 1729 (5.4%) young Bromley residents had been tested by Bromley testing sites, of whom 94 had a positive result (5.4%). A similar proportion, 5.3%, of Bromley residents had been tested between April and September 2008, via both Bromley and non-Bromley testing sites. This is a real achievement, with uptake rates increasing from one quarter to the next. However, the rates are considerably short of the target uptake of 17% for 2008-9.

Actions taken to maximise uptake have so far included: training of staff in pharmacies, school health services, Young Parents service, the 8 Contraceptive & Reproductive Health Clinics, Youth Workers and Colleges. Outreach workers, an organisation known as ‘Metro’, has been contracted to go out to venues where young people are likely to found. Football matches, Colleges, Bromley High Street, Pubs, JusB [a community voluntary organisation for young people] are just some of the examples where Metro have ‘outreached’ so far. Also letter has twice been sent out to all people aged 15 – 24.

Table 1 shows a breakdown of tests done on Bromley residents in a six month period of 2008. During that time 482 residents (28%) were tested outside the district. The majority of these were tested in family planning clinics in Lewisham.

Vital signs indicators for May 2009 show that great strides have been made in increasing uptake of Chlamydia screening, which is now very close to the target of 17% for this year (see fig 26).
In December 2008, a health equity audit of the screening programme was carried out, and the main findings were:

**Data**
- There are two main datasets describing Chlamydia screening activity: The local dataset provides information on tests done via Bromley testing sites, for both residents and non-residents. The HPA data provides information on all tests done on Bromley residents, wherever they were done.
- Uptakes rates for these sets of data are therefore different.
- Postcode data on individuals has to be converted to SOA codes before they can be used for auditing purposes. It would be easier to audit uptake rates by area regularly if denominator data were included in the dataset.
- Tests done via the internet or METRO are not coded by the HPA as having been done in Bromley.
- There is no reliable data on the number of testing kits being handed out, therefore we do not know what proportion of kits result in a test.

**Activity and progress to date**
- The overall uptake of screening in Bromley residents is 6.7% for the period April to September 2008 (HPA data). This is lower than Greenwich and Lewisham, but higher than for London and the UK.
• 72% of residents are being tested via Bromley sites, and 28% via sites outside the borough. The majority of tests done outside the borough are being done via Lewisham contraceptive services.

• Lewisham tests more people via contraceptive services than any other London borough, and the positive test rate is also higher, at 11.8%. A much higher proportion of tests are done via contraceptive services in Bromley than in Bexley.

• Bromley has a lower positive test rate than neighbouring boroughs.

• Bromley, Bexley and Greenwich seem to be unusual in using the internet as a source of testing kits.

• METRO outreach is responsible for a higher proportion of tests in Bexley and Greenwich, as compared to Bromley.

• METRO activity in certain geographical areas has increased uptake among younger age groups, and in males, but the test positive rate is low.

• The proportion of tests done by METRO is lower than in Bexley and Greenwich. This may be due to METRO starting their activity later in Bromley.

• A relatively high proportion of tests was done by Bromley GPs, as compared with Bexley and Greenwich, but is low compared to London and the UK.

• A higher proportion of tests are done by pharmacies in Bromley than in London and the UK. In London wide data, a relatively high proportion of tests done in pharmacies are positive (8.2%).

• We make little use of youth services as a source of testing

• Although 8.6% of tests done via TOP services are positive, very few tests are being done in BBG.

• Positive test rates are relatively low for education outlets in London, nevertheless 3% of tests done in London and 8% of tests done in the UK were done via educational settings, with none at all done locally.

• Only 54 tests done via Bromley testing sites were on non-residents, and most of these were done via pharmacies or contraceptive services.

Table 23: Number of tests done on Bromley residents and via Bromley sites
April – September 2008

| Numbers |
|---------------------|------|
| All Tests on Bromley residents | 1746 |
| Bromley residents tested in BBG | 1262 |
| Of which: | |
| Bromley residents tested in Bromley | 1245 |
| Bromley residents tested in Bexley | 17 |
| Bromley residents tested in Greenwich | 0 |
| Bromley residents tested outside BBG | 484 |
| tested via contraceptive services | 427 |
| tested via youth services | 25 |
| tested via other sites | 32 |
| Tests done on non-Bromley residents via Bromley sites | 54 |
| via pharmacies | 21 |
| via contraceptive services | 17 |
| other | 16 |
Table 24 shows how Bromley screening activity compares with that of neighbouring boroughs, and with London and the UK. Bromley has a lower coverage rate than both Greenwich and Lewisham, but higher than Bexley, London and the UK. The positive test rate, however, is lower than the other boroughs, and lower than that for London and the UK. The implications of this will be discussed under the section on positive tests, below.

Table 24:

<table>
<thead>
<tr>
<th>Source of Screening</th>
<th>Bromley</th>
<th>Bexley</th>
<th>Greenwich</th>
<th>Lewisham</th>
<th>London</th>
<th>UK</th>
</tr>
</thead>
<tbody>
<tr>
<td>No tested</td>
<td>1,746</td>
<td>1,158</td>
<td>1,972</td>
<td>4,385</td>
<td>45,142</td>
<td>255,875</td>
</tr>
<tr>
<td>Coverage %</td>
<td>5.3</td>
<td>4.1</td>
<td>6.4</td>
<td>13.5</td>
<td>4.6</td>
<td>8.4</td>
</tr>
<tr>
<td>Positives %</td>
<td>6.7</td>
<td>7.2</td>
<td>8.4</td>
<td>11.8</td>
<td>7.6</td>
<td></td>
</tr>
<tr>
<td>% tests provided by:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internet/other</td>
<td>37</td>
<td>33</td>
<td>18</td>
<td>3</td>
<td>7</td>
<td>10</td>
</tr>
<tr>
<td>Outreach</td>
<td>20</td>
<td>33</td>
<td>38</td>
<td>2</td>
<td>23</td>
<td>15</td>
</tr>
<tr>
<td>GP</td>
<td>6</td>
<td>0</td>
<td>3</td>
<td>7</td>
<td>17</td>
<td>26</td>
</tr>
<tr>
<td>CCS</td>
<td>31</td>
<td>11</td>
<td>33</td>
<td>87</td>
<td>33</td>
<td>2</td>
</tr>
<tr>
<td>Pharmacies</td>
<td>5</td>
<td>3</td>
<td>5</td>
<td>1</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>TOP</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>14</td>
</tr>
<tr>
<td>Youth</td>
<td>1</td>
<td>16</td>
<td>2</td>
<td>2</td>
<td>12</td>
<td>8</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source: National Chlamydia Screening Programme

The most notable differences between Bromley and other areas in terms of the source of tests are:
- Lewisham has a much higher rate of testing via contraceptive services than Bromley, but also than anywhere else
- We make little use of youth services as a source of testing
- The proportion of tests done by METRO is lower than in Bexley and Greenwich. This may be due to METRO starting their activity later in Bromley.
- A relatively high proportion of tests was done by Bromley GPs, as compared with Bexley and Greenwich, but is low compared to London and the UK.
- A higher proportion of tests are done by pharmacies in Bromley than in London and the UK.
F. Health promotion/improvement service

Two important pieces of guidance have been published by NICE that should inform sexual health promotion programmes and activities. These are:

1. ‘One to one interventions for reducing the transmission of STIs including HIV, and to reduce the rate of under 18 conceptions, especially among vulnerable and at risk groups’. NICE 2007
2. ‘Behaviour change at population, community and individual levels’. NICE October 2007.

1. One to one interventions for reducing the transmission of STIs including HIV, and to reduce the rate of under 18 conceptions, especially among vulnerable and at risk groups

The important aspects of the guidance on reducing STIs and under 18 conceptions included the identification of people in the population who are most at risk, and recommended interventions.

Key groups at risk of STIs were identified as:
• men who have sex with men
• people coming from areas of high HIV prevalence

Key groups at risk of under 18 conception were teenagers:
• from disadvantaged backgrounds
• in or leaving care
• with low educational attainment

Sexual health problems also disproportionately affect asylum seekers and refugees, sex workers and their clients, and the homeless. Factors which increased risk in all groups were alcohol/substance misuse, early onset of sexual activity, unprotected sex and frequent change of, or multiple, partners. Risky sexual behaviour is contributed to by low self esteem, lack of knowledge or skills, lack of negotiation skills, peer pressure, and attitudes of society that affect access to education and services.

The guidance identified the professional groups who should take action in this area as being GPs, GUM and community sexual health services, school health services and other community-based services. The main recommended intervention was that these services should take responsibility for identifying individuals at high risk and offer ‘structured interviews by practitioners trained in sexual health’. It was also emphasised that partner notification and follow-up should be a responsibility of all these agencies.

The guidance also emphasised the need to make information and advice on contraception (including emergency contraception) and avoiding STIs available in multiple settings, including:

- GP surgeries
- contraception and GUM clinics
- TOP services
- Pharmacies
- Schools
- Youth services
2. ‘Behaviour change at population, community and individual levels’.
The second important piece of NICE guidance that is relevant to sexual health promotion was produced on the basis of a review of the evidence of what works in changing behaviour at three levels, population, community and individual.

Central to the recommendations is that those planning interventions should:
- Be specific about the behaviour they are trying to change, and the results they are seeking
- Be specific about the intervention itself
- Be specific about how and where it will be used
- Be explicit about the underlying theory
- Evaluate the intervention in terms of measurable outcomes

It also makes the points that ‘Effective interventions target specific groups and are tailored to meet their needs’ and ‘Service user views may be helpful in planning interventions’. In particular health professionals need to understand the pay off to individuals of apparently damaging behaviour, and any intervention needs to be culturally sensitive to the group at which it is aimed.

The Health Improvement (HI) team for sexual health
The team consists of five full time staff, including
- The team leader
- A project co-ordinator
- Three sexual health advisors (Young people, HIV and vulnerable groups)

They are based at Beckenham clinic, while the Heads of Health Promotion are based at Bassetts House. In the recent separation of the Community Provider Unit and the PCT, the Health Improvement Service (HIS) was placed within the CPU.

Current health improvement activity is focussed on the following groups (Table 25):
- Young people who are sexually active, or may be soon
- Parents and carers of young people
- Professionals who come into contact with young people
- Afro-Caribbean men
- Gay and bisexual men
- Youth offenders
- Looked after children

It is hard to reach gay and bisexual men in Bromley, probably as a result of homophobic attitudes and fear of violence. HI sessions that are advertised and held at gay venues are poorly attended. Another hard to reach group is Black Africans, and there are no programmes targeted at this group, despite the high risk of HIV. The Ahead programme mostly reaches Black Caribbean people.
<table>
<thead>
<tr>
<th>Service</th>
<th>What do they provide?</th>
<th>Who delivers the services?</th>
<th>What is the profile of the service users?</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Condom Distribution</td>
<td>Free condoms to those under 24 years</td>
<td>40 providers including: youth centres, some GP practices, voluntary organisations, colleges, Sure start centres, looked after children’s team, Bromley Youth offenders team</td>
<td>Mainly those under 24 years but is open to all at GP practices</td>
<td></td>
</tr>
<tr>
<td>AHEAD project</td>
<td>Free condoms and leaflets on sexual health targeted at the Afro-Caribbean population</td>
<td>9 Barbers</td>
<td>Afro-Caribbean male and female</td>
<td></td>
</tr>
<tr>
<td>Condoms for Gay &amp; Bisexual men</td>
<td>Email service targeted at the Gay &amp; Bisexual population</td>
<td>Health improvement team provide condoms upon request by email</td>
<td>Gay &amp; Bisexual</td>
<td></td>
</tr>
<tr>
<td>2. Health education/promotion</td>
<td>Children’s Centre (Sure start centres)</td>
<td>Sexual health education provided by the Health Improvement team. Health education at every secondary school on Sexual health, teenage pregnancy, smoking, drugs, alcohol &amp; self esteem. Includes 2 Special schools and 2 colleges</td>
<td>All areas with a focus on vulnerable areas</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Enrichment days</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Youth Offending teams</td>
<td>Awareness sessions for young offenders which could be part of the rehabilitation programme designed for the youth</td>
<td>Have done 3-4 sessions with small groups</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Looked after children/Youths leaving care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Training</td>
<td>Training on SRE &amp; HIV</td>
<td>Training the trainers on Sex &amp; Relationship education and HIV 4 times a year</td>
<td>Open to any professional working in LBB on a voluntary basis</td>
<td>50 people per year</td>
</tr>
<tr>
<td></td>
<td>DELAY</td>
<td>Training for any professional to work with young people about delaying sexual encounters</td>
<td>Open to those who work with young people</td>
<td></td>
</tr>
<tr>
<td>Confidentiality</td>
<td>Training on confidentiality issues with a focus on young people’s confidentiality</td>
<td>GPs/Practice nurses</td>
<td>None</td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>What do they provide?</td>
<td>Who delivers the services?</td>
<td>What is the profile of the service users?</td>
<td>Quantity</td>
</tr>
<tr>
<td>---------</td>
<td>-----------------------</td>
<td>----------------------------</td>
<td>------------------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td><strong>4. Sexual health awareness</strong></td>
<td>Health Boards at schools</td>
<td>Every 6th form will have a health board from this month onwards. In the future, will liaise with school nurses to tailor it to need</td>
<td>Pupils at all secondary schools</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Health boards at GP Practices</td>
<td>About 13 practices have health boards with a specific focus on young people</td>
<td>Every one</td>
<td>25,000 distributed</td>
</tr>
<tr>
<td></td>
<td>Young People Information cards</td>
<td>Information cards with a list of all services which have been widely distributed to schools and other settings. One card is given out with every enrichment day pack</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Youth Offending teams</td>
<td>Awareness sessions for young offenders which could be part of the rehabilitation programme designed for the youth</td>
<td>Have done 3-4 sessions with small groups</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Looked after children/Youths leaving care Speakeasy</td>
<td>An opportunity for parents and carers to acquire the skills they need to talk to their children about sex and sexuality</td>
<td>Parents and Carers</td>
<td></td>
</tr>
<tr>
<td><strong>5. Campaigns</strong></td>
<td>Sexual Health Week (National) Sexual Health</td>
<td>Run in the summer in August</td>
<td>Local population</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Locally run campaign around Christmas</td>
<td>Local population</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pharmacy awareness</td>
<td>The health improvement team gets involved and sends out information packs to all pharmacies on Sexual health</td>
<td>Local population via local pharmacies</td>
<td></td>
</tr>
<tr>
<td><strong>6. Needle exchange programme</strong></td>
<td>Junction drop in centre</td>
<td>Opens 2-3 times a week plus one evening per week. Provides subsidised meals for registered users (people living with HIV), condoms are also provided. The Health Improvement team also run a weekly health group for gay men.</td>
<td>180 registered users of which about 40% are from Bromley</td>
<td></td>
</tr>
</tbody>
</table>
In terms of NICE guidance, the Health Improvement team take responsibility for groups within Bromley, but do not do one to one work. Each project it targeted at a specific group and evaluation is done on an ad hoc, rather than routine, basis. Currently, evaluation forms from training events are not being analysed on a regular basis, and reports on evaluations of the projects in Table x are not available.

The HI team take responsibility for providing sexual health promotion materials, posters and leaflets, to GPs, clinics, pharmacies etc, throughout the borough. The extent to which these materials are displayed, however, is patchy. Some GP surgeries do not put posters up, and it is not possible to put posters on the walls at the Beacon, due to restrictions over using blue tack.

The provision of one to one sessions for people at risk of poor sexual health, a key intervention recommended by the NICE guidance, is not consistent, as there are insufficient staff to provide it routinely. An additional problem is that men and women tend to prefer to talk to staff of the same sex.

Another key intervention relates to partner notification, but again, the HI team have no authority to ensure this happens.

G. HIV Specialist nursing service

The HIV Specialist Nursing Service is run by two specialist nurses. They are employed by the Community Provider Unit but based in the GUM clinic at Beckenham Beacon. They have a current caseload of 192 patients with HIV, of whom around 30 have complex psycho-social needs. Numbers are increasing from year to year.

Provision includes:
- Seeing all newly diagnosed patients, providing support and information, and assessing their clinical needs and referring appropriately.
- Supporting pregnant women with HIV, facilitating their care and liaising with maternity services.
- Provision of community care for people with HIV who are accessing GUM services outside the borough, as many do.
- An adherence support programme for people on retroviral treatment.
- Providing psychological support. (this is a specialist service in areas of higher prevalence, and needs to be considered in Bromley, as numbers increase).

In addition, the team work closely with the HIV team in Health Improvement, providing advice and support on staff training programmes and events, and strategic planning for the reduction of HIV infection and increase in detection rates.

It is important to note that this is not a counselling service, and that there is no specialist HIV counselling service in the borough. Clients either use mainstream counselling services, which are often inappropriate, or go outside the borough.

H. Community Pharmacy

Community Pharmacists come in contact with a significant part of all parts of the population daily and are usually located in areas where they are easily accessible. There is no requirement for an appointment to see a Pharmacist who are in most cases open for long hours and hence, are very flexible. For many people, they are the first point of contact with a healthcare professional. Community Pharmacists are
therefore well-placed to engage with their local communities and make a contribution to public health, and yet their role so far has been largely untapped.

In Bromley, there are 58 PCT licensed pharmacies. About 40 out of the 58 pharmacies have a private consultation space, which is especially essential when providing sexual health/contraception services. It is estimated that there is at least one pharmacist at each of these pharmacies, with a total number of pharmacists in the borough between 70 and 100.

As part of the pharmacy contract and essential service provision all pharmacies are required to provide health promotion services either opportunistically (depending on the patient’s requirements) or to all customers on specific topics as directed by the PCT. There are usually between 4 to 6 of such campaigns per year and the topics addressed includes amongst others, raising awareness of Sexual health, STIs and signposting customers to relevant services.

**Specialist Service: Emergency Hormonal contraception (EHC) provision**

Community pharmacists are increasingly playing a role in promoting safer sex and contraception, including the provision of over the counter Emergency hormonal contraception (EHC). Since 2001, there have been a number of UK schemes that have enabled pharmacists to supply free EHC to under 16-year-olds. Currently, in Bromley, there are 6 pharmacies that provide free EHC to under 16s, with a plan to extend this service to two additional pharmacies soon - as shown in the map below. The age below which free EHC is available is planned to be increased to 18 in the near future. The distribution of pharmacies that provide EHC to under 16s is concentrated around the North of Bromley (Fig 27).

**Figure 27**

**Distribution of Community Pharmacists providing EHC to under 16s**
Chlamydia screening and treatment is another area that the Community Pharmacists actively participate in. Presently, there are 18 pharmacies that do provide this service to young people between the age of 16 and 24 years. (See Chlamydia screening section). As regard to condom distribution, in Bromley, there is no free condom provision in pharmacies currently; although pharmacies do sell condoms.

Training on the provision of EHC and Chlamydia screening & treatment is provided for pharmacists including Locum pharmacists. The training also addresses issues around consent, especially with EHC as the patients/customers are under 16.

I. School Health Service

Staffing
Bromley's school health service is made up of 15 school nurses (10 WTE). The remit of their work is to cover
- 78 primary schools
- 18 senior schools
- 2 colleges
- 2 Pupil Referral Units (PRU) and
- The Youth Offending team (YOT)

Activities
The school nurses deliver educational sessions on sexual health and other health matters, to primary and senior schools. In primary schools, the school nurses give a ‘Puberty Talk’ to years 5 & 6 annually. In year 9 in senior schools, the school nurses work together with the Health Improvement & the Drug/Alcohol teams, to hold an annual whole day events called Enrichment Days. These are a series of educational workshops on a range of health issues including Teenage Pregnancy, STIs and Contraception, which have been well evaluated by both pupils & staff. In the past year the programme has extended from only 10 secondary schools, to all secondary schools in the district.

School nurses also cover pupils at the Pupil Referral Units (PRU), whom they see on a one to one basis or as a group to give advice/education and signpost to relevant health services. One school nurse is assigned to work with the Youth Offending Team (YOT), for 2.5 days per week, giving advice/education and signposting to relevant services on an individual basis or in small groups. All young offenders are offered a health assessment by this nurse.

In the two colleges in Bromley, the school nurses facilitate the provision of Chlamydia screening/treatment and condom distribution, as well as providing health education and signposting. Each educational setting has a named school nurse who, in addition to providing all the services mentioned above, facilitates other agencies to come and give educational talks to the pupils, and offers a weekly drop-in-service to deal with individual as well as group concerns/queries. However, each school nurse is currently the named nurse for more than one educational setting.

The Health Improvement team report that most school nurses have attended training in sexual health, but unfortunately not all schools have a school nurse, and nurses have many other priorities. Most schools have counsellors, but these counsellors are not necessarily trained in sexual health.
J Voluntary organisations
The Metro centre is a charity working in partnership with statutory and voluntary organisations serving lesbians, gay men, bisexual and transgendered (LGBT) people and those questioning their sexuality. It is based in Greenwich.

They have a Chlamydia outreach service which goes into schools, colleges, youth groups, cinemas, high streets and hard-to-reach groups including the travelling community. They distribute Chlamydia packs. They have outreach teams who work in Bromley.

They have clinics at their centre, known as ‘Pitstop’ clinics. There is one twice a week for MSM, and once a week for women who have sex with women. It is a walk-in clinic, and offers the following:

- HIV testing
- Hepatitis A testing
- Hepatitis B testing
- Hepatitis C testing
- Syphilis testing
- Gonorrhoea testing
- Chlamydia testing
- Hepatitis A & B Vaccinations

They use the Abbott HIV test which uses a fingerprick sample of blood and can give a result in 15 minutes. If this test is positive then a full sample of blood can be sent for testing. Patients wait in the waiting room for the result and there are local volunteers and staff there to support them. They have a system with the local GU services so that there is a referral pathway for a positive result.

The Pitstop Manager, Andrew Evans, has noticed that there are a considerable number of Bromley residents who come to the Metro centre for sexual health services, especially MSM.

They are looking into getting a 4th generation HIV test which allows the detection of antibodies from 3 weeks after exposure (rather than 3 months which is the current situation). Currently, even if people have a negative HIV test, if there has been a history of exposure in the last 3 months then clients are recommended to have another test 3 months after the last exposure.

Clinical services are provided by their team of nurses. This service is mainly for asymptomatic patients but they are currently developing a PGD with Queen Elizabeth Hospital to allow them to treat symptomatic patients, and to provide post-exposure prophylaxis.

They have a mentoring service for HIV-negative men who want help to remain HIV negative. There are two clinics for African people.

They have an outreach team who visit various venues and give out condoms, lubricants and answer questions about sexual health. They are looking into the possibility of testing for Gonorrhoea on the outreach service.
The Junction is a Bromley based centre for people living with HIV. It provides advice and support, regular drop in sessions, groups for men and women, outings and events and complementary therapies. It is highly valued by the people who use it, who get much of the information they need on local services from here.

Connexions is a youth support service providing advice, information, support and personal development opportunities for all 13-19 year olds, and young people with disabilities up to the age of 25. Its aim is to link up the many different services that help young people to make the important decisions that affect their lives. These services include careers services, youth services, welfare, housing, and health. Support provided included individual support from a personal advisers who are based in schools, colleges, youth organisations and at the Connexions Centre in Bromley, plus relevant information on a wide range of issues via a website and helpline.

8. Stakeholder and User views

Main points:

- Staff report a high level of denial among Bromley adults about teenage sex, leading to parents opting out of sex education and authorities unwilling to encourage sex education and services in schools. Teenagers, on the other hand, believe that all teenagers are having sex. These beliefs increase sexual activity among teenagers, while hindering the provision of the information they need.

- Young people at most risk of poor sexual health are likely to have missed out on sex education in schools, and their social circumstances (eg teenage pregnancy, being in care, youth offending, school exclusion, gay but not ‘out’) both create and perpetuate this lack of contact with mainstream sources of information and support. As a result, these young people have a particularly low awareness of the risks of unprotected sex.

- Most young people have heard of the morning after pill, but knowledge about where to get it is patchy, and the cost of obtaining it from pharmacies (£25) deters people from getting it. Also, under 16s are not able to buy it without being accompanied by an adult.

- The most common source of information on sexual health and services is word of mouth, mostly friends and GPs. Internet is another important source. Young people do not gain much information from school nurses, but would like to.

- The level of knowledge of the choice of sexual health services available was generally low.
- The most important attributes of a service for users were that it was informal, friendly, confidential and treated them with respect.
- Walk in clinics involve long waits, and people are often turned away. Appointment systems in the past, however, have had high DNA rates.
- Most users of CRH and GUM clinics rated highly the friendliness of staff, clarity of explanations, and sufficiency of time with staff, but many felt the waiting times were too long.
- Clinics/advice services in or near schools and colleges are used and valued.
- Going to a sexual health or contraception clinic is very daunting for most young people, so it needs to be made easy, and staff need to be aware of how embarrassed they may be. Information on what actually happens in the clinics could help, and it is also important that people are not turned away, once they do attend.
- There is a demand for services during the day, early morning, evenings and Saturday afternoons. Some people like young people clinics, others are more concerned with having a choice of clinic days and times.
- Generally people felt there were not enough clinics in each locality, and that Beckenham Beacon was too far to go from many parts of the borough
- There is a demand for both appointment and walk-in clinics (NB appointment systems have not worked well in the past).
- Because not all contraceptive clinics provide all forms of contraception and STI screening, and because the GUM clinic does not provide contraception, people are not infrequently told to go elsewhere.
- Both staff and users think the wait for LARCs (up to 2 months) is too long.
- Suggestions by patients at the CRH clinic included: an ‘express service’ for condoms and repeat prescriptions.
- Many users said they would use more comprehensive services.
- Communication within the service is patchy, with changes in clinic times and other details not always communicated to other clinics, Health Improvement, school nurses and the Chlamydia screening team.
- Users do not like having to wait outside the BB clinic until it opens
- More advertising of services is needed, the internet, posters and leaflets are favoured forms of advertising. Currently it is not easy to find information on the internet.
• The specialist HIV support at The Beacon is highly valued.
• Gay men tend to use services outside the borough, which are tailored to their client group. Therefore it was difficult to access views from gay men.
• Very young girls are unlikely to attend contraceptive clinics alone and thoughts need to be given as to other ways of providing these services.
• Some staff believe that girls in care, youth offenders and those not in education, employment or training, often choose to get pregnant due to perceived lack of other options in their lives, and as a way of finding love and purpose, and accessing housing and benefits.

An important part of any needs assessment is gathering the views of the people who run the services, the people who use them, and the people who need them but don’t use them. Using a combination of questionnaires, workshops and interviews, in a range of settings, we gathered views from:

**Staff who work at/in:**
Beckenham Beacon Sexual Health Clinic
Contraception and reproductive health service (C&RH)
Young parents midwives team (YPM)
Youth offending team (YOT)
Drugs and alcohol team (DAT)
Health Improvement Service (HIS)
Looked after children team (LAC)
School nurse service (including Orpington College)
Bromley College student liaison team
Connexions (for those not in employment, education or training NEET)
Metro and The Junction (voluntary sector)

**Users and potential users at:**

<table>
<thead>
<tr>
<th>Service/Setting</th>
<th>Number of Users</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Beacon Sexual Health Clinic (two week survey)</td>
<td>192</td>
</tr>
<tr>
<td>Contraceptive and reproductive health clinics (two week survey)</td>
<td>104</td>
</tr>
<tr>
<td>Young parents Midwives service (two week survey)</td>
<td>52</td>
</tr>
<tr>
<td>The Junction (for people with HIV) (two week survey)</td>
<td>10</td>
</tr>
<tr>
<td>Bromley College (informal discussions)</td>
<td>18</td>
</tr>
<tr>
<td>Orpington CRH clinic (informal discussions)</td>
<td>14</td>
</tr>
<tr>
<td>The Beacon Sexual Health Clinic (informal discussions)</td>
<td>14</td>
</tr>
<tr>
<td>YP CRH at Beckenham Beacon (informal discussions 2008)</td>
<td>12</td>
</tr>
<tr>
<td>YP CRH at Beckenham Beacon (informal discussions 2009)</td>
<td>14</td>
</tr>
<tr>
<td>Young People attending Biggin Hill Air Fair (questionnaire)</td>
<td>52</td>
</tr>
<tr>
<td>Teenage mothers at Connexions (informal discussions)</td>
<td>10</td>
</tr>
<tr>
<td>Looked After Children (informal discussions)</td>
<td>5</td>
</tr>
<tr>
<td>Youth offenders (informal discussions)</td>
<td>4</td>
</tr>
<tr>
<td>Afro-Caribbeans at barbers and hairdressers (informal discussions)</td>
<td>27</td>
</tr>
<tr>
<td>Gay men's group (informal discussions)</td>
<td>9</td>
</tr>
<tr>
<td><strong>TOTAL USERS CONSULTED</strong></td>
<td><strong>527</strong></td>
</tr>
</tbody>
</table>
Views should be interpreted with caution
It is important to remember that the views and comments that are presented here are those of individuals, or groups of individuals, that are reporting things that they have heard from friends as well as their own personal experiences. An individual’s experience of a service will be affected by many factors, including how often they use that service, the circumstances in which they used it, and how they were feeling at the time. Comments therefore need to be viewed in that light, and the expertise and experience of staff providing the services will be invaluable in interpreting them.

The GUM clinic at Beckenham Beacon
User views
Questionnaires were handed out at Beckenham Beacon GUM clinic over a 2 week period. 192 responses were obtained, or whom 93 were male and 99 were female. 60% of attenders lived in BR1, BR2 or BR3 (Mottingham and Chislehurst).

Figure 28  Age of respondents
84% were self-referred, most of the remainder were referred by their GP. 36% of people said they would use contraceptive services and 15% smear testing if they were available at the clinic.

Most people heard about the clinic through friends or the internet, with GPs as the third most common source. Only 4 people (2%) said they heard about it from a poster. 83% of those responding waited less than 48 hours from first contacting the clinic before being seen. Of those who completed their questionnaire at the end of their visit, just over half had spent between 1 and 2 hours in the clinic, with around 1 fifth spending 2-3 hours and 6% being in the clinic for over 3 hours. Around a fifth of people spent less than 1 hour in the clinic.

**Figure 30 Source of information about the clinic**

<table>
<thead>
<tr>
<th>How did you hear about us?</th>
<th>No. People</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>School nurse</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Youth Club</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Bromley YPs clinic</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>NHS Direct</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>Yellow Pages</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>School counsellor</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td>Live locally</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td>Advert</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td>Beacon</td>
<td>2</td>
<td>1%</td>
</tr>
<tr>
<td>Family member</td>
<td>3</td>
<td>2%</td>
</tr>
<tr>
<td>Poster</td>
<td>4</td>
<td>2%</td>
</tr>
<tr>
<td>Partner</td>
<td>6</td>
<td>3%</td>
</tr>
<tr>
<td>Family Planning Clinic</td>
<td>18</td>
<td>9%</td>
</tr>
<tr>
<td>GP</td>
<td>35</td>
<td>18%</td>
</tr>
<tr>
<td>Friend</td>
<td>67</td>
<td>30%</td>
</tr>
<tr>
<td>Internet</td>
<td>58</td>
<td>30%</td>
</tr>
</tbody>
</table>
86% of respondents rated the friendliness of staff 8 out of 10 or more, with no marked differences between receptionists, nurses and doctors. 86% scored the clarity of explanation they were given as 8 or more. Only one person said they had not had enough time with the person they saw.

Figure 32: On a scale from 0-10 how friendly did you find the service?
Users were asked about the factors which were important to them when deciding where to have a check-up or treatment for sexually transmitted infections.

<table>
<thead>
<tr>
<th>Service feature</th>
<th>% who thought it important or very important</th>
</tr>
</thead>
<tbody>
<tr>
<td>Confidential service</td>
<td>90%</td>
</tr>
<tr>
<td>Friendly staff</td>
<td>85%</td>
</tr>
<tr>
<td>Walk in service</td>
<td>82%</td>
</tr>
<tr>
<td>Short waiting times</td>
<td>81%</td>
</tr>
<tr>
<td>Results available the same day or next day</td>
<td>81%</td>
</tr>
<tr>
<td>Evening service</td>
<td>71%</td>
</tr>
<tr>
<td>Saturday service</td>
<td>67%</td>
</tr>
<tr>
<td>Easy access by public transport</td>
<td>67%</td>
</tr>
<tr>
<td>Appointment system</td>
<td>58%</td>
</tr>
</tbody>
</table>

Additional comments were that the waiting time was too long, and that the Croydon clinic was much quicker. In addition, there were comments that people should be told if there is going to be a long delay. One comment was that the results of the HIV test should take less than 2 weeks, and that the wait for results generally is too long. There was also a complaint about people waiting outside the clinic and being seen by passers-by, and perhaps people who know them, something that was observed by a member of staff during an informal visit to the clinic in June 2009. Suggestions to improve the service included having a ticketing system outside the clinic, if people had to wait there.

Specific comments:
‘I think the Mayday clinic in Croydon is much quicker, it does not take half as long as this clinic. Please do something. I could not stay in the clinic to be seen as result of time taking, I have waited for over three hours.’
‘The nurse who saw me was gentle, fast and understanding, even though I was very nervous I left feeling satisfied and confident, Thank you.’
‘You shouldn’t be asked to pay parking as the amount of time spent waiting is dependant on you/ your service rather than me. Someone with a long wait is “punished” with an expensive ticket’

‘The staff were really friendly and relaxed.’

‘All the staff are very friendly and made me feel very comfortable. The waiting time was just so long.’

‘If I couldn’t have got in today I would have gone to Croydon cos I know I could have got in there today - wanted to be seen today’.

Informal discussions with nine men at a gay men’s group revealed that the men felt uncomfortable at the GUM clinic, and that they would prefer to see male doctors and nurses. A gay man wrote a letter to the News Shopper saying that he had been going to the Beckenham GUM clinic for some years and complained about the time he had to wait for results and the manner in which it had been reported to him. He then went to The Metro in Greenwich:

“It runs a walk-in service for gay men on Wednesdays from 6.30pm until 8.30pm and on Saturdays between 11am and 1pm. I arrived five minutes early but was greeted at the door by a very friendly young woman. After being offered tea or coffee I filled in a registration form. Within 10 minutes I was called in to see a very kind male nurse, who asked some questions and took some blood. After no more than 10 minutes I was called back and given my HIV result, which I am pleased to say was negative.”

Views of GUM staff

The consultant who runs the young people’s clinic is concerned about young teenagers, both heterosexuals and young gay men, who have risky behaviours but have had little in the way of sex education because of antipathy to sex education among Bromley parents. She is concerned that the current service is not providing the one-to-one counselling of at risk individuals because there are insufficient grade 7 staff to do this. There are also problems about having to reduce the numbers of patient appointments because of staff absence and no cover, resulting in patients being turned away. The service provides contraceptive advice and free condoms, but is unable to provide other forms of contraception.

Staff realise that there are problems with long waits with the walk in service, but there was a high DNA rate with the previous appointment system, which meant that less people were seen and resources were wasted. Staff would like to be able to provide a faster testing service, but investment in newer technologies is required for this. The need for an integrated service is recognised.

The Contraception and Reproductive Health Service (CRH)

User views

In June 2009 a survey by questionnaire was conducted in all community CRH clinics. 104 users completed the questionnaire. 100 respondents were female, and the highest proportion of respondents was in the 15-19 age group. 20% lived in SE20.
Figure 34  Age of C&RH respondents

![Age of C&RH respondents chart]

- **Age Range**: n = 89 (15 not recorded)

<table>
<thead>
<tr>
<th>Age Range</th>
<th>No. People</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-19 yrs</td>
<td>21</td>
<td>24%</td>
</tr>
<tr>
<td>20-24 yrs</td>
<td>19</td>
<td>21%</td>
</tr>
<tr>
<td>25-29 yrs</td>
<td>15</td>
<td>17%</td>
</tr>
<tr>
<td>30-34 yrs</td>
<td>11</td>
<td>12%</td>
</tr>
<tr>
<td>35-39 yrs</td>
<td>10</td>
<td>11%</td>
</tr>
<tr>
<td>40-44 yrs</td>
<td>6</td>
<td>7%</td>
</tr>
<tr>
<td>45-49 yrs</td>
<td>5</td>
<td>6%</td>
</tr>
<tr>
<td>50-54 yrs</td>
<td>1</td>
<td>1%</td>
</tr>
<tr>
<td>55-59 yrs</td>
<td>1</td>
<td>1%</td>
</tr>
</tbody>
</table>

Figure 35

![Post Code chart]

- **Post Code**

<table>
<thead>
<tr>
<th>Post Code</th>
<th>No. of People</th>
</tr>
</thead>
<tbody>
<tr>
<td>BR1</td>
<td>5</td>
</tr>
<tr>
<td>BR2</td>
<td>6</td>
</tr>
<tr>
<td>BR3</td>
<td>13</td>
</tr>
<tr>
<td>BR4</td>
<td>14</td>
</tr>
<tr>
<td>BR5</td>
<td>12</td>
</tr>
<tr>
<td>BR6</td>
<td>1</td>
</tr>
<tr>
<td>CR0</td>
<td>1</td>
</tr>
<tr>
<td>CR3</td>
<td>1</td>
</tr>
<tr>
<td>SE</td>
<td>1</td>
</tr>
<tr>
<td>SE19</td>
<td>18</td>
</tr>
<tr>
<td>SE20</td>
<td>21</td>
</tr>
<tr>
<td>SE26</td>
<td>9</td>
</tr>
<tr>
<td>TN16</td>
<td>18</td>
</tr>
</tbody>
</table>

Figure 36

![Preferred type of visit chart]

- **Preferred type of visit**

- Walk-in, 56, (54%)
- Appointment, 27, (26%)
- Not recorded, 21, (20%)
The most common sources of information about the service were a friend or a GP, with internet as the third most common. 26% of respondents said they would prefer an appointment system to ‘walk in’.

**Figure 37**

![Bar chart showing how respondents heard about the service.](chart.png)

Of those who answered the question, 87% (72 people) waited under 48 hours to be seen after first contacting the clinic. Almost half the respondents were in the clinic for less than 1 hour, with a third being in the clinic for between 1 and 2 hours.

**Figure 38**

![Pie chart showing time spent in clinic.](chart.png)

Over 80% scored the friendliness of staff as 8 or more out of ten, with no marked differences between receptionists, nurses and doctors. 63% rated the clarity of explanations from staff at 10/10, with a further 20% scoring 8 or 9. Only 3% felt they had not had enough time with the doctor or nurse that they saw.
11% of people had been turned away from the clinic before as it was too busy, and the same proportion had had to come back to the clinic another time for something that wasn’t available at the clinic they attended. Two-thirds of people have never attended a GUM clinic for testing of sexually transmitted infections, and 71% said they would use a STI screening service if it was available at the contraceptive clinic.

Of the 48 people aged under 25, 25 had been tested for Chlamydia. 15 people in this age group said they had not been offered Chlamydia screening.

When asked how they would like to see sexual health services improved, six people said they wanted more opening days and longer clinics, and five said they would like waiting times to be less.
Other comments included:

‘Alright service, friendly, just long waits could improve’
‘The clinic here is absolutely amazing, I would be devastated if it wasn’t here. The staff are so helpful and friendly unlike my GP and GP nurse, it is so clean here too’.
‘I couldn’t find clinic on the website i.e. times, I had to ring Farnborough hospital, the website is a little confusing. Fabulous attention – thanks.’
‘To have more doctors appointments and not have to wait months when you can go to Lewisham clinics (by saver centre) when you can have everything done in one night.’
‘Would appreciate a number system rather than name called out.’
‘I feel that the appointment system worked better, I have been turned away on a couple of occasions because it is too busy but I come straight from work.’
‘I’ve been coming here for 4 years and everyone is so friendly. I feel very comfortable coming here and wouldn’t go anywhere else.’

In May 2008, a consultation with 12 users was conducted at the Young People’s Contraception and Reproductive Health Service at Beckenham Beacon. This was conducted by a Health Improvement advisor for young people.

Comments that were made included:

- Liked Beckenham Beacon as it was local, the staff have time for you
- Waits too long – usually at least an hour
- Dislike being sent away
- Professionals should be approachable, friendly and non-judgemental.
- The service should be reliably confidential
- There is only one clinic a week, would like more choice of days and times, and to be able to go to any clinic
- Preferred times included early mornings, 5-9pm (not Fridays), and Saturday afternoons
- One person suggested an ‘express’ service for simple needs, eg condoms or repeat prescriptions
- Have to wait outside for clinic to open
- Would like more literature in the waiting area
- Liked the environment but would like a television
- Needs to be better advertised
- Most were brought by a friend

Comments included:

“I would like the clinic combined as I went to the other place then I had to come here – what a waste of time and I was really worried”

“I think it’s important for young people to be assured that they’re doing the right thing by seeking advice on their sexual health. Many young people now tend to put it off as it can be daunting to speak to people about it.”

“I think that they should be taught how to talk to young people on their level and make them feel comfortable and safe. As for some young people it can be a very embarrassing situation.”
“There was also a youth worker who sat with the young people in the waiting area and played games with us to calm us down and ease the situation.”

Another informal consultation was conducted with 14 users at Orpington contraceptive clinic. The main issues that arose here were that some users:

- Were not aware of alternative sources of sexual health advice
- Had lower expectations of having access to STI screens than at the Beacon clinic
- Complained about waiting more than an hour
- Would prefer appointments to walk in
- Would like clinics to be more frequent and during the day as well as evening
- Did not want to be asked to come back, or go to a different clinic

“Good but it’s usually a long wait - they could do with having appointments”
“Would go to my doctor if I could get the same treatment as here and if it is was local”
“would not want to go anywhere else –don’t know anywhere anyway-have heard there are other places but don’t know where they are”

Informal consultations were held at other local clinics, and general points that emerged were.
- The clinic environments were largely friendly, with welcoming receptionists
- The staff are hard working and committed but demoralised by not being able to give a good service due to insufficient staffing levels.
- Excess numbers of requests for smears are causing pressure on the service, and staff have been told to prioritise people wanting contraception.

Views of CRH staff
Staff from the contraceptive and reproductive health service were asked a number of questions about their services and the people who attend. They believed that unwanted pregnancies were happening because of lack of knowledge about: the risks of pregnancy, how to prevent it, where to get help, and emergency contraception. Embarrassment leading to reluctance to talking to people about sexual health was also cited as a factor, as was alcohol.

Staff were well aware of long waits in clinics, up to two hours, and the problem of having to ask people to come back if they were too busy, or attend another clinic if they needed a method that could not be provided there. Their own views of the service were that the staff are very dedicated and friendly and welcoming to clients, but there are too few of them. They also think opening times need reviewing, that the long waits for LARCs need to be addressed, and that appointments are needed as well as ‘walk in’, particularly for smears and LARCs. They experience doing a lot of cervical smears, and believe that this is because GPs aren’t doing them. They would like to see more staff in clinics, proper cover for annual leave and sickness, longer opening times, more complex patient clinics and more outreach work in schools and colleges. They would also like to see an integrated service, offering STI screening and advice, as well as contraception.

Some believe that better signposting is required to inform people of the service, on the internet and in local media.
Teenage pregnancy in Bromley
Views of pregnant teenagers

Pregnant teenagers are a very important group to understand because they are sexually active young people whom the services have failed to reach, and many of them are in one or more of the vulnerable groups.

A two week survey of users of the young parents’ midwives service was conducted in June 2009. 52 people completed the questionnaire, and these were the main findings:

- There are about a hundred births to girls under 18 in Bromley each year.
- A third of respondents were aged 20-24.
- The vast majority were White British
- More than half had grown up in single parent families and social care, 40% were living in council accommodation and 13% said they had no qualifications.
- One in five had booked later than 20 weeks
- 84% said their pregnancy was unplanned, of whom over half were not using contraception at the time.
- Only five respondents said they had thought of getting the emergency contraceptive pill, of whom three said they hadn’t because of cost
- Lack of services in Biggin Hill was raised as an issue
- More than half of respondents were resident in BR2, BR5 or SE20
- 56% described themselves as either unemployed and not in education, or as full time carers.
- 88% (46) of respondents said they planned to use contraception once they had had their baby, and 30 would go to their GP for advice on this, 18 to their midwife, and 10 to a CRH clinic.
- The most common source of help for sexual health was a friend (28), followed by a parent or carer (12) and the internet (10).
- The most common desired improvement in sexual health services was better advertising, with more access to leaflets and posters, and information from a school nurse.
- The most important attribute of a service was that it was informal and friendly (28) and dedicated to young people (12). Over half of respondents said that local clinics were welcoming to young people. Only 16 said they were at convenient times.
- Just eight respondents said they would delay pregnancy if they could have their time again.
Graphs:  Figure 41

![Age Distribution Graph]

<table>
<thead>
<tr>
<th>Age</th>
<th>15 yrs</th>
<th>16 yrs</th>
<th>17 yrs</th>
<th>18 yrs</th>
<th>19 yrs</th>
<th>20 yrs</th>
<th>21 yrs</th>
<th>22 yrs</th>
<th>24 yrs</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. of mothers</td>
<td>1</td>
<td>5</td>
<td>7</td>
<td>7</td>
<td>14</td>
<td>8</td>
<td>6</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>%</td>
<td>2%</td>
<td>10%</td>
<td>13%</td>
<td>13%</td>
<td>27%</td>
<td>15%</td>
<td>12%</td>
<td>6%</td>
<td>2%</td>
</tr>
</tbody>
</table>

Figure 42

![Post Codes Pie Chart]

<table>
<thead>
<tr>
<th>Post Codes</th>
<th>BR5</th>
<th>BR4</th>
<th>BR3</th>
<th>BR2</th>
<th>BR1</th>
<th>TN16</th>
<th>SE19</th>
<th>SE20</th>
<th>SE9</th>
</tr>
</thead>
<tbody>
<tr>
<td>%</td>
<td>25%</td>
<td>7%</td>
<td>9%</td>
<td>15%</td>
<td>7%</td>
<td>7%</td>
<td>2%</td>
<td>15%</td>
<td>4%</td>
</tr>
</tbody>
</table>
The current pregnancy
Of those who answered the question, 20% (9) booked later than 20 weeks gestation. Three of these had not realised they were pregnant, and the others ‘didn’t know’ why they hadn’t booked earlier. 84% (44) said their pregnancy was unplanned, and of those, more than half were not using any contraception at the time they conceived. Of the 43% who were using contraception, 7 were using condoms, 11 were using the pill, and 1 was using an injectable contraception. Only five respondents said they had thought of getting the morning after pill, of whom three said they hadn’t because of cost, one ‘left it too late’, and one didn’t know where to get it.

88% (46) of respondents said they planned to use contraception once they had had their baby, and 30 would go to their GP for advice on this, 18 to their midwife, and 10 to a CRH clinic.
Figure 45

How many weeks into your pregnancy did you first book for antenatal care

- 20 weeks or less, 36, (70%)
- More than 20 weeks, 9, (17%)
- Not recorded, 7, (13%)

Figure 46

If unplanned, were you using any contraception around the time you became pregnant?

(No. = 44)

- Yes, 19, (43%)
- No, 24, (55%)
- Not recorded, 1, (2%)

Figure 47

If yes, what method were you using

(No. = 19)

<table>
<thead>
<tr>
<th>Method</th>
<th>No. of mothers</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pill</td>
<td>11</td>
<td>58%</td>
</tr>
<tr>
<td>Condoms</td>
<td>7</td>
<td>37%</td>
</tr>
<tr>
<td>Injected contraceptive</td>
<td>1</td>
<td>5%</td>
</tr>
</tbody>
</table>
Figure 48
If you weren’t using contraception at the time you became pregnant, was it because.....

![If you were not using contraception, was that because......](image)

Accessing services
The most common source of help for sexual health was a friend (28), followed by a parent or carer (12) and the internet (10). Interestingly, only one person said they would consult a leaflet, whereas 24 said the leaflets would be a good way of informing people about services. A similar number felt that internet and sex education lessons were a good way of informing people, and 12 cited school nurses. Therefore it seems that these young people would like access to leaflets and posters, and information from a school nurse, but that these are not available to them. Only five said that a telephone helpline would be helpful.

The most important attribute of a service was that it was informal and friendly (28) and especially for young people (12). 10 people said they would like it to be in a place they knew. Over half of respondents said that local clinics were welcoming to young people. A little fewer said they were well advertised, in convenient places, and provided all the help they needed, while just 16 said they were at convenient times.

Figure 49
The first time you needed help for contraception or pregnancy testing, or other sexual health matter, where is the first place you looked?

![First advice/help.....](image)
Figure 50
When choosing a service for contraception or other sexual health matter, what are the most important things to you?

[Bar chart showing the most important things to respondents, with categories such as "Close to where I live or work," "Away from where people are likely to know me," "Clinics are at convenient times," "There is help for more than one problem," "A place that I know," "It is a service for young people," and "Informal and friendly." The bars indicate varying numbers of responses for each category.]

Figure 51
What do you think of the sexual health services that are in Bromley?

[Bar chart showing the responses to the question, with categories such as "Well advertised," "Welcoming to young people," "Convenient places," "Convenient times," and "Provide all the help I need." The chart includes bars for "Agree," "Neither agree or disagree," "Disagree," and "Not recorded." The numbers indicate the distribution of responses across these categories.]
Figure 52
What would be the best way of letting young people know about what services are on offer?

What would be the best way of letting young people know about what services are available?

![Bar chart showing responses to the question: What would be the best way of letting young people know about what services are available?]

<table>
<thead>
<tr>
<th>Method</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>College</td>
<td>1</td>
</tr>
<tr>
<td>School counsellors</td>
<td>3</td>
</tr>
<tr>
<td>Telephone helpline</td>
<td>5</td>
</tr>
<tr>
<td>School Nurses</td>
<td>12</td>
</tr>
<tr>
<td>Internet site</td>
<td>24</td>
</tr>
<tr>
<td>Leaflets and posters</td>
<td>24</td>
</tr>
<tr>
<td>Sex education lessons</td>
<td>25</td>
</tr>
</tbody>
</table>

Views from Young Parent Midwives
There are about a hundred births to girls under 18 in Bromley each year, and the Young Parents Midwives take care of these girls from the time they book till the neonatal period. Their impression, from their work with this group, is that teenage mothers tend to be low achievers, who come from fragmented families or single parent families where mother had their first baby very young. In their experience, the traveller community tends to have children young, sex is a taboo subject, and many are catholic and against using contraception. They estimate that about one in four pregnancies are planned, and that around one in ten go on to have another baby within the next year. In the first four months of 2009, there were three concealed pregnancies. Pregnancy seemed to be more common in certain schools, for example Bishop’s Justice and Buller’s Wood.

Problems with accessing contraceptive advice:
The midwives reported that young girls do not want to go to their GP or school nurse for contraceptive advice, because of confidentiality, and under 16s are unable to obtain emergency contraception unless accompanied by an adult. Other comments were: they don’t know where the clinics are, it isn’t possible to call for advice outside clinic times, either in the contraceptive service or the STI service, and clients have to wait outside at STI clinic, until the doors open.

Reasons for getting pregnant
The midwives reported that most of their clients were not using contraception at the time they became pregnant, mostly because they didn’t realise they were at risk of getting pregnant – they had had unprotected sex before and not become pregnant, so thought it safe to continue. Often they have been put under pressure to have sex by their boyfriend. Their clients mostly know where to go for STI problems, but not for help or advice if they are pregnant.

Services needed
The midwives felt there was a need for more dedicated young people’s services, especially in Biggin Hill, proper counselling for pregnant young people, more activity
around sexual health by school nurses, and if possible, contraceptive services in or close to schools. They commented that the service at the colleges works well. They feel that there is a great deal of denial, in Bromley, about children having sex, which means that information young people need is not provided. They felt that a telephone helpline would be great.

**Views from people with HIV**

Bromley Council conducted a consultation in October 2008, supported by volunteers from The Junction and an independent facilitator. It involved two half day workshops with informal discussions and questionnaires. The main points that emerged were:

- The importance of good quality information, which is not only about where services can be accessed, but how these services can help them and which GPs, for example, are knowledgeable about HIV.
- People reported the GUM clinic as a ‘life-saver’, knowledgeable, caring and efficient, and particularly mentioned the HIV nurses as being very helpful and supportive.
- The Junction was highly valued for provision of information, the opportunity to exchange information and experiences informally, and the services of the Citizen’s Advice Bureau.
- Concern was expressed about the paucity of information available at the mental health services at Yeoman House, and in some voluntary sector mental health services.
- Hospital ward staff varied in their ability to signpost people to appropriate sources of help.
- Services from GPs were said to be variable, with some very knowledgeable and sensitive about HIV and others not.
- There needs to be more outreach to younger people and people from minority communities. The lack of services in the south of the borough also needs to be addressed.

**Views of Afro-Caribbean men and women**

An informal consultation was conducted by the health improvement department in Afro-Caribbean barbers and hair-dressers, June 2009.

Comments made by men:

‘I’m not waiting outside to be seen, I would go somewhere else’

‘The one in Sydenham is good.’

‘I go to King’s Caldecot or Mayday because you know they open early everyday and at Kings you can go in the evening’.

‘Info with condoms you give out here would be good’

‘Like being able to get condoms at barbers’

‘Need to be open later in the evening as some of us work you know’

‘Get really pissed off when you down there and there are no tickets left’

Comments made by women:

‘Its well embarrassing, they should have a women’s only day’

‘Would be better if you could get C and R and STI at same time like at Sydenham.’
‘Need some appointments, have been myself and tickets have run out. If that was a bloke he would go and spread it further!

Should not have to queue outside!!

Students and staff at schools and colleges

Bromley College
The main campus of Bromley College is just south of Bromley Town. In the college there are boards which have posters with sexual health advice (eg check urself and condomessentialwear), although no information about local clinics or emergency contraception. Free condoms are given out in the common room, and there are leaflets about where else condoms are given out, and other sexual health matters. These are open to view and students may feel too embarrassed to pick them up in front of other people. A family planning nurse visits once a week and there is an excellent student liaison service.

Views of students at Bromley College
Informal discussions with individuals and small groups, using a semi-structured questionnaire, were conducted with 18 students at Bromley College: 13 female, 5 male, age range 17-37.

Students reported having learnt most about sex and relationships from friends and sex education in schools. Family, television and magazines, and doctors were also important sources. In terms of sexual health services, many of the students had had all their help and advice from the college clinic, student liaison service and outreach workers from Metro. Metro was described as ‘good fun’ as they were offered the chance of a prize and all their friends were having themselves tested for Chlamydia. A few had also done the postal testing. However many didn’t know how else they would get the test if they wanted to be tested again.

In terms of using sexual health services, one group of girls said they didn’t know where to go for sexual health services, and didn’t think there were any in Bromley. Beckenham Beacon was considered too far to go. Downham clinic was commonly used, as Beckenham is too slow ‘you need to be there all day’ or because people hadn’t heard of Beckenham.

‘It takes enough courage to decide to go to a clinic, then having to make your way all the way to Beckenham puts most people off’

One person felt that young people should be actively encouraged to see their GP as:
‘you could be there to see them for anything, no-one would know’ and ‘they’re local and easy to use’

Ways in which students felt services could be improved included:
- Having the nurse in college for more days of the week
- Having a clinic in college
- Education: ‘young people need to have education about how to get help when they’re in trouble, and not just be lectured about safe sex’
• Clinics open at different times, mornings, evenings, weekends, and on more sites.
• Some were happy with internet coverage of sexual health, the college handbook and common room boards have information on sexual health, but some felt that advertising could be better.
• Many thought that sexual health in general was well publicised but not where they could actually go in Bromley
• Suggestions as to where publicity should be placed included: a website which has everything about sex including local services; buses and bus stops; libraries; toilets, including leaflets in toilets as people feel too embarrassed to pick up leaflets in common rooms; and shopping centres. Advertising on condom packets, like with smoking, about the risks. One person mentioned a stand which was in a shopping centre at Xmas, he thought that more things like this should be done.
• More postal testing, easy to do ‘I did mine with my mum and sister’

In terms of their own sexual activity, respondents were aware of the importance of using protection, and said they use protection almost always, or ‘whenever they (partner) wants to’, ‘whenever I have any’, ‘every time’. Reasons for having unprotected sex included,
- ‘it feels better’
- ‘lack of courage and knowledge of the consequences of not using protection.’
- ‘lack of experience’
- embarrassment in front of their sexual partner, ‘people are nervous to be the first one to bring up the subject and don’t want to offend them, don’t want them to think they think they have an STI’
- ‘can’t afford it’

When asked how people could be helped to have safer sex, answers included:
- ‘more graphic details of the consequences of not using it’
- ‘more sex education at school’
- ‘keep telling people about it so it is natural for people to use it’
- more places to get free contraception eg condoms

Most had heard of the morning after pill, and knew what it was for, and most people knew they could get it from chemists. A few knew they could get it from their GP or sexual health clinic. People were concerned about the price of getting it from chemists. Another concern was having male staff at the chemist as they would be shy to ask.

“you need to strike a balance: people need to know they can get it and where, but should still be using safe sex”

**The Student Liaison team**
There is a student liaison team based in the student common room. They are friendly and approachable and have a good relationship with the students, who come to them for all sorts of advice including on sexual health matters.
The deputy manager of the team had a number of concerns about the provision of sexual health for younger people:
Emergency contraception
Only one chemist does emergency contraception for the over 17s for free, otherwise they have to pay £26. The other option for students is to go to the hospital, but she has known situations where girls wait there all day, getting more panicky and give up and go home. She feels that students are generally comfortable with chemists for EHC but the price is a barrier for many, and the fact that it is hard to find out which chemists are available when time is of the essence in getting the tablets. She wondered whether it would be possible to have them in machines or in more mainstream chemists in busier places, such as Boot's.

Sexual health services and education
Some students who have attended Beckenham have complained that they were not treated well. She gets the impression that many students don’t like going to their GP or hospital for STI testing/contraception/emergency contraception in case people see them there in the waiting room. The staff are not told whether there are changes to timings of clinics, so sometimes they give the wrong advice to students. She does not know where to access extra leaflets if she needs them.

There are many messages in the media about safe sex and STIs etc, but she thinks young people would also benefit from more messages about there being “no rush” to have sex

They will be running a student-led sexual health campaign in September, which is part of the “Want Respect? Wear a Condom” campaign. Young people will be running the campaign, so that there is peer-to-peer education.

Orpington College
As well as at Bromley college, there are two Contraception and Reproductive Health clinics a week at Orpington College, which provide emergency contraception and other forms of contraception, excluding LARCs. Young people wanting LARCs are referred to their GP or an appropriate CR&H clinic. The nurse there reports that alcohol is a major cause of unprotected sex, and lack of knowledge about services.

Youth offenders
Views from youth offenders and the Youth Offending Team nurse
The nurse tries to see all the new youth offenders, and performs a Health Needs Checklist. An immunisation programme is performed, with all the young people offered a BCG vaccine and girls offered HPV. She talks to them about sexual health and organises Enrichment Days for them, as many have not had these at school; these cover drugs and alcohol, sexual health and teenage pregnancy. Free condoms are available at the service. She can do Chlamydia testing although many of the clients are under 16 and she is not allowed to perform these on under 16 year olds.

In her experience, those most at risk of getting pregnant are the younger girls (aged 13-15), those without a strong family network, and those who only attend school intermittently or not at all. Reasons for young people becoming pregnant in her experience are:
- a decision on their part as they want someone to love and be loved
- reluctance to take pills, injections or implants
- going to CRH clinics alone puts them off going
- belief that they will get accommodation
In addition, she has found that many of the young people who get pregnant continue with the pregnancy. This is not due to lack of access to services, but because many are against the idea of abortion, especially those aged 13-14. They find it very hard to believe that only 24% of under 16 year olds are having sex, they are convinced that “everyone else is doing it”.

Reasons that people are not accessing services are:
- embarrassment, especially to answer awkward questions and have intimate examinations
- lack of support and not having anyone to go with them
- location, most people do not have the money to get to Beckenham Beacon, also the bus journey is difficult and there are no train services

Those that do access services have the following opinions about them:
- GUM clinic: most are glad they went, however they had a long wait and it was a long distance for them. They would prefer to go to the young persons’ clinic however the one clinic slot once a week is also difficult for them.
- Ethelbert Young Person’s clinic is popular but should be advertised more.

Her suggestions to improve services are to have more advertising and more local services rather than just one GUM clinic. She also thinks that it would be worth having a clinic once a week at the YOT team, as many of them are getting pregnant at a young age and are put off from attending clinics elsewhere. They are also a hard group to connect with, they require a lot of time to make them feel comfortable and to build a rapport, which conventional services often don’t give them. They would respond to services that are the least ‘clinical’ as possible. She also suggested having more 1:1 work at the pupil referral unit, to explain to them about sexual health, but she cannot do this alone. She suggested having an outreach team, as many girls don’t come into the YOT office so don’t have contact with her. This includes people living in supported lodgings and hostels, as these are the highest risk to have early pregnancies in her opinion. Those who stay at home, either because they are in breach of their order, or because they have been in prison, have no access to services and are at high risk of teenage pregnancy.

One teenage youth offender had these comments to make about sexual health: “I didn’t realize it was that easy to get tested, just weeing into a pot. It was weird and I felt embarrassed doing it around other people, but they were all having fun with it.” (about Chlamydia testing)

All he knows about sexual health and the Beckenham Beacon is from the YOT, not school.

“I have been meaning to go but it is quite far.”

To improve services, he suggested better locations for young people, and giving lessons about how the check-up actually works: “You hear all these horror stories about needles and it puts you off, if it was as easy as the Chlamydia test then I would be less scared of going.”
Parents
Several agencies have reported that the attitudes of parents are an important factor in whether young people receive and act on sex education. Many parents are reported as being against sex education in schools, especially in religious schools, as they feel that sex education encourages sex.

Young people not in education, employment or training (NEET)
Connexions is a Bromley based charity which provides individual support to young people. Discussions with a personal adviser who supports NEETs recognise that this group is at high risk of teenage pregnancy, often because they see little else in the way of opportunities. Her impression is that many lack understanding of the risks of unprotected sex. They give out free condoms at the service, but often the young people don’t know how to use them.

In her experience, reasons for people not accessing sexual health services are:
- long waiting times
- restricted opening times and having to fit around these
- embarrassment
- negative connotations
- having to be there early to get a slot

Changes that she suggested are:
- shorter waiting times
- longer opening times
- making sure people know about access to condoms, by increasing publicity.

School children know this but those not at school might not know this so much.

Looked After Children
5 looked after children were consulted, 3 females and 2 males. The age range was 15-17. Most of them had learnt the most about sex and relationships from school. When asked what type of service they preferred, the majority would like their GP or the LAC service, as they prefer people that they are comfortable with. None of them had used the GUM clinic at Beckenham. Suggestions for improving sexual health services included: having appointments; more information about services; “speed up the queue by having more staff, otherwise people will leave.”

All the girls were aware of LARC. Protection currently used included the implants, the pill and condoms. One of the young people obtained condoms from “friends who get it from the clinics”. Those who were pregnant before mentioned that this was one of the reasons they used contraception now. Reasons they thought that people don’t use protection included:

“They want to have a baby; they see teenagers with babies and want to be like them.”
“It’s not always available.”
“Feels better”
“It is weird to talk to adults about contraception”

When asked what could be done to help people who don’t use protection, answers included:

“Go on the ‘bar’ or the coil”
“Tell them all the stuff that can happen if they don’t use it.”
“More people in schools and high streets to talk to people.”
“Fake babies to put people off.”

Most of the young people had heard of the morning after pill and a few knew they could get it from a clinic if they needed to, but only one knew that they could be obtained from pharmacies.

All of those consulted had heard of Chlamydia. One went to their GP to be tested but was sent to the GUM clinic. Another said he hasn’t been tested as “I don’t have it, I haven’t had unprotected sex.”

Most of them thought that there wasn’t enough information about services. Suggestions included:

- leaflets
- advertising in the paper
- schools, colleges
- YOT
- Posters and billboards

Other suggestions for improvements included:

“having more people like Lissa (the LAC nurse)”
“Get parents involved”

9. Summary of current service provision; achievements and areas for development.

In drawing together the data on sexual health status and services, and canvassing the views of both providers and users, four key themes have emerged:

1. Vulnerable groups
Bromley as a whole has better sexual health than the national average, but there are pockets of deprivation and certain at risk groups where the incidence of STIs and unwanted pregnancy are as high as areas in inner London. This means that efforts at educating young people in sexual health have a high success factor for some parts of the population, but are failing to reach others. Some steps have been taken to address the problems presented by at risk groups, for example the appointment of an outreach specialist contraception nurse for two days a week, and certain campaigns run by the Health Improvement directorate, but indicators suggest that they may not be enough. NICE guidance emphasises individual interventions; group interventions in high risk young people have not been proven effective, and may even increase pregnancy rates (Wiggins et al. BMJ 2009; 339: b2534) .

2. Good services, but fragmented and not enough of them
There are many dedicated staff in Bromley, who work very hard to provide good sexual health services and to care for vulnerable groups. The service, however, is fragmented, over-stretched, there are not enough clinics with enough choice of times and contraceptive methods in each locality, and not enough staff to cope with demand at individual clinics. In addition, a combination of not having the right kinds of staff and historical separation of services means that patients cannot access
everything they need at one site. A lack of shared information systems and poor communication between services is also a problem. As a result of these factors, patients who have made the effort to attend may be turned away or referred elsewhere.

3. Cultural attitudes and beliefs
Efforts by the Health Improvement Service to improve sexual health in Bromley are hindered by three key factors: the attitudes and beliefs of adults in Bromley that teenagers are too young to have sex, the attitudes and beliefs of young people that all teenagers are having sex, and the fact that an extremely important part of improving sexual health, that of identifying and counselling at risk individuals, is outside their remit.

4. Informing young people about services
Whereas young people in mainstream education are well-informed about sexual health, they are less well informed about sexual health services on offer in their area, and how to access them.

Issues for individual services
A great deal of information has been collected in this needs assessment, and individual services will wish to examine this in detail in order to inform future developments of their service. A summary of the positive aspects of current services, followed by areas for development, are given below.

What is good about current provision in Bromley that we should preserve and build on?

Genito-urinary medicine service
- Walk in service
- 98 % of patients seen within 48 hours
- Specialist staff
- Young persons clinic once a week
- Specialist HIV nursing service, highly valued by patients
- Clinics every day
- Full STI screens
- Contraceptive advice and free condoms

Contraception and Reproductive Health Service
- Committed, trained staff, who see the need for change
- All levels of contraceptive service catered for
- Offers alternative to people who do not wish to go to their GP
- Walk in service
- Some dedicated young people’s clinics, with friendly welcoming environments.
- Appointment system for certain clinics
- Good provision in some areas of the borough
- Can deal with complex cases and act as a source of advice to GPs and others

Primary Care
- All 51 GP practices provide some level of sexual health service
- 13 LES practices are able to provide up to level 2 sexual health services
**TOP services**
- Comprehensive, specialist service, provided by independent providers
- Self referral possible
- Central booking system
- Proportion of women having abortion before 9 weeks gestation is better than national average
- 79% of abortions funded by NHS
- Choice of medical and surgical methods
- Contraceptive advice provided
- New family planning nurse post, aimed at reducing repeat abortion rate

**Chlamydia Screening**
- Dedicated team
- Increasing numbers of pharmacies participating
- Multiple testing sites throughout the borough, including internet access
- Commendable achievement in increasing uptake to very near the target for 2009

**Health Improvement**
- Dedicated, committed staff for Sexual health, HIV and teenage conceptions.
- Wide range of campaigns and other activities taking place, including free condoms, staff training, and education for parents and carers.
- Work closely with many relevant agencies, including voluntary sector
- Have achieved a good level of knowledge of sexual health matters among college students

**Public information**
- There is a 24 hour information line for CRH clinics
- There is an email address for people to write and ask for information
- There are a wide range of leaflets on local services, for both public and staff

**What problems and gaps in provision are there?**

**Genito-urinary medicine service**
- There are long waits at the clinics and patients are regularly turned away from due to lack of slots. This may occur either because more people turn up than available slots, or because a member of staff is absent.
- Patients have to wait out in the street for the clinic to open
- There is insufficient staff time to provide one-to-one counselling for at risk individuals, as recommended in NICE guidance.
- There is only one clinic in the borough that provides a comprehensive STI service, which means that people from other parts of the borough have long distances to travel and are consequently less likely to use the service.
- Apart from young people, there are no specialist clinics, eg for gay men.
- A full contraceptive service is not available.
- Patients have to wait up to three weeks for test results
- Changes in the service are not always communicated to related services such as health improvement and Chlamydia screening.
- Numbers of people with HIV are increasing, but the service is not expanding.
There is a high late HIV diagnosis rate.

**Contraception and Reproductive Health Service**

- Uptake of contraceptive services is 30% lower than national average, and large numbers of people use clinics in Lewisham.
- Only 50% of clinics can provide all types of contraception.
- Long waits at walk in clinics, with people turned away when full.
- High numbers of smears, that could be done in primary care.
- Users would like more choice of days and times of clinics.
- A need for more clinics aimed at after school demand.
- Low uptake of LARCs, though improving during 2009.
- Long waits for LARCs in general clinics, though short for daytime specialist LARC clinics.
- 81% of LARCs prescribed are injectables, whereas implants are four times more effective. This rate has improved in recent months.
- Are trained to provide STI screens, but in practice there isn’t time.
- Communication with the GUM service could be better.
- Some areas are poorly served, especially in terms of doctor clinics.
- There are no full time staff, and most are sessional.
- High teenage pregnancy and abortion rates in certain areas of the borough.
- Knowledge of service provision among young people appears low.
- Emergency contraception is very expensive, and only six pharmacies provide free EHC to under 16s.
- The service is not reaching some vulnerable groups.

**Primary Care**

- Sexual health service provision and prescribing rates vary widely between practices, and even between LES practices.
- Prescribing rates are not related to LES status.
- Half of the LES practices do not provide services to non-practice patients, some because they don’t have enough space.
- A number of practices do not do IUD insertions.
- There are insufficient trained staff to provide LARCs.
- Many women are going to CRH clinics for smears, rather than GP.
- Not all practices exhibit information and publicity on sexual health issues.

**TOP services**

- All services are outside the borough.
- Medical abortions could be provided within the borough, but are not.
- Not all kinds of contraception have been funded, until recently.
- Repeat abortion rate is 23% higher than national average.

**Health Improvement**

- Campaigns and programmes do not currently adhere to NICE guidance on changing behaviour.
- Individual interventions, as recommended in NICE guidance on reducing STIs and teenage conceptions are not under the remit of HIS.
- Young people in education have good levels of knowledge on sexual health, but are not so well informed on services.
• Although some education of parents and carers is provided, this is not routinely available.
• There is no current campaign designed to raise awareness of HIV in Black Africans, as they are hard to reach.

Public information
• The 24 hour information line for CRH services only gives information on clinics, and which kinds of outlets emergency contraception can be obtained from. There is no information on what the clinics offer (half of them do not offer a full service), or on condom provision, STI help, Chlamydia screening, pharmacies that provide free EC for under 16s etc. The web address for more information is not given either.
• Both the information line and information email address are used very little, and it is likely that they are not well publicised.
• Not all GP practices display the information materials supplied to them.
• Users say that leaflets are useful and would like more of them in waiting rooms.
• Leaflets in colleges, and other sites where young people congregate, need to be placed where young people can pick them up without being seen.

10. Recommendations, Conclusions and Next Steps

There are four main areas that need to be addressed.

A  Vulnerable groups and individuals. In order to address current inequalities in sexual health in Bromley, both prevention and service provision needs to be tailored to specific groups who are at high risk of poor sexual health. This should include the development of tailored services for vulnerable individuals, and identifying and counseling vulnerable young people when they attend mainstream services.

B  Service provision. An integrated service is needed which provides STI diagnosis and treatment, contraception advice and provision, and health promotion. These new services need to be provided equitably across the borough, at times that local people can access them, and with sufficient capacity to avoid the current problem whereby people are turned away or have to wait for long periods.

C  Cultural attitudes and beliefs. The obstacles to sexual health posed by attitudes and beliefs of both young and older people need to be addressed in the health improvement strategy.

D  Information and publicity
The ways in which services are publicised needs to be reviewed and improved.

Recommendations for specific services:
Genito-urinary medicine services
• Provide full STI screens at clinics throughout the borough.
• Incorporate rapid HIV testing and other new technologies which can provide quicker and easier tests.
• Identify which clinics people are turned away from most regularly, and increase provision accordingly.
• Introduce flexibility in clinic length, so that nobody is turned away.
• Review staffing, so that skills and training is matched with demand. In particular more nurses/sexual health advisers are needed who are able to prescribe and to counsel at risk individuals, and who are able to insert implants and IUDs.
• Provide an indoor waiting area for patients, with a ticketing system.
• Provide partial appointment clinics, and explore ways of reducing the DNA rate, e.g. texting appointments the day before. Liaise with clinics with shorter waiting times to see how they achieve this.
• Provide a full contraceptive service.
• Patients would like to be able to choose whether they see a male or female, and the possibility of providing this should be explored.
• Plan ahead for increasing numbers of people with HIV, especially staffing levels of HIV specialist nursing team.
• Consider ways of fast tracking patients who only need condoms or repeat prescriptions.
• Develop regular communications to ensure other SH services are kept aware of changes in the service.
• Review all clinics in terms of young people friendliness, presence of volunteer youth workers, television, coffee etc. Visit metro and other successful clinics to observe.
• Consider whether the service wishes to attract gay men who are currently using tailored services outside the borough, and if so how this could be achieved.
• Provide more literature in waiting rooms.

**Contraception and Reproductive Health Service**

• Review staffing and training, with the aim of increasing the numbers of staff who are able to administer LARCs, and having more staff who work longer hours.
• Increase the number of clinics which provide all forms of contraception, thereby reducing waits for LARCs.
• Increase uptake of LARCs, especially implants, by measures above.
• Increase awareness of IUD as a form of emergency contraception, as it is more effective than the hormonal method and can be used long term.
• Address the problem of people being turned away from clinics, and provide appointment as well as walk-in clinics.
• Aim to provide, for all users, a daytime and an out of hours clinic within reasonable reach on every day of the week.
• Review all clinics in terms of young people friendliness, television, coffee etc. Visit metro and other successful clinics to observe.
• Conduct a special review of service provision in areas of high teenage pregnancy and abortion rates, including the Crays, Penge, Annerley, BR5 and Biggin Hill.
• Establish C&RH services at or close to schools and colleges where these rates are high.
• Provide STI screens as a standard part of the service.
• Ensure that all areas of the service are kept informed about developments and changes in the service, including school nurses and the Chlamydia Screening Team.
• Provide over the counter emergency contraception free or at the cost of a prescription, at all pharmacies if possible, and to all ages. Also explore ways in which EHC may be accessed discreetly, for example vending machines, via the internet, provided routinely with other forms of contraception.
Investigate the feasibility of providing contraceptive services for specific vulnerable groups at places where they attend. Eg youth offenders, looked after children, travellers, black Africans, possibly via mobile clinics, or by using voluntary agencies.

Ensure that nurses and advisers for vulnerable groups know where to refer people at high risk.

Develop peer support schemes within vulnerable groups, with friends who can accompany young people to clinics.

Evaluate the new outreach post for vulnerable groups, to assess uptake and adequacy. Increase input on contraception with teenage mothers, whether TOP or continuing with pregnancy.

Monitor the success of new the specialist contraception nurse in TOP service.

Primary Care

Work with primary care to increase consistency of sexual health care provision and ability to provide LARCs.

Monitor the provision of sexual health services in General Practice, especially smears and LARCs.

Increase provision of nurse training in contraception by including clinical placements as part of the LES review

Review training needs in primary care.

Investigate the perception of C&RH staff that general practices are not doing enough smears.

Review the provision of sexual health publicity materials in practice waiting rooms.

Introduce routine testing for HIV in areas of high prevalence.

Health education and prevention

Review and evaluate current activities in the light of the needs assessment and NICE guidance.

Plan and evaluate health improvement activities using NICE guidance on behaviour change, and preventing STIs and teenage conceptions.

Work with local services to ensure that NICE guidance on identifying and counselling individuals at risk is implemented.

Make information about local services, including details of times of clinics, an integral part of sex education in schools and colleges, so that every young person knows where to go for help for both preventive care and help when they're in trouble.

Increase publicity of the telephone and email information service, which is greatly under-used at present.

Work with drugs and alcohol team to look at ways of reducing the effects of substance misuse on sexual health.

Review current advertising of services in light of user views.

Introduce regular education for parents, as part of sex education in schools, including awareness raising about sexual orientation. Part of this should include enabling parents to express their concerns about sex education. This should be especially encouraged for parents who choose to withdraw their children from SRE lessons.

Plan a campaign to raise awareness of HIV in Black Africans, both men and women, and to increase testing and reduce late diagnosis rates. Consider
working with surrounding boroughs who have larger populations of Black Africans.

- Monitor late diagnosis rates of HIV, and identify at risk groups.
- Increase routine testing for HIV in general practice, community and hospital settings, especially in areas of high prevalence (a pilot project to raise awareness in GP practices in high risk areas is being planned).
- Build on young people’s tendency to consult friends for advice by setting up peer mentoring programmes (recommended in ‘Going All the Way’).
- Increase provision of one to one guidance in schools, either through school nurses, or training counsellors and making sexual health part of their remit.

Chlamydia Screening
- Continue recruiting core services to undertake Chlamydia screening.
- Enable outreach nurses to offer Chlamydia screening to under 16s.
- Use Metro to access hard to reach groups, rather than easy to reach young people who are at low risk of infection.

Communication, Information and Publicity
- Increase access to telephone advice, not just in clinic times. Clinic phones could be forwarded to the central phone number when clinics are closed.
- The information line should have an option to speak to someone and should also direct callers to the PCT web-site.
- The information line number and website address need to be advertised more widely, including schools, colleges, clubs and other venues that attract young people.
- There should be a web-page for local sexual health services, which cover all possible areas, including contraceptive advice, where to get free condoms, emergency contraception, STI advice, Chlamydia screening, pregnancy testing and advice, TOP services (including where they can self-refer), location of pharmacies, and which provide free emergency contraception to under 16s, where to get emergency contraception out of hours. The website should contain a map of where services are based, preferably a facility to enter a post code for ‘find your nearest clinic’. It should also contain up to date information on clinic closures and other changes. This should be a resource for both staff and the public.
- The website address and information line number need to be widely advertised, and new ways that young people can obtain information about sexual health services should also be considered, eg by text.
- Engage with school counsellors and nurses to increase their ability to provide sexual health advice and signposting in schools and colleges.
- Make existing information cards and leaflets available at schools.
- Set up regular communication channels between services, to ensure they keep each other informed about changes in clinics.

Other recommendations
- Establish an integrated IT system for all sexual health services.
- Review possibility of having TOP services within the borough, especially medical abortions.
- In Oxleas contract, include the provision of psychological services for people with HIV.
- Investigate the need for interpreter services, and how these could be provided.
In implementing these recommendations, the PCT should work closely with schools and colleges, voluntary organisations that support sexual health, and the local authority. The sexual health strategy should be included in all the main strategy documents for the borough, including the local area agreement and Building a Better Bromley.

Conclusions and next steps
There are many good features of the sexual health services in Bromley, including dedicated and enthusiastic staff, a well-functioning GUM service, a choice of C&RH services and a number of special services. This needs assessment has highlighted the need to build on these successes and move towards a more integrated and better publicised service. It provides the basis for a new strategy for an integrated sexual health service in Bromley, which focuses not only on a high quality, accessible service to those who need it, but also an integrated approach to preventing sexually transmitted diseases, reducing the numbers of unwanted pregnancies, and enhancing sexual health in our population.

The National Strategy for Sexual Health and HIV (DOH 2001) defined sexual health as:

“the capacity and freedom to enjoy and express sexuality without exploitation, oppression, physical or emotional harm with equitable access to services to maintain and improve well-being.”.

To that end, our sexual health strategy will aim to move our local service towards one which:

- Has a welcoming culture that is confidential, respectful and recognises the diversity of relationships.
- Is accessible to all who need it, including those who find it difficult to access mainstream services
- Promotes safer sex and the importance of good sexual health.
- Encourages self care by providing appropriate information and support.
- Is provided by a range of professionals and agencies which work together to improve the sexual health of the population.

Implementation will be achieved through a strong commissioning framework and a programme management approach.
GLOSSARY

STI  Sexually Transmitted Disease
GUM  Genito-urinary Medicine
C&RH  Contraception and Reproductive Health
MSM  Men who have sex with men
SEL  South East London
NEET  Young people Not in Education, Employment or Training
LAC  Looked After Children
YOT  Youth Offender Team
DAT  Drug and Alcohol Team
LES  Locally Enhanced Service (GP)
HIS  Health Improvement Service
TOP  Termination of Pregnancy, or abortion
LARC  Long Acting Reversible Contraception (injections, implants and intrauterine devices)