Sexual and Reproductive Health in Croydon

A Joint Strategic Needs Assessment (JSNA)

December 2018

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Note on data cut off period

The data in this chapter of the JSNA was the most recent published data as at December 2018. Readers should note that more up-to-date data may have been subsequently published, and are advised to refer to the sources noted in the chapter for the latest information.

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Executive Summary

Overview and Context

- In terms of population trends, it is estimated that by 2031 almost a third of the population will be under 21, with 67% of a non-white British ethnicity.
- Croydon's local sexual health strategy from 2011 – 2016 expired, requiring a renewed strategy
- Local services are being recommissioned over the next few years, with the opportunity to reassess how they are delivered
- A new needs assessment will give the opportunity to reassess how services can be most effectively delivered for Croydon residents.

Contraception

- An estimated 5% of resident women aged 13-54 had a main method of contraception. A user dependent method (UDM) is the main method chosen by residents (66%), compared to LARC (24%), with the majority of LARC prescriptions from GP practices rather than Sexual and Reproductive Health (SRH) services.
- In 2016, approximately 1,960 emergency hormonal contraceptive pills were prescribed by GPs and 870 by Sexual and Reproductive Health (SRH) services.
- Approximately 3% of women receiving emergency contraception from a SRH service were fitted with an intrauterine device (IUD), and 9.1% were prescribed emergency contraception more than once within the same year.
- Of those attending pharmacies for EHC, all provision was to women under 25, and just over half were to women of a black / black British ethnic group.

Conceptions (including terminations of pregnancy)

- Croydon has a high rate of under 18 conceptions. In 2016, 175 young women aged under 18 became pregnant, a rate of 25 per 1,000 resident women. This rate is higher than both the London and England average and was the third highest rate in London.[1]
- 17% of all under 18 conceptions in Croydon in 2016 were to women under 16 years of age. This is similar to the proportion seen across London (16%) and England (14%). In 2016, Croydon had an under 16 conception rate of 4.5 per 1,000 resident women. This rate is higher than both the London and England average and was the second highest rate in London.[2]
- Teenage conceptions are more likely to result in a termination, this is particularly clear in Croydon where the proportion resulting in a termination is now higher than that seen across London and England.[3]
- Croydon has a higher abortion rate than both London and England and this is apparent across all age groups. While more teenage conceptions result in a

[1] ONS. *Conception Statistics*; 2016
[2] ONS. *Conception Statistics*; 2016
[3] ONS. *Conception Statistics*; 2016

termination, around 60% of all abortions to Croydon residents in any given year are provided to women aged 25 and over.[4]

- In Croydon, those aged 25 or over account for the majority of women having terminations and more than half of these terminations are provided to women who have previously had a termination before in their life. Approximately a third of all terminations in any given year are to women in this age group who have previously had a termination. Croydon has a higher proportion of repeat terminations than London and England in both the under 25 and 25 and over age groups.[5]

Sexually Transmitted Infections

- In 2017, 5.6% of all tests to Croydon residents resulted in a positive diagnosis of an STI, higher than the positivity rate in London (4.9%) and England (4.7%), suggesting effective targeting.
- In 2017, the rate of new STI diagnoses in Croydon was 1,136 per 100,000 population (all ages), lower than the rate seen across London (1,335 per 100,000) and higher than the rate across England (743 per 100,000).
- In Croydon, an estimated 9.6% of women and 12.9% of men presenting with a new STI at a sexual health service between 2012 and 2016 became re-infected with a new STI within 12 months. These rates are higher than those seen nationally where 7.0% of women and 9.4% of men were re-infected in the same time period.
- The rate of STI diagnoses positively correlates with deprivation category across Croydon.
- In 2017, the majority of new diagnoses were in those aged 25-34. Females were more proportionately represented in the younger age groups compared to males, with 71% of all diagnoses in those aged 0-19 being female. This falls to 26% of all diagnoses being in women in those aged 45 and over.
- The proportion of 15-24 year olds screened for chlamydia in Croydon has fallen slightly in recent years, and was significantly lower than the London average in 2017. This has been accompanied by a drop in the proportion diagnosed.
- Chlamydia screening coverage was highest amongst females and older ages, while positivity rates were inversely related, with younger ages (15-19) having positivity rates of 15%, compared to 5% in ages 25 and over.
- Outside of the National Chlamydia Screening Programme (NCSP), sexual health screening and diagnoses has remained fairly consistent over the past five years, with 23% of the resident population being screened. For both indicators, Croydon is lower than the wider London region and higher than England.
- The most common diagnoses in Croydon in 2017 were of chlamydia, making up 43% of all diagnoses in the borough, followed by gonorrhoea and non-specific genital infection.
- Two thirds of all genital herpes diagnoses are female, while two thirds of all gonorrhoea diagnoses are males.

[4] Department of Health. *Abortion Statistics for England and Wales*; 2017
[5] Department of Health. *Abortion Statistics for England and Wales*; 2017

HIV

- In 2016, the diagnosed HIV prevalence rate in Croydon was 5.4 per 1,000 population aged 15-59 years, compared to 2.3 per 1,000 in England and 5.8 per 1,000 in London.
- A third of the middle super output areas (MSOAs) in Croydon had a prevalence rate higher than 6 per 1,000 population (higher than the London average).
- Croydon has a high diagnosed prevalence and incidence rate among statistical neighbours.
- Of Croydon HIV diagnosed residents seen for care in 2016, just over half were male and the majority (83%) were aged 35 or over. Males were more proportionately represented in the older age groups compared to females, with 60% of all diagnoses in those aged 50 or above being male.
- Two thirds had a probable route of infection through heterosexual contact. Other non-sexual probable routes of infection (such as injecting drug use, mother to child, blood/blood products) accounted for just 4% of diagnoses.
- Gender balance varies between the different ethnic groups diagnosed with HIV with two thirds of all black Africans diagnosed being female and 86% of all white people diagnosed being male.
- In 2016, 96.2% of residents with diagnosed HIV were receiving ART compared to 97.2% of London residents and 96% of England residents.
- In 2014-16, Croydon had the fifth highest late diagnosis HIV proportion in London, and third highest among statistical neighbours.
- Within Croydon, overall HIV testing coverage is falling slightly to be similar to the London average, after being above both London and England since 2009. Despite this fall, almost three in every four eligible new attendees accept an HIV test. This fall in testing coverage in the borough can be directly related to a fall in coverage in females, where in 2017 one in every three women eligible did not accept a test. Coverage in males, including Men who have sex with men (MSM) continues to be high.

Recommendations

Some key recommendations highlighted in this needs assessment include:

- Creation of a clear pathway outlining where and when conversations on contraception can take place across different settings with women, with follow-up mechanisms, either via phone or recall to service, where contraception choices can be further discussed if needed, concerns can be addressed and decisions can be supported.
- Ensuring clear referral pathways are in place from all providers after prescription of emergency contraception - for LARC, if LARC cannot be given immediately, and for information on long-term contraception options. This should include follow-up mechanisms, such as text messages, or phone calls to re-attend services, to reduce the incidence of repeat EHC prescriptions.
- Using targeted RSE to under-25s and overrepresented ethnicities to increase awareness of long-term contraception use, with workshops complemented with

other types of media, and across a range of settings, particularly non-healthcare settings. This importantly should be inclusive of men and women.

- Ensuring pathways are in place after abortion to ensure women are able to access contraception, and referred for LARC as appropriate.
- Increasing awareness of STIs, reducing risk of transmission, and how to access testing and treatment in the Croydon population generally and specifically high-risk groups through a number of specific activities discussed in the section. Some of these activities include:
    - Cross-promoting programmes and campaigns across services, using the Making Every Contact Count approach
    - Promoting information and signposting in non-healthcare settings e.g. nightclubs, and adjacent services such as drug and substance misuse services, the Homeless Health team, and voluntary organisations.
    - Targeted promotion and information giving in youth services such as schools, colleges, youth groups and outreach centres.
    - The use of pop-up clinics in college settings (these would not have to be very frequently) to encourage opportunistic testing, and reduce barriers to testing and attendance.
    - Consider how peer engagement and influence can be better used to highlight regular testing.
- Identification and follow-up of high-risk individuals, with partner notification, testing and treatment, advice on avoiding re-infection and three-month follow-up through a number of strategies.
- Raise awareness and uptake of HIV testing across all demographics and especially in at risk groups to reduce the undiagnosed proportion of the population.

More detailed recommendations are highlighted under each topic of this needs assessment.

1. Introduction & Context

Unlike other areas of health, sexual health is not defined by one demographic, or one epidemiology. It affects individuals throughout the life-course – from pre-conception, to those living with sexually transmitted illnesses (STIs) later in life.

WHO defines sexual health as '*an integral part of overall health, well-being and quality of life… a state of physical, emotional, mental and social well-being in relation to sexuality… not merely the absence of disease, dysfunction or infirmity*[6].' The definition also highlights a '*positive and respectful approach to sexuality and sexual relationships*' with the '*possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence'*, emphasising the importance of inclusivity, and safe, consensual relationships and a sexual health service that respects these.

As with other areas of social spending, funding for sexual health services has decreased in England (almost 4% decrease between 2013/14 and 2015/16) [7], despite demand for services increasing (new attendances to clinics increased from 2.21 million in 2013 to 2.62 million in 2017)[8]. Public health spending reductions in the council are planned until 2020/21, necessarily constraining sexual health funding[9].

Better testing, programmes such as the HPV vaccination, and changing sexual practices are also contributing to a changing pattern of STIs; though non-specific genital infections (NSGI) and genital warts have decreased, diagnoses of syphilis and gonorrhoea increased[10], while drug resistant strains of STIs have emerged[11].

However, the benefits of an effective sexual health service are undeniable - for every £1 spent on teenage pregnancy, £11 is saved in other healthcare costs[12]. Navigating these changes without compromising on quality is one of the biggest challenges facing sexual health.

Source: The King's Fund

[6] World Health Organisation. *Defining sexual health*; 2006.
[7] The King's Fund. *What do cuts in sexual health services mean for patients?*; 2017.
[8] PHE. *Attendances by gender, sexual risk & age group, 2013 – 2017*; 2018.
[9] LGA. *Public health funding in 2016/17 and 2017/18*; 2016.
[10] PHE. *Sexually transmitted infections and screening for chlamydia in England, 2017*; 2018.
[11] PHE. *Multi-drug resistant gonorrhoea in England: 2018*; 2018.
[12] The King's Fund. *Making the case for public health interventions*; 2014.

Why do we need a sexual health needs assessment?

In Croydon, the last sexual health needs assessment took place in 2010, which explored sexually transmitted infections, contraception and reproductive health, teenage conceptions, terminations and births, and vulnerable and high risk groups. Priority areas were continuously explored through updates to the Sexual Health, Reproductive Health and HIV Partnership Board. However, changes have occurred nationally, regionally, and locally since the last needs assessment:

- In 2013, a new sexual health framework was developed by the Department of Health
- This was accompanied by changes in sexual health commissioning responsibilities between local authorities, CCGs and NHS England
- The London Sexual Health Transformation Programme resulted in the Integrated Sexual Health Tariff, and a new sexual health service model involving self-sampling and online e-services
- Croydon's local sexual health strategy from 2011 – 2016 expired, between 2017 – 2018 in depth analysis was undertaken on four key areas within sexual and reproductive health; teenage conception, termination of pregnancy, late HIV diagnosis and sexually transmitted infections as part of the overall prevention framework being used by Croydon Council. The creation of the 2018 teenage pregnancy action plan resulted from this work.
- Finally, local services are being recommissioned over the next few years, with the opportunity to reassess how they are delivered

A new needs assessment will give the opportunity to reassess how services can be most effectively delivered for Croydon residents.

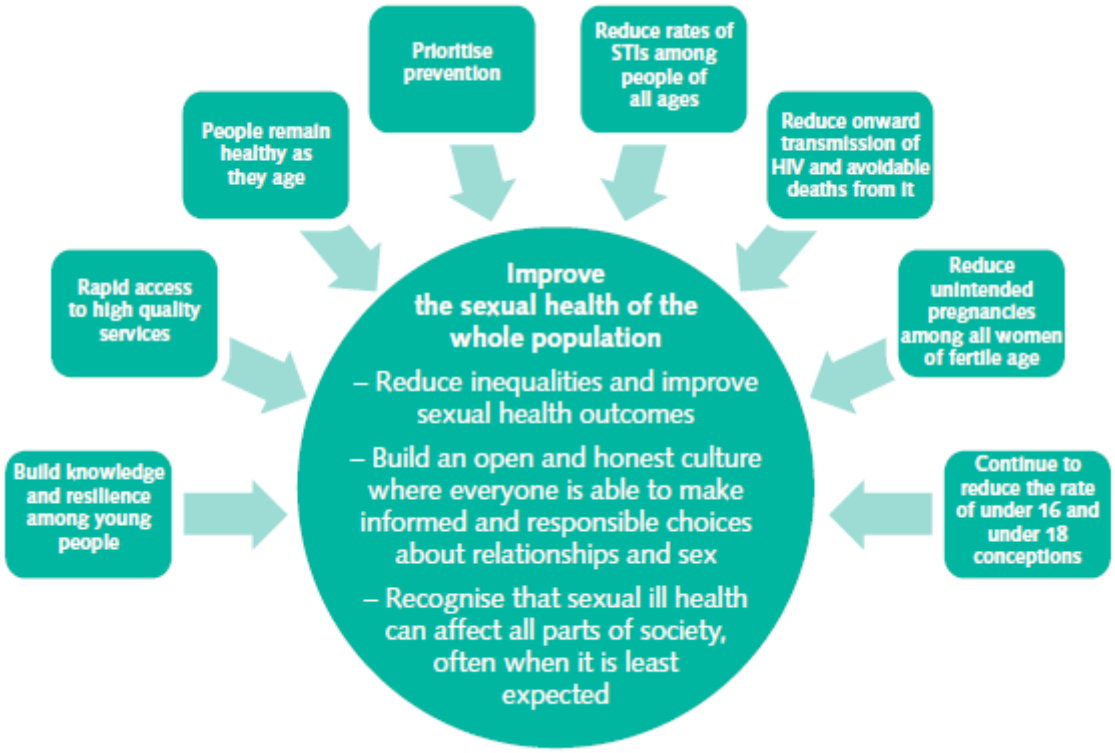
1.1 Aims

The aim of this needs assessment is to capture the current state of sexual health and sexual health services in Croydon. This will inform service development by helping to:

- Identify unmet need
- Prioritise services according to need
- See where primary care services could be enhanced, or where better integration of services could occur
- Identify opportunities for cross-boundary and cross-organisational collaboration
- Identify future trends and anticipate service delivery accordingly

1.2 Policy context

Nationally, in 2013 the Department for Health (DH) published *A Framework for Sexual Health Improvement in England*[13]. The objectives it identified are set out below:



Source: Department of Health - A Framework for Sexual Health Improvement in England

Bearing in mind the local prevention framework being developed, the DH '**Prioritise Prevention**' ambition is particularly relevant:

> **AMBITION: Prioritise prevention**
>
> - Build a sexual health culture that prioritises prevention and supports behaviour change.
> - Ensure that people are motivated to practise safer sex, including using contraception and condoms.
> - Increased availability and uptake of testing to reduce transmission.
> - Increase awareness of sexual health among local healthcare professionals and relevant non-health practitioners, particularly those working with vulnerable groups.

The Framework also highlights the 'Making Every Contact Count' approach to raise sexual health as part of routine healthcare, regardless of reason for attendance. As stigma still prevents seeking help for issues such as non-consensual sex, abuse and violence, these points of interaction take on greater significance for identification and intervention.

[13] Department of Health. *A Framework for Sexual Health Improvement in England;* 2013.

Additionally, the Framework recognises that health promotion alone does not create healthy behaviour. Instead, **targeted behaviour change interventions**, drawing on **robust evidence bases**, were identified as key to prevention.

Other important guidance includes:

- The 2014 DH guidance *Developing strong relationships and supporting positive sexual health*[14] for the Health Visiting and School Nurse Programme, advising on effective delivery of **Personal, Social and Health Education (PSHE)** and **Relationship and Sex Education (RSE)** to support the contraceptive and sexual health needs of young people.
- Public Health England's (PHE) *Health promotion for sexual and reproductive health and HIV Strategic action plan, 2016 to 2019*[15], outlines **the PHE support to local partners** in reducing the HIV and STI burden, unplanned pregnancies, and under 18 and under 16 conceptions.

Many sexual health indicators including under 18 conceptions, chlamydia diagnoses (15 – 24 years old) and people presenting with HIV at a late stage of infection can be found in the Public Health Outcomes Framework.

1.3 Commissioning context

After 2013, commissioning arrangements were mandated as below:

Local authorities will commission	Clinical Commissioning Groups (CCGs) will commission	The NHS Commissioning Board will commission
• Comprehensive sexual health services. These include: • contraception, including LESs (implants) and NESs (intra-uterine contraception) and all prescribing costs, but excluding contraception provided as an additional service under the GP contract; • sexually transmitted infection (STI) testing and treatment, chlamydia screening as part of the National Chlamydia Screening Programme (NCSP) and HIV testing; • sexual health aspects of psychosexual counselling; and • any sexual health specialist services, including young people's sexual health and teenage pregnancy services, outreach, HIV prevention and sexual health promotion, services in schools, colleges and pharmacies.	Most abortion services (but there will be a further consultation about the best commissioning arrangements in the longer term) Sterilisation Vasectomy Non-sexual health elements of psychosexual health services Gynaecology, including any use of contraception for non-contraceptive purposes.	Contraception provided as an additional service under the GP contract HIV treatment and care (including drug costs for post-exposure prophylaxis after sexual exposure) Promotion of opportunistic testing and treatment for STIs, and patient-requested testing by GPs Sexual health elements of prison health services Sexual Assault Referral Centres Cervical screening Specialist fetal medicine services

Source: Department of Health - A Framework for Sexual Health Improvement in England

[14] Department of Health. *Developing strong relationships and supporting positive sexual health*; 2014.
[15] PHE. *Sexual and reproductive health and HIV: strategic action plan*; 2015.

PHE document *Making It Work (2014)* advocates a **whole-systems approach** to commissioning sexual health services, noting commissioned services that link to sexual health if not explicitly so (e.g. drug and alcohol services, family support, education, housing, general practice, gynaecology and mental health services) and the potential for collaboration and increased impact[16].

London has two sexual health programmes coordinated across boroughs:

- **The London HIV Prevention Programme** - a programme of joint commissioning of HIV prevention services by all 33 London councils, involving campaigns, communications, condom distribution and targeted outreach hosted by the London Borough of Lambeth.
- **The Sexual Health London Programme (SHLP)** - developed from the London Sexual Health Transformation Programme (LSHTP). This was designed to deliver a collaborative commissioning model for open access sexual health services, with better integration of genitourinary and sexual and reproductive health services. It lead to the Integrated Sexual Health Tariff, London-wide service specifications and new models of service to improve outcomes. The SHLP is currently hosted by the City of London Corporation, and from 2018 includes:

    - a new online self-sampling service for asymptomatic residents to be tested and treated (provided by Preventx and Chelsea and Westminster NHSFT),
    - open-access clinics providing integrated sexual health services, including infections and contraception. Self-sampling kits will also become available in clinics to be given out to eligible service users to use in clinic or elsewhere.

  While Croydon is part of the SHLP, it has adopted the Integrated Sexual Health Tariff, and sits on the SHLP Strategic Board, it has not yet signed up to the online service. However, it remains a named authority in the contracting, along with several other boroughs, which means it maintains the option of joining the service if it wishes to.

  Symptomatic patients must still attend sexual health clinics, or other face-to-face healthcare providers, and how the online service will mitigate changes in clinic numbers still needs to be monitored and assessed.

1.4 Demographic Context

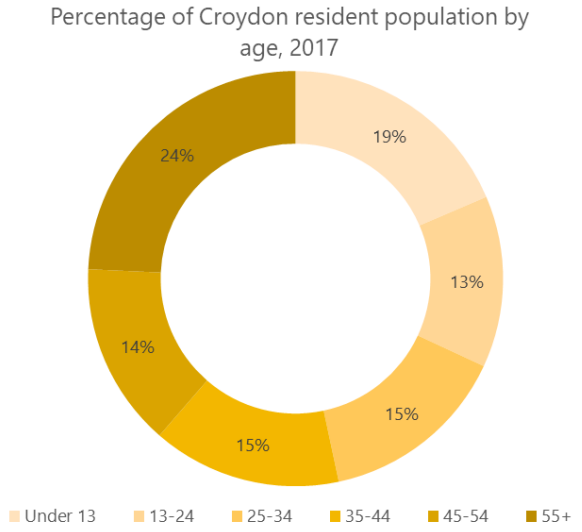
Croydon is the **fifth** largest borough in London with an estimated 384,837 people living in the borough in 2017, making it the **second largest** population in London[17]. By 2031, there are predicted to be 444,576 people living in Croydon, an increase of 15% from 2017 estimates. In the small area in the town centre where the majority of planned developments are, the population is predicted to increase by **90%** in the same time period.[18] Although this is indicative of an increased burden of care locally, sexual health services are open access, independent of borough of residence, and therefore factors such as where residents work,

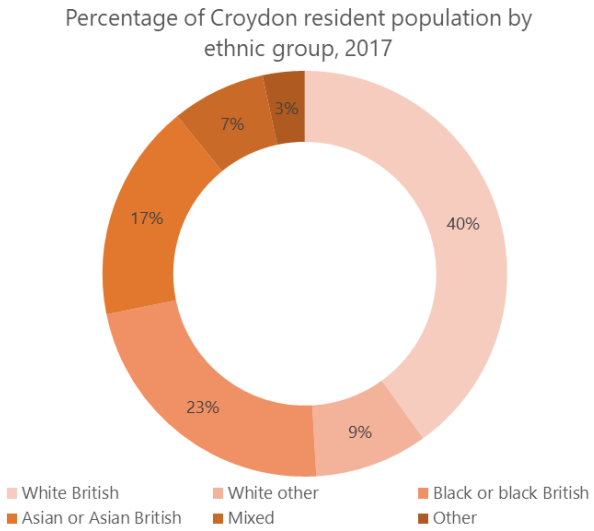
[16] PHE. *Making it work: a guide to whole system commissioning for sexual health, reproductive health and HIV*; 2014.
[17] Office for National Statistics (ONS). *Mid-year population estimates*; 2017
[18] Greater London Authority (GLA). *MSOA housing-led population projections*; 2016

study or spend leisure time may have bigger impact on where and how they access services.

Age and Ethnicity

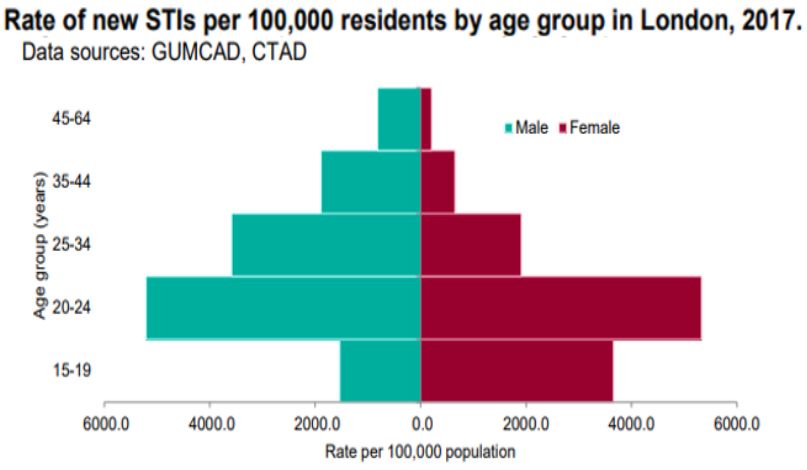
2017 estimates show that **almost a third of Croydon residents were aged under 25**[19], and **60% had a non-white British ethnicity**[20]. Population predictions estimate that in 2031 almost a third of the population will be aged under 21, and the proportion of those with a non-white British ethnicity will increase to 67%.[21]

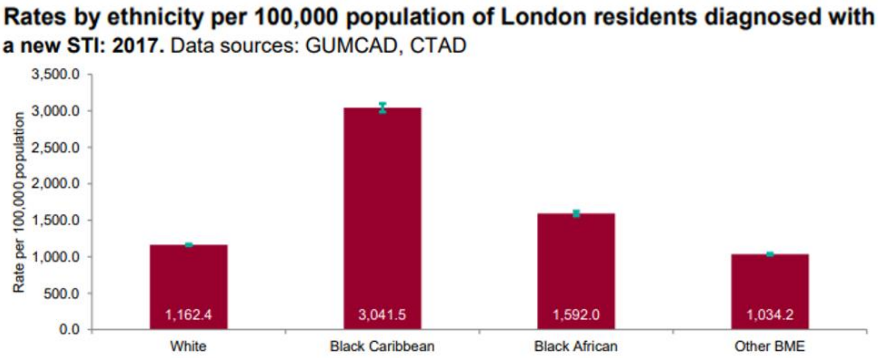




When this is put in the context of 2017 STI figures, where the highest proportion of STIs in London residents diagnosed in 15 to 24 year olds (36%), and black ethnic minorities having the highest rate of new STIs[22], the potential burden on services is considerable. Even adjusting for socioeconomic deprivation, ethnicities such as Black Caribbean are shown to have higher rates of STI diagnoses, showing that sexual behaviour, atittudes to risk and contextual factors need to be considered and addressed in any interventions.[23]

[19] ONS. *Mid-year population estimates*; 2017
[20] GLA. *ethnic group housing-led population projections*; 2016
[21] GLA. *ethnic group housing-led population projections*; 2016
[22] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/731736/spotlight_on_sexually_transmitted_infections_in_london_2017_data.pdf
[23] https://sti.bmj.com/content/91/Suppl_1/A2.3





Source: PHE - Spotlight on sexually transmitted infections in London – 2017 data

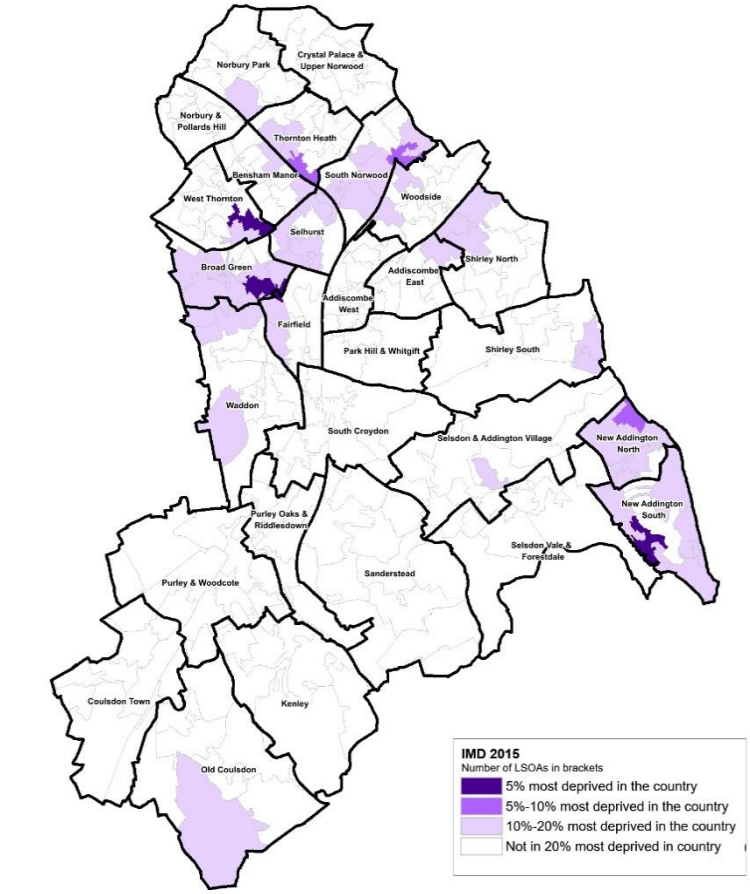
Deprivation

Multiple studies have demonstrated a link between socioeconomic deprivation and sexual health[24, 25]. In terms of deprivation:

- Croydon is the 19th (out of 33) most deprived borough in London
- In 2016, an estimated 10,261 (2.7%) people in Croydon lived amongst the 10% most deprived areas in the country (2 darkest shades of purple in map)
- 83,078 (21.9%) people in Croydon live amongst the 20% most deprived areas in the country (all purple in map)

[24] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4520210/
[25] https://jech-bmj-com.ezproxy.library.qmul.ac.uk/content/69/1/49

Indices of Deprivation 2015 (with new Croydon wards)
Croydon Lower Super Output Areas (LSOAs)



Vulnerable and High-Risk Groups

Sexual and domestic violence screening and referral pathways are important to ensure potential victims receive specialised help from the police, social services and further healthcare services. Screening settings should include support and advice around antenatal care, termination and repeat terminations of pregnancy and female genital mutilation (FGM).

Commercial sex workers are at risk of poorer sexual health outcomes, and have a strong association with compounding problems such as violence, sexual violence and drug and alcohol problems. Specialised outreach services are key here, due to issues around legality, societal bias, and issues with accessing services at regular opening hours.

1.5 Current services within Croydon

Service mapping of Croydon sexual health services and an overview of the sexual and reproductive health landscape in Croydon are included in Appendix I and Appendix II

respectively. Croydon Health Services (CHS) currently provide an integrated sexual health service, combining the Contraception and Sexual Health Service, and the Genitourinary Medicine Service.

Primary care services include general practice, enhanced sexual health pharmacies (ESHPs), non-enhanced sexual health pharmacies, and other commissioned services such as Marie Stopes International and the chlamydia screening programme. There are also services for young people such as Family Nurse Partnership, health visiting, school nursing, and the Young People's Sexual Health Service, outreach services such as Croydon's Homeless Health Team, and third sector organisations.

2 Contraception

There are a range of contraception methods available, guided by clinical indications and user preference. In addition, effectiveness is dependent on correct and consistent use of the contraception, leading to broad division of the several types:

- **Where user failure is least likely to occur**, either because it is intended to be permanent, e.g. sterilisation, or due to being a long-acting reversible contraceptive (LARC). Defined in NICE guidelines as methods which require administration less than once per cycle or month, these include the **intrauterine device (IUD)**, **the intrauterine system (IUS)**, **the contraceptive implant**, and **injectables**[26]. For these, effectiveness remains high, even with less than perfect use[27].
- **Where user failure is more likely to occur** e.g. **patches**, **vaginal rings**, **oral contraceptive pills**, **condoms**, **diaphragms** and **fertility awareness methods,** also defined as user-dependant methods (UDM), these require users to remember to use them daily, or each time they have sex, depending on the method. Effectiveness of these methods drops considerably with inconsistent or imperfect use.
- **Emergency contraception** – these include the IUD, which can be used up to five days after unprotected sexual intercourse or contraceptive failure[28], and two types of emergency hormonal contraceptive pills, one for use within 3 days, and another for use within 5 days [29].

2.1 Best Practice

NICE guidelines on contraception are specified for under 18s, under 25s and for LARCs, and discusses the importance of:

- Collaborative, evidence-based commissioning arrangements between different localities to ensure **comprehensive, open-access services are sited in convenient locations**, such as city centres, or near to colleges and schools, so no young person is deprived of contraceptive services because of where they live.

[26] NICE. *CG30 - Long-acting reversible contraception*; 2014.
[27] FPA. *Your Contraceptive Choices Chart*; 2017.
[28] As long as within 5 days of earliest predicted ovulation date.
[29] NICE Clinical Knowledge Summary. *Contraception – emergency*; 2016.

- **Comprehensive referral pathways** for young people that include; abortion, maternity, genitourinary medicine (GUM), pharmacy and all other relevant health, social care and children's services, and should cover youth and community services, education, and voluntary and private sectors services.

LARC, in particular, has key priorities of:

- Women requiring contraception being **given information and offered a choice of all methods, including LARC**.
- Healthcare professionals advising women about contraceptive choices should be **competent in helping women consider and compare the risks and benefits of all methods relevant to their individual needs**, and manage common side effects and problems.
- Those who do not provide LARC within their service should have an **agreed referral mechanism for LARC**.
- Healthcare professionals should receive **training to develop and maintain the skills to provide intrauterine or subdermal options**.

In 2016, NICE released a Quality Standard on contraception, with the Quality Statement on emergency contraception: '**women asking for emergency contraception are told that an intrauterine device is more effective than an oral method**'[30], with providers, health professionals, and commissioners responsible for ensuring the protocols and procedures are in place to give this advice, that **rapid referral pathways are in place for women who choose an emergency IUD if they are not able to fit one immediately**, and that **oral emergency contraception is offered in the interim**.

The Faculty of Sexual and Reproductive Healthcare in the UK have also created eligibility criteria for contraceptive use for use by prescribers and providers to ensure that risk assessments looking at past medical history are done correctly by prescribers and providers.

2.2 Contraception Use in Croydon – Facts, Figures and Trends

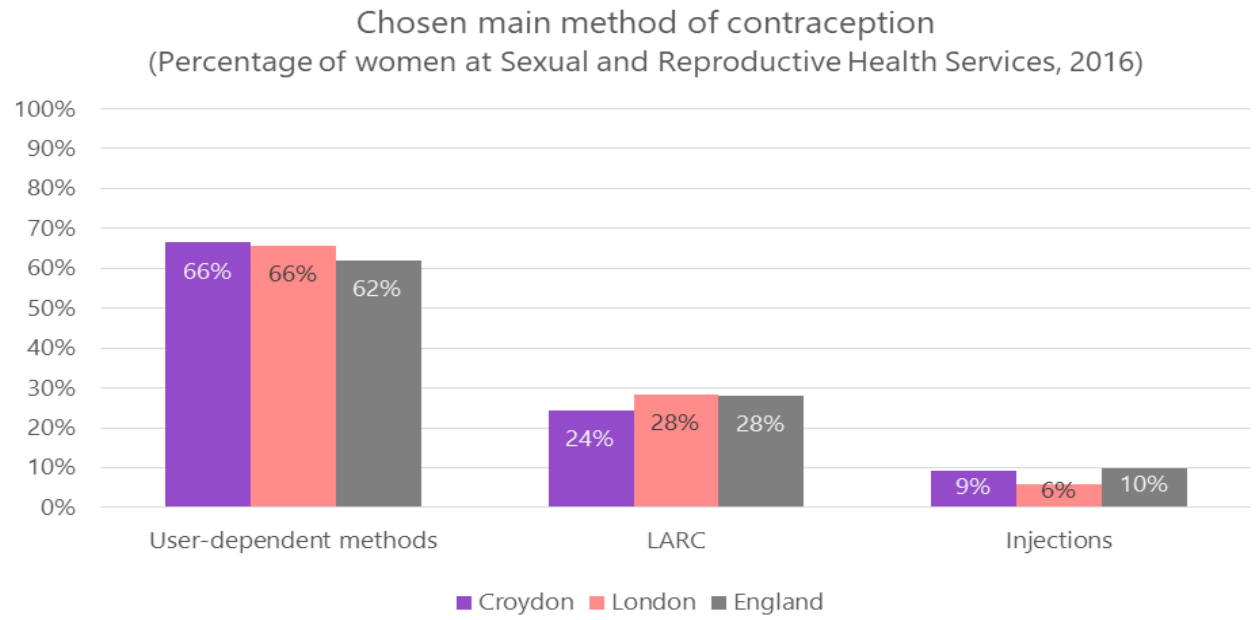
Contraception information presented below is based on data collected from sexual health services and GPs, and does not necessarily represent the total amount of contraception used by Croydon residents. For example, private prescriptions are not reflected in the figures. Furthermore, data tends to be prescription-linked rather than patient-linked, meaning that user-dependent methods (UDM) prescribed more than once a year will be necessarily overrepresented. Available data also does not currently include LARC

[30] NICE. *QS129 – Emergency Contraception*; 2016. Quality Standards set out priority areas for quality improvement in health and social care, particularly where variation is to be found. These contain a list of statements to help improve and standardise care.

contraception bought by a local authority or community SRH service but provided within General Practice[31].

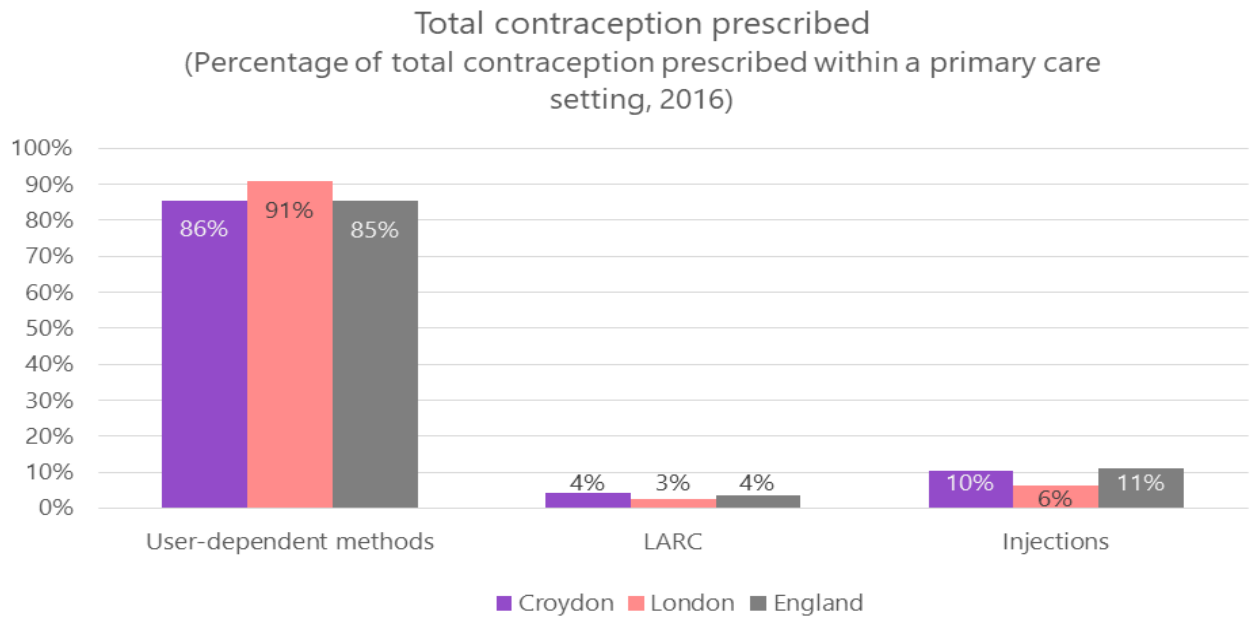
An estimated **5%** of all resident women aged 13-54 had a main method of contraception reported within a sexual and reproductive health service, a rate of 52.04 per 1,000 women. **This is a higher rate than England (47.52) but lower than London (69.29)**[32].

Within sexual and reproductive health services, the main method of contraception chosen by Croydon women was **UDM**. The percentage choosing **LARC was lower than both London and England**, with more Croydon women choosing injections over other LARC (compared to London)[33]. Similarly, within primary care settings, the majority of prescriptions collected were also UDM.

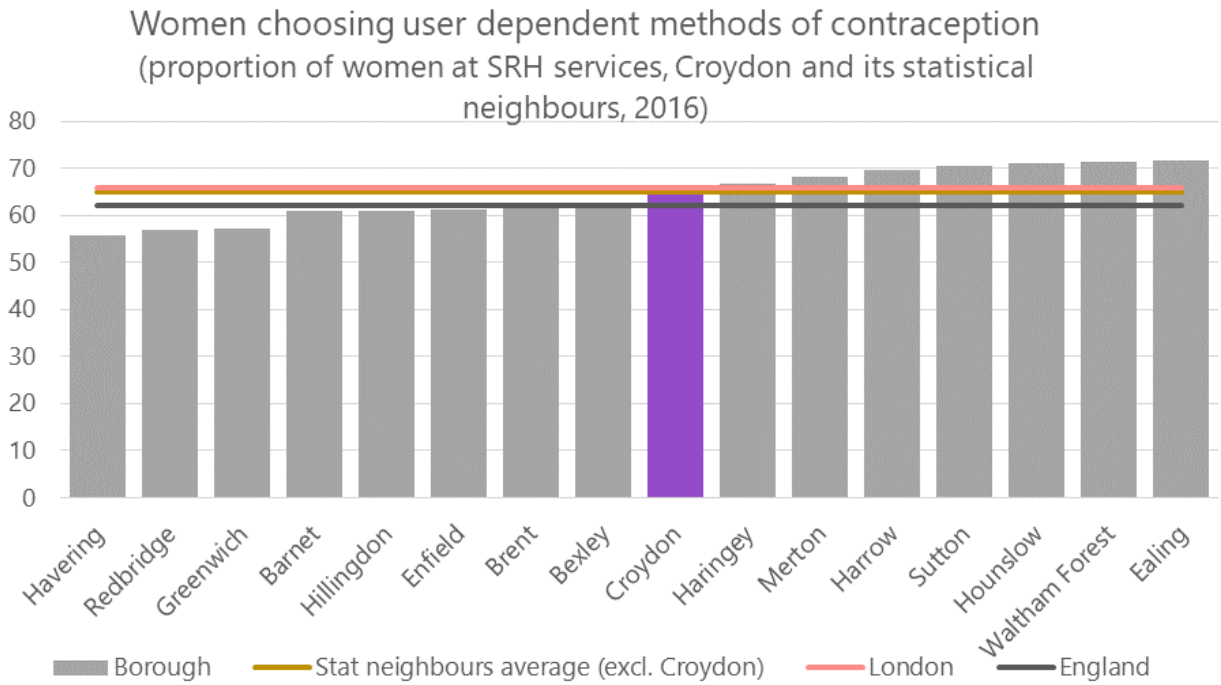


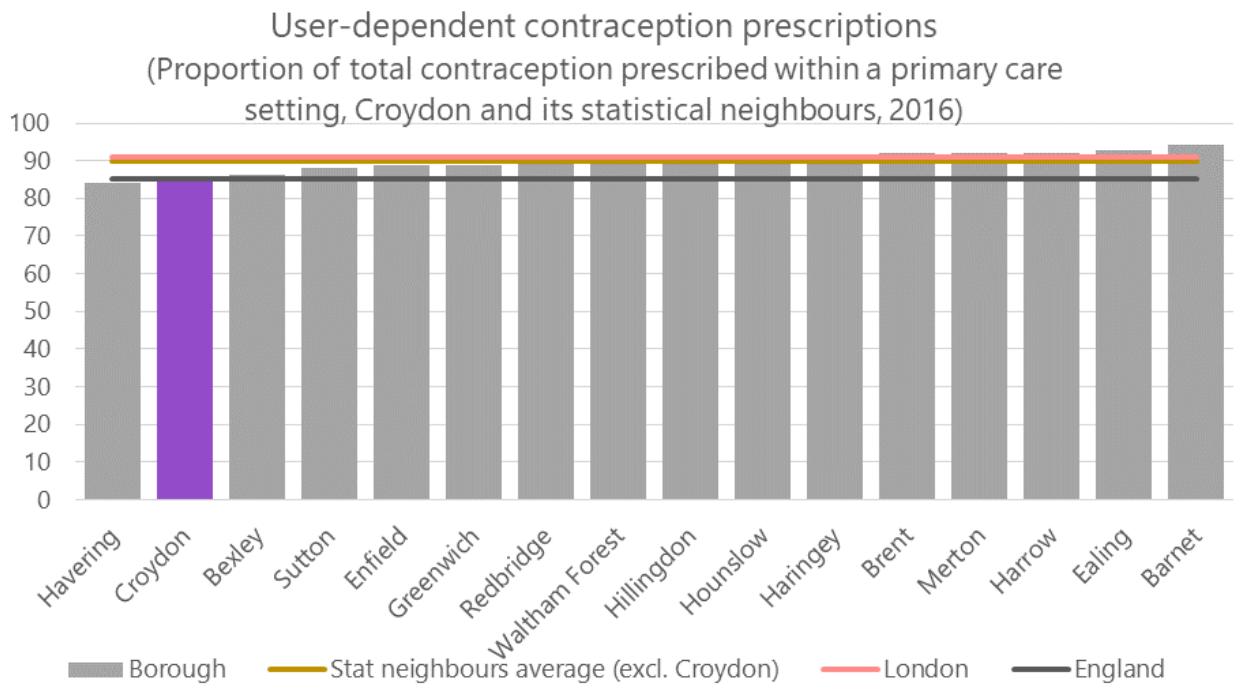
Source: Sexual and Reproductive Health Activity Dataset (SRHAD) taken from [Public Health England Sexual and Reproductive Health Profiles]

[31] Prescribing Analysis Cost Tabulation (PACT). Detailed in Local authority HIV, sexual and reproductive health epidemiology report (LASER) taken from *HIV & STI Web Portal* (restricted access only).
[32] NHS Digital Sexual and Reproductive Health Activity Dataset (SRHAD) taken from *Public Health England Sexual and Reproductive Health Profiles* and *ONS mid-year estimates* (2016).
[33] SRHAD taken from *Public Health England Sexual and Reproductive Health Profiles*. Figures represent the percentage of female attendees choosing each main method reported at the last attendance in the year where a main method of contraception is recorded.

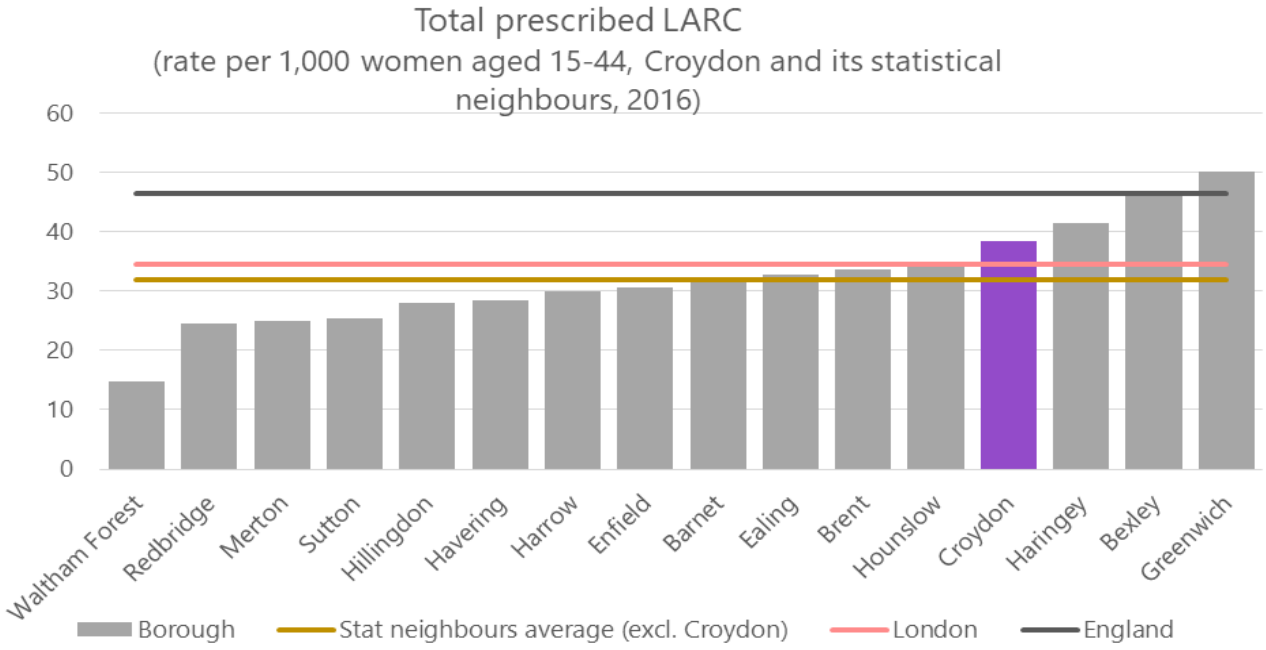


When comparing to statistical neighbours, UDM prescriptions from SRH services is comparable, while in primary care it is lower.

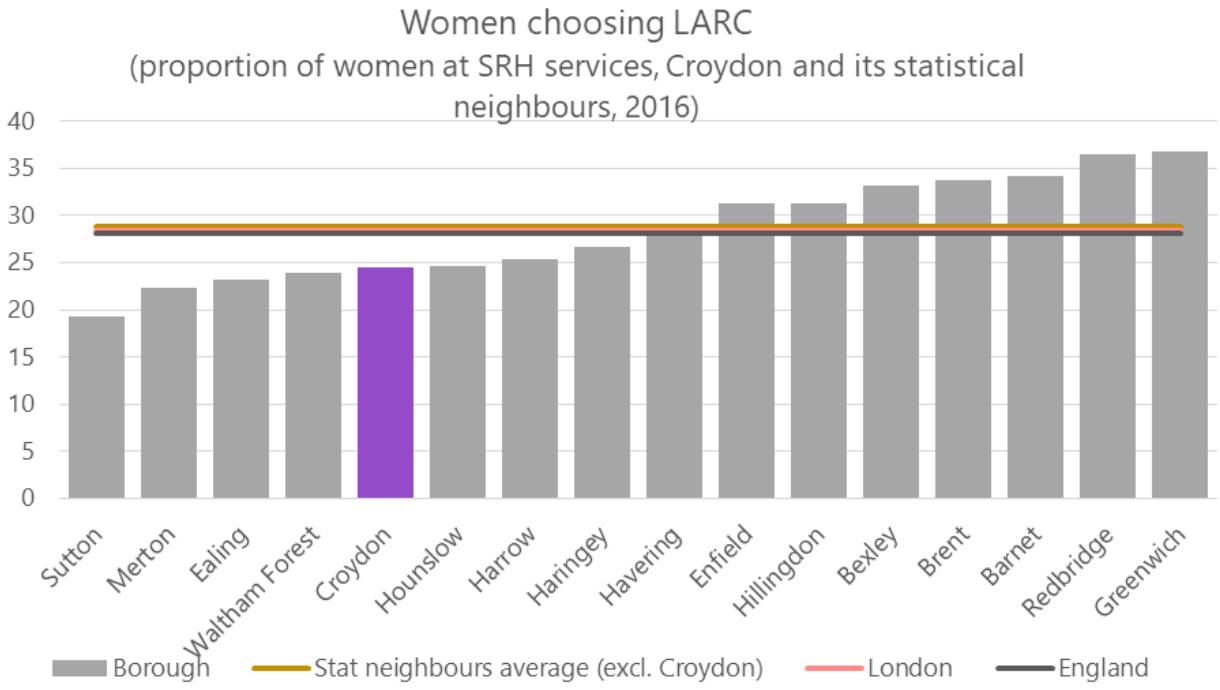


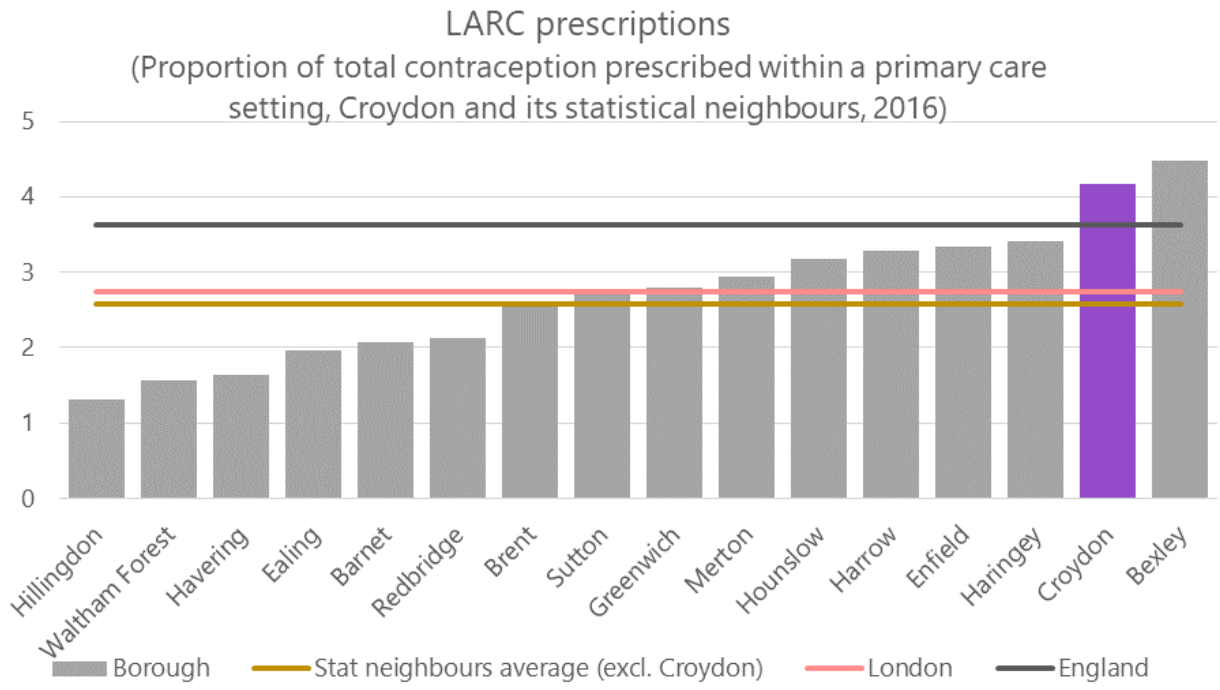


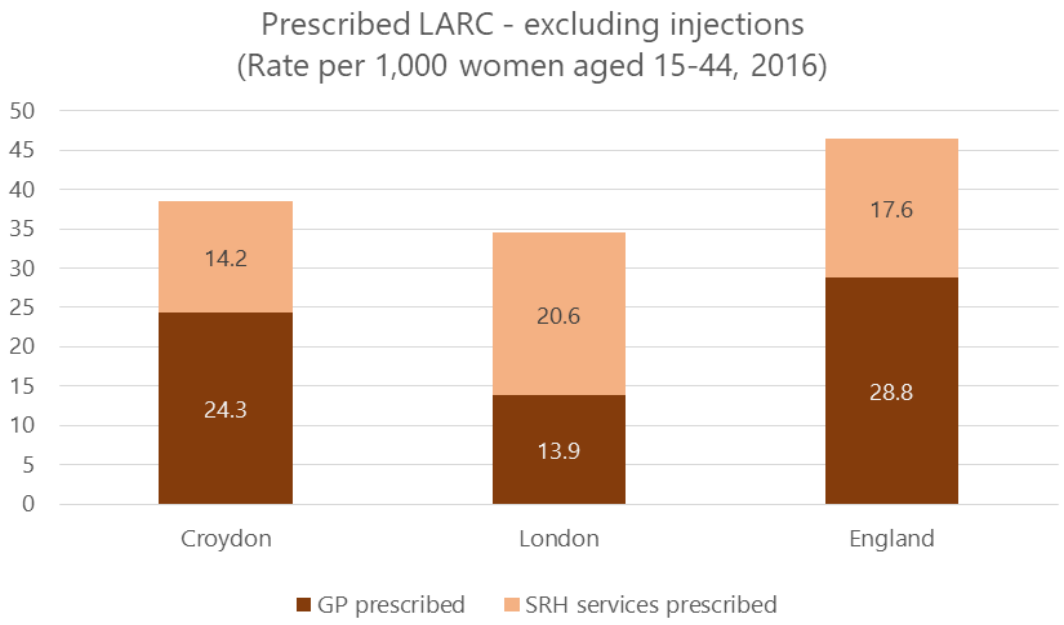
In 2016, 38.5 per 1,000 women aged 15-44 were prescribed LARC (excluding injections). This is higher than the London rate of 34.5 but lower than the England rate of 46.4. **The majority of all LARC prescriptions in Croydon were from a GP with Sexual and Reproductive Health services making up just over a third of all prescriptions (37%)**. This is similar to England but lower than seen across London where 60% of all LARC prescriptions are from Sexual and Reproductive Health services.[34]



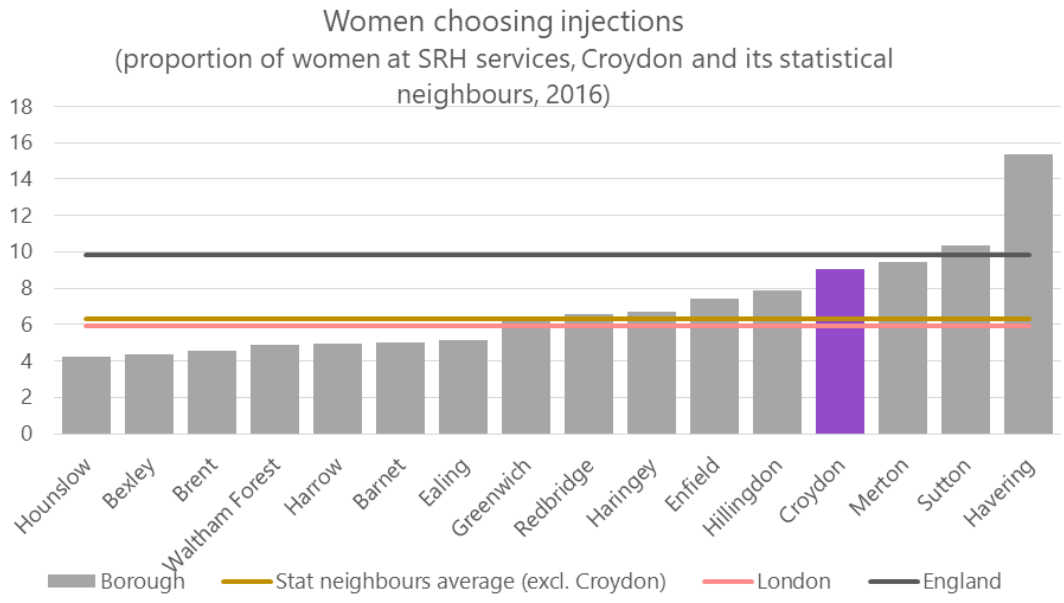
[34] PHE. *Sexual and Reproductive Health Profiles*; 2016

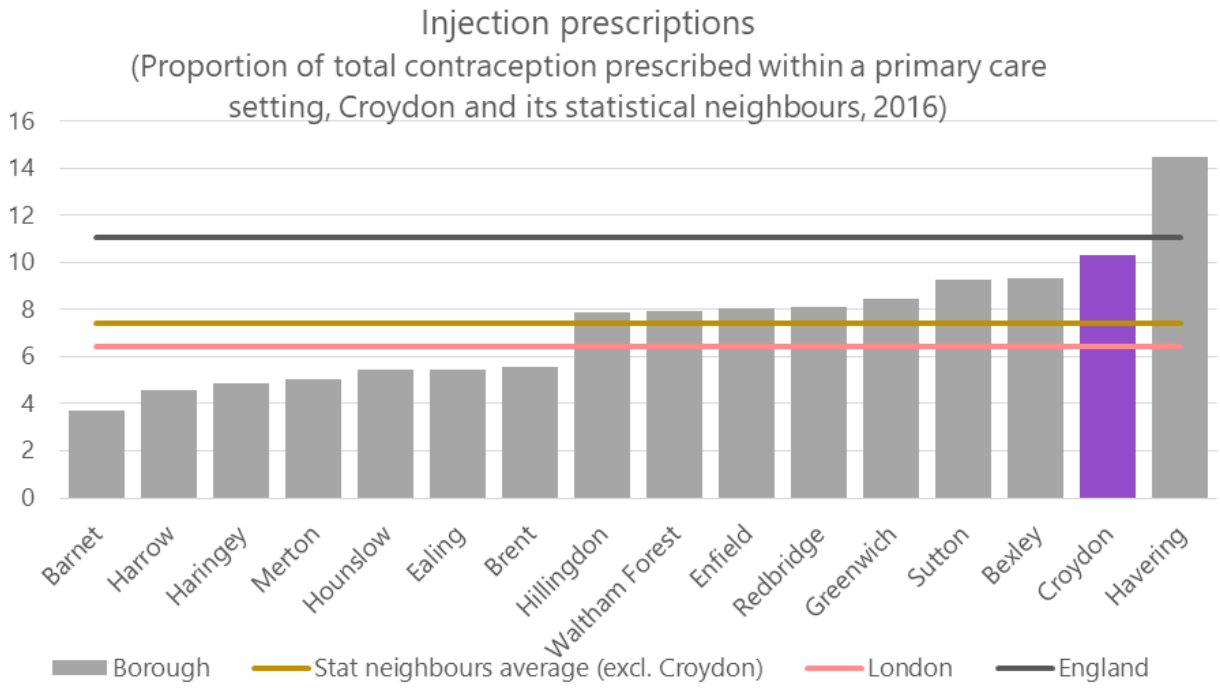

Women choosing LARC
(proportion of women at SRH services, Croydon and its statistical neighbours, 2016)
40
35
30
25
20
15
10
5
0
Sutton
Merton
Ealing
Waltham Forest
Croydon
Hounslow
Harrow
Haringey
Havering
Enfield
Hillingdon
Bexley
Brent
Barnet
Redbridge
Greenwich
Borough
Stat neighbours average (excl. Croydon)
London
England


LARC prescriptions
(Proportion of total contraception prescribed within a primary care setting, Croydon and its statistical neighbours, 2016)
5
4
3
2
1
0
Hillingdon
Waltham Forest
Havering
Ealing
Barnet
Redbridge
Brent
Sutton
Greenwich
Merton
Hounslow
Harrow
Enfield
Haringey
Croydon
Bexley
Borough
Stat neighbours average (excl. Croydon)
London
England



Croydon's prescriptions of injections were higher than average among statistical neighbours, both in SRH services and primary care.





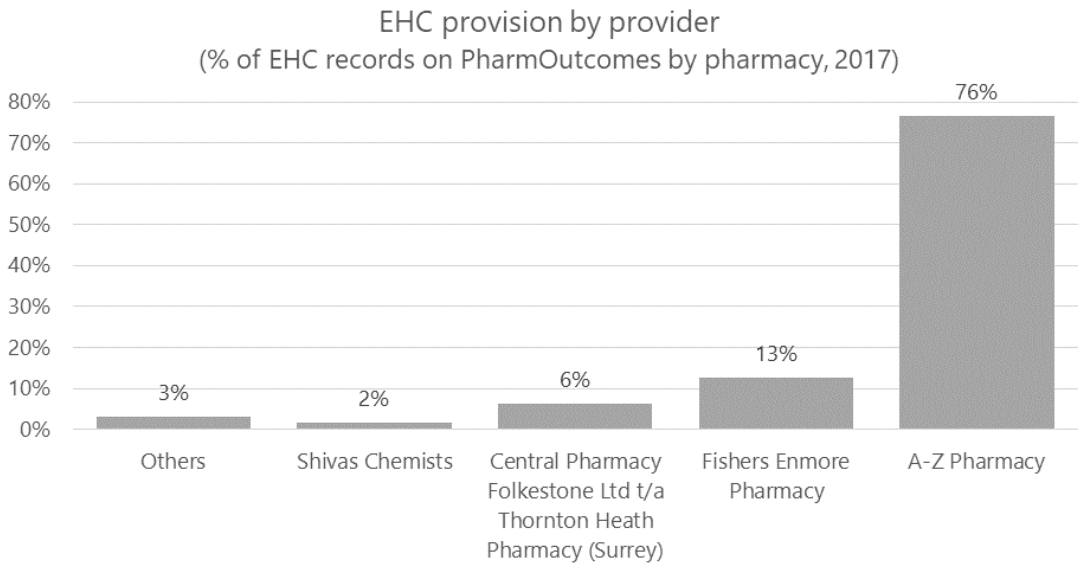
Emergency Hormonal Contraception

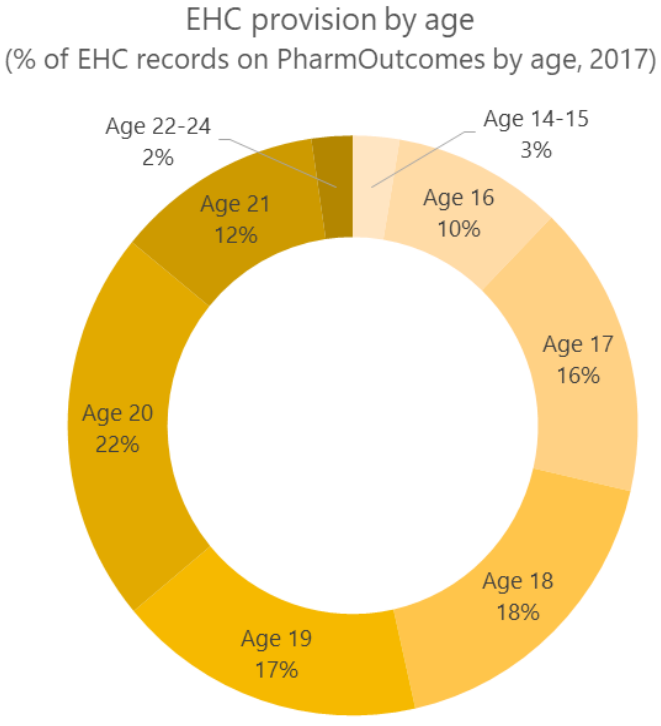
In 2016, approximately 1,960 emergency contraceptive pills were prescribed by GPs and 870 prescribed by sexual and reproductive health services.[35]

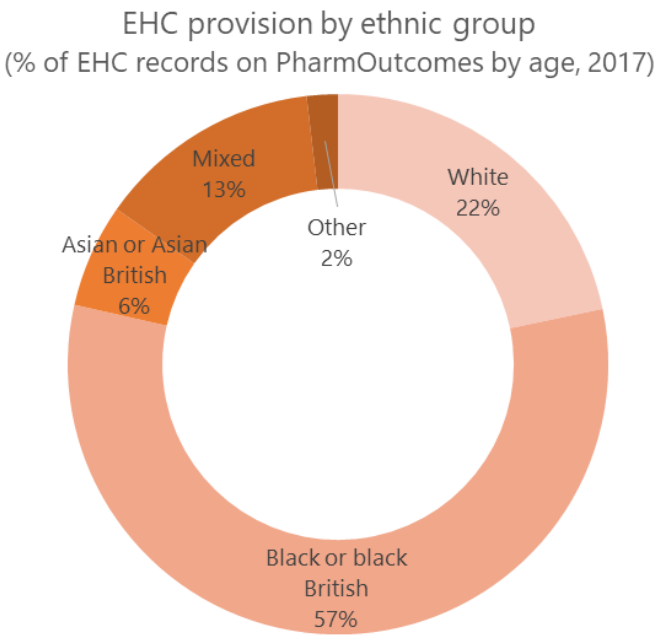
Approximately **3%** of all Croydon women receiving emergency contraception from a sexual and reproductive health service were fitted with an IUD. **9.1% were prescribed emergency contraception more than once in the same year**.[36]

Emergency contraception delivered by pharmacies within the borough is captured via a system called PharmOutcomes. In 2017, 1,631 instances of EHC provision were recorded via this system from thirteen separate pharmacies. The majority were recorded by A-Z Pharmacy. **All provisions were to women under the age of 25 and just over half were to women of a black / black British ethnic group.** Of all records, 77% were to women who live in the borough and a further 19% were to women without a recorded area of residence, 4% of records were to women who lived outside of Croydon.

[35] PACT and SRHAD. Detailed in LASER taken from *HIV & STI Web Portal* (restricted access only). Figures have been rounded to the nearest five.
[36] SRHAD. Detailed in LASER taken from *HIV & STI Web Portal* (restricted access only). Figures have been rounded to the nearest five.


EHC provision by provider
(% of EHC records on PharmOutcomes by pharmacy, 2017)
80%
70%
60%
50%
40%
30%
20%
10%
0%
3%
2%
6%
13%
76%
Others
Shivas Chemists
Central Pharmacy Folkestone Ltd t/a Thornton Heath Pharmacy (Surrey)
Fishers Enmore Pharmacy
A-Z Pharmacy


EHC provision by age
(% of EHC records on PharmOutcomes by age, 2017)
Age 22-24
2%
Age 14-15
3%
Age 21
12%
Age 16
10%
Age 17
16%
Age 20
22%
Age 18
18%
Age 19
17%



Comparative data with pharmacies in statistical or geographical neighbours are unfortunately not available.

2.3 Available services

Contraception is free of charge and available in the UK from a number of sources:

- general practices,
- level 2 sexual and reproductive health (SRH) services,
- young person's clinics,
- NHS walk-in centres (emergency contraception only),
- specialist sexual health services (SHSs) (emergency contraception and male condoms), pharmacists under a Patient Group Direction (oral and emergency contraception and condoms)
- abortion providers are commissioned locally to provide contraception including LARC.

Emergency contraception can also be bought over the counter at any pharmacy and at private clinics[37].

Condoms can be purchased from pharmacies, supermarkets, other retailers or alternatively obtained free from sexual health services and condom distribution schemes, such as the C-Card scheme.

Croydon residents also have the option to obtain contraception from some services outside the borough if desired.

[37] Local authority HIV, sexual and reproductive health epidemiology report (LASER); 2016.

Commissioned Service	Contraception Provision
General Practitioners	All forms of LARC, oral prescriptions and emergency hormonal contraception provided free of charge
Pharmacies	ESHPs provide emergency hormonal contraception and oral prescriptions free of charge to women aged under the age of 21, paid for by the local authority
Croydon Health Services	All forms of LARC, oral prescriptions and emergency hormonal contraception provided free of charge
Croydon Homeless Health	Oral prescriptions and emergency hormonal contraception provided free of charge
Marie Stopes International	All forms of LARC and oral prescriptions provided free of charge
C-card scheme	Provision of a range of free condoms and lubrication. In addition, some paper-based resources provided to signpost young people 13-24 years and some vulnerable groups to other resources, and also face to face confidential advice from trained practitioners working alongside young people.

2.4 Recommendations

- Ensure women are fully informed of their contraceptive choices, risks and benefits, counselled that IUD is more effective than an oral method, and appropriately referred or prescribed their preferred method, with the necessary follow-up.
    - Regular refresher training for staff involved in advising women, including general practice staff.
    - Accurate and consistent recording across providers when LARC has been offered, when it has been declined, and when it is inappropriate for prescription.
    - Clear referral pathways for LARC if a provider is unable to provide it.
    - Creation of a clear pathway outlining where and when conversations on contraception can take place across different settings with women, with follow-up mechanisms, either via phone or recall to service, where contraception choices can be further discussed if needed, concerns can be addressed and decisions can be supported.
    - Use the statistical neighbour average as target for LARC prescriptions where it falls below.
    - Use the London average as a target for women to have a contraception prescribed, if appropriate for them.
    - Share learning with other boroughs and national teams to identify how data accuracy could be improved i.e. prescription data that is patient-linked, rather than prescription linked would get a more accurate picture of contraception uptake in Croydon.

- Increase uptake of contraception after attendance for emergency contraception, according to a locally agreed target.
    - Up-to-date training for staff at all providers on counselling women through the options for emergency contraception, highlighting the role of LARC.
    - Clear referral pathways are in place from all providers after prescription of emergency contraception - for LARC, if LARC cannot be given immediately, and for information on long-term contraception options. This should include follow-up mechanisms, such as text messages, or phone calls to re-attend services, to reduce the incidence of repeat EHC prescriptions.
    - User engagement to understand how the referral pathways and follow-up can be best implemented.
    - Stakeholder engagement, particularly in primary care (general practices and pharmacies) to establish how referral pathways for follow-up after EHC currently work, how they could be improved, and what training is required to support them.

- Increase awareness of contraception methods and services among target populations.
    - User engagement, particularly in overrepresented ethnicities to see where services could improve uptake of long-term contraception options, if appropriate.
    - Use targeted RSE to under-25s and overrepresented ethnicities to increase awareness of long-term contraception use, with workshops complemented with other types of media, and across a range of settings, particularly non-healthcare settings. This importantly should be inclusive of men and women.
    - Consider where RSE can be used with parents or carers, as appropriate, to encourage open conversations on contraception, and awareness of its role in good sexual health.

- Collaborate with adjacent and outreach services to increase uptake and referrals e.g. Turning Point, Homeless Health service, mental health services, particularly in high-risk and hard to reach groups.

3 Conceptions (including terminations of pregnancy)

3.1 Best Practice

Under 18 Conceptions

Most teenage pregnancies are unplanned and, nationally, around half end in an abortion. While for some young women having a child when young can represent a positive turning point in their lives, for many more teenagers bringing up a child is extremely difficult and often results in poor outcomes for both the teenage parent and the child. Research

evidence[38], particularly from longitudinal studies, shows that teenage mothers are less likely to finish their education, are more likely to bring up their child alone and in poverty and have a higher risk of poor mental health than older mothers. Infant mortality rates for babies born to teenage mothers are around 60% higher than for babies born to older mothers. The children of teenage mothers have an increased risk of living in poverty and poor quality housing and are more likely to have accidents and behavioural problems.

Under 18 conceptions are one of the three Public Health Outcomes Framework Indicators on sexual health. DH ambitions in this area are for all young people to receive appropriate information and education to make informed decisions, and to have information and access to the full range of contraceptive methods.

NICE guidelines on under 18 conceptions include:

- Ensuring sufficient sexual health services providing contraceptive and abortion services with adequate training and governance are in place.

Specifically focusing on vulnerable young people under 18 (from disadvantaged backgrounds, in or leaving care, or with low educational attainment):

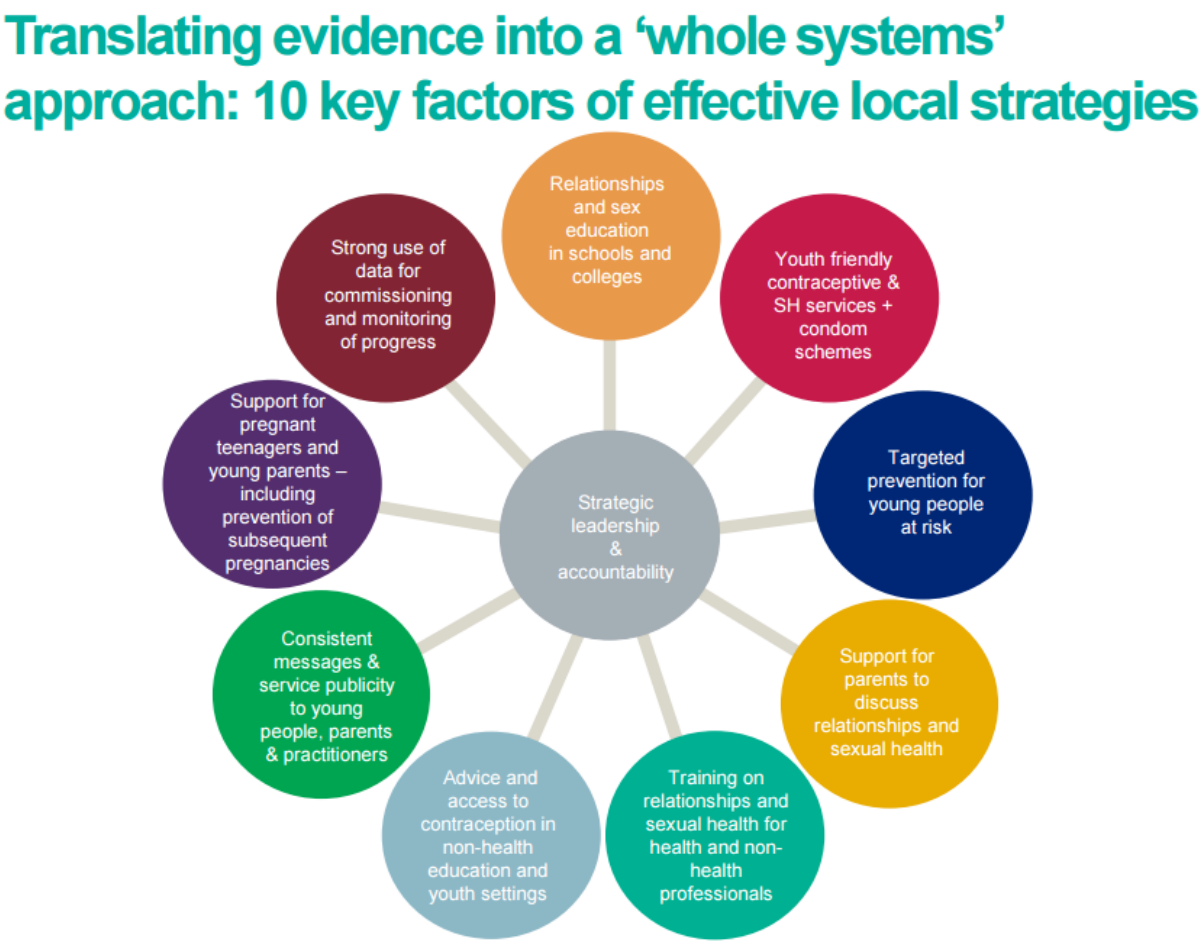
- Using healthcare settings (primary care, community contraceptive services, antenatal and postnatal care, abortion and genitourinary medicine (GUM) services, drug/alcohol misuse and youth clinics, and pharmacies) and non-healthcare settings (schools, education, and outreach centres).
- Providing one to one sexual health advice on all methods of reversible contraception, emergency contraception and other reproductive issues and concerns.
- If pregnant or already mothers, regularly visiting, giving health promotion advice in line with NICE guidance on postnatal care with opportunities for returning to education, training and employment in the future, and where appropriate, referring the young woman to the relevant agencies, including services concerned with reintegration into education and work[39].

In 2018, PHE published a *Teenage Pregnancy Prevention Framework* to help commissioners assess and identify gaps in local services and pathways, and included a self-assessment pathway. PHE identified that collaborative work between agencies and services was key to a successful teenage pregnancy prevention model. 10 key factors were identified in the framework as key to a collaborative, whole systems approach shown in the figure below. The 7 ‘You’re Welcome’ standards for young person’s health were also highlighted in the design of young people friendly services[40].

[38] Teenage Pregnancy Strategy: Beyond 2010, Department for Children, Schools and Families and the Department of Health, 2010

[39] NICE. *Public Health Guideline PH3 - Sexually transmitted infections and under-18 conceptions: prevention*; 2007.

[40] PHE. *Teenage Pregnancy Prevention Framework*; 2018.



Source: PHE - Teenage Pregnancy Prevention Framework

Repeat Terminations

No specific guidelines exist around repeat abortions. However, they are a cohort that requires attention. They may reflect the better access to abortion services, and the decrease in stigma that is associated with the procedure. There is also the acknowledgement that increasing life-spans and women choosing to start families later in life, and to have smaller families are all factors that have increased the likelihood of repeat terminations. There are also other, more complex reasons a woman may have repeat terminations, for example, the Royal College of Obstetricians and Gynaecologists notes the importance of not forgetting that repeat terminations, maybe, indicate someone experiencing domestic and sexual abuse[41].

The Department of Health Framework also highlights that women having repeat abortions can share the poor understanding of fertility and use of contraception that is found in women having terminations more generally. A study also found that 57% of the 430 women interviewed were using contraception when they conceived, however the majority of these

[41] RCOG. *Evidence-based Clinical Guideline Number 7 - The Care of Women Requesting Induced Abortion*; 2011.

were user-dependent methods, with higher rates of failure[42]. Another study estimated that 35% of women who have abortions would experience at least one more unintended pregnancy within two years if they used a contraceptive method with a failure rate of 10%[43] - this is the rate that many user-dependent methods fall near to with typical use[44]. The same study also found that women seeking repeat abortions were more likely to be black, have left school early, be living in rented accommodation, report an earlier age at first sexual experience, to use a less reliable method of contraception at sexual debut, and to report a greater number of lifetime sexual partners.

The risks with repeat terminations are mainly concerned with it being a physical, medical or surgical intervention, with the normal associated risks, rather than having any specific complications[45].

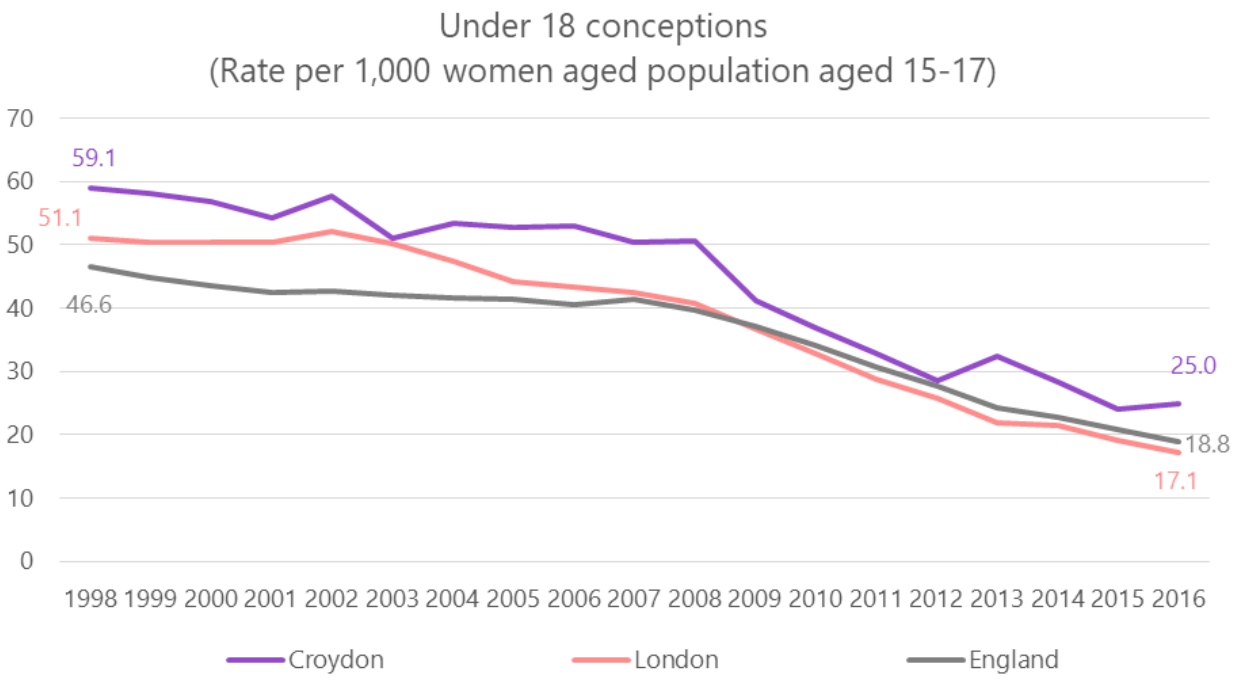
The Royal College of Obstetricians and Gynaecologists (RCOG) noted that increased IUD use immediately after abortion should theoretically prevent repeat terminations, with one study showing these findings. As a result, it recommends that:

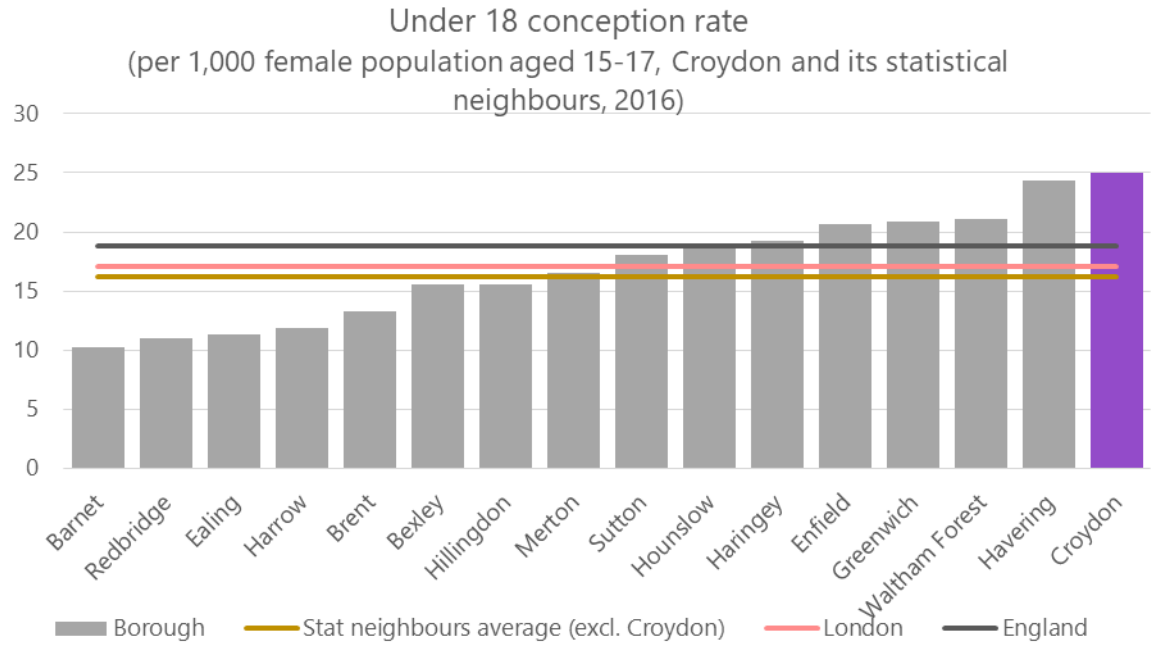
- Abortion services should be able to provide all methods of contraception, including long-acting methods, immediately after abortion.
- Women should be advised of the greater effectiveness of long-acting reversible methods of contraception.
- Before a woman is discharged, future contraception should have been discussed with each woman and contraceptive supplies should have been offered[46].

3.2 Conceptions in Croydon – Facts, Figures and Trends

Croydon has a high rate of under 18 conceptions. In 2016, 175 young women aged under 18 became pregnant, a rate of 25 per 1,000 resident women. **This rate is higher than both the London and England average and was the third highest rate in London.**[47] 30 of these young women were aged under 16.

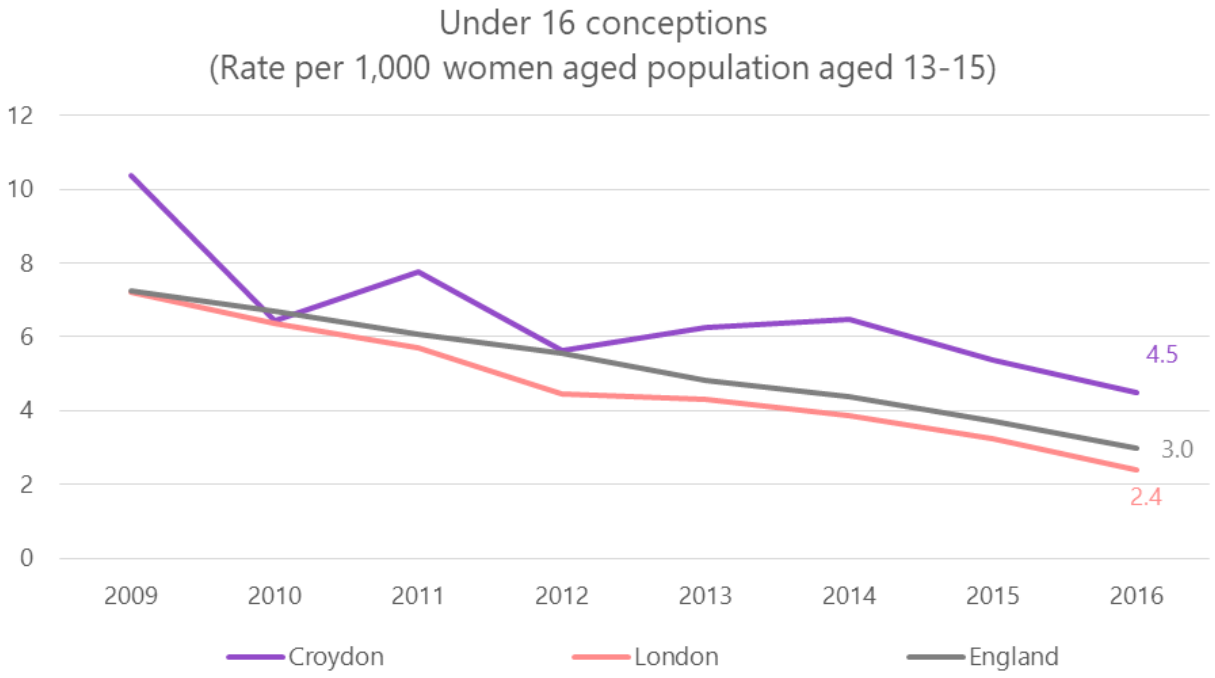
[42] Marie Stopes & The Open University. *Abortion, contraceptive uptake and use among young women*; 2014.
[43] Stone and Ingham in BMJ Sexual & Reproductive Health. Who presents more than once? Repeat abortion among women in Britain; 2011.
[44] NICE Clinical Knowledge Summary. *Contraception – emergency*; 2016.
[45] Brook. *Frequently asked questions about 'repeat abortion'*; 2014.
[46] RCOG. *Evidence-based Clinical Guideline Number 7 - The Care of Women Requesting Induced Abortion*; 2011.
[47] ONS. *Conception Statistics*; 2016

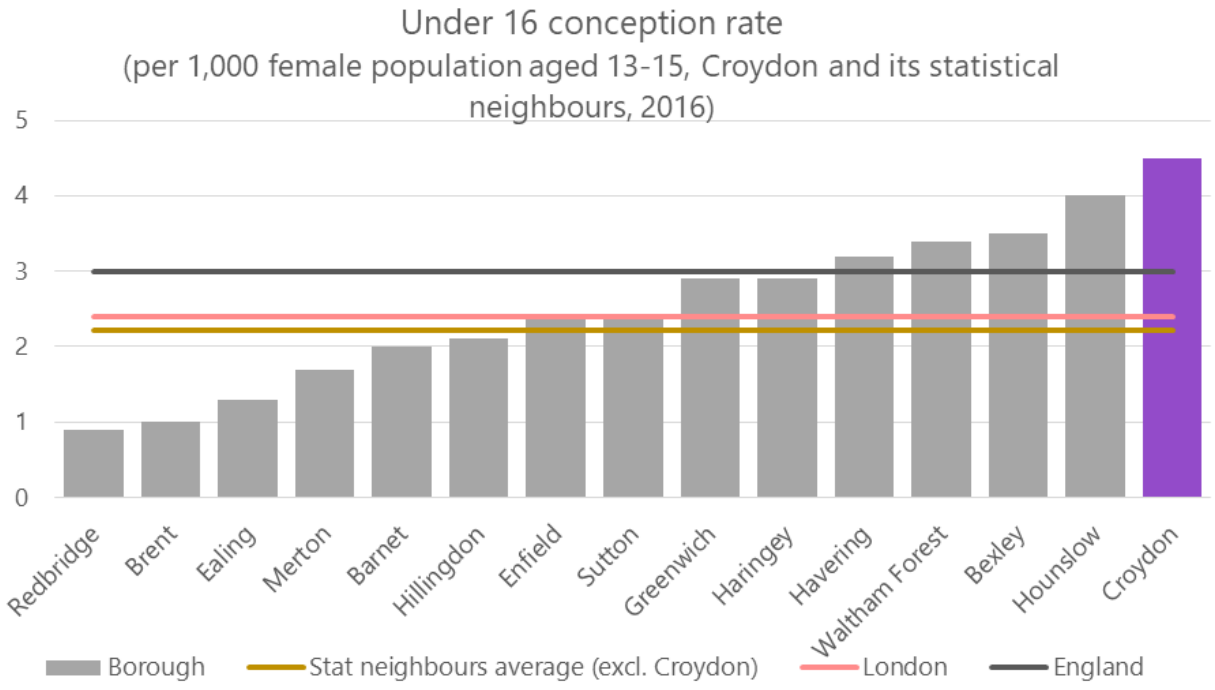




17% (30 of 175) of all under 18 conceptions in Croydon in 2016 were to women under 16 years of age. This is similar to the proportion seen across London (16%) and England (14%). In 2016, Croydon had an under 16 conception rate of 4.5 per 1,000 resident women. **This rate is higher than both the London and England average and was the second highest rate in London.**[48]

[48] ONS. *Conception Statistics*; 2016

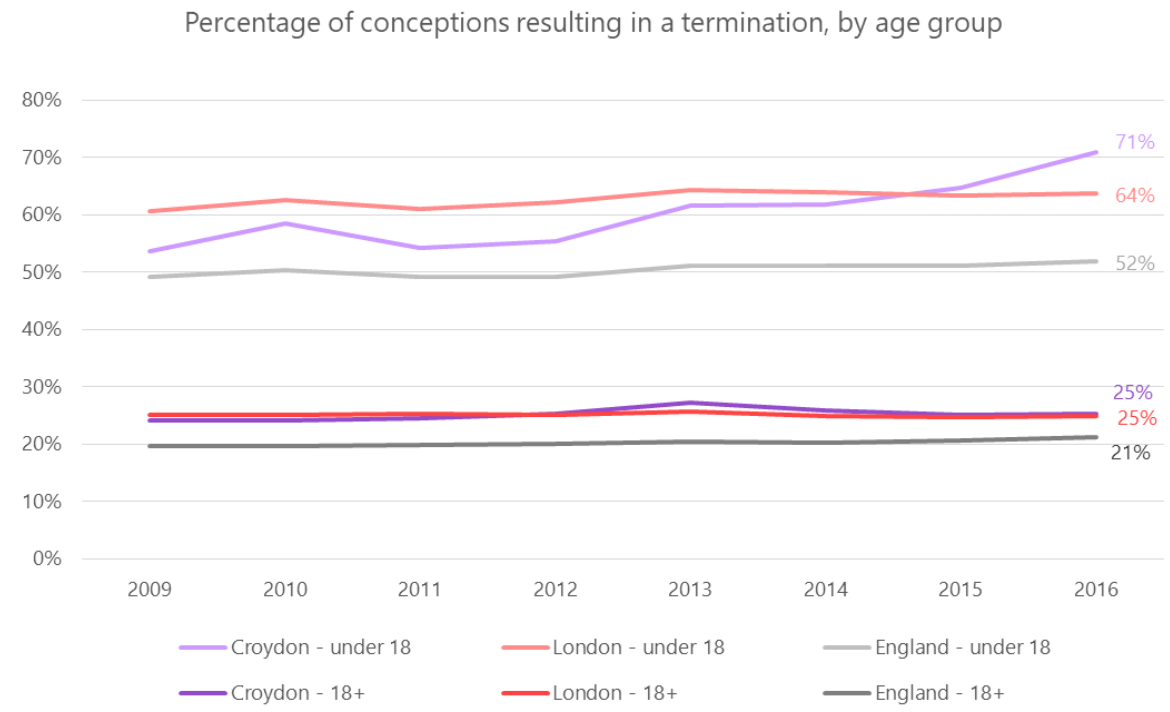


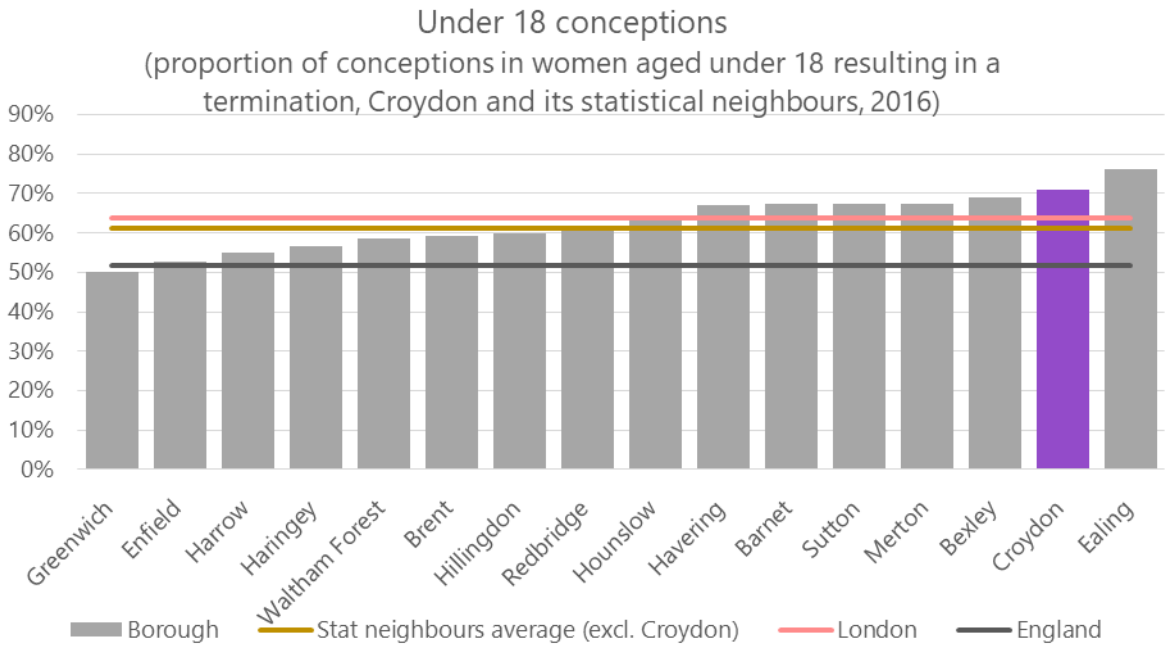


3.3 Terminations of Pregnancy – Facts, Figures and Trends

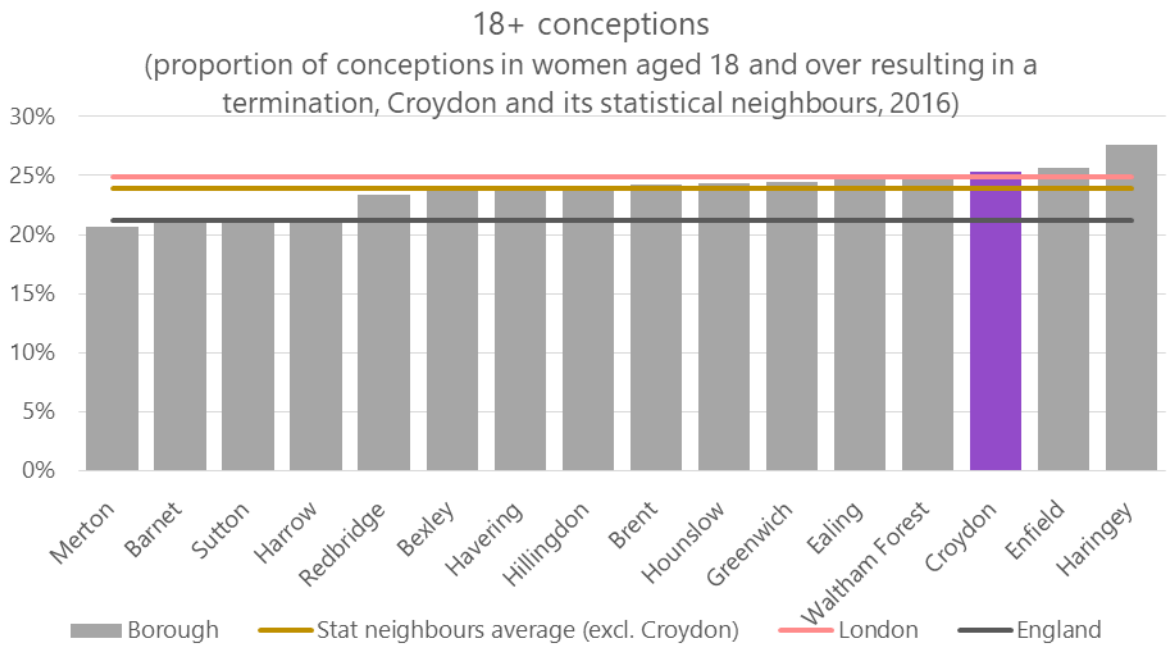
Terminations of pregnancy can indicate a lack of access to good quality contraception services and advice, as well as problems with individual use of contraceptive method.

Teenage conceptions are more likely to result in a termination. This is particularly clear in Croydon where the proportion resulting in a termination is (71%) now higher than that seen across London (64%) and England (52%).[49] In 2016, 124 of the 175 young women aged under 18 who became pregnant had their pregnancy result in a termination.

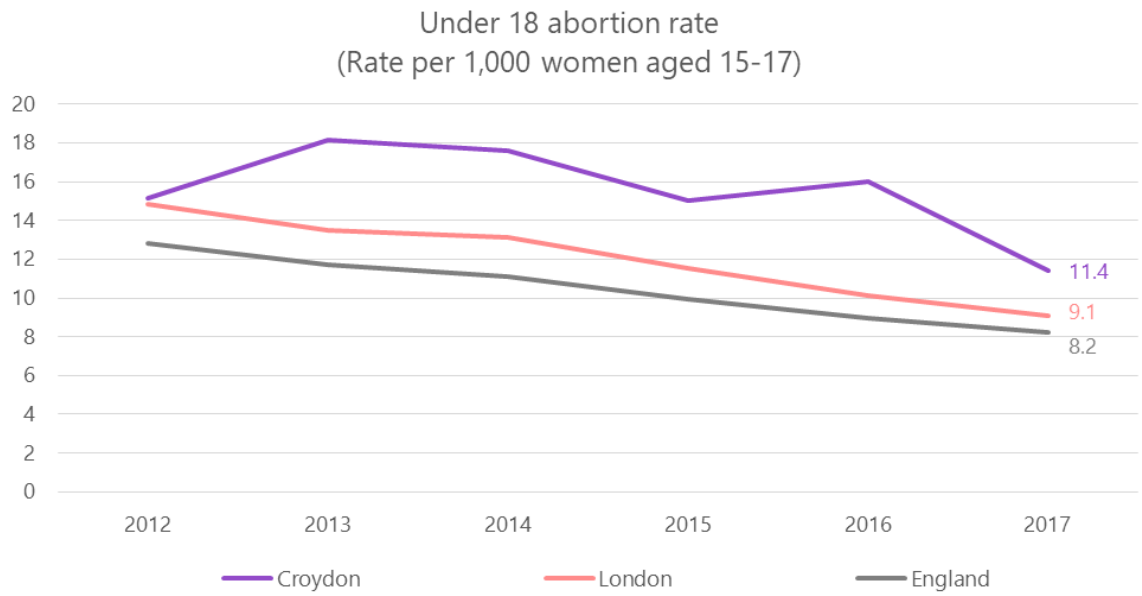




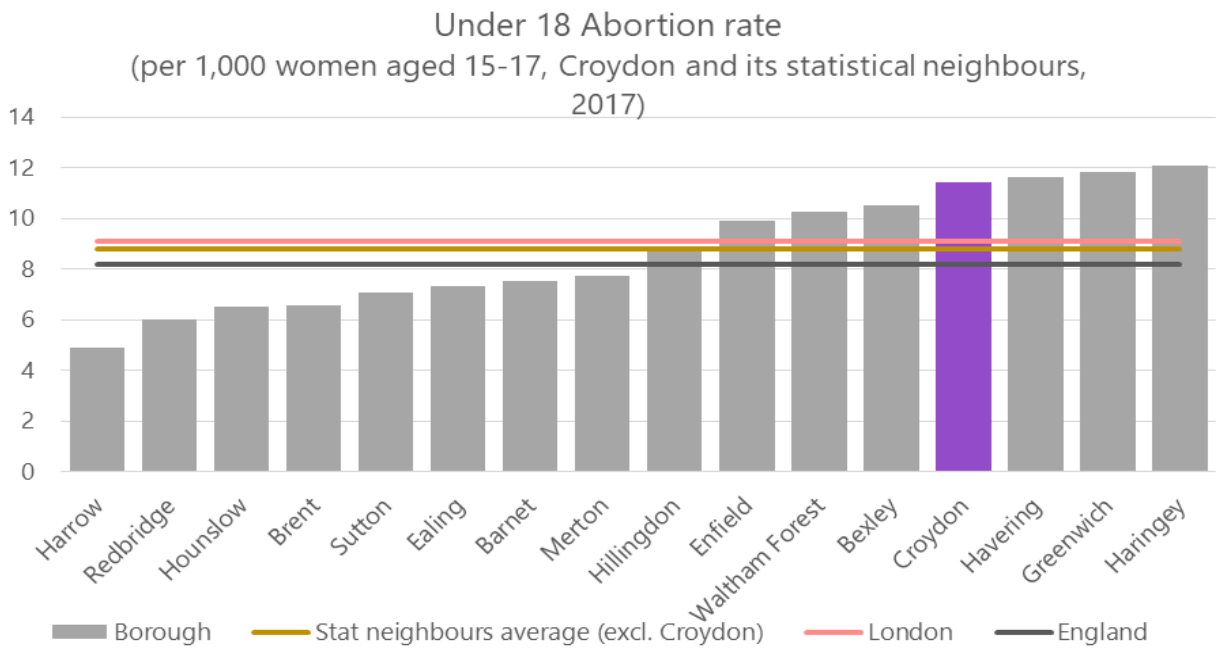
[49] ONS. *Conception Statistics*; 2016

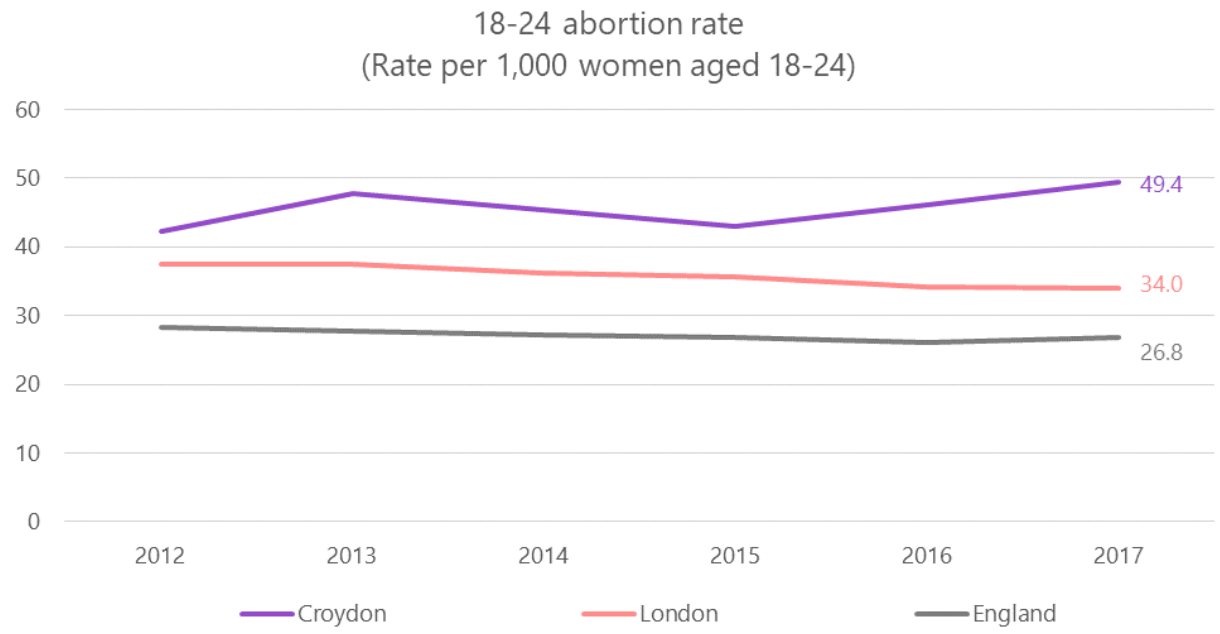


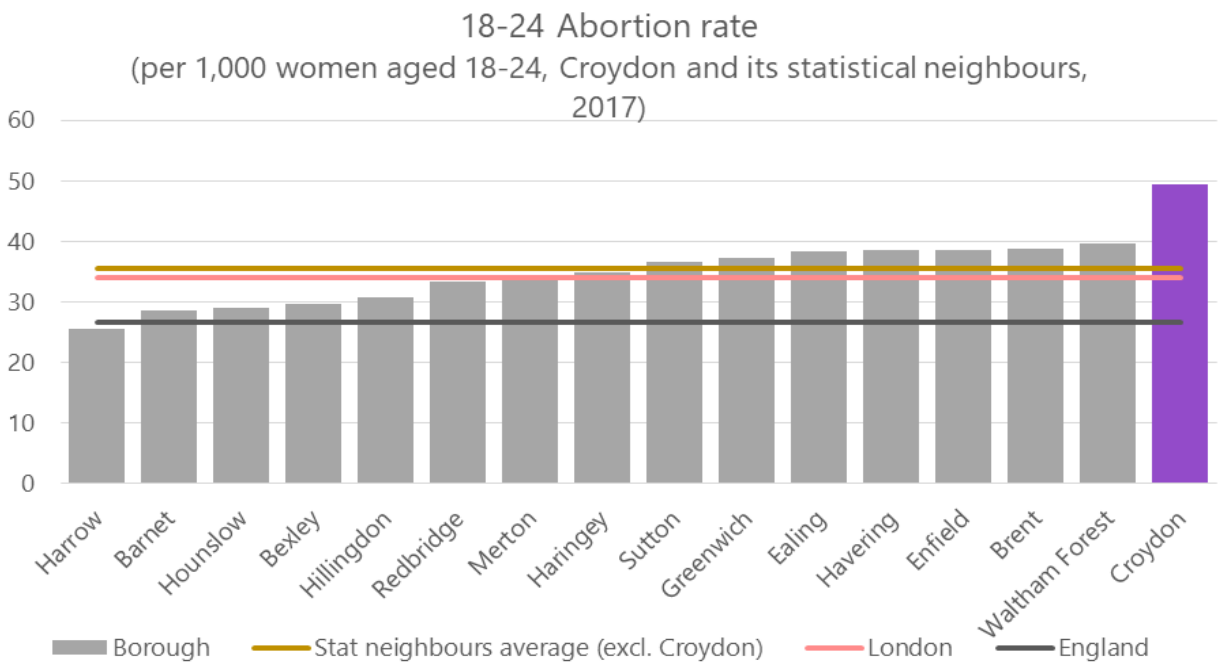
Croydon has a higher abortion rate than both London and England and this is apparent across all age groups. While more teenage conceptions result in a termination, around 60% of all abortions to Croydon residents in any given year are provided to women aged 25 and over.[50]

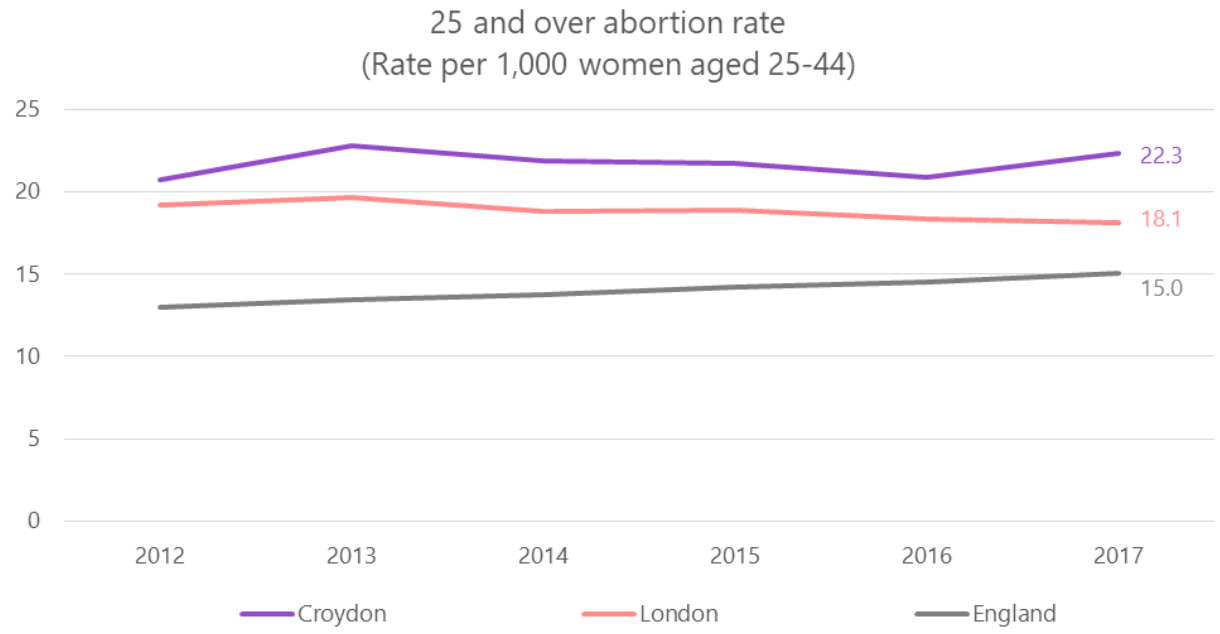


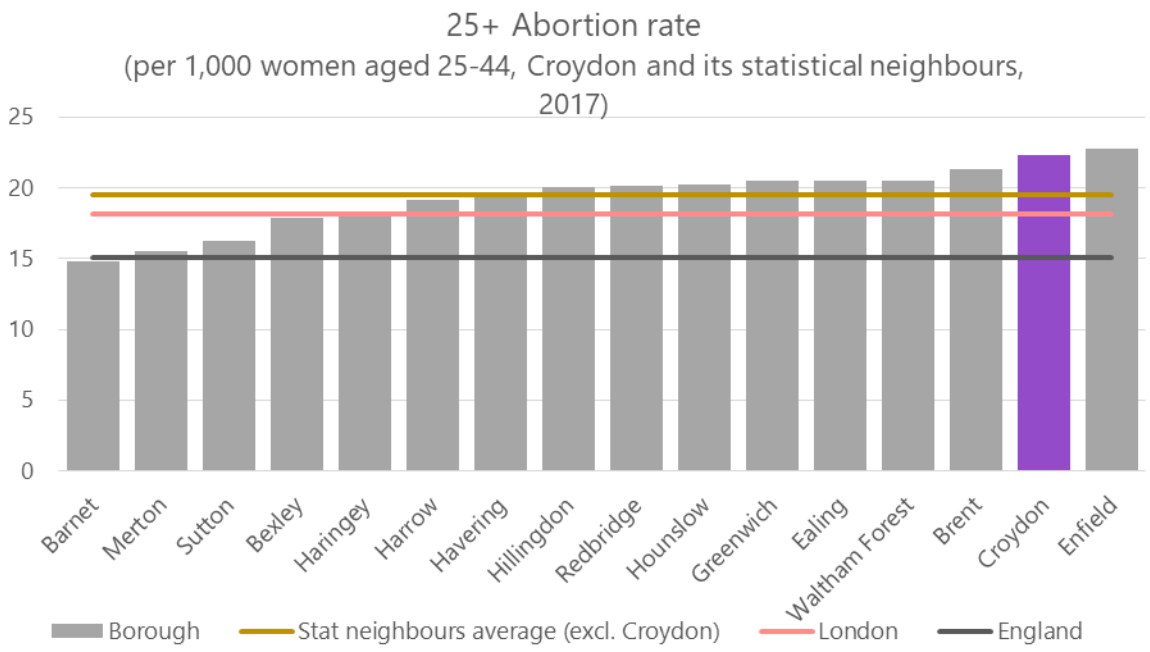
[50] Department of Health. *Abortion Statistics for England and Wales*; 2017


Under 18 Abortion rate
(per 1,000 women aged 15-17, Croydon and its statistical neighbours, 2017)
14
12
10
8
6
4
2
0
Harrow
Redbridge
Hounslow
Brent
Sutton
Ealing
Barnet
Merton
Hillingdon
Enfield
Waltham Forest
Bexley
Croydon
Havering
Greenwich
Haringey
Borough
Stat neighbours average (excl. Croydon)
London
England

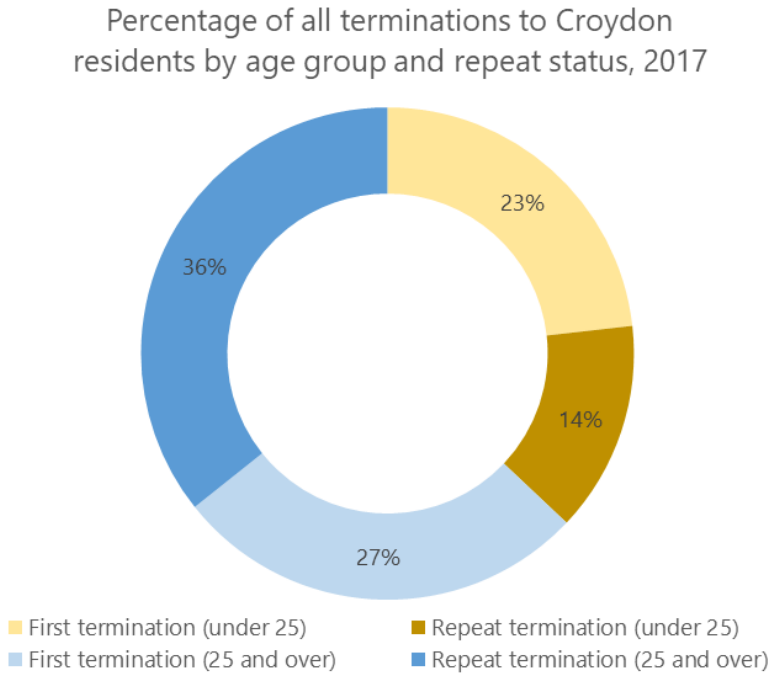

18-24 abortion rate
(Rate per 1,000 women aged 18-24)
60
50
40
30
20
10
0
2012
2013
2014
2015
2016
2017
49.4
34.0
26.8
Croydon
London
England


18-24 Abortion rate
(per 1,000 women aged 18-24, Croydon and its statistical neighbours, 2017)
60
50
40
30
20
10
0
Harrow
Barnet
Hounslow
Bexley
Hillingdon
Redbridge
Merton
Haringey
Sutton
Greenwich
Ealing
Havering
Enfield
Brent
Waltham Forest
Croydon
Borough
Stat neighbours average (excl. Croydon)
London
England

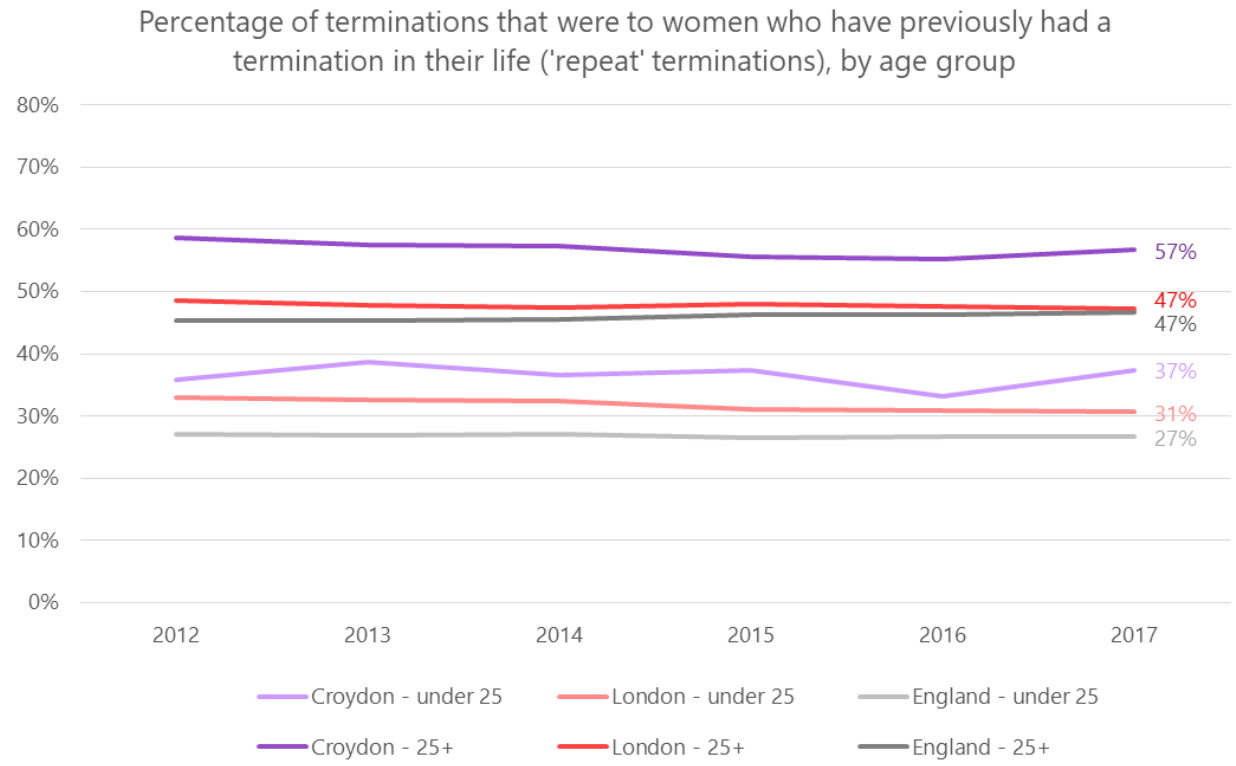

25 and over abortion rate
(Rate per 1,000 women aged 25-44)
25
20
15
10
5
0
2012
2013
2014
2015
2016
2017
22.3
18.1
15.0
Croydon
London
England

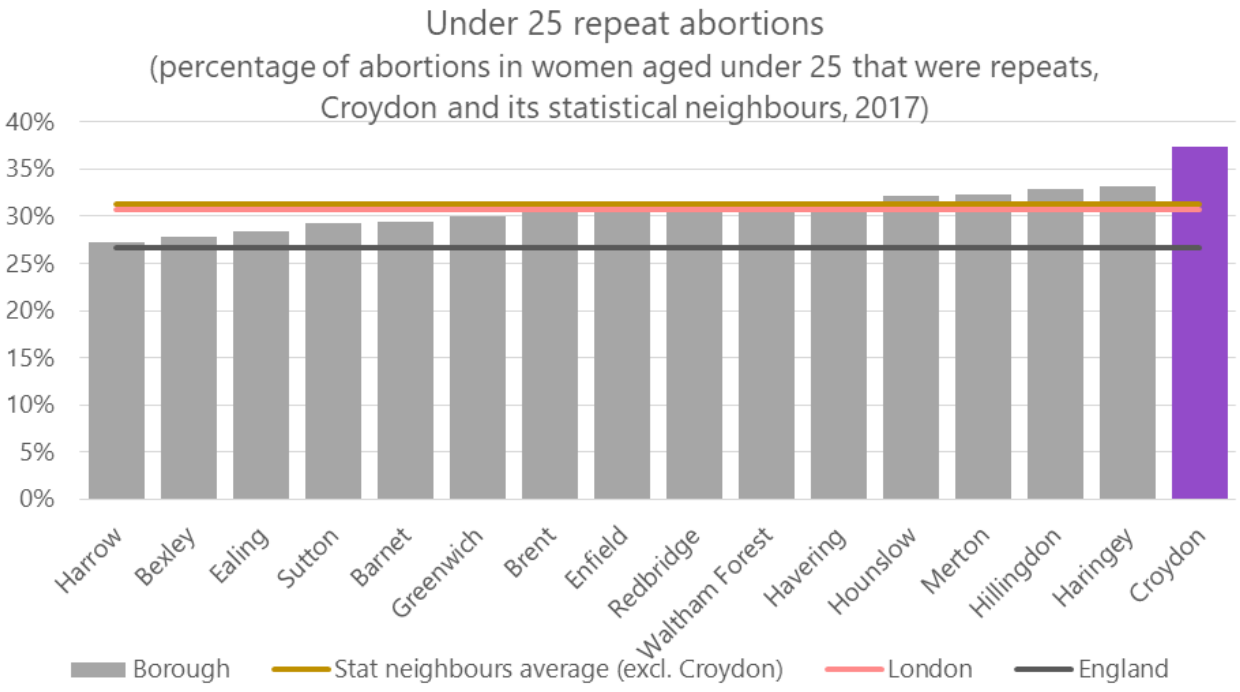


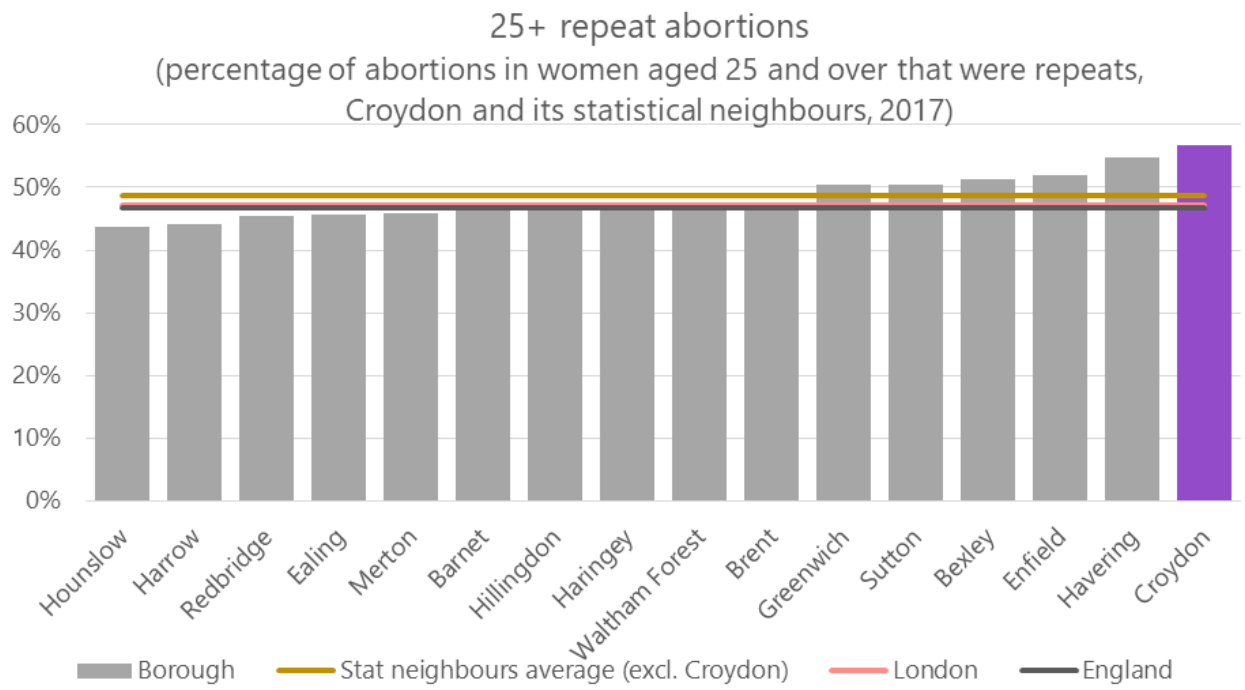
In Croydon, those aged 25 or over account for the majority of women having terminations and more than half of these terminations are provided to women who have previously had a termination before in their life. Approximately a third of all terminations in any given year are to women in this age group who have previously had a termination. **Croydon has a higher proportion of repeat terminations than London and England in both the under 25 and 25 and over age groups**.[51]



[51] Department of Health. *Abortion Statistics for England and Wales*; 2017


Percentage of terminations that were to women who have previously had a termination in their life ('repeat' terminations), by age group
80%
70%
60%
50%
40%
30%
20%
10%
0%
2012
2013
2014
2015
2016
2017
57%
47%
47%
37%
31%
27%
Croydon - under 25
London - under 25
England - under 25
Croydon - 25+
London - 25+
England - 25+


Under 25 repeat abortions
(percentage of abortions in women aged under 25 that were repeats, Croydon and its statistical neighbours, 2017)
40%
35%
30%
25%
20%
15%
10%
5%
0%
Harrow
Bexley
Ealing
Sutton
Barnet
Greenwich
Brent
Enfield
Redbridge
Waltham Forest
Havering
Hounslow
Merton
Hillingdon
Haringey
Croydon
Borough
Stat neighbours average (excl. Croydon)
London
England



3.4 Available services

Croydon residents choosing to terminate a pregnancy can do so at whichever service they choose, although Croydon commissions Marie Stopes International for pregnancy termination services.

Commissioned Service	Contraception Provision
General Practitioners	Provide pregnancy tests for women who believe they may be pregnant.
Pharmacies	ESHPs provide free pregnancy tests for women up to the age of 21.
Croydon Health Services	Provide pregnancy tests for women who believe they may be pregnant. Health Visiting Team and Family Nurse Partnership provide support for mothers.
Croydon University Hospital	Provide pregnancy tests and have specific team of midwives for teenage mothers.
Marie Stopes International	Provide terminations of pregnancy and counselling around this

3.5 Recommendations

- Aim to reduce overall termination rates to a locally set target.

- Ensure pathways are in place after abortion to ensure women are able to access contraception, and referred for LARC as appropriate.
- Optimise RSE in school settings, colleges and alternative education providers.
- Ensure *You're Welcome standards* are maintained across young people's services.
- Provide more intensive RSE and contraceptive support to young people at greater risk. This may be by identifying schools with higher levels of deprivation in students (free school meal eligibility, persistent school absence), services for looked after children and care leavers, LGBTQ+ youth groups, young women who are already mothers.
- Deliver the recommendations that arise from the Young Person's Sexual Health event in March 2018.

4 Sexually Transmitted Infections

Sexually transmitted infections (STIs) are transmitted through sexual contact, such as vaginal, anal or oral sex, with an infected partner. Infections can cause symptoms, or be asymptomatic, and those infected are at increased risk of HIV, certain types of cancer, infertility and mother-to-child transmission can result in neonatal mortality or significant congenital morbidity.

4.1 Best practice

NICE has issued two guidelines on STIs (excluding HIV), looking into prevention of STIs, and condom distribution schemes, which include ensuring services are appropriately in place to provide testing, treatment and partner follow-up, with appropriate referral pathways, staff training and governance in place. Recommendations for more specific target populations include to:

- Ensure individuals at **higher risk of STIs are identified from their history**[52].
- After an STI diagnosis:
  - Support patients in **partner notification, testing and treatment** when necessary
  - Provide patients and partners **with infection-specific information, advice on avoiding re-infection, chlamydia**, and consider providing **home sampling kits**
- For vulnerable young people under 18 (e.g. from disadvantaged backgrounds, in or leaving care, or with low educational attainment):
  - **provide one to one sexual health advice** on preventing STIs, all methods of contraception, and other reproductive issues and concerns.
  - If pregnant or already mothers, discuss the above with **appropriate referrals to other agencies**, and which more specifically can be delivered by midwives and health visitors.

[52] Men who have sex with men, people who have come from or who have visited areas of high HIV prevalence, and those with history of alcohol of substance misuse, early onset of sexual activity, unprotected sex and frequent change of and/or multiple sexual partners.

The *National Chlamydia Screening Programme*, launched in 2003, aims to opportunistically test all sexually active people under the age of 25 annually, or with each change of sexual partner (whichever is more frequent) in primary care and sexual health consultations, or through self-sampling kits ordered online or through specialist services. Early diagnosis of chlamydia reduces the duration of infection, risk of complications and risk of spread to others.

Emerging STIs, antibiotic resistance and changing sexual practices

As recently as July 2018, British Association for Sexual Health and HIV (BASHH) released a draft guidance on mycoplasma genitalium[53]. There is an estimated prevalence of 1-2% in the UK population, and 4-38% in those attending STI clinics. Of particular concern is the resistance found to the antibiotic treatment azithromycin, estimated at 30-40% in the UK[54]. Similarly the reporting in 2018 of the first globally reported case of multi-drug resistance gonorrhoea has also caused concern, particularly due to previous outbreaks of drug-resistant strains of gonorrhoea in the UK[55]. As a result, effective partner notification, three-month testing and appropriate prescribing[56] are vital to reducing resistance.

The rise in availability of pre-exposure prophylaxis (PrEP) has had a dramatic effect on HIV transmission rates[57], however concerns exist as to whether this may encourage a drop in condom use, and therefore increase risk of other STI transmissions. Therefore discouraging high risk behaviour and continuing to emphasise the important role of barrier protection is key to ongoing prevention of STIs[58].

4.2 STI Testing in Croydon – Facts, Figures and Trends

Within Croydon, the proportion of **the 15-24 year old population screened for chlamydia has fallen slightly in recent years**, and was significantly **lower than the London average** in 2017. This fall in testing may be responsible for the very small drop in the proportion diagnosed.[59]

[53] BASHH. *2018 BASHH UK national guideline for the 2 management of infection with Mycoplasma genitalium*; 2018.

[54] NHS. *New guidelines issued on the 'STI most people have never heard of';* 2018.

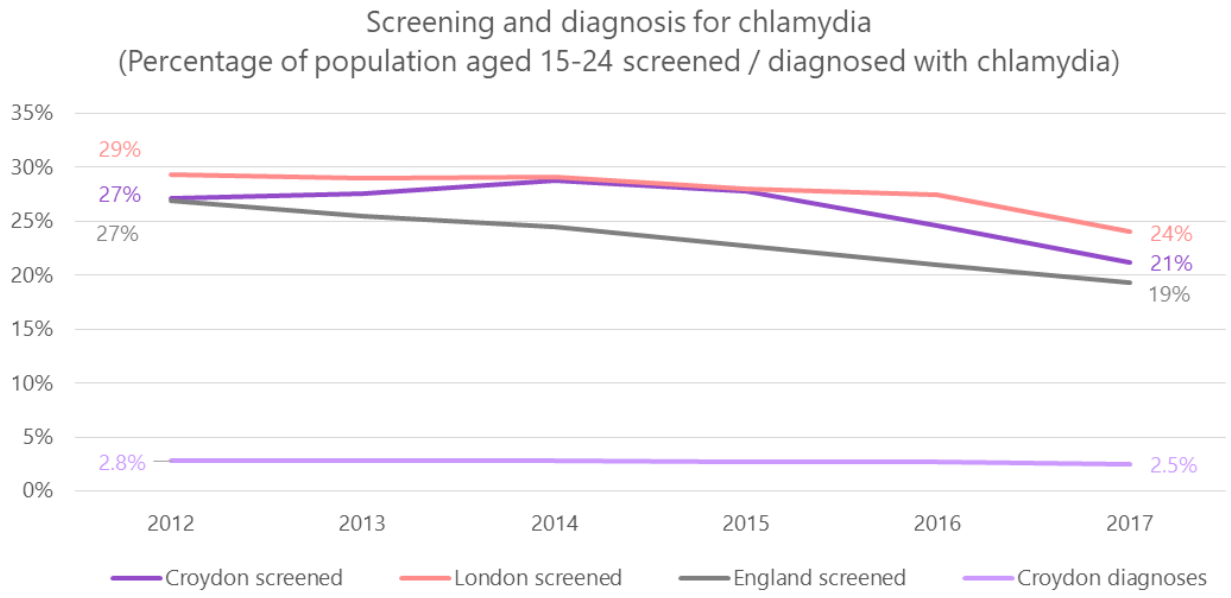
[55] BASHH. *Emergence Of Multi-Drug Resistant Gonorrhoea Highlights Urgent Need For Reversal Of Sexual Health Cuts*; 2018.

[56] BMJ Sexually Transmitted Infections. *Which azithromycin regimen should be used for treating Mycoplasma genitalium? A meta-analysis*; 2017.

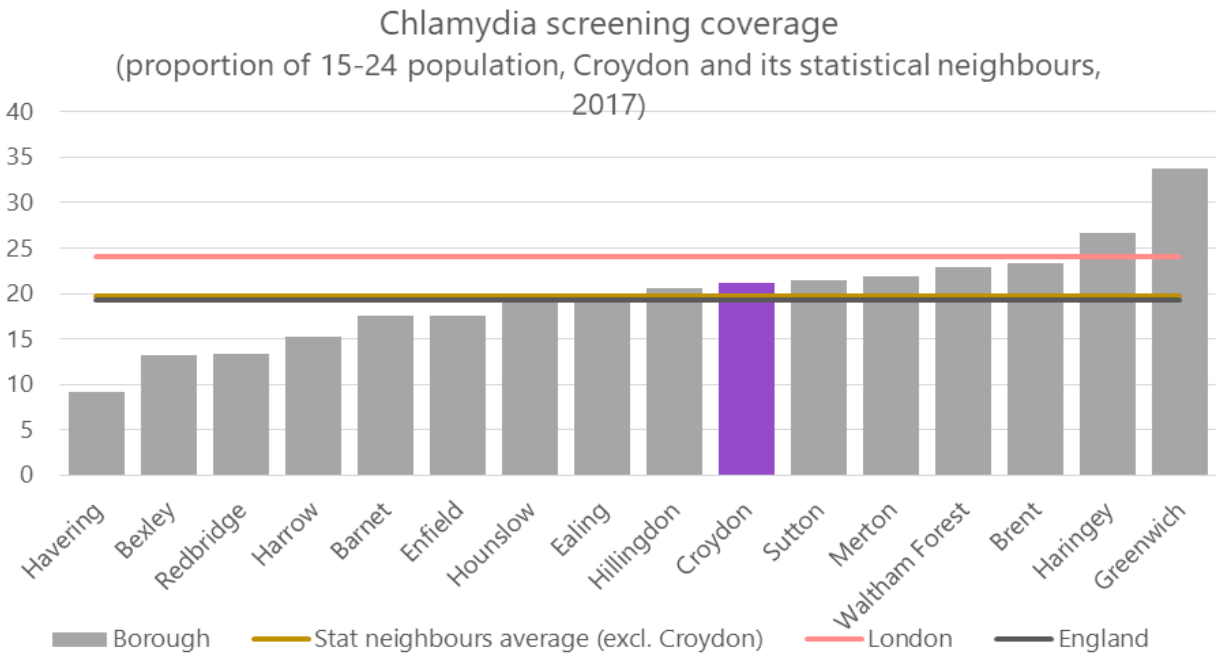
[57] New Scientist. *Massive drop in London HIV rates may be due to internet drugs;* 2017.

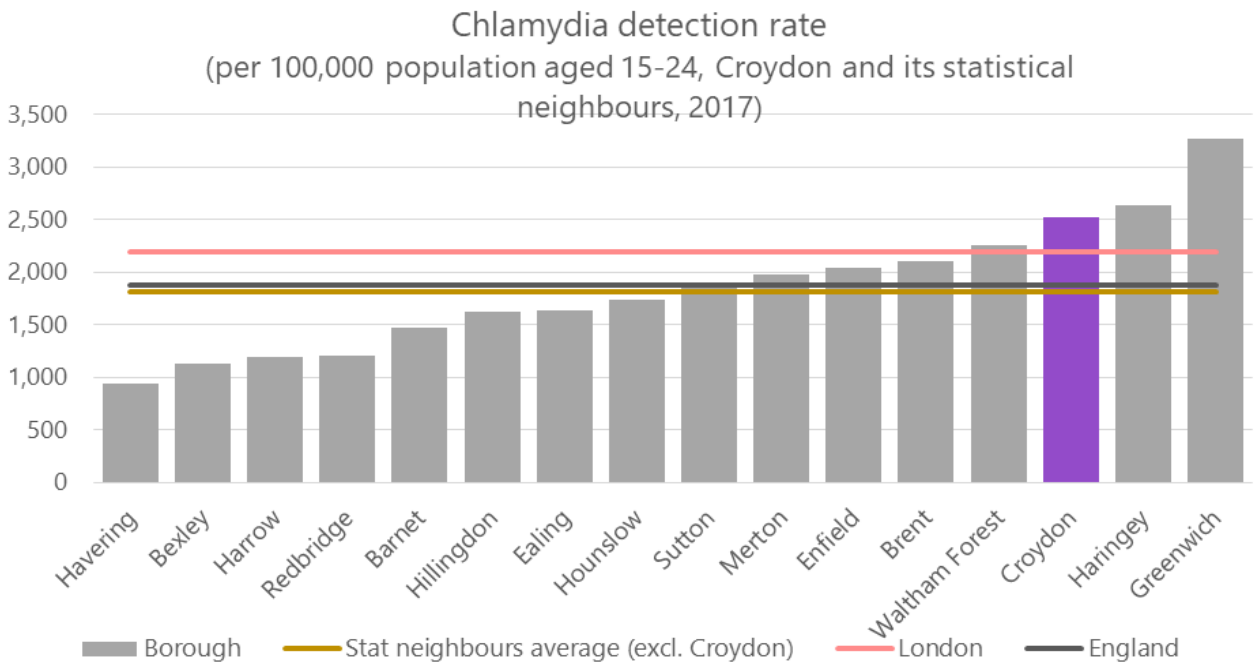
[58] NAT. *Should We Worry About The Effect Of Prep On STI Rates?;* 2017.

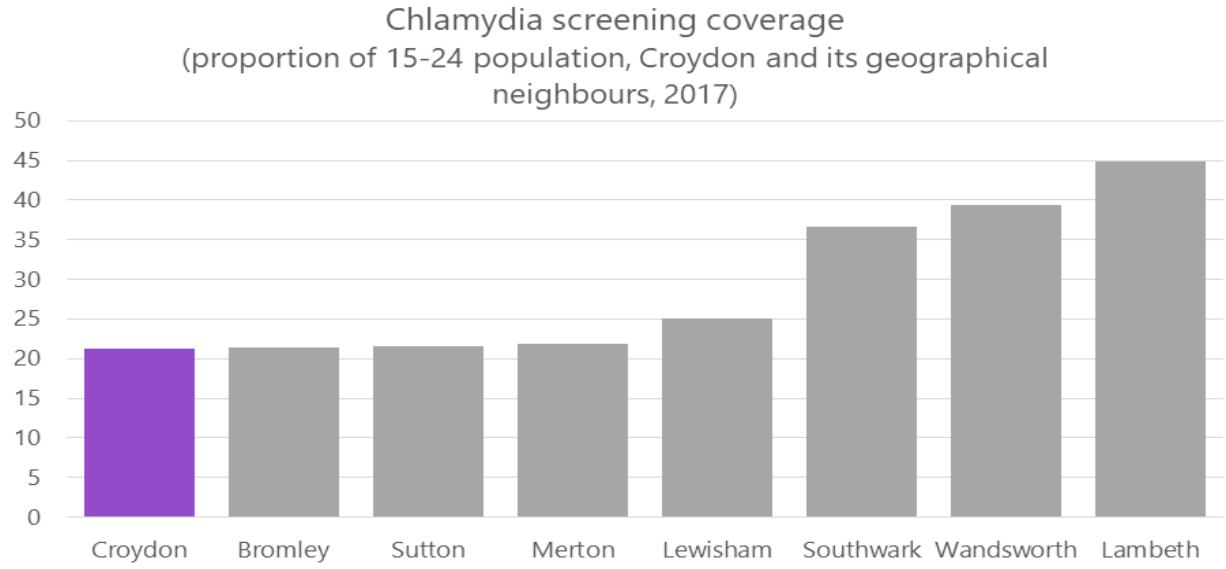
[59] GUMCADv2 and CTAD, taken from *Public Health England Sexual and Reproductive Health Profiles*. Coverage data represent the number of tests reported, and not the number of people tested. Figures represent tests and diagnoses among people attending specialist and non-specialist sexual health services in England.

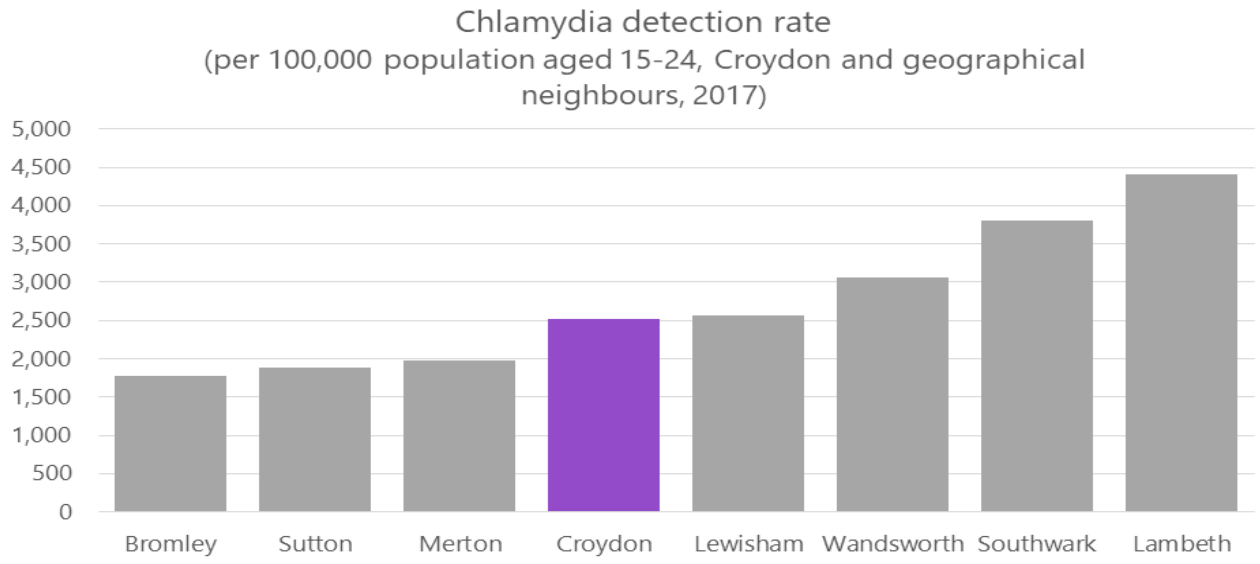


This screening coverage is **comparable** to statistical neighbours, with a **better than average detection rate**; however, coverage falls considerably when compared to Croydon's South London neighbours.

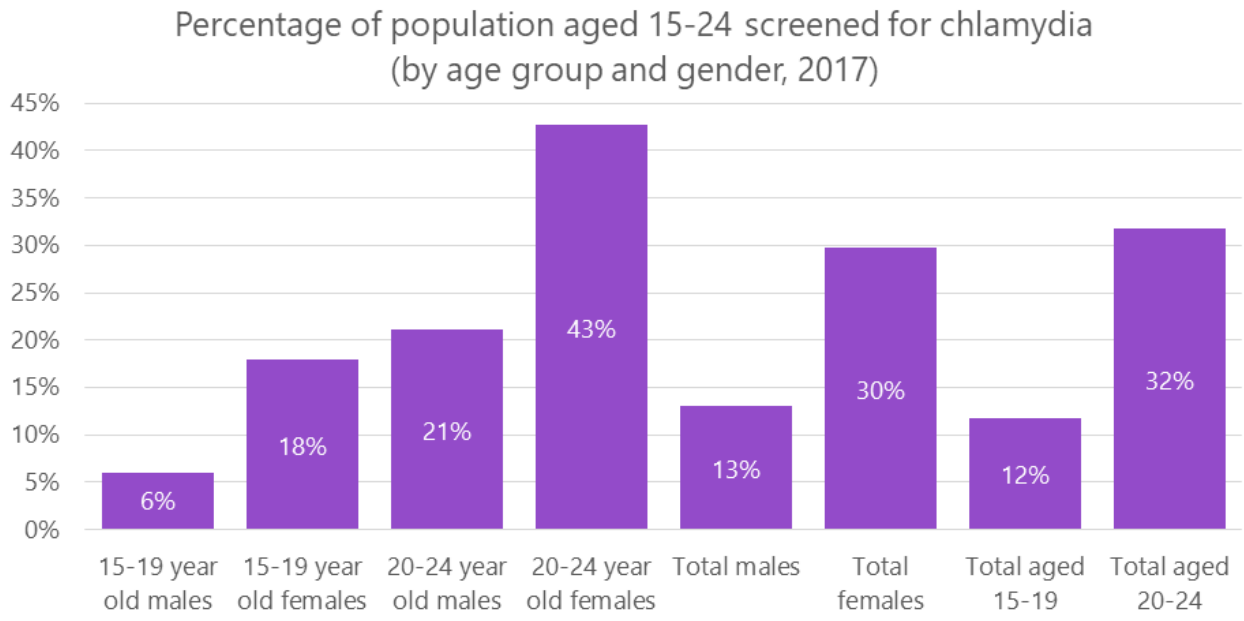



Chlamydia detection rate
(per 100,000 population aged 15-24, Croydon and its statistical neighbours, 2017)
3,500
3,000
2,500
2,000
1,500
1,000
500
0
Havering
Bexley
Harrow
Redbridge
Barnet
Hillingdon
Ealing
Hounslow
Sutton
Merton
Enfield
Brent
Waltham Forest
Croydon
Haringey
Greenwich
Borough
Stat neighbours average (excl. Croydon)
London
England


Chlamydia screening coverage
(proportion of 15-24 population, Croydon and its geographical neighbours, 2017)
50
45
40
35
30
25
20
15
10
5
0
Croydon
Bromley
Sutton
Merton
Lewisham
Southwark
Wandsworth
Lambeth



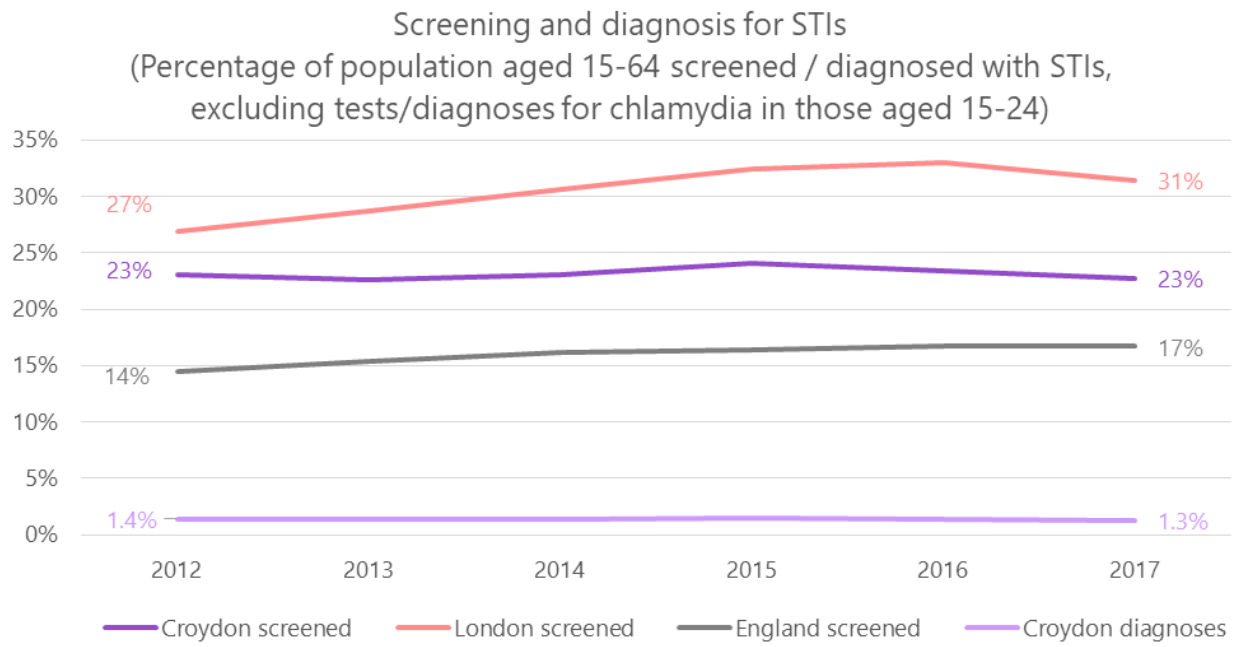
Chlamydia screening coverage of Croydon residents in 2017 was **higher among older ages (20-24) and females**.



12% of all tests to Croydon residents aged 15-24 resulted in a positive diagnosis of chlamydia, a small increase from previous years. The **younger ages (15-19) had higher positivity rates**, with approximately 15% of tests resulting in a positive diagnosis compared to 10% of tests in the 20-24 age group and 5% of tests in those aged 25 and over.[60]

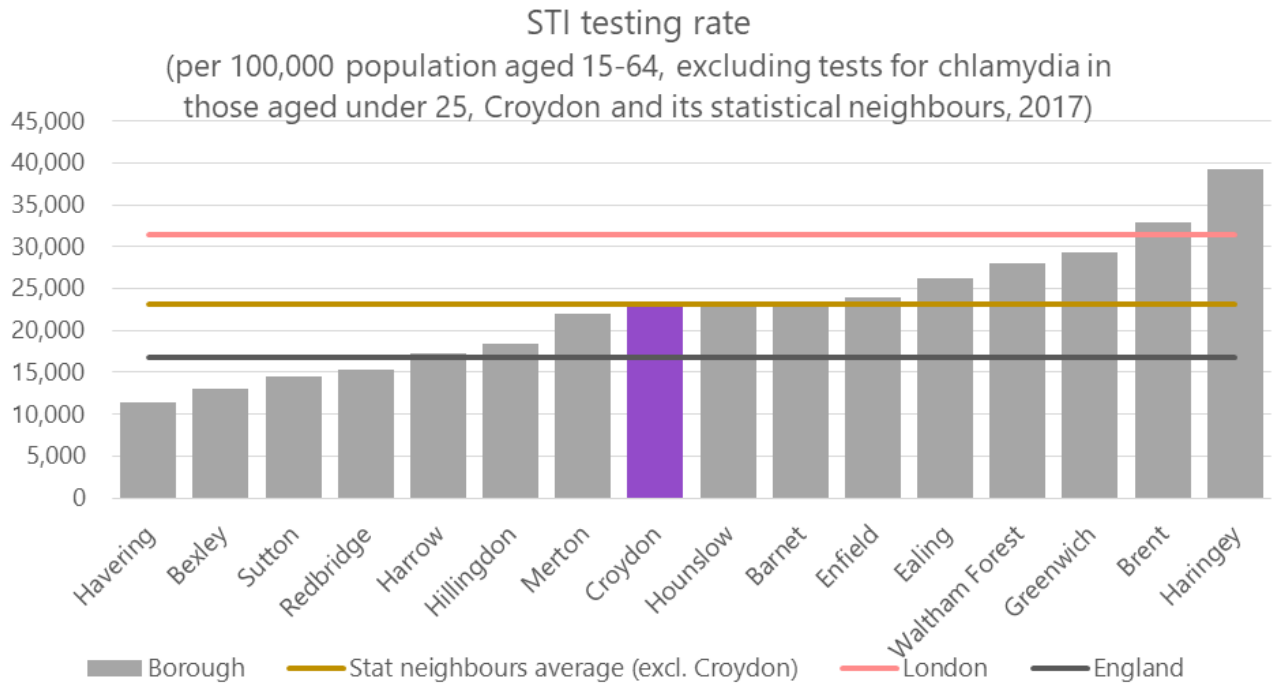
[60] CTAD, taken from *HIV & STI Web Portal* (restricted access only).

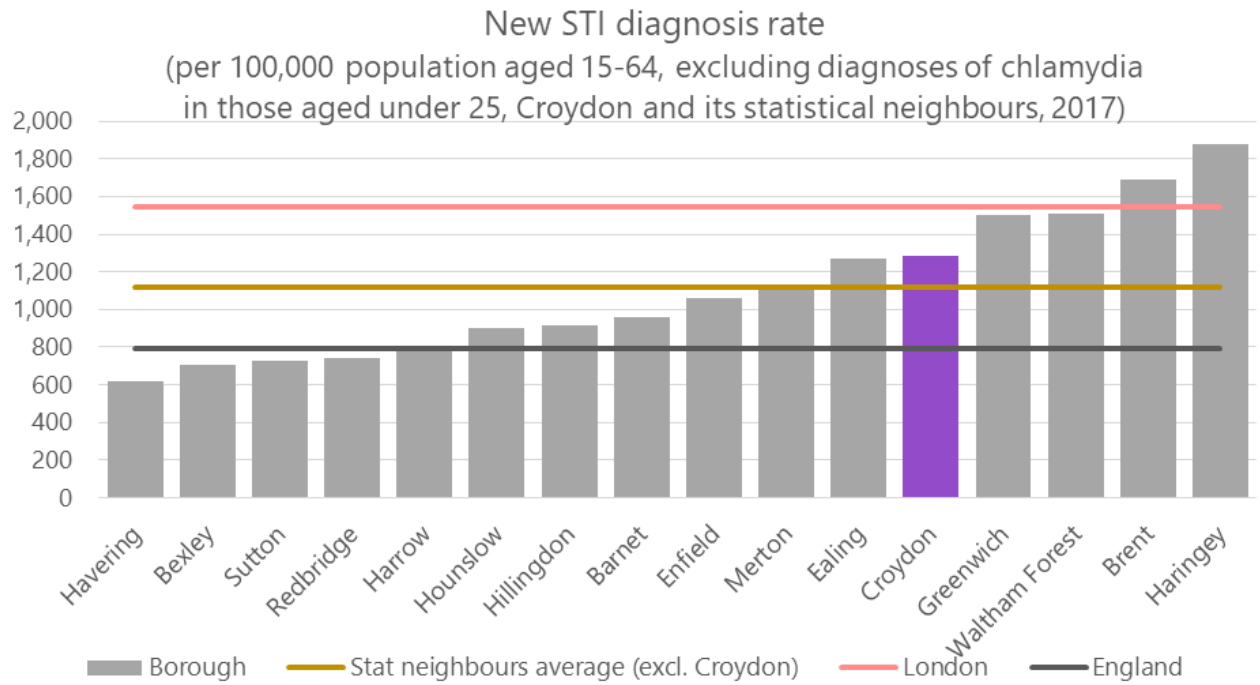
Aside from the NCSP, sexual health screens for STIs have remained fairly consistent over the past five years with **23% of the resident population being screened**. Similarly, the proportion diagnosed has remained consistent. For both indicators, Croydon is **lower than the wider London region and higher than England**.[61]

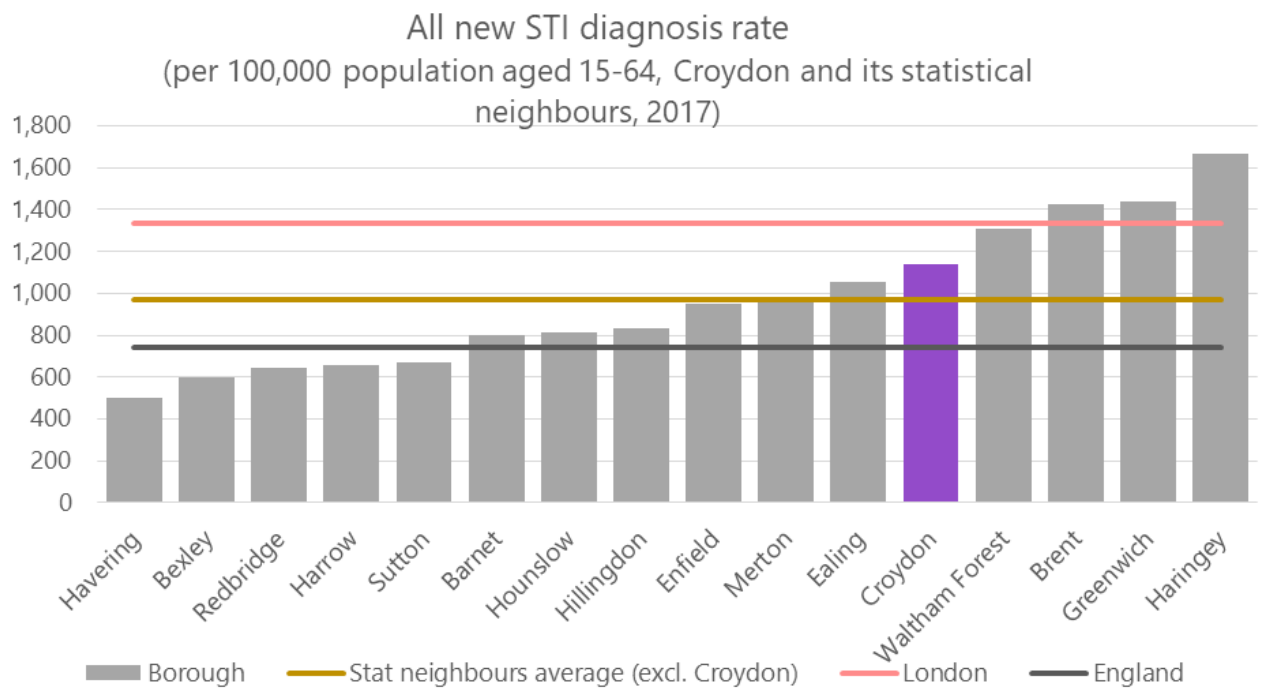


In 2017, **5.6%** of all tests to Croydon residents resulted in a positive diagnosis of an STI, **higher than the positivity rate in London (4.9%) and England (4.7%)**. These figures exclude tests for chlamydia in those aged 15-24.[62] In comparison to the statistical neighbours, Croydon is slightly below average in its testing rate, while above average in its new STI diagnoses rate.

[61] GUMCADv2 and CTAD, taken from *Public Health England Sexual and Reproductive Health Profiles*. Coverage data represent the number of tests reported, and not the number of people tested. Figures represent tests and diagnoses among people attending specialist and non-specialist sexual health services in England.
[62] GUMCADv2 and CTAD, taken from *Public Health England Sexual and Reproductive Health Profiles*. Figures represent diagnoses among people attending specialist and non-specialist sexual health services in England.


STI testing rate
(per 100,000 population aged 15-64, excluding tests for chlamydia in those aged under 25, Croydon and its statistical neighbours, 2017)
45,000
40,000
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
Havering
Bexley
Sutton
Redbridge
Harrow
Hillingdon
Merton
Croydon
Hounslow
Barnet
Enfield
Ealing
Waltham Forest
Greenwich
Brent
Haringey
Borough
Stat neighbours average (excl. Croydon)
London
England


New STI diagnosis rate
(per 100,000 population aged 15-64, excluding diagnoses of chlamydia in those aged under 25, Croydon and its statistical neighbours, 2017)
2,000
1,800
1,600
1,400
1,200
1,000
800
600
400
200
0
Havering
Bexley
Sutton
Redbridge
Harrow
Hounslow
Hillingdon
Barnet
Enfield
Merton
Ealing
Croydon
Greenwich
Waltham Forest
Brent
Haringey
Borough
Stat neighbours average (excl. Croydon)
London
England

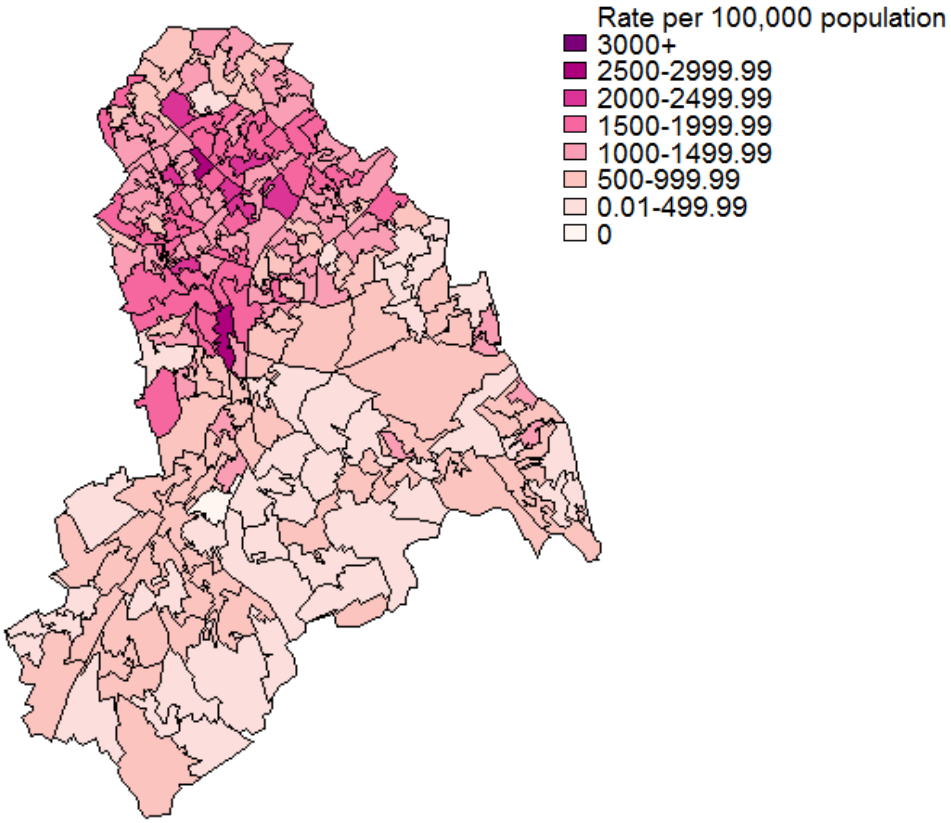


Incidence

In 2017, the rate of new STI diagnoses in Croydon was **1,136 per 100,000 population** (all ages). This is **lower than the rate seen across London (1,335 per 100,000) and higher than the rate across England (743 per 100,000)**.[63] This rate is variable across the lower super output areas (LSOAs) of Croydon.[64]

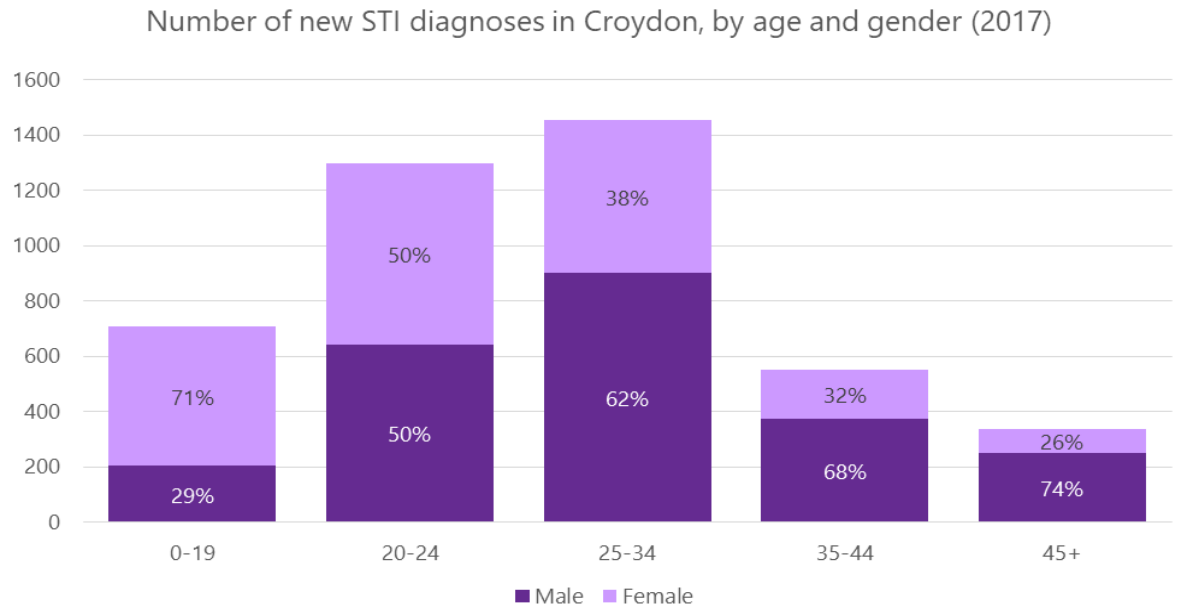
[63] Genitourinary Medicine Clinic Activity Dataset (GUMCADv2) and Chlamydia Testing Activity Dataset (CTAD) taken from *Public Health England Sexual and Reproductive Health Profiles*. Figures represent diagnoses among people accessing specialist and non-specialist sexual health services in England.

[64] GUMCADv2 and CTAD. Detailed in LASER taken from *HIV & STI Web Portal* (restricted access only).



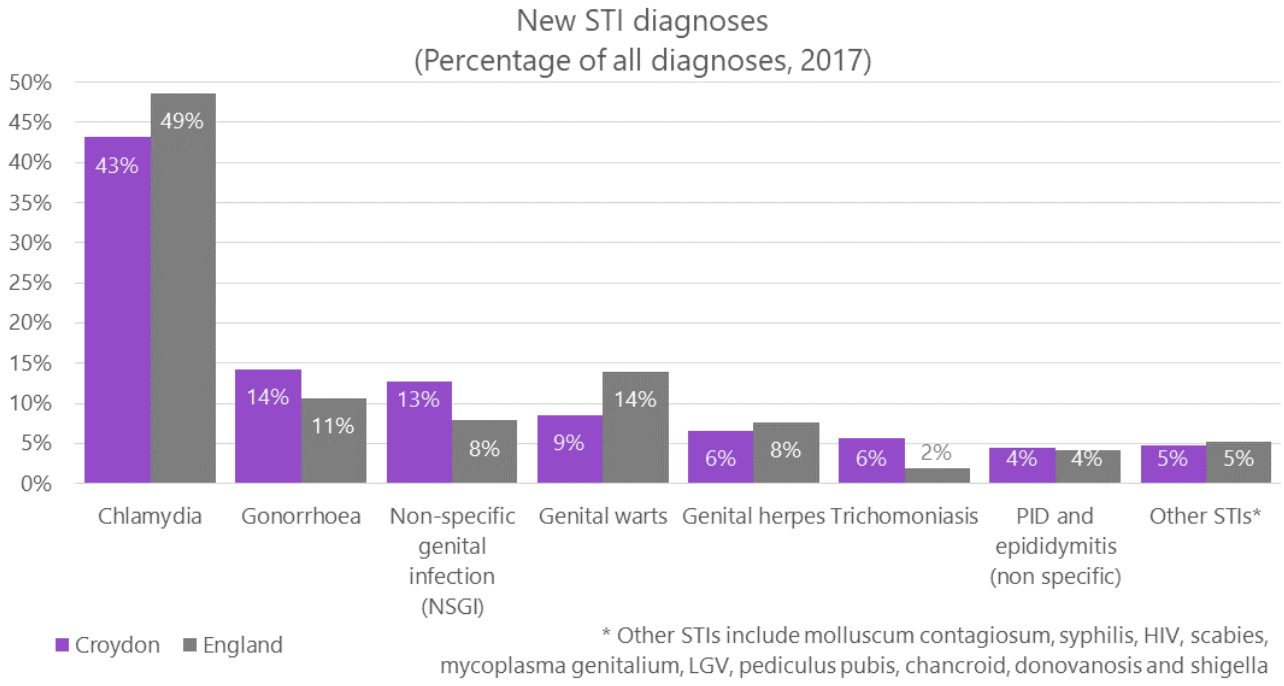
Map of 2016 LASER data

In 2017, the **majority of new diagnoses were in those aged 25-34**. Females were more proportionately represented in the younger age groups compared to males, with **71% of all diagnoses in females aged 0-19** compared to just 26% of all diagnoses in those aged 45 and over.[65]

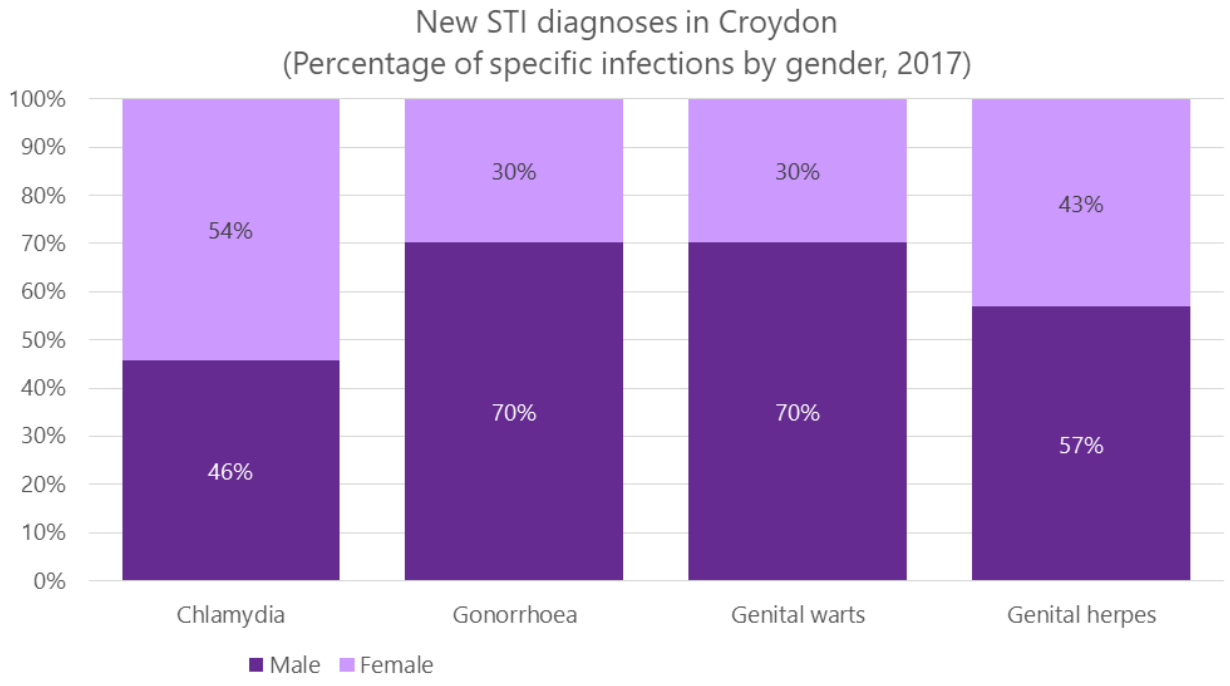


[65] GUMCADv2 and CTAD, taken from *HIV & STI Web Portal* (restricted access only).

The most common diagnoses in Croydon in 2017 were of **chlamydia**, making up **43%** of all diagnoses in the borough. The next most common diagnoses were of gonorrhoea and non-specific genital infection.[66]



Looking at only the five most common STIs in Croydon in 2017, **two thirds of all genital herpes diagnoses are in females** while **two thirds of all gonorrhoea diagnoses are in males**.



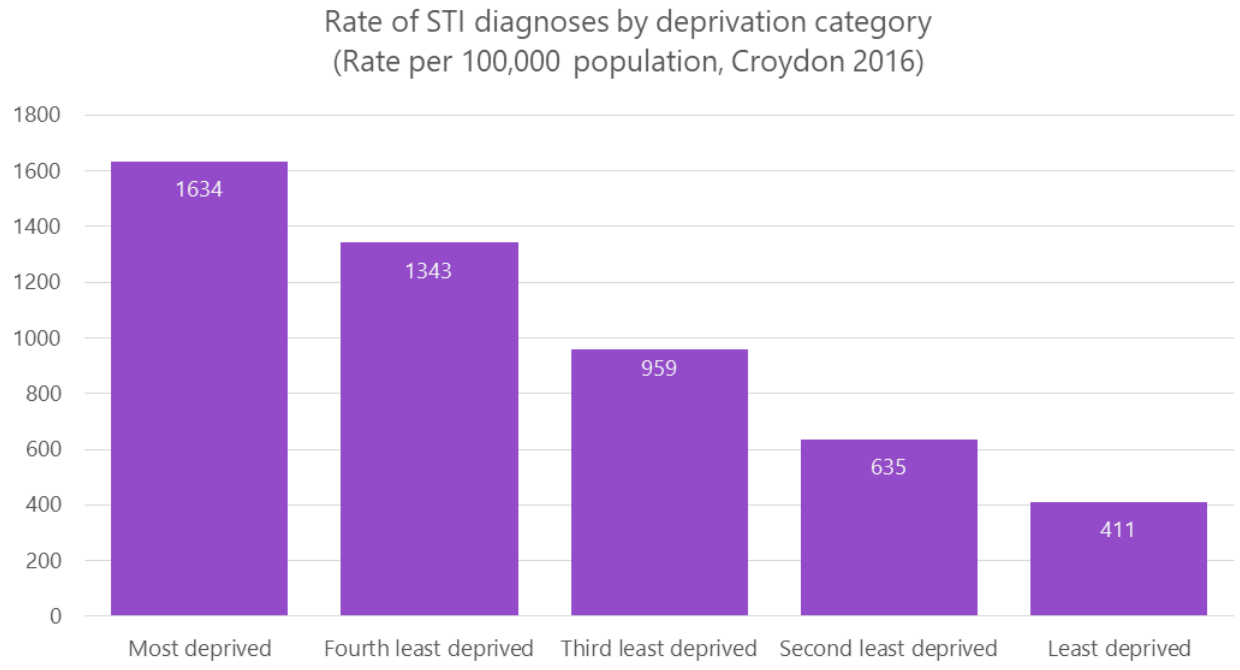
[66] GUMCADv2 and CTAD, taken from *HIV & STI Web Portal* (restricted access only).

Reinfection with an STI is a marker of persistent risky behaviour. In Croydon, an estimated **9.6% of women and 12.9% of men presenting with a new STI at a sexual health service during the five year period from 2012 to 2016 became re-infected with a new STI within 12 months**. These rates are higher than those seen nationally where 7.0% of women and 9.4% of men were re-infected in the same time period.[67]

Prevention groups

Young people (aged 15-24) experience high rates of new STIs and are also more likely to become re-infected with STIs, contributing to infection persistence and health service workload. In Croydon in 2016, **46%** of all new STIs were diagnosed in people in this age group. An estimated **19% of 15-19 year old women** and **18% of 15-19 year old men** presenting with a new STI at a sexual health service during the 5 year period from 2012 to 2016, became **re-infected with an STI within 12 months**.[68]

Socio-economic deprivation (SED) is a known determinant of poor health outcomes and data from sexual health services show a strong positive correlation between rates of new STIs and the index of multiple deprivation across England. The relationship between STIs and SED is probably influenced by a range of factors such as the provision of and access to health services, education, health awareness, health-care seeking behaviour and sexual behaviour. This positive correlation seen nationally can also be seen across Croydon.[69]



[67] GUMCADv2 and CTAD, taken from *HIV & STI Web Portal* (restricted access only).
[68] GUMCADv2 and CTAD, taken from *HIV & STI Web Portal* (restricted access only).
[69] GUMCADv2 and CTAD and 2015 Index of Multiple Deprivation (IMD) scores. Detailed in LASER taken from *HIV & STI Web Portal* (restricted access only).

4.3 Available services

Commissioned Service	STI Screening Provision
General Practitioners	Commissioned to provide free screening for chlamydia and gonorrhoea for under 15s as part of the NCSP
Pharmacies	ESHPs provide free screening for chlamydia for those under the age of 25 as do some other specific non-enhanced pharmacies, but not all
Croydon Health Services	Provide screening for all STIs and all ages
Croydon University Hospital	Maternity unit provides routine, opt-out free syphilis testing for pregnant women
Croydon Homeless Health	Provide free screening for chlamydia and gonorrhoea for under 25s
Marie Stopes International	Provide free screening for chlamydia and gonorrhoea
Online services	Free chlamydia and gonorrhoea screening tests can be ordered from Preventx via the freetest.me website for under 25s

4.4 Recommendations

- Increase awareness of STIs, reducing risk of transmission, and how to access testing and treatment in the Croydon population.
    - Cross-promote programmes and campaigns across services, using the Making Every Contact Count approach e.g. cross-promotion of chlamydia testing in the C-Card scheme to maximise the reach of commissioned services.
    - Promote information and signposting in non-healthcare settings e.g. nightclubs, and adjacent services such as drug and substance misuse services, the Homeless Health team, and voluntary organisations.
    - Regular updates to staff in above settings' services to ensure they can appropriately refer people seeking testing and treatment.

- Increase awareness of STIs, reducing risk of transmission, and how to access testing and treatment in high-risk groups.
    - Target promotion and information giving in youth services such as schools, colleges, youth groups and outreach centres.
    - Consider use of pop-up clinics in college settings (these would not have to be very frequently) to encourage opportunistic testing, and reduce barriers to testing and attendance.
    - Consider how peer engagement and influence can be better used to highlight regular testing.

- Relationship building and outreach to parents and carers of high-risk groups, to encourage positive attitudes to sexual health, and responsible testing.
- Consider promotion using milestones and change in circumstances e.g. starting college, registering with a new GP, changing partners as opportunities to get tested.
- Target socio-economically deprived populations through local primary care services, but also linked services, such as drug and alcohol, social care, housing, maternity services and children's services.
- Target high risk individuals via online dating and/or hook-up social media platforms.
- User engagement in high-risk groups to identify further points of potential intervention.
- User engagement with men to also identify barriers to screening and testing.

- Increase screening for all STIs according to locally set targets, for example, closer to the London average.

- Identification and follow-up of high-risk individuals, with partner notification, testing and treatment, advice on avoiding re-infection and three-month follow-up.
  - Up-to-date training for GP practices, and other services such as A&E and mental health services, on identifying high-risk individuals from their history.
  - Clear recall process for three-month follow-up in services.
  - Recall processes that also signpost to other services to reduce barriers to follow-up.
  - Aim to reduce number of men and women presenting with re-infection within 12 month closer to the London average.

5 Human Immunodeficiency Virus

The human immunodeficiency virus (HIV) infects cells of the immune system, destroying or impairing their function of fighting infection and disease. This causes "opportunistic infections" to take advantage of the weakened immune system and cause associated illnesses. HIV can be transmitted sexually; by contaminated blood products via transfusions, contaminated needles or other sharp instruments; and 'vertically' from mother to child during pregnancy or childbirth or through breastfeeding[70].

Free and effective antiretroviral therapy (ART) in the UK has transformed HIV from a fatal infection into a chronic but manageable condition. People living with HIV in the UK can now expect to live into old age if diagnosed promptly, however, PHE estimated that in 2015, 13,500 or 13% of people living with HIV in the UK were still undiagnosed, providing considerable risk of onward transmission[71]. The same report also noted that the proportion undiagnosed was higher amongst populations considered to be at lower risk of HIV e.g.

[70] WHO. *HIV/AIDS*; 2017.
[71] PHE. *HIV in the UK: 2016 report*; 2016.

among non-black African heterosexual men and women, at 21%, indicating the continuing importance of universal testing and awareness raising.

5.1 Best Practice

People presenting with HIV at a late stage of infection has been highlighted as a Public Health Outcomes Framework (PHOF) indicator. Department of Health (DH) highlighted the importance of health promotion, supporting 'sustained behavioural change' and testing in non-specialist healthcare settings in areas and communities with high prevalence of HIV.

HIV Prevention England is a national HIV prevention programme in England, particularly working with black African and Men who have sex with men (MSM) communities to increase testing, support sustained condom use and to tackle stigma within communities and more widely.

NICE guidelines on testing include:

- **Targeting HIV testing** based on local prevalence for different areas and communities
- Offering and recommending testing for **anyone seeking STI testing** across services, or identified as **high-risk**
- Offering testing to anyone who **registers with a GP practice**, is **having a blood test and not had an HIV test in the last year**, or **opportunistically at consultations**, as appropriate
- **Testing in outreach and detached services**, such as pharmacies, voluntary sectors or venues where high-risk sexual behaviour may occur, if appropriate, with **those declining testing being made aware of self-sampling options**[72]

NICE's Quality Standards on HIV testing include:

- **Offer HIV testing routinely in hospitals** in areas of high or extremely high HIV prevalence which help to reduce stigma associated with HIV testing
- Offer HIV testing in primary or secondary care in those **newly diagnosed with an indicator condition**
- Young people and adults in at-risk groups who test negative for HIV are **advised that the test should be repeated at least annually**[73]

[72] NICE. *NG60 - HIV testing: increasing uptake among people who may have undiagnosed HIV*; 2016.
[73] NICE. *QS157 - HIV testing: encouraging uptake*; 2017.

Case Study: Increasing HIV testing with GP Registration

Offering HIV testing to anyone who registers with a GP practice has long been best practice in high-prevalence areas, nonetheless, it has proven difficult to implement.

However at a practice in Lewisham, uptake of HIV testing on registration improved significantly after changes were made to how it was offered. Rather than being signposted to a GP to be consented, instead, as part of the registration paperwork, a form was included that discussed routine screening of diabetes and HIV, described it was necessary due the make-up of the area, and asked for consent. A leaflet was provided on request on HIV testing, if there were any further questions, and practice staff that gave the forms at reception were comfortable with the process.

From 2013 to 2014, before the pilot started, HIV test on registration occurred in 1 out of 351 registrations.

In 2014-2015, this improved to 50 out of 359 registrations.

And in 2016 – 2017 HIV testing on registration uptake improved to 144/417.

Therefore a large proportion increase was seen in HIV testing on registration, with negligible additional workload on staff.

Data owned by Dr Emily Symington, GP.

PrEP

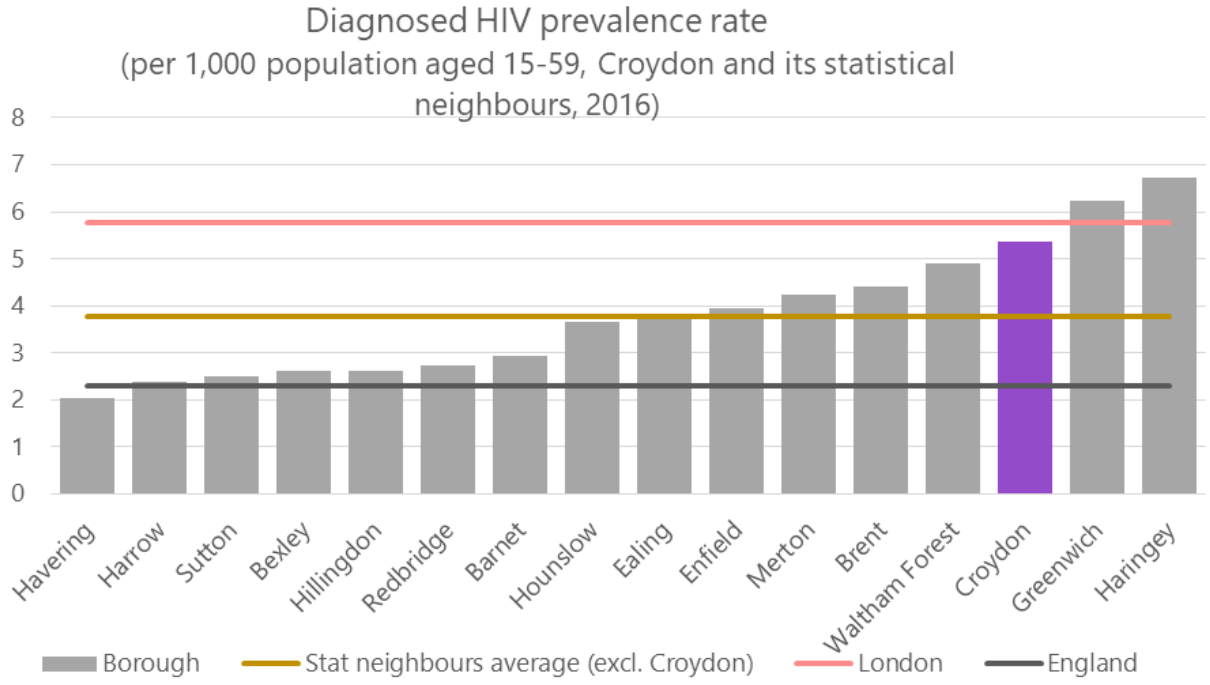
A large-scale study of pre-exposure prophylaxis (PrEP) is taking place in England (the PrEP IMPACT trial), of which Croydon University Hospital is one of the participating clinics. The high level of uptake of PrEP has meant that by June 2018 NHS England announced it was considering a proposal for a further 3,000 places to be made available on the trial. The trial is due to finish in 2020, however BASHH published a community statement in July 2018 advocating for the introduction of a national programme for PrEP as soon as possible. For it to be routinely available by April 2019, the statement advises NHS England and local authority commissioners would need to agree and disseminate as soon as possible a timetabled roadmap of the necessary decision-making process that would be needed[74].

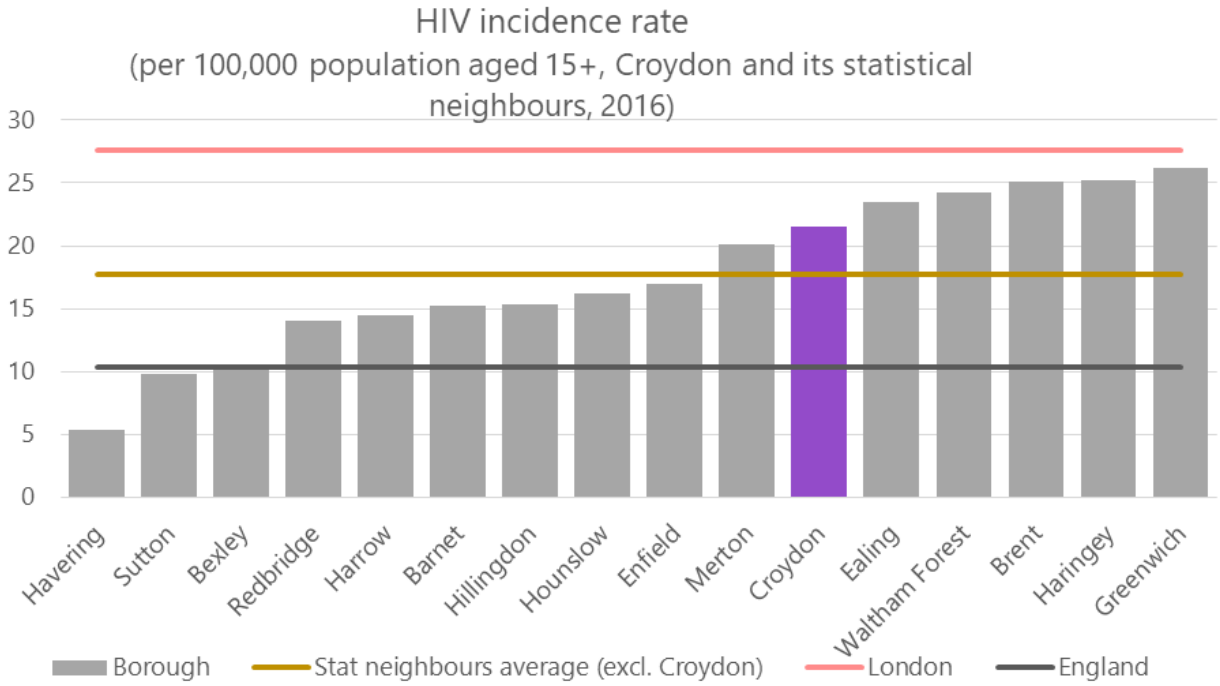
5.2 HIV in Croydon – Facts, Figures and Trends

In 2016, the diagnosed HIV prevalence rate in Croydon **was 5.4 per 1,000 population aged 15-59 years, compared to 2.3 per 1,000 in England and 5.8 per 1,000 in London**.[75] A **third** of the middle super output areas (MSOAs) in Croydon had a prevalence

[74] BASHH. *We need PreP on the NHS now*; 2018.
[75] HIV and AIDS Reporting System (HARS) taken from *Public Health England Sexual and Reproductive Health Profiles*.

rate **higher than 6 per 1,000 population (therefore higher than the London average)**.[76] Croydon has a **high diagnosed prevalence rate, even among statistical neighbours**, and also has a **higher than average incidence** rate among statistical neighbours.

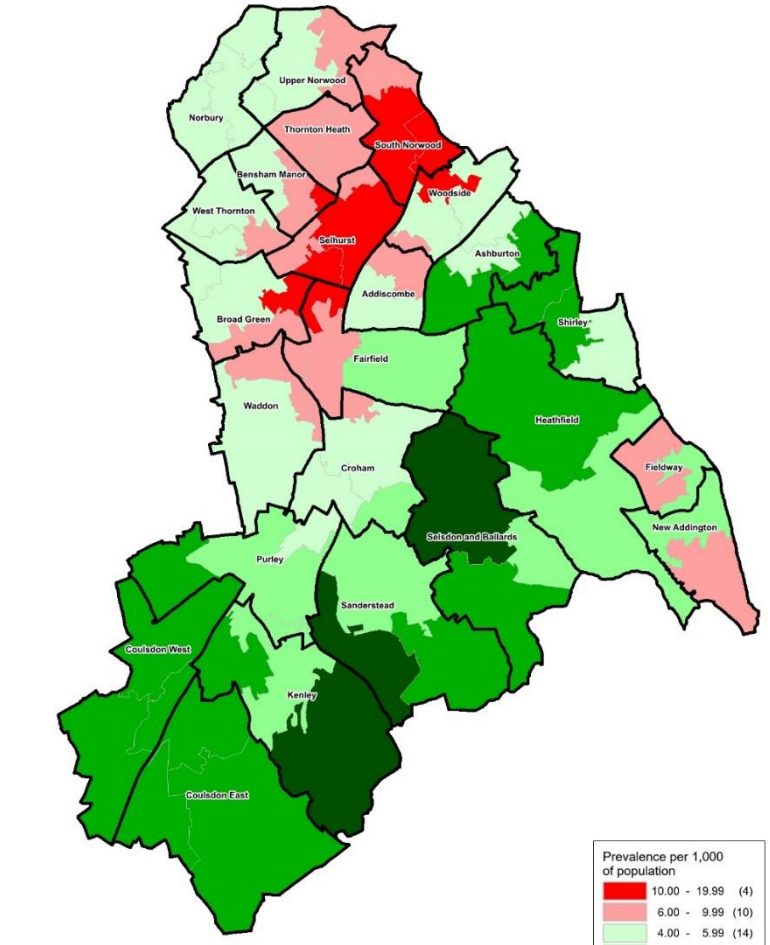




[76] Survey of Prevalent HIV Infections Diagnosed (SOPHID) LA-level tables (sent securely via email to local teams, restricted access)

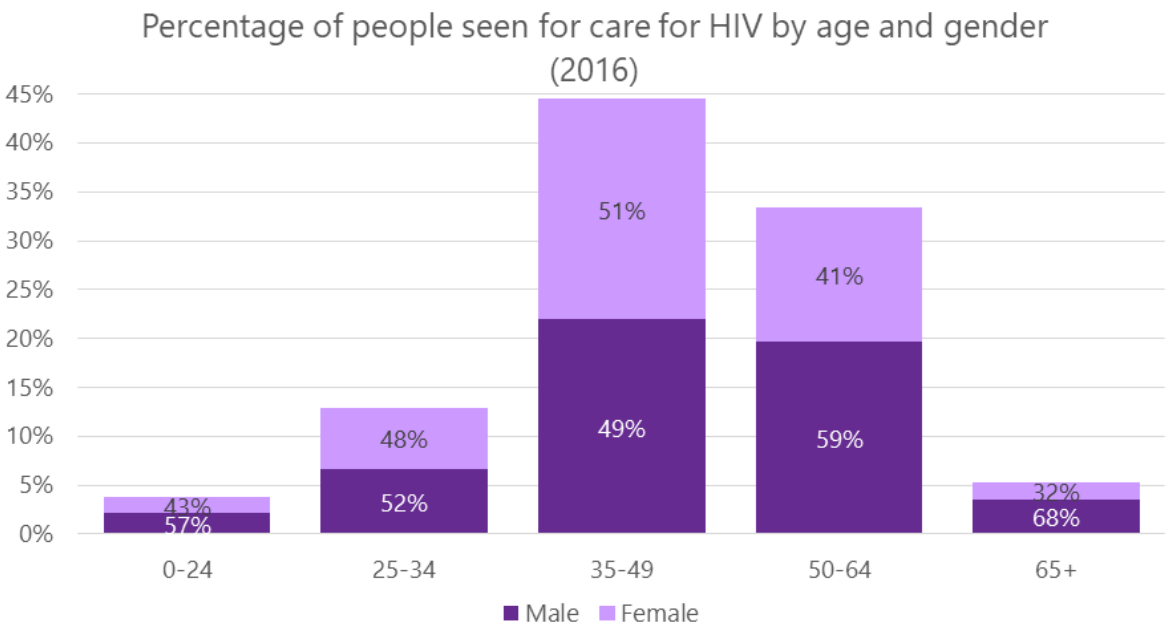
This map shows distribution of diagnosed prevalence by Middle Super Output Area in Croydon.

Prevalence of diagnosed HIV in 15-59 year olds (per 1,000) by Middle Super Output Area (MSOA) of residence in 2016

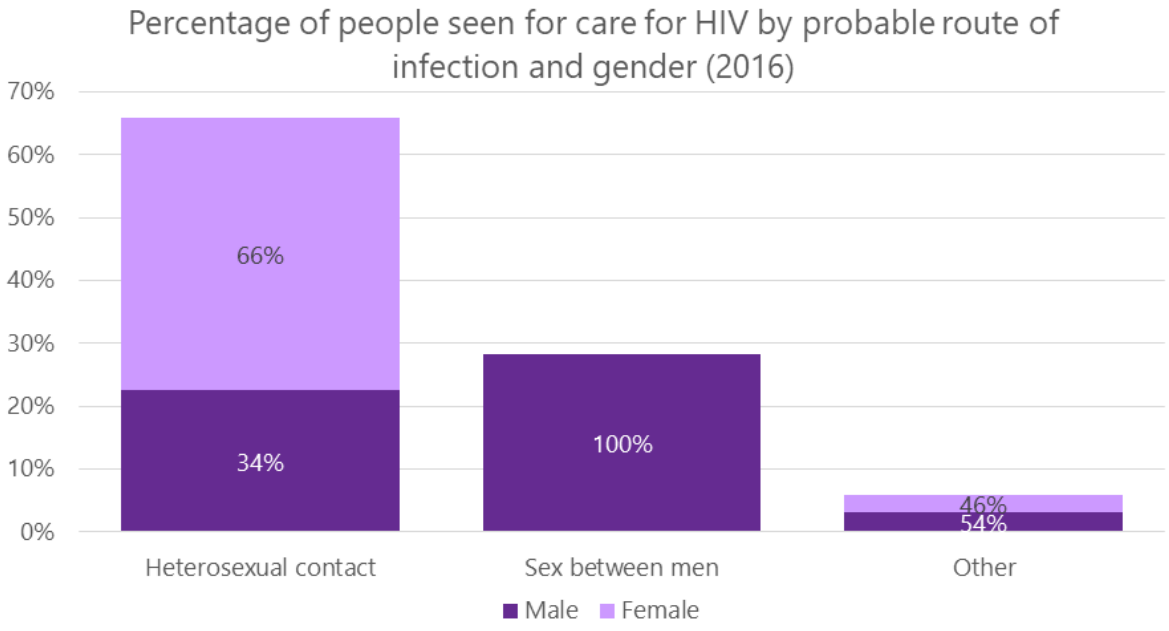


Of the cases of HIV diagnosed in Croydon residents seen for care in 2016, the **majority (83%) were aged 35 or over** and **just over half were male**. Males were more proportionately represented in the older age groups compared to females, with **60% of all diagnoses in those aged 50 or above being male**, which may reflect the role antenatal care testing has in female diagnoses.[77]

[77] SOPHID LA-level tables (sent securely via email to local teams, restricted access)

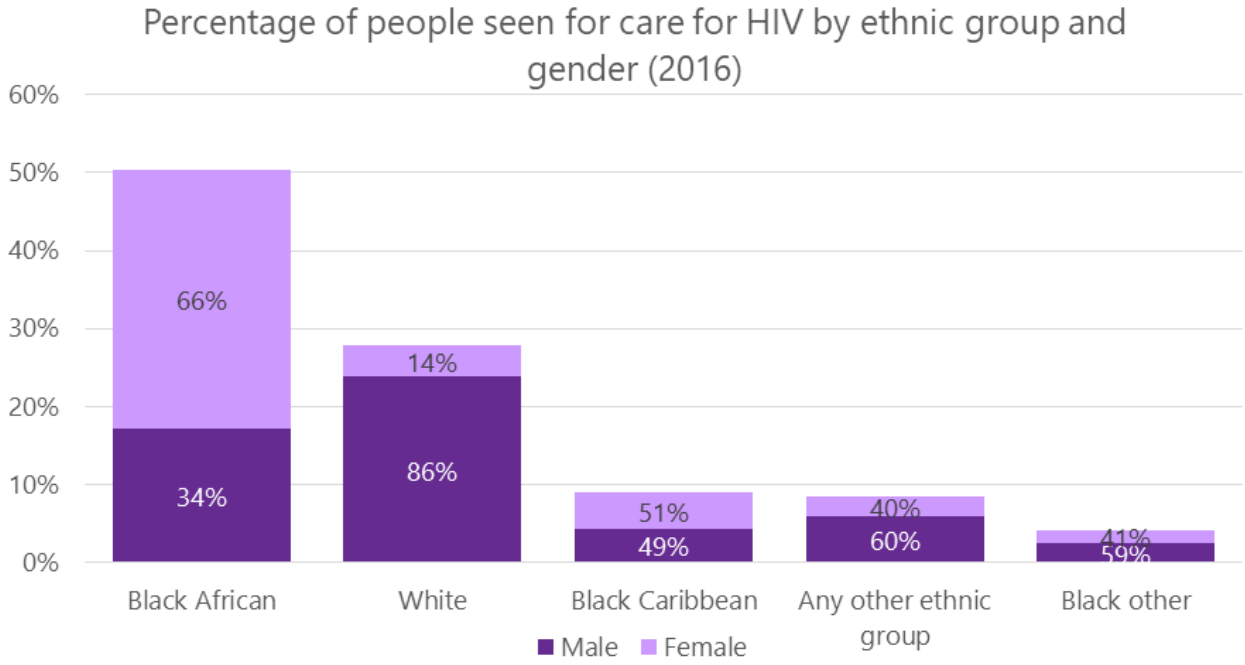


Two thirds had a probable route of infection of heterosexual contact. Other non-sexual probable routes of infection (such as injecting drug use, mother to child, blood/blood products) accounted for just 4% of diagnoses.[78]



Gender balance varies between the different ethnic groups diagnosed with HIV, with **two thirds of all black Africans diagnosed being female** and **86% of all white people diagnosed being male**.[79]

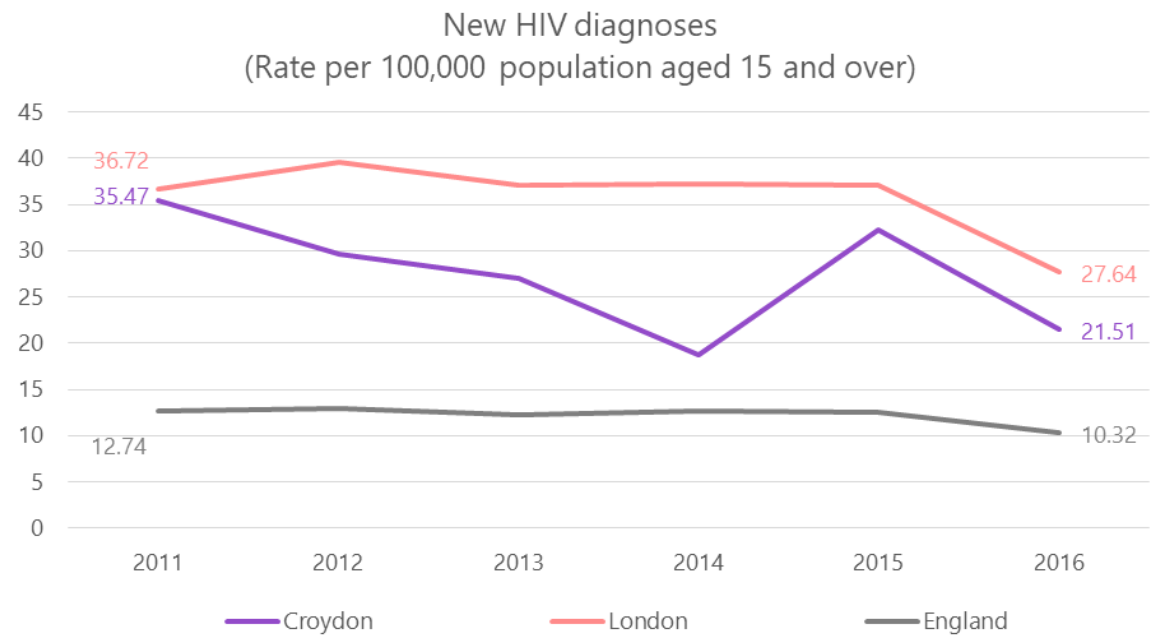
[78] SOPHID LA-level tables (sent securely via email to local teams, restricted access)
[79] SOPHID LA-level tables (sent securely via email to local teams, restricted access)



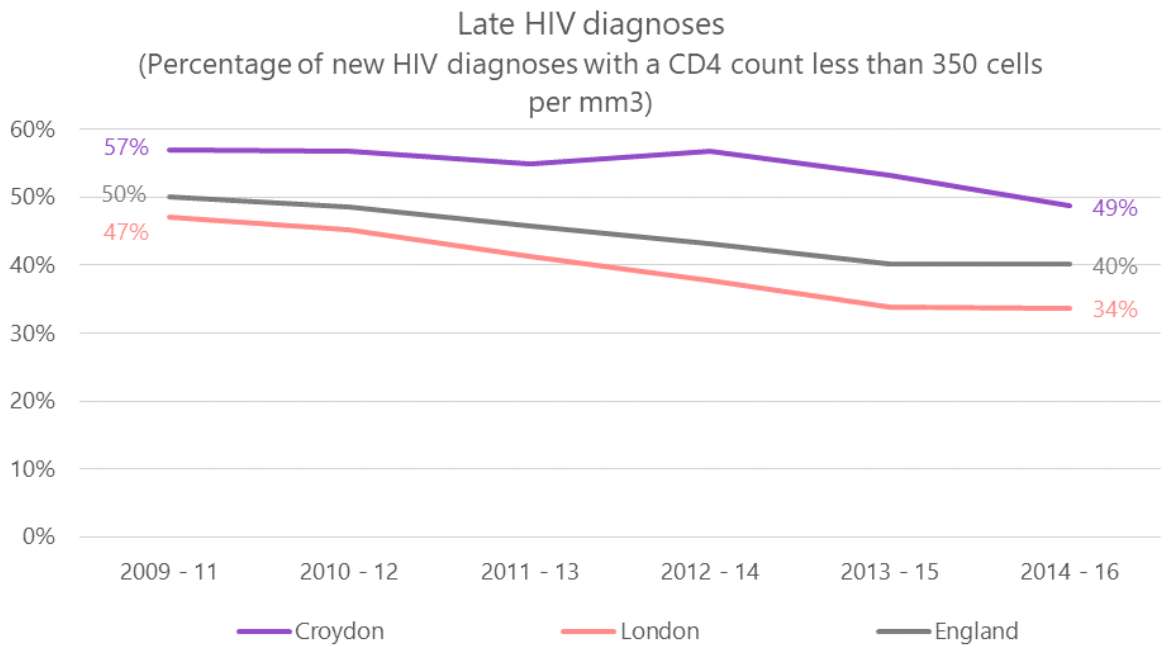
The British HIV Association (BHIVA) advised in its 2015/16 policy that all individuals diagnosed with HIV start antiretroviral therapy[80], regardless of CD4 count, and this has been adopted as NHS England commissioning policy from March 2018[81]. In Croydon in 2016**, 96.2% of residents with diagnosed HIV were receiving ART** compared to **97.2% of London residents and 96% of England residents**.[82]

New HIV diagnosis is not synonymous with incidence, however, it provides a timely insight into the onward HIV transmission in a country and consequently allows targeting efforts to reduce transmission. In Croydon, the new HIV diagnosis rate has fluctuated in recent years.[83]

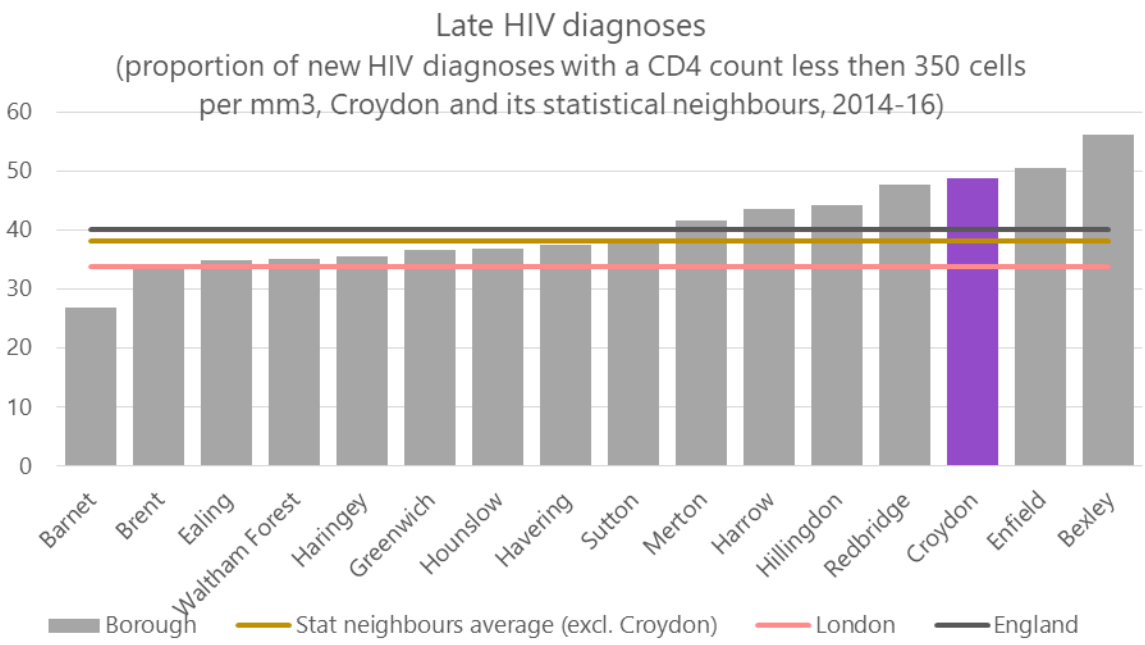
[80] BHIVA. *British HIV Association guidelines for the treatment of HIV-1-positive adults with antiretroviral therapy 2015, 2016 interim update*; 2016.
[81] NHSE. *Clinical Commissioning Policy: Immediate antiretroviral therapy for treatment of HIV-1 in adults and adolescents*; 2018.
[82] SOPHID LA-level tables (sent securely via email to local teams, restricted access)
[83] HIV and AIDS Reporting System (HARS) taken from *Public Health England Sexual and Reproductive Health Profiles*.



A key strategic priority is to decrease HIV-related mortality and morbidity through reducing the proportion and number of HIV diagnoses made at a late stage of HIV infection. Late diagnosis is the most important predictor of morbidity and mortality among those with HIV infection. Those diagnosed late have a ten-fold risk of death compared to those diagnosed promptly and is essential to evaluate the success of expanded HIV testing. In 2014-16, Croydon had the **fifth highest late diagnosis proportion in London**, and **third highest among statistical neighbours**.[84]

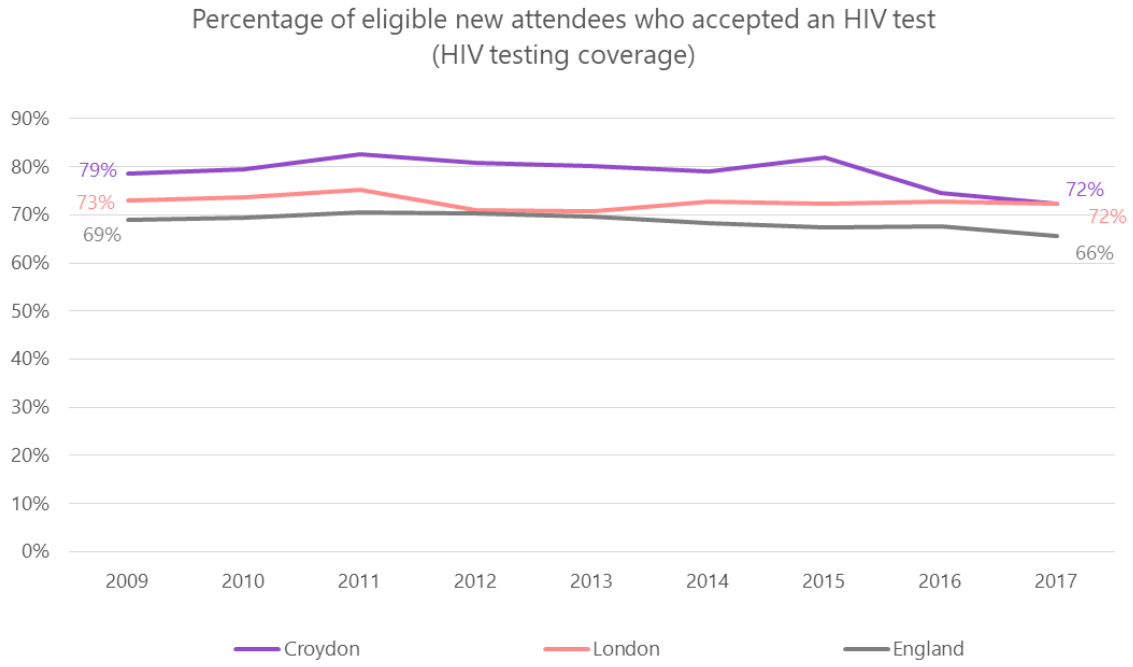


[84] HIV and AIDS Reporting System (HARS) taken from *Public Health England Sexual and Reproductive Health Profiles*.

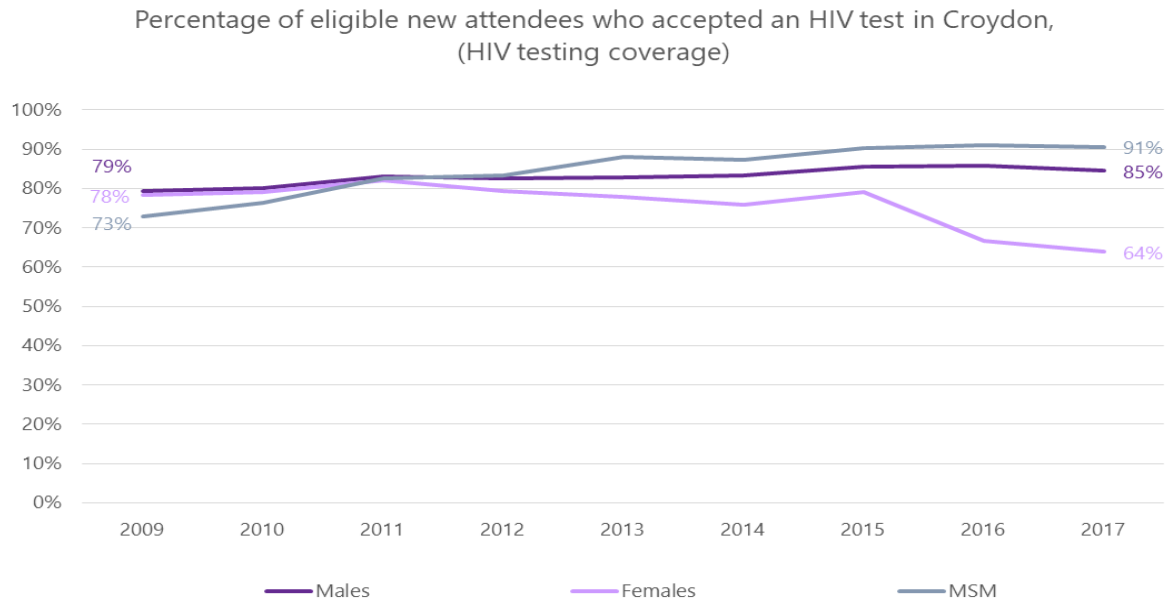


Testing for HIV

Within Croydon, **overall HIV testing coverage is falling slightly** to levels similar to the London average, after being above both London and England since 2009. Despite this fall, **almost three in every four eligible new attendees accept an HIV test**. This fall in testing coverage in the borough is **directly related to a fall in coverage in females where in 2017 one in every three women eligible did not accept a test**. Coverage in males (including MSM) continues to be high.[85]



[85] HIV and AIDS Reporting System (HARS) taken from *Public Health England Sexual and Reproductive Health Profiles*.



5.3 Available Services

Croydon residents can request HIV testing online or access some services outside of the borough should they choose to be screened for STIs elsewhere.

Commissioned Service	STI Screening Provision
General Practitioners	Prescriptions and ongoing care for non-HIV conditions in people living with HIV
Croydon Health Services	HIV screening, treatment prescriptions and advice
Croydon University Hospital	Routine HIV screening in maternity
Croydon Homeless Health	HIV screening, treatment prescriptions and advice
Marie Stopes International	Provide HIV opt-out testing
National HIV testing week	Outreach programme providing HIV screening, diagnosis and advice at various places throughout the borough
Metro	Provide HIV advice, advocacy and support
Online services	Free HIV tests can be ordered from PreventX website

5.4 Recommendations

- Raise awareness and uptake of HIV testing across all demographics to reduce the undiagnosed proportion.
    - Implement routine testing in A&E and acute medical and surgical admission units.

    - Create a pathway where people are signposted to other services, and self-sampling options if they decline testing at that point.

- Raise awareness and improve HIV testing in at-risk groups.
    - Train staff at providers or healthcare settings to identify high-risk people, and indicator conditions that would merit an HIV test, including at GP practices and A&E.
    - Cross-promote with STI prevention campaigns to promote yearly testing, focusing on healthcare and non-healthcare settings, such as pharmacies, voluntary sectors or venues where high-risk sexual behaviour may occur.
    - Create pathways for patients being referred to hepatology and respiratory clinics to get HIV screening on attendance.

- Offer an HIV test at GP practices when patients are registering, or when having a blood test if they have not had an HIV test in the past 12 months.
    - Consider using examples, such as the Lewisham case study in the Best Practice section, to improve HIV testing uptake in general practice on patient registration, by making it routine.
    - Introduce an e-flag on GP systems to help identify those who are having a blood test, and have not had an HIV test in the last year to improve offering and uptake during consultation.

6 Summary of Recommendations

<u>Contraception</u>

- Ensure women are fully informed of their contraceptive choices, risks and benefits, counselled that IUD is more effective than an oral method, and appropriately referred or prescribed their preferred method, with the necessary follow-up.
    - Regular refresher training for staff involved in advising women, including General Practice staff.
    - Accurate and consistent recording across providers that LARC has been offered, when it has been declined, and when it is inappropriate for prescription.
    - Clear referral pathways for LARC if a provider is unable to provide it.
    - Creation of a clear pathway outlining where and when conversations on contraception can take place across different settings with women, with follow-up mechanisms, either via phone or recall to service, where contraception choices can be further discussed if needed, concerns can be addressed and decisions can be supported.
    - Use the statistical neighbour average as a target for LARC prescriptions where it falls below.
    - Use the London average as a target for women to have a contraception prescribed, if appropriate for them.

    - Share learning with other boroughs and national teams to identify how data accuracy could be improved i.e. prescription data that is patient-linked, rather than prescription linked would get a more accurate picture of contraception uptake in Croydon.

- Increase uptake of contraception after attendance for emergency contraception, according to a locally agreed target.
    - Up-to-date training for staff at all providers on counselling women through the options for emergency contraception, highlighting the role of LARC.
    - Clear referral pathways are in place from all providers after prescription of emergency contraception - for LARC, if LARC cannot be given immediately, and for information on long-term contraception options. This should include follow-up mechanisms, such as text messages, or phone calls to re-attend services, to reduce the incidence of repeat EHC prescriptions.
    - User engagement to understand how the referral pathways and follow-up can be best implemented.
    - Stakeholder engagement, particularly in primary care (GP practices and pharmacies) to establish how referral pathways for follow-up after EHC currently work, how they could be improved, and what training is required to support them.

- Increase awareness of contraception methods and services among target populations.
    - User engagement, particularly in overrepresented ethnicities to see where services could improve uptake of long-term contraception options, if appropriate.
    - Use targeted RSE to under-25s and overrepresented ethnicities to increase awareness of long-term contraception use, with workshops complemented with other types of media, and across a range of settings, particularly non-healthcare settings. This importantly should be inclusive of men and women.
    - Consider where RSE can be used with parents or carers, as appropriate, to encourage open conversations on contraception, and awareness of its role in good sexual health.

- Collaborate with adjacent and outreach services to increase uptake and referrals e.g. Turning Point, Homeless Health service, mental health services, particularly in high-risk and hard to reach groups.

<u>Conceptions (including terminations of pregnancy)</u>

- Aim to reduce overall termination rates to a locally set target.
- Ensure pathways are in place after abortion to ensure women are able to access contraception, and referred for LARC as appropriate.
- Optimise RSE in school settings, colleges and alternative education providers.
- Ensure *You're Welcome standards* are maintained across young people's services.
- Provide more intensive RSE and contraceptive support to young people at greater risk. This may be by identifying schools with higher levels of deprivation in students (free

school meal eligibility, persistent school absence), services for looked after children and care leavers, LGBTQ+ youth groups and young women who are already mothers.
- Deliver the recommendations that arise from the Young Person's Sexual Health event in March 2018.

Sexually Transmitted Infections

- Increase awareness of STIs, reducing risk of transmission, and how to access testing and treatment in the Croydon population.
    - Cross-promote programmes and campaigns across services, using the Making Every Contact Count approach e.g. cross-promotion of chlamydia testing in the C-Card scheme to maximise the reach of commissioned services.
    - Promote information and signposting in non-healthcare settings e.g. nightclubs, and adjacent services such as drug and substance misuse services, the Homeless Health team, and voluntary organisations.
    - Regular updates to staff in above settings services to ensure they can appropriately refer people seeking testing and treatment.

- Increase awareness of STIs, reducing risk of transmission, and how to access testing and treatment in high-risk groups.
    - Target promotion and information giving in youth services such as schools, colleges, youth groups, outreach centres.
    - Consider use of pop-up clinics in college settings (these would not have to be very frequently) to encourage opportunistic testing, and reduce barriers to testing and attendance.
    - Consider how peer engagement and influence can be better used to highlight regular testing.
    - Relationship-building and outreach to parents and carers of high-risk groups, to encourage positive attitudes to sexual health, and responsible testing.
    - Consider promotion using milestones and change in circumstances e.g. starting college, registering with a new GP, changing partners as opportunities to get tested.
    - Target socio-economically deprived populations through local primary care services, but also linked services, such as drug and alcohol, social care, housing, maternity services and children's services.
    - User engagement in high-risk groups to identify further points of potential intervention.
    - User engagement with men to also identify barriers to screening and testing.

- Increase screening for all STIs according to a locally set targets, for example, closer to the London average.

- Identification and follow-up of high-risk individuals, with partner notification, testing and treatment, advice on avoiding re-infection and three-month follow-up.

- Up-to-date training for GP practices, and other services such as A&E and mental health services, on identifying high-risk individuals from their history.
- Clear recall process for three-month follow-up in services.
- Recall processes that also signposting to other services to reduce barriers to follow-up.
- Aim to reduce number of men and women presenting with re-infection within 12 month closer to the London average.

HIV

- Raise awareness and uptake of HIV testing across all demographics to reduce the undiagnosed proportion.
  - Implement routine testing in A&E and acute medical and surgical admission units.
  - Create a pathway where people are signposted to other services, and self-sampling options if they decline testing at that point.

- Raise awareness and improve HIV testing in at-risk groups.
  - Training staff at providers or healthcare settings to identify high-risk people, and indicator conditions that would merit an HIV test, including at GP practices and A&E.
  - Cross-promote with STI prevention campaigns to promote yearly testing, focusing on healthcare and non-healthcare settings, such as pharmacies, voluntary sectors or venues where high-risk sexual behaviour may occur.
  - Create pathways for patients being referred to hepatology and respiratory clinics to get HIV screening on attendance.

- Offer an HIV test at GP practices when patients are registering, or when having a blood test if they have not had an HIV test in the past 12 months.
  - Consider using examples, such as the Lewisham case study in the Best Practice section, to improve HIV testing uptake in general practice on patient registration, by making it routine.
  - Introduce an e-flag on GP systems to help identify those who are having a blood test, and have not had an HIV test in the last year to improve offering and uptake during consultation.

7 Further Information

Public Health England (PHE) regularly updates its Sexual and Reproductive Health Profiles containing a wide range of LA level information. Croydon's most recent profile can be found here; https://fingertips.phe.org.uk/static-reports/sexualhealth/e09000008.html?area-name=croydon

Last needs assessment: https://www.croydonobservatory.org/wp-content/uploads/2016/11/JSNA-Chapter-Sexual-Health-2010-11.pdf

Previous sexual health strategy: http://www.croydonobservatory.org/wp-content/uploads/2016/11/Croydon-Sexual-Health-Strategy-2011-2016.pdf

8 Appendices

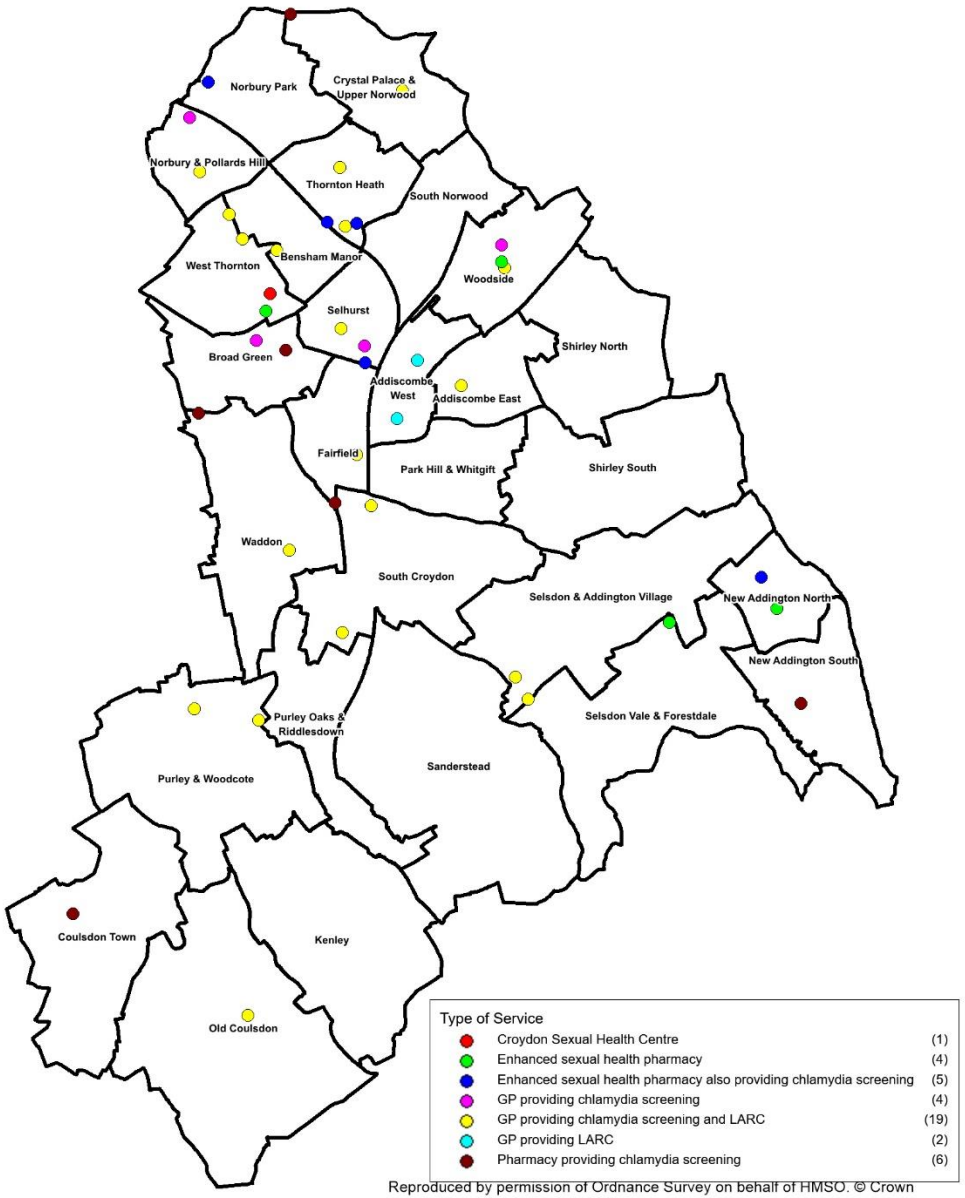
8.1 Appendix I - Croydon Providers

Provider	What is provided
Croydon Health Services (CHS)	An Integrated Sexual Health Service, which includes: • Contraception (full range e.g. LARC, injections, oral prescriptions, EHC) (IHS, Dom care) • HIV testing and diagnoses (IHS, YP service, Dom care) • STI testing and diagnoses (IHS, YP service, Dom care) • STI and HIV treatment (IHS, Dom care) – HIV treatment commissioned by NHSE • Pregnancy testing (IHS, Dom care) • Psychosexual counselling (IHS) • Advice & information (IHS, YP, outreach, Dom care) • Self-esteem and healthy relationships (IHS, YP, outreach, Dom care) • Referrals for cervical screens, terminations, maternities,
Croydon University Hospital	• Follow-up / tests / treatment for cervical cancer • Vasectomy and sterilisation • HIV testing (A&E, Hepatology, Chest Clinic, Maternity) • STI testing (Maternity) – syphilis • STI / HIV treatment / support? • Pregnancy testing (maternity, for self-referrals) • Support around maternity (miscarriages, teenage pregnancy, ectopic pregnancies, PID) • Advice & information
General Practitioners (GPs)	• Cervical screens • Contraception (LARC, injections, oral prescriptions, EHC) • Prescriptions for menopause • Chlamydia screening and diagnosis • Pregnancy tests • PID / ectopic pregnancy? • Advice & information

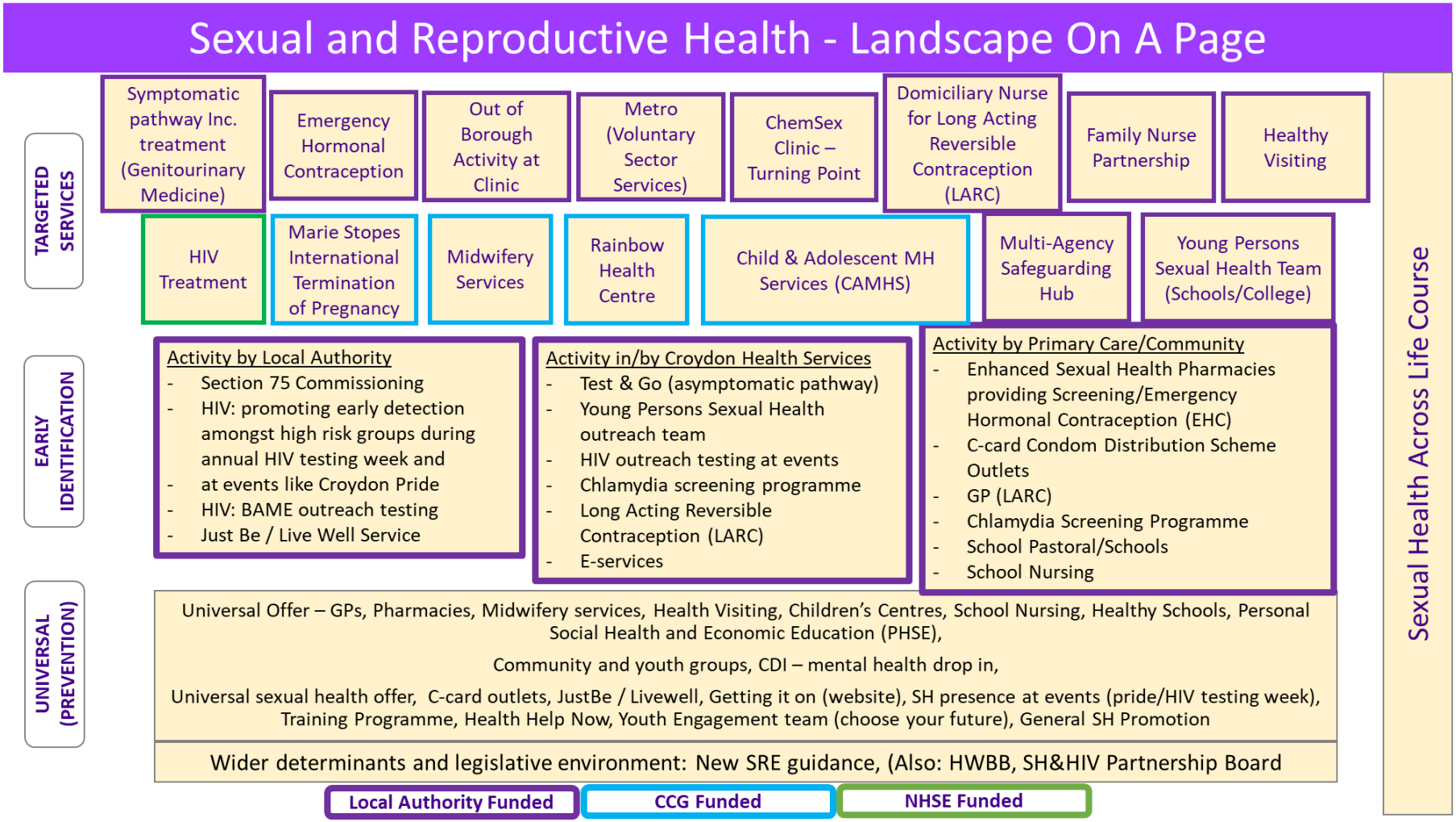
Provider	What is provided
	• Referrals for cervical screen follow-ups, infertility, HIV screening, STI screening (except for chlamydia), terminations, maternities, healthy relationship support
Enhanced Sexual Health Pharmacies	• Contraception (free EHC, oral prescriptions for women up to the age of 21) • Chlamydia screening and diagnosis (for anyone up to the age of 25) • Chlamydia treatment prescriptions (for anyone up to the age of 25 and their partners) • Pregnancy tests (free for women up to the age of 21) • Advice & information, signpost as necessary
Non-enhanced SH pharmacies	• Contraception (paid-for by user EHC) • Chlamydia screening and diagnosis (age25) – only specific non-enhanced SH pharmacies that are commissioned to deliver chlamydia screening. • Advice & information, signpost as necessary
Marie Stopes International (MSI)	• Contraception (LARC, injections, oral prescriptions) • Chlamydia and gonorrhoea screening and diagnosis (treatment?) • Terminations of pregnancy • Counselling (around terminations) • Advice & information • HIV screening • Referrals for STI screening (except chlamydia and gonorrhoea), complex terminations
Croydon Homeless Health team	• Contraception (free EHC, oral prescriptions) LARC? • Screening & diagnosis of all STIs and HIV • Support for maternities • Advice & information, signpost as necessary • Referral for terminations
National HIV testing week	• HIV screening and diagnoses • Advice & information, signpost as necessary
Metro	• HIV advice, advocacy and support

Provider	What is provided
C-card providers	• Free condom distribution and chlamydia screening going forward
Other	• Preventx, Teenage pregnancy midwife, FNP, Sisters Project, Health visiting, Early help hub, Early Intervention team, LA outreach, no recourse to public funding, school nursing, college pastoral support, Croydon drop-in, Just Be website, Getting It On website, family resilience service, The Bridge, Lives Not Knives, Social Care, Drug and Alcohol support, offending teams

Sexual Health Services - Q3 2017



8.2 Appendix II – Overview of the Sexual and Reproductive Health Landscape in Croydon



9 Acknowledgements

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