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West Sussex Sexual Health Needs Assessment: Final Report

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About Nudge Associates Limited

Nudge Associates Limited offers specialist training and management consultancy services to the health, well-being and development sectors.

Nudge Associates Limited brings together public health experts, including former members of the Department of Health National Support Teams who supported the majority of health partnerships across England. An elite network with first-hand experience of translating national public health policy into locally relevant practice and outcomes.

Nudge Associates Limited provides extensive knowledge and a rich diversity of delivery experience working with the public, private and voluntary sectors with particular expertise focused on sexual health, reproductive health, HIV prevention, treatment and care, substance misuse and mental health.

Nudge Associates Limited would like to thank all those who participated in this Sexual Health Needs Assessment.

CONTENTS

Abbreviations used throughout this sexual health needs assessment report

BASHH	British Association for Sexual Health and HIV
BHIVA	British HIV Association
CASH	Contraception and Sexual Health
CCGs	Clinical Commissioning Groups
CQC	Care Quality Commission
DH	Department of Health
EHC	Emergency Hormonal Contraception
FE	Further Education
FSRH	Faculty for Sexual and Reproductive Health
GUM	Genito Urinary Medicine
HE	Higher Education
HPE	HIV Prevention England
ISHS	Integrated Sexual Health Service
JSNA	Joint Strategic Needs Assessment
KIs	Key Informants (refers to stakeholders with a professional interest)
KPIs	Key Performance Indicators
LAs	Local Authorities
LAC	Looked After Children
LARC	Long Acting Reversible Contraception
LATs	Local Area Teams
LGBTI	Lesbian, Gay, Bi-sexual, Transgender and Intersex
MEDFASH	Medical Foundation for Sexual Health and HIV
NAATs	Nucleic Acid Amplification Tests
NHSE	National Health Service England
PEPSE	Post-Exposure Prophylaxis after Sexual Exposure
POCT	Point of Care Testing
PH	Public Health
PHE	Public Health England
PHOF	Public Health Outcomes Framework
PrEP	Pre-Exposure Prophylaxis
PSHE	Personal, Social and Health Education
SHNA	Sexual Health Needs Assessment
SRE	Sex and Relationships Education
STI	Sexually Transmitted Infection
SUs	Service Users (refers to existing and potential users, clients, patients)
ToP	Termination of Pregnancy
WSCC	West Sussex County Council
WSHT	Western Sussex Hospital NHS Foundation Trust

1 EXECUTIVE SUMMARY: A SEXUAL HEALTH NEEDS ASSESSMENT

NB: The term 'sexual health' used throughout this report includes reproductive health and HIV.

1.1 The World Health Organisation (WHO) working definition of sexual health is: *"…a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled."*[1]

1.2 Furthermore, *"Sexual and reproductive health and well-being are essential if people are to have responsible, safe, and satisfying sexual lives. Sexual health requires a positive approach to human sexuality and an understanding of the complex factors that shape human sexual behaviour. These factors affect whether the expression of sexuality leads to sexual health and wellbeing or to sexual behaviours that put people at risk or make them vulnerable to sexual and reproductive ill health. Health programme managers, policy-makers and care providers need to understand and promote the potentially positive role sexuality can play in people's lives and to build health services that can promote sexually healthy societies."*[2]

1.3 In February 2014, West Sussex County Council (WSCC) commissioned Nudge Associates Limited to undertake a population focused sexual health needs assessment incorporating a stakeholder engagement process with key informants and service users.

1.4 The aim was to gather a comprehensive picture of the sexual health needs of the population of West Sussex, to examine the local epidemiological evidence and to elicit opinions on whether the current services and delivery models meet the diverse population needs of West Sussex, in order to determine the most appropriate way forward for sexual health services throughout West Sussex.

1.5 Sexual health commissioning responsibilities for West Sussex include open access to genito-urinary medicine, contraceptive services for all ages, Human Immunodeficiency Virus (HIV) testing, psychosexual counselling and sexual health promotion.

[1] WHO, 2006a

[2] Defining Sexual Health: Report on a Technical Consultation on Sexual Health, 2002

The Methodology

1.6 The methodology used for this Sexual Health Needs Assessment followed "Sexual Health Needs Assessment – a how to guide" published by the Department of Health National Support Teams in 2007. This involves a mixed methodology with three core elements to support triangulation of evidence, desk-based literature; data review and analysis including mapping of existing service provision and the characteristics of sexual transmitted infections (STIs); key stakeholder/informant interviews with a wide range of providers (in the NHS and Local Authorities), commissioners, clinicians, primary care and other interested stakeholders; and service user and general population engagement and consultation. A semi-structured question framework was employed for the key informant interviews based on the "Key Question Framework" developed by members of Nudge with members of the Department of Health National Support Teams for Sexual Health, Response to Sexual Violence and Teenage Pregnancy.

Epidemiology

1.7 A quantitative data analysis is provided in the full report, providing an overview of the epidemiology of sexual health in West Sussex, including trends and variations in HIV and STI prevalence, teenage pregnancy rates, contraceptive provision and abortion rates. The analysis includes Genito-Urinary Medicine (GUM) Clinic activity data in relation to patient attendances and diagnoses at the three GUM clinics in West Sussex. Key messages are given below.

1.8 For West Sussex as a whole, rates of STIs and teenage pregnancy are below the England average but the picture is less uniform across West Sussex districts, with some areas having rates above the England average. Some areas also have pelvic inflammatory disease admissions and sexual offences rates above the national average (Crawley, Worthing and Arun).

HIV

1.9 The number of people diagnosed HIV in West Sussex has more than tripled between 2002 and 2012 (rising from 215 to 713). The highest numbers and greatest increases are in Crawley (60% increase) and Worthing, although in 2012 there was a spike of new diagnoses (17) among Arun residents, predominantly among males aged 35-64[3].

[3] There are a growing number of people being diagnosed with HIV later in life. The median age of diagnosis for MSM in England was 34 years, with one in nine being diagnosed over the age of 50. The median age of diagnosis was slightly

Overall, males account for the large majority of new HIV diagnoses. It is estimated that in the most recent year that data is available (2012) there are another 225 undiagnosed cases of HIV in West Sussex[4]. A linear projection based on past trends suggests the number of HIV diagnosed persons in West Sussex could reach around 923 by 2017. The rates (per 1,000 population) of diagnosed HIV prevalence for Crawley, Worthing and Adur equate to 3.0, 2.4 and 2.1 respectively. It should be noted that the National Institute for Health and Care Excellence (NICE[5]) guidance and national HIV testing guidelines[6], produced by the British HIV Association (BHIVA[7]), the British Association of Sexual Health and HIV (BASHH[8]) and the British Infection Society (BIS, now the British Infection Association[9]), recommend expanding HIV testing in areas of more than 2 in 1,000.

1.10 Based on Health Protection Agency[10] (on 1 April 2013 HPA became part of Public Health England) estimates of the average annual expenditure for each HIV patient accessing care, the annual treatment cost for West Sussex HIV patients was around £9.9m (£13,900 per patient) in 2011/12, with the forecast increase of diagnosed patients adding around £2.9m to West Sussex's annual treatment costs, an increase of 29%.

1.11 Half of the new diagnoses in West Sussex were late diagnoses[11], with individuals having a significantly increased risk of contracting opportunistic diseases (a quarter of deaths among HIV positive individuals in the UK are where diagnoses are too late for effective treatment. Across West Sussex districts, some areas have a high proportion of late diagnoses (e.g. estimated at 67% in Chichester). In 2012, around 18,200 HIV tests were offered to West Sussex residents attending GUM of which 71% accepted, a lower proportion than the England average rate of 82%. The highest uptake rates were from men who have sex with men (86%). There is an association between rates of HIV testing and the proportion of late HIV diagnoses across the West Sussex districts.

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older for both heterosexual men and women, with 42 being the average age among men and 39 among women. - See more at: http://www.nat.org.uk/HIV-Facts/Statistics/Latest-UK-statistics/HIV-diagnoses.aspx#sthash.QfX1UYHS.dpuf

[4] Based on Public Health England estimates.

[5] https://www.nice.org.uk

[6] http://www.bhiva.org/documents/Guidelines/Testing/GlinesHIVTest08.pdf

[7] http://www.bhiva.org

[8] http://www.bashh.org

[9] http://www.britishinfection.org

[10] http://www.hpa.org.uk/HPAwebHome/

[11] A late diagnosis is defined as having a CD4 count below 350 cells/mm³ within three months of diagnosis. Previously it meant having a CD4 count below 200 cells/mm³ within 91 days of diagnosis; this is now referred to as a very late HIV diagnosis. See more at: http://www.nat.org.uk/HIV-Facts/Statistics/Latest-UK-statistics/Late-diagnosis.aspx#sthash.A73KT8pT.dpuf

Districts with higher testing uptake rates have a smaller proportion of late HIV diagnoses compared to those districts with lower uptake rates.

Sexually Transmitted Infections

1.12 The overall rates of STI diagnoses in West Sussex are below the England average, but this varies across districts with Crawley and Worthing having rates for some STIs above the national average (although these differences are not significant, except for the rate of diagnosed Chlamydia in Worthing). From 2010-12 Crawley had high and increasing rates of gonorrhoea and syphilis, and Worthing had the highest rates of chlamydia among the 15-24 age group. Overall in 2012, there were 2,488 new diagnoses of gonorrhoea, genital warts, syphilis and chlamydia. Women with a STI diagnosis tend to be in the age range 16-19 with a peak in the 20-24 year age group for chlamydia, gonorrhoea and genital warts. For men, chlamydia and genital warts peak in the 20-24 age group, with a peak in gonorrhoea and herpes among the 20-34 age group. The overwhelming majority of STI diagnoses are among heterosexual males and females except for syphilis and gonorrhoea among men where homosexual men account for 55% and 43% respectively of all diagnoses. Residents born in the UK account for up to 87% of diagnoses for most STIs except for syphilis where a third of diagnoses are from those born outside the UK.

Sexual Health Screens

1.13 In 2012 West Sussex had 20,400 first time attendances at a GUM clinic, of which 15,200 included a sexual health screen, of which 60% were in the 20-34 age group; although there are a significant number of sexual health screens to women under 20 years and to men over 35 years. Crawley has the highest rate of sexual health screens followed by Worthing. Around 16% of residents age 15-24 were screened for chlamydia in 2012, below the national average of 25%, although in Worthing the proportion screened has increased over recent years.

1.14 The vaccination coverage for Human Papilloma Virus (HPV) was 87%, above the England average.

Teenage Pregnancy

1.15 The under 18 conception rate is lower than the England rate although there is considerable variation across the districts (rates vary between 13.3 and 32.6 per 1,000 females aged 15-17 years). The downward trend in the rate has mirrored the national and regional trend downwards. In 2012 there were 308 under-18 conceptions, 191 fewer than in 2008 and the latest data shows a continuation of the falling rate. The drop in the teenage conception rate is mirrored by reductions in teenage birth and abortion rates. The association between alcohol related admissions and teenage pregnancy seen nationally is also evident in West Sussex, with higher under 18 conception rates in West Sussex districts that see a rate of under-18 alcohol-specific admissions around 60 per 1,000 or higher.

Contraception

1.16 The latest annual data indicates 17,400 first attendances for contraceptive reasons at West Sussex clinics, equating to around 12% of the female population aged 15-44, higher than the England proportion of 8.7%. The majority of first contacts are for user dependent methods i.e. those methods such as oral contraceptive pills. Rates of GP prescribed long-acting reversible contraception (LARC) are above the national average[12]. However rates of contraceptive prescribing vary widely across GP practices (e.g. in Crawley there is a 2.8 fold difference between GP practices with the lowest and highest prescribing rates, plus a threefold difference in relation to LARC prescribing).

Abortions

1.17 The all age abortion rate is 15.6 per 1,000 females 15-44, lower than the England rate of 17.7. Nearly four in five abortions were less than 10 weeks gestation, which is consistent with the national average and 91% are less than 13 weeks. The proportion of abortions for women under 25 that were repeat abortions was 25%, slightly lower than the England average. NHS Coastal West Sussex CCG had the highest age standardised abortion rate (15 per 1000 females aged 15-44) and Crawley CCG the highest proportion of repeat abortions (40%). The large majority of abortions are provided in the independent sector.

GUM Activity

[12] i.e. sub-dermal implants, injections and intrauterine devices/system.

1.18 In 2012 16,400 patients attended clinics. 53% of first attendances were heterosexual women, 39% were heterosexual males, 6% homosexual males, with bisexual men and women attendees making up 2%. The vast majority were born in the UK although there was some variation with 34% and 13% of attendees born outside UK in Crawley and Worthing respectively. The vast majority of attendances at West Sussex clinics were from West Sussex residents, 4% were from Brighton and Hove and 3% from Surrey.

Sexual Behaviour

1.19 With respect to 16-24 year olds in further and higher education in West Sussex, a survey[13] has shown high non-use of contraception at first intercourse, and among males 19.9% had taken a test for a STI whilst 6.1% had tested positive for a STI. For females it was 27.8% and 2.9% respectively.

A Framework for Sexual Health Improvement in West Sussex

1.20 The remainder of this report follows the five key objectives for improved sexual health outcomes outlined in 'A Framework for Sexual Health Improvement in England' (Department of Health 2013) as follows:

- Accurate, high quality and timely information that helps people to make informed decisions about relationships, sex and sexual health
- Preventative interventions that build personal resilience and self-esteem and promote healthy choices
- Rapid access to confidential open-access, integrated sexual health services in a range of settings, accessible at convenient times
- Early, accurate and effective diagnosis and treatment of STIs, including HIV, combined with the notification of partners who may be at risk
- Joined up provision that enables seamless patient journeys across a range of sexual health and other services – this will include community gynaecology, antenatal and HIV treatment and care services in primary, secondary, and community settings

1.21 In addition there is a section on commissioning, contracting and procurement.

[13] West Sussex NHS PCT – Lifestyles of 16-24 year olds in Higher Education (HF) and Further Education (FE) Colleges in West Sussex (2008)

1.22 Responses about key issues and challenges are included from Key Informants (KIs), and from Service Users (SUs), and suggested approaches and recommendations as ways forward are also provided.

Responses from Key Informants (KIs) and Service Users (SUs)

The following KI and SU views (Stakeholders) provide a snapshot of opinions and perceptions gathered during this population focused sexual health needs assessment. Although they may not represent the actual views of a majority of stakeholders, it is likely that they indicate the need for improvement in certain areas such as, better communication or signposting to services etc.

The Nudge Associates Limited delivery team acknowledges that some stakeholders may not have been able to participate at the time of this consultation.

Commissioning, Contracting and Procurement

Key issues and challenges identified by KIs included:

1.23 KIs have found the transition of commissioning responsibilities from Primary Care Trusts to different organisations[14] challenging (see Box A). This was particularly relevant to the transfer to Local Authorities (LAs) and to Clinical Commissioning Groups (CCGs) although some KIs felt that the transition in relation to HIV treatment and care had gone pretty smoothly. However some confusion was revealed in relation to the intentions of the NHS Commissioning Board, operating as NHS England (NHSE) and there were fears expressed at the suggestion of a model designed for London being applied locally.

Box A: Post transition commissioning responsibilities for sexual health services

Sexual health services are commissioned at a local level to meet the needs of the local population, including provision of information, advice and support on a range of issues, such as sexually transmitted infections (STIs), contraception, relationships and unplanned pregnancy.

[14] CCGs, NHSE, and LAs

Local authorities commission comprehensive open access services available for the benefit of all people present in the local authority's area (including free STI testing and treatment, notification of sexual partners of infected persons and free provision of contraception). Some specialised services are directly commissioned by clinical commissioning groups (CCGs), and at the national level by NHS England.

Local Authorities (LAs) commission:

– Comprehensive sexual health services including most contraceptive services and all prescribing costs, but excluding GP additionally provided contraception

– Sexually transmitted infections (STIs) testing and treatment, chlamydia screening and HIV testing

– Specialist services, including young people's sexual health, teenage pregnancy services, outreach, HIV prevention, sexual health promotion, services in schools, college and pharmacies

Clinical Commissioning Groups (CCGs) commission:

– Most abortion services;

– Sterilisation

– Vasectomy

– Non-sexual health elements of psychosexual health services

NHS England (NHSE) commissions:

– Contraception provided as an additional service under the GP contract

– HIV treatment and care (including drug costs for Post-Exposure Prophylaxis after Sexual Exposure (PEPSE)

– Promotion of opportunistic testing and treatment for STIs and patient-requested testing by GPs

– Sexual health elements of prison health services

– Cervical Screening

– Specialist foetal medicine services

1.24 KIs believe that the cultural shift from the NHS to LA accountability flags up fragmentation across the whole system in relation to sexual health, specifically between other NHS partners such as CCGs and NHSE. This has become evident as commissioners and providers attempt to agree interim tariffs, contracts and service user pathways within the new arrangements under the local procurement and contracting rules.

1.25 There are concerns that there does not appear to be one organisation that holds the strategic overview for the whole system and the various funding streams, and there was a lack of clarity on leadership and accountability for the whole service user pathway. This was also reflected in the stakeholder survey.

1.26 Due to perverse funding incentives, such as different payment processes, it was felt that GPs are not appropriately engaged in providing a full range of contraceptive service provision.

1.27 While cross-charging arrangements will be required for out of area attendees and the Health and Social Care Act makes open-access explicit (as in the Local Authority is responsible to provide open access to all people present), there is some local concern that open access might be under threat.

1.28 Some KIs considered that there was too much emphasis on HIV and GUM and not enough on contraceptive services.

1.29 There is a lack of clarity in relation to what HIV treatment and care is delivered within GUM services, and the costs of HIV treatment delivered from within GUM need to be disaggregated from the core GUM treatment costs.

1.30 The question of HIV treatment as prevention within the GUM service is also unclear.

1.31 There was universal consensus across KIs about the need for an integrated tariff.

1.32 There is no universal agreement on what should be the definition of an integrated service or what is meant by prevention in the context of sexual health.

1.33 The majority of KIs appeared unsure of the total resource allocation for sexual and reproductive health service provision. It is important for service providers to inform themselves of the budget provided to them from commissioners.

1.34 KIs definitely wanted to play a role in determining the needs and priorities for investment.

1.35 Respondents to the stakeholder survey were in favour of the voluntary sector having a role in the delivery of sexual and reproductive health services.

Commissioning, Contracting and Procurement

Key issues and challenges identified by SUs included:

1.36 Service users highlighted a lack of integration between health and social care.

1.37 Amongst gay men and people affected by HIV, there was particular concern about services being put out to tender and the splitting off sexual health from other services given the possibility of co-infections.

1.38 A number mentioned the importance of maintaining free access across county boundaries.

1.39 Service users stressed the importance of user involvement.

Commissioning, Contracting and Procurement

SUGGESTED APPROACHES/RECOMMENDATIONS raised by KIs and SUs included:

1.40 ***Recommendation 1:*** It was suggested that one lead commissioning role be identified in relation to all elements of sexual health commissioning across West Sussex to avoid fragmentation and ensure seamless pathways for patients. Section 75 or other appropriate arrangements could be explored across partnerships. It was suggested by some that risk sharing arrangements be agreed between all commissioning partners in order to mitigate against potential financial risks should the sexual health statistics significantly increase. It is therefore recommended that a high level commissioning sexual health strategy group should be developed to support the commissioning lead who needs to have formal delegated responsibility to facilitate the commissioning processes across WSCC, CCGs and NHSE (and their LATs).

1.41 ***Recommendation 4:*** Commissioning intentions should to be clearly outlined for providers regarding which HIV and integrated sexual health services are required for WSCC, with reference to the indicators in the Public Health Outcome Framework and epidemiological evidence, and to the roles of the LAT, CCG and WSCC in commissioning these. These intentions should be developed in line with a sustainable commissioning strategy developed through partnership working across the county. The sexual health strategy group should identify the initial overarching priorities for how to proceed including deciding what to keep, what to devolve e.g. to third sector, agree the vision and shift towards an integrated model of care for patients, supporting self-management, increasing productivity, looking at new technologies, and ensuring staff and service user engagement at all levels.

1.42 ***Recommendation 5:*** Although an interim local tariff has been agreed for the current year, work needs to be done, in year, to address financial implications.

1.43 ***Recommendation 7:*** Commissioners may wish to consider the benefit of completing a pathways risk analysis across all disciplines in relation to sexual health.

1.44 ***Recommendation 10:*** A robust performance management framework should be developed across the three commissioning elements to ensure equity of access.

1.45 ***Recommendation 14:*** GPs could consider signing-up to a single service specification for sexual health services in primary care, which would outline the expected service delivery, and implications for practice and group level. Funding could be dependent on achieving the Key Performance Indicators (KPIs) e.g. in relation to LARC fitting, HIV testing and Chlamydia screening. This could strengthen the role of GPs particularly in more rural areas and would allow GPs to develop a more integrated model of sexual health provision centred on primary care and targeted at more vulnerable communities. Increasing the number of pharmacists in these arrangements would be beneficial in rural settings.

Access to Information

Key issues and challenges identified by KIs included:

1.46 Information was needed re what services were available where. Just under half the respondents to the Survey Monkey questionnaire were unaware where they could access sexual health services in the WSCC area.

1.47 Some KIs felt that the Western Sussex Hospitals NHS Foundation Trust website was not youth friendly, was overly wordy and inappropriately targeted. It was felt that more use could be made of social media to advertise services (this seems supported by broader research[15] where teens seem to dominate traditional social networks like Facebook/Twitter). KIs felt that some strategic planning and development of mass and social media resources was necessary countywide. Preferred locations for information were schools, colleges and universities, GPs and pharmacies, local bars and clubs, NHS Direct (no longer in existence) and community health services.

1.48 There were different views expressed on the HIV Prevention England mass media campaign – some felt it relevant and valuable, others felt it was not branded in a way

[15] Source: Pew Research Center studies, 2013

that speaks to the populations it needs to reach in West Sussex. It was felt that there was a need to be more collaborative with key stakeholders about the messages to be relayed in any future campaigns. There was no consensus expressed on the effectiveness of sexual health prevention media campaigns in general and respondents to the stakeholder survey rated promotion of services to vulnerable groups as the area of current service delivery working least well.

1.49 Decommissioning of some local VCO providers has resulted in a shift in responsibilities with nurses in the Integrated Sexual Health Service (ISHS) delivering work to reach specific groups. However there was concern from some KIs about disinvestment in Lesbian, Gay, Bisexual (LGB) targeted work, especially for young people.

1.50 Recognising the limited role of councils in, Personal, Social and Health Education (PSHE) in the era of academies and free schools, access to Sex and Relationships Education (SRE) in schools and colleges was of concern. Many KIs felt that WSCC did not currently have comprehensive guidance to address young people's sexual health needs in schools and colleges.

1.51 There was universal consensus about the need for a consistent SRE policy that offers young people the right to access appropriate information and helps them make informed choices. (See the House of Commons Education Report, *Life Lessons: PSHE and SRE in schools*[16]).

1.52 KIs identified the specific needs of Looked After Children (LAC), including children and young people placed by another local authority in West Sussex, as a priority to address.

1.53 Most KIs felt that access to information and more innovative prevention ideas should be advertised through social media, but there was a difference in opinion about what they thought would work - some thought it should be factual information, others felt it should be more about directing people to services.

Access to Information

Key issues and challenges identified by SUs included:

[16] http://www.publications.parliament.uk/pa/cm201415/cmselect/cmeduc/145/14502.htm

1.54 Service users highlighted the need to normalise (i.e. not treat differently) good sexual health messages throughout life, starting with conversations when people are aged 11-12 through to older age groups. They also felt that subjects needed to cover more than STIs and preventing pregnancy e.g. including fertility, cervical screening, sexuality etc.

1.55 Older people thought there were missed opportunities to engage with their age group about good sexual health e.g. in the environment of wellness checks.

1.56 People highlighted the lack of posters in male and female toilet cubicles.

1.57 43% of survey respondents said they would not know where to go to get emergency contraception, and participants in the qualitative interviews believed that it was always free and that under 16s could get it. They were surprised that it could actually cost up to £30 if accessed through a pharmacy.

1.58 The group of young people in care who took part in a group discussion knew where to go for emergency hormonal contraception (EHC) – for them knowing there was emergency contraception was most important.

1.59 Participants felt that people with learning disabilities might not know where to go for EHC and that support workers might not be helping with this.

1.60 For those gay men and people affected by HIV surveyed, no one seemed to be aware of the potential to access post exposure prophylaxis after sexual exposure (PEPSE) at A&E.

1.61 Participants talked about using Google to find out where services were. An app for young people was mentioned and a number of people referred to Your Space. No one mentioned FPA or Brook as sources of information.

1.62 Contrary to broader research indicating a high use of social media by young people (in particular Facebook/Twitter)[17], a specific group of 'young people in care' when interviewed said they would not follow anything to do with sexual health on Twitter and similarly 84.1% of respondents to the survey stated they would not follow local sexual and reproductive health services even if they were on social media such as Facebook/Twitter.

[17] Source: Pew Research Center studies, 2013

Access to Information

SUGGESTED APPROACHES/RECOMMENDATIONS raised by KIs and SUs included:

1.63 ***Recommendation 26:*** The planned sexual health forum should be reintroduced to increase and improve communication with representatives across the provider and commissioning spectrum including the third sector and also service users (Appendix I).

1.64 ***Recommendation 27:*** An annual sexual health event[18] was suggested to share information, provide updates and provide opportunities for a question and answer session.

1.65 ***Recommendation 28:*** Access to information should be increased in relation to where services are, opening times and what they offer, in a range of community locations. Relevant information could be provided in public spaces such as libraries, swimming pools, pubs, and hairdressers in addition to the areas mentioned above.

1.66 ***Recommendation 29:*** All service providers and commissioners together with WSCC Children's Services department should consider the specific needs of LAC.

1.67 ***Recommendation 31/32:*** Although the young people interviewed/surveyed as part of this consultation seemed to indicate they would not follow local sexual and reproductive health services if they were on social media, commissioners may wish to specifically consult with young people on how they would wish to be engaged about sexual health through social media. This could include assessment of different IT engagement tools – such as use of podcasts and the WSHT website – could be reviewed in relation to their perceived 'youth friendliness' as part of this exercise.

1.68 ***Recommendation 33:*** There should be appropriate web links between WSCC and all its service providers, across all hub and spoke services provided by WSHT and third sector organisations.

1.69 ***Recommendation 37:*** There is a need to link in with HIV Prevention England more proactively and take the opportunity of using their resources.

[18] *Nudge Associates Limited note for consideration:* Would this need to be a stand-alone sexual health event, or could it be a wider public health event with a sexual health slant to it? If a wider PH event it could reinforce (i) the importance of sexual health as part of wider general health and well-being and (ii) the links between sexual ill health and risk-taking behaviour in the round, such as smoking, and use of alcohol and or recreational drug use?

Preventative Interventions

Key issues and challenges identified by KIs included:

1.70 Many KIs are frustrated by the lack of a coordinated response to STI/HIV prevention.

1.71 Concerns were raised about how to better align clinical service provision with the prevention agenda. Some KIs commented that solely providing negative diagnoses within a clinical setting was a missed opportunity with at risk individuals (e.g. those having unsafe sex). Proactive engagement on sexual behaviour is an important part of HIV/STI prevention and commissioned capacity for prevention within clinical settings to some seemed limited.

1.72 The lack of consistent SRE provision in schools was cited by almost all KIs as representing a major gap in health education and prevention work.

1.73 A significant number of KIs felt that messages promoting condom use had faded and that there needed to be a higher profile for their use. KIs expressed concern that access to resources for condoms and associated literature had been reduced. Some KIs highlighted that the C-Card scheme has only limited distribution points for access to free condoms.

1.74 Concern was also expressed about the increase in chemsex[19] amongst young gay men and the need to ensure that those involved have access to appropriate support as a priority.

1.75 The "Find it Out" services for young people were highly commended but there was frustration that there was only limited sexual health outreach provision available in the seven spoke services and therefore missed opportunities to offer information on sexual health.

1.76 Although there had been a reduction in teenage pregnancy, KIs considered that proactive prevention work on teenage pregnancy was not rigorous or effective enough to address unintended conception rates and repeat abortions amongst teenagers.

[19] Chemsex is a term that came from apps like Grindr, Scruff, BBRT (Bareback Real Time) and others. Chemsex (chemical sex) is just the slang term for sexualised drug use by men who have sex with men. It's usually defined by the use of crystal meth, mephedrone, GHB/GBL – just to facilitate sex."

Although there has been a reduction, it was expressed that more proactive prevention work would reduce those rates further.

1.77 Repeat termination rates (across all age groups) should be addressed offering access to all methods of contraception and in particular the most effective LARCs.

Preventative Interventions

Key issues and challenges identified by SUs included:

1.78 All highlighted the need to provide integrated health and social care services to promote good sexual health (as per WHO definition previous).

1.79 Only 22% of service users who responded to the survey had ever had a chlamydia test.

1.80 All the young people (aged 15-19) who took part in the survey had a chlamydia test over a year ago.

1.81 Only 25.6% of survey respondents had previously had a HIV test at some time.

1.82 Issues were highlighted around the use of drugs and alcohol increasing vulnerability and decision-making.

1.83 Service users highlighted the need to get the balance right to make people aware about the risks of unprotected sex with people from high prevalence HIV countries without appearing racist.

Preventative Interventions

SUGGESTED APPROACHES/RECOMMENDATIONS raised by KIs and SUs included:

1.84 ***Recommendation 39:*** Multi-disciplinary models of prevention and care would support the provision of prevention advice and could also provide co-commissioning opportunities in support of other public health issues such as alcohol and substance misuse and smoking.

1.85 ***Recommendation 40:*** WSCC could consider use of a consistent methodology applied across all settings, such as the BASK (behaviour, attitudes, skills and knowledge) model to evaluate the effectiveness of prevention with a range of voluntary community organisations (VCOs) currently commissioned to provide sexual health services, along with a standardised sexual health history taking pro-forma.

1.86 ***Recommendation 41:*** There is an opportunity to introduce STI/HIV testing and pregnancy testing in a broader range of community and primary care settings and to incorporate much broader risk factors (such as drug and alcohol misuse) into a more holistic intervention portfolio.

1.87 ***Recommendation 45:*** Recognising the increasing autonomy of schools and academies, WSCC could maintain an ongoing dialogue with school heads and governors about the public health importance of SRE in relation to normalising STI/HIV testing and chlamydia screening for the health benefits of young people.

1.88 ***Recommendation 48:*** Offering proactive support and counselling especially to young mothers who have repeated pregnancies and abortions and ensuring they have access to LARC should be maintained as priority.

1.89 ***Recommendation 49:*** Availability of condoms is fundamental to an effective prevention strategy. Improving the C-card scheme via updates and training of other non-sexual health professionals to help promote and administer the scheme was highly recommended.

Rapid Open Access to Integrated Sexual Health Services

Key issues and challenges identified by KIs included:

1.90 Only just half of respondents said they would know where to go to access sexual and reproductive health services, with slightly more saying they would know where to access emergency contraception.

1.91 There was widespread recognition that a large amount of work had been done since the re-commissioning of WSHNHST to provide integrated sexual health services in West Sussex, and that this had been done by close working together. There are however some agreed gaps in provision, e.g. the need for a level three integrated sexual health service in Bognor.

1.92 Many KIs welcomed the efforts of, and the benefits achieved by the outreach team.

1.93 Abortion services through British Pregnancy Advisory Service (BPAS) were widely commended by KIs for easy access and swift appointments, and the fact that they offered a range of STI tests and LARC after termination.

1.94 There were felt to be discrepancies in equal access to ISHSs provision due to differing opening times in all 3 hubs and spokes. It was felt that availability of staff rather than service need was taking priority in relation to opening times and more needed to be done to increase out of hour's provision. Respondents to the stakeholder survey also mentioned this.

1.95 Some KIs felt that too much priority was given in relation to provision in the coastal region and that not enough was done to address the gaps in rural areas, particularly in the context of poor and expensive transport links.

1.96 There is no central booking system for patients to use, no online/text based provision for booking appointments, obtaining results or for identifying opening times for services across the country.

1.97 There were mixed messages from service providers regarding the level of engagement with GPs and there were concerns that many pharmacies were not engaged with broader sexual health provision.

1.98 There is a perception that not all sexual health sessions have staff dual trained in both STI and contraception and available to provide a fully comprehensive level of service in all spokes and in some of the hub services.

Rapid Open Access to Integrated Sexual Health Services

Key issues and challenges identified by SUs included:

1.99 Everyone interviewed highlighted the lack of privacy and concerns about confidentiality that arose from having to go through a GP receptionist system to access sexual and reproduction health services and privacy/confidentiality was rated as the most important aspect by respondents to the survey. Nevertheless 68% said that they would prefer to attend services based at their GP practice because they offered a full range of sexual and reproductive health services. There were also problems of getting a GP appointment quickly and not being able to request a female or male doctor. One service user gave an example of waiting 3 weeks to see a female doctor.

1.100 There was some concern about the sharing of records. People with HIV had separate records on the GUM system but there were times when information had to be shared e.g. when starting medication or becoming ill and being admitted to hospital.

1.101 In general, design of physical space was highlighted as important to enable confidentiality and services should review their arrangements on an annual basis to

ensure their existing structure is working for service users. A question about this could be added to service user questionnaires.

1.102 Some expressed frustration with some systems of registration (e.g. filling in lengthy forms each time they attended).

1.103 Over 80% of people completing the survey could reach the main services by public transport. Around 16% of people could not and for a quarter of respondents, journeys could take over 30 minutes. Those living with HIV had longer journeys to specific centres providing HIV care. People living in rural areas also had longer journeys.

1.104 People living in the north west of the county were more likely to access services outside of the county. People were surprised that there seemed to be little provision in between Brighton and Crawley where populations were larger.

1.105 People highlighted the importance of having specialist and experienced staff on the premises, although it was felt they might not need this specialist attention every time they visited the service. Those affected by HIV talked about the need to maintain expertise for HIV and co-infections like hepatitis. The importance of good communications skills was highlighted. It was felt that highly qualified GP practice nurses should be able to provide contraception services and not just doctors. A number talked about having to go to their GP because they weren't aware of any alternative options for them.

1.106 Interview participants suggested that university students across West Sussex were more poorly served than college students.

1.107 People talked about the advantage of a well-stocked pharmacy adjacent to a clinic that was able to dispense prescriptions almost immediately.

1.108 Drop in services were highly rated by interviewees, who also stated that they wanted clinics to be open after normal 'school/work hours' later into the evenings and at weekends (opening on both Saturdays and Sundays). For young people in care, sexual health services being open at night was one of their most important things.

Rapid Open Access to Integrated Sexual Health Services

SUGGESTED APPROACHES/RECOMMENDATIONS raised by KIs and SUs included:

1.109 ***Recommendation 54:*** There was broad consensus that a site in Bognor be identified; agreed and refurbished to meet the gap in sexual health provision should be addressed as a priority.

1.110 ***Recommendation 52:*** There is a need to increase the number of STI/HIV tests in the community. There is an opportunity to work in closer partnership with the VCOs and other local services to provide point of care testing in a variety of settings especially in Crawley where the majority of the more vulnerable African communities live.

1.111 ***Recommendation 53:*** GPs interviewed felt that there would be benefit from WSCC introducing the Buddy scheme adopted in Surrey where GPs trained in sexual health are able to initiate and support the training and competences of their colleagues. In addition some felt that surgeries could carry out contraceptive implants and intrauterine contraceptive devices (IUCDs) through public health agreements for patients registered at neighbouring practices.

1.112 ***Recommendation 55:*** Where possible the work of the outreach team/outreach workers should be extended.

1.113 ***Recommendation 56:*** Discrete service for young people should be provided as a larger package in community settings including a more collaborative approach with drug and alcohol services, including pregnancy testing, Point of Care Testing (POCT), condoms and EHC.

1.114 ***Recommendation 57:*** Opening times across all services should be reviewed to ensure there is consistent accessibility across the county.

1.115 ***Recommendation 64:*** West Sussex should continue to support the HalveIt[20] Campaign, which is seen as an effective intervention.

Early Accurate Diagnosis and Treatment

Key issues and challenges identified by KIs included:

1.116 There was consensus that HIV/STI testing was an effective intervention.

[20] http://www.halveit.org.uk

1.117 Most KIs were unsure whether service users were getting early diagnoses and treatment; most felt that access to services in urban areas was adequate but not in more rural areas where access was unknown or patchy.

1.118 Opening hours were unknown by many KIs which raised questions as to how services are marketed by WSCC and the providers.

1.119 The clinical nurse HIV specialist team is a highly respected resource although there were some concerns that referral rates in the north of the county were lower than the country average.

1.120 KIs highly commended the single IT network (Blithe Lilie) for electronic patient records which enables enhanced clinical care, minimises duplication of records, facilitates partner notification and lowers infection rates.

Early Accurate Diagnosis and Treatment

Key issues and challenges identified by SUs included:

1.121 HIV testing is happening in some gay bars and clubs but not in all localities. Although there are no dedicated gay venues in Worthing, there appears to be no alternative outreach HIV testing activity in the area.

1.122 Young people in care rated services lower than most people who completed the survey.

1.123 For people diagnosed with HIV there was concern that reduced access to community support workers meant that when someone was diagnosed there was no one for them to talk to.

Early Accurate Diagnosis and Treatment

SUGGESTED APPROACHES/RECOMMENDATIONS raised by KIs and SUs included:

1.124 ***Recommendation 76:*** A coordinated engagement process with voluntary services, GPs, and statutory services to enhance the education and testing of vulnerable communities at venues and times outside traditional clinical services should be undertaken.

1.125 ***Recommendation 78:*** Increasing the referral rates to the clinical nurse HIV specialist team would benefit patients and support them at home. Increased numbers of

referrals from the Crawley clinic would be appropriate because Crawley's record of referrals is perceived by some KIs as too low.

1.126 ***Recommendation 79:*** A website for West Sussex that supports a central call centre with access to all integrated sexual health hub and spoke clinics would promote an efficient use of resources. A commissioned call centre for self-triage should be part of the computer programming as provided by a growing number of services around England.

1.127 ***Recommendation 80:*** Easier access to EHC in rural areas is essential.

Joined up provision

Key issues and challenges identified by KIs included:

1.128 Most KIs believed that service users were transferring seamlessly between the different services. Some however were concerned that people got lost between services e.g. GPs were singled out as no mechanism exists to evaluate the outcome of their referrals into or between sexual health services.

1.129 Some KIs were unclear regarding the totality of sexual health service provision. This lack of awareness among service providers was also mentioned in the stakeholder survey.

Joined up provision

Key issues and challenges identified by SUs included:

1.130 Everyone who took part in the interviews felt there should be one-stop shops delivering a full range of services. People were clear that they did not want to separate into community, ages or split into other groups.

1.131 Some people felt that it would be better to provide a few comprehensive services, open during evenings and weekends, strategically placed with good transport links, rather than lots of small services and mobile clinics. There was also concern regarding parity if mobile facilities were set up in some rural areas and not others.

Joined up provision

SUGGESTED APPROACHES/RECOMMENDATIONS raised by KIs and SUs included:

1.132 ***Recommendation 82:*** Commissioners should consider funding the development of a West Sussex clinical support network, which incorporates the HIV clinical nurse

specialist team. This should include funding a dedicated role to manage the network to coordinate services and delivery across the county in a similar fashion to the South West London HIV and Sexual Health Network (SWAGNET[21]).

1.133 ***Recommendation 84:*** Pathways between providers need to be better understood by all professions.

1.134 ***Recommendation 85:*** It is also recommended that there be more support for skills development and some felt the need for further training on confidentiality. The majority of KIs requested a specific HIV and sexual health training and development programme for all Local Authority partners, GPs with a special interest and third sector organisations.

1.135 ***Recommendation 86:*** Respondents to the stakeholder survey suggested the need for sexual health staff training in conducting child protection assessments, cultural awareness, drug cultures for young people, implant training, men who have sex with men issues, personal, social, health and economic education (PSHE) within schools, sexual health for people with disabilities, training for staff in children's centres about the C-Card, treating under-18s, understanding of domestic and sexual abuse, plus working with vulnerable children.

1.136 ***Recommendation 87:*** GPs with a special interest in sexual health services should be advertised so that their patients can approach those surgeries with confidence.

2 INTRODUCTION AND CONTEXT: COMMISSIONING LANDSCAPE

[21] http://www.swagnet.nhs.uk

NB: The term 'sexual health' used throughout this report includes sexual health, reproductive health and HIV.

2.1 In February 2014, West Sussex County Council (WSCC) commissioned Nudge Associates Limited to undertake a population based sexual health needs assessment (SHNA) incorporating a stakeholder engagement process to actively listen to the views of key informants (KIs) and service users (SUs) across a range of different specialities and involvement, all with an interest/role/view on the provision of sexual health services across the county.

2.2 The aim was to gather a comprehensive picture of the sexual health needs of the population of West Sussex; to examine the local epidemiological evidence and to elicit KIs opinions on whether the current delivery models meet the diverse population needs of West Sussex. This is not a clinical review, but rather an attempt to determine the most appropriate way forward for sexual health services throughout West Sussex.

2.3 Sexual Health is not just about preventing disease or infection but also means promoting good sexual health in a wider context, including relationships, sexuality and sexual rights.

2.4 From April 1st 2013, Local Authorities (LAs) took over the responsibility for public health from the NHS, including key responsibility for commissioning sexual health services to meet local population needs.

2.5 Responsibility for commissioning sexual health services now sits across LAs, Clinical Commissioning Groups (CCGs) and NHS England's (NHSE) Local Area Teams (LATs) (see Box A).

2.6 The Department of Health (DH), Public Health England (PHE) and NHS England (NHSE) have issued a range of guidance and other supporting documentation over the last year to support commissioning of sexual health services following transition (see 2.18).

2.7 The Health and Social Care Act 2012 has led to significant changes in structure, provision, incentives, regulation, commissioning and monitoring within LAs and health systems. Whilst the transition has been challenging and disruptive, there are now new opportunities to tackle sexual health inequalities and to embed an approach based on the social determinants of health across the system.

2.8 With the pursuit of quality improvement in service delivery, this can only be achieved with the full participation and collaboration between providers and commissioners across the partnership of NHS, Voluntary and Community Organisations (VCOs) and LAs. Any service configuration requires a shared strategic vision and approach, which should include KIs and SUs contributions with a view to developing proactive alliances between all stakeholders.

2.9 As part of their new commissioning role, WSCC are managing complex and fragmented pathways for sexual health with other local commissioning partners.

2.10 Key sexual health commissioning responsibilities for West Sussex County Council Public Health Team are:

- Open access Genito-Urinary Medicine
- Contraceptive services for all ages
- HIV testing
- Sexual health promotion

> ***"Changes to local health services are to be decided and led locally. Local healthcare organisations, doctors, nurses and other health professionals, with their knowledge of the patients they serve, are best placed to decide what services they need for patients in their area."***[22]

2.11 This population focused SHNA aims to inform future commissioning decisions. It is hope that WSCC notes the findings from this SHNA and gives careful and considered thought to future service configuration.

2.12 WSCC has responsibility for delivering on the indicators set out in the Public Health Outcomes Framework (PHOF). Taking on the critical role for local health improvement at a time of growing demand and potential diminishing funding requires confident and robust leadership from all stakeholders, robust service management and excellent commissioning relationships.

2.13 Local population sexual health statistics are documented in the epidemiology section of this report, and the LA should use the epidemiological evidence base to implement any changes to meet local population need – making decisions about how to redesign services and develop the organisational structures best suited to support and deliver them.

[22] Department of Health, England, 2012

2.14 Transforming services whilst simultaneously coping with complex organisational change, meeting operational and quality targets, plus aiming for improved outcomes with decreasing resources is a challenging agenda. Competing priorities faced by local government means that any reviews of services should address the longer-term financial implications and consequences.

2.15 A clear evidence base and knowledge of the needs of SUs should lead to intelligent procurement and evaluation.

> *Public sector bodies* ***"…must, when making decisions of a strategic nature about how to exercise its functions, have due regard to the desirability of exercising them in a way that is designed to reduce the inequalities of outcome which result from socio-economic disadvantage."***[23]

2.16 The overall sexual health budget is one of the largest budgets in public health, and by law, sexual health clinical services need to remain open access i.e. individuals are able to self-refer into services.

2.17 Nationally however, LAs will be required to make substantial savings and the sexual health budget is only 'ring fenced' until April 2016.

Guidance issued by Government

2.18 The Coalition Government has to date published six key documents to support LAs in their commissioning responsibilities for sexual health:

- A Framework for Sexual Health Improvement in England[24]
- Commissioning Sexual Health Services and Interventions: Best Practice for Local Authorities[25]
- Public Health Outcomes Framework 2013 to 2016[26]
- Integrated Sexual Health National Service Specification
- Public Health Services Contract
- Sexual Health Services: Key principles for cross charging

[23] The Equality Act, 2010

[24] https://www.gov.uk/government/publications/a-framework-for-sexual-health-improvement-in-england

[25] https://www.gov.uk/government/publications/commissioning-sexual-health-services-and-interventions-best-practice-guidance-for-local-authorities

[26] https://www.gov.uk/government/publications/healthy-lives-healthy-people-improving-outcomes-and-supporting-transparency

A Framework for Sexual health Improvement in England (Department of Health, 2013)[27]

2.19 This provides WSCC with a framework and guidance for planning and commissioning sexual health services.

2.20 The document is the result of detailed consultation with the Sexual Health Forum and the professional bodies (including BASHH, BHIVA, FSRH, MEDFASH), which represent the needs of providers. It aims to offer the best possible outcomes for SUs. The priority areas reflect the broad agreement of those concerned with improving sexual health.

2.21 The key aims for Government and LAs are to improve the sexual health and well-being of the whole population by:

- Reducing inequalities and improving sexual health outcomes
- Building an honest open culture where everyone is able to make informed and responsible choices about relationships and sex
- Recognising that sexual ill-health can affect all parts of society

2.22 Government has examined the evidence base for improved sexual health outcomes with relevant professional bodies highlighting 5 key objectives:

- Accurate, high-quality and timely information that helps people to make informed decisions about relationships, sex and sexual health[28]
- Preventative interventions that build personal resilience and self-esteem and promote healthy choices[29]
- Rapid access to confidential, open-access, integrated sexual health services in a range of settings, accessible at convenient times[30]
- Early, accurate and effective diagnosis and treatment of STIs, including HIV, combined with the notification of partners who may be at risk[31]
- Joined-up provision that enables seamless patient journeys across a range of sexual health and other services – this will include community gynaecology, antenatal and HIV treatment and care services in primary, secondary and community settings[32]

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[27] https://www.gov.uk/government/publications/a-framework-for-sexual-health-improvement-in-england

[28] Kirby D, *Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases*, National Campaign to Prevent Teen and Unplanned Pregnancy, 2007

[29] Ibid

[30] Building the Bypass – Implications of Improved Access to Sexual Healthcare', Mercer C et al, *Sexually Transmitted Infections* 2012; 88: 9–15

[31] Ibid

[32] Integration of STI and HIV Prevention, Care and Treatment into Family Planning Services: A Review of the Literature, Church K and Mayhew SH, Studies in Family Planning 2009; 40(3): 171–86

Commissioning Sexual Health Services and Interventions: Best Practice for Local Authorities (Department of Health, 2013)[33]

2.23 This guidance was issued prior to the transfer of responsibilities for commissioning sexual health to LAs in April 2013.

> ***"The significant expertise available in the field of sexual and reproductive health and HIV can be used to support the achievement of local public health outcomes. To optimise these outcomes, local government will need to commission services that ensure open access in a timely manner. There is strong evidence to suggest that people should be able to receive sexual and reproductive healthcare within 48-hours of seeking to do so and faster if care is urgent."***[34]

2.24 The Local Authorities (Public Health Functions and Entry to Premises by Local Health Watch Representatives) Regulations 2013 require LAs to arrange for the provision of certain services, including:

- Open access sexual health services for everyone present in their area, covering free HIV and STI testing and treatment;
- Notification of sexual partners of infected persons; and
- Free contraception and reasonable access to all methods of contraception.

2.25 The regulations require LAs to provide these services but they do not set out how the services should be provided, nor impose any requirements on the numbers of services, locations, opening times, type of service model, waiting times or staffing levels. All of these will be determined locally and will make a difference to the quality of services and the achievement of the PHOF.

2.26 SUs attending from 'out of area' are able to access services wherever they are but LAs will need to arrange out of area payments for sexual health services, which are consistent with confidentiality requirements and an agreed tariff price.

2.27 HIV testing will be the responsibility of the LAs although treatment and care costs will be the responsibility of the specialist commissioners in NHSE.

Public Health Outcomes Framework 2013 to 2016 (Department of Health, 2014)[35]

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[33] https://www.gov.uk/government/publications/commissioning-sexual-health-services-and-interventions-best-practice-guidance-for-local-authorities

[34] Sexual and Reproductive Health and HIV: Crucial Issues for Health JSNAs and Local Health and Well-being Strategies: BASHH, BHIVA, THT, MEDFASH et. al. 2012

[35] https://www.gov.uk/government/publications/healthy-lives-healthy-people-improving-outcomes-and-supporting-transparency

2.28 The public health outcomes framework for England sets out objectives for the public health system in the 3 years from April 2013. It consists of 4 domains and over 60 indicators for measuring progress. Three indicators specific to sexual health are within domain two and three as follows:

- **Domain 1: Improving the wider determinants of health**
    - Objective: improvements against wider factors that affect health and well-being and health inequalities

- **Domain 2: Health improvement**
    - Objective: people are helped to live healthy lifestyles, make healthy choices and reduce health inequalities
        - **Under-18 conceptions**

- **Domain 3: Health protection**
    - Objective: the population's health is protected from major incidents and other threats, while reducing health inequalities
        - **Chlamydia diagnoses rates (15–24 year olds)**
        - **People presenting with HIV at a late stage of infection**

- **Domain 4: Healthcare public health and preventing premature mortality**
    - Objective: reduced numbers of people living with preventable ill health and people dying prematurely, while reducing the gap between communities

2.29 Coordinated efforts of local authorities through both public health and social care – and combined contributions with the NHS to improve outcomes for specific groups are required to meet these indicators. The following table highlights:

- The local authority commissioning responsibilities related to the indicators outlined in the Department of Health's Public health in local government: commissioning responsibilities
- The Department of Health's reasons for including each of the indicators in the framework, outlined in the technical specifications for the framework
- Links to NICE Pathways that include the guidance. NICE Pathways are interactive flow diagrams showing how all the NICE recommendations for a particular topic fit together, whether they are about public health, disease prevention in the NHS, clinical care or social care
- Identifies the indicators in Domain 4 that are shared with the NHS outcomes framework

2.30 The professional bodies (FSRH, BASHH, BHIVA) have also stated that aiming for and achieving the following additional outcomes would bring significant further benefits to sexual health[36]:

- Giving women of all ages control of their fertility through access to a full range of contraceptive choices and abortion
- A reduction in new diagnoses of other STIs including gonorrhoea & genital warts

[36] Sexual and Reproductive Health and HIV: Crucial Issues for Health JSNAs and local Health and Well Being Strategies: BASHH, BHIVA, THT, MEDFASH et. al. 2012

Public health outcomes framework	Rationale for including	Local authority commissioning responsibility	NICE Pathway with recommendations	Links to individual NICE guidance documents
Under-18 conceptions	The inclusion of this indicator signals the continuing importance of teenage pregnancy as a key measure of health inequalities and child poverty. Reducing under-18 conceptions has important benefits for short and long term health outcomes. Teenage parents are at increased risk of postnatal depression and poor mental health in the three years following birth. They are more likely than older mothers to have low educational attainment, experience adult unemployment and be living in poverty at age 30. Their children experience higher rates of infant mortality and low birth weight, A&E admissions for accidents, and have a much higher risk of being born into poverty.	Comprehensive sexual health services; Local initiatives to tackle social exclusion.	Preventing sexually transmitted infections and under-18 conceptions	**Published** Prevention of sexually transmitted infections and under-18 conceptions (NICE Public Health Guidance 3) Long-acting reversible contraception (NICE Clinical Guideline 30)
Chlamydia diagnoses rates (15–24 year olds)	Chlamydia causes avoidable sexual and reproductive ill health, including symptomatic acute infection and complications such as pelvic inflammatory disease (PID), ectopic pregnancy and tubal-factor infertility. The chlamydia diagnosis rate among under-25s is a measure of chlamydia control activities that can be correlated to changes in chlamydia prevalence (and thereby to changes in ill health due to chlamydia). Increasing the diagnostic rate will reduce the prevalence of asymptomatic infections. Inclusion of this indicator in the 'Public	Comprehensive sexual health services; Public health services for children and young people aged 5–19.	Preventing sexually transmitted infections and under-18 conceptions	**Published** Prevention of sexually transmitted infections and under-18 conceptions (NICE Public Health Guidance 3)

	health outcomes framework' will allow progress that has already been made towards establishing widely available access to chlamydia screening though a range of health services to be built upon over the coming years.			
People presenting with HIV at a late stage of infection	The late HIV diagnosis indicator is essential to evaluate and promote public health and prevention efforts to tackle the impact of HIV infection. Over half of patients newly diagnosed in the UK are diagnosed late and 90% of deaths among HIV positive individuals within one year of diagnosis are among those diagnosed late. Inclusion of this indicator in the 'Public health outcomes framework' will focus efforts to expand HIV testing and to reduce late HIV diagnoses in the UK. Without a reduction in late HIV diagnosis, consequences may include: continued high levels of short-term mortality in those diagnosed late, poor prognosis for individuals diagnosed late, onward transmission of HIV and higher healthcare costs.	Comprehensive sexual health services; Supporting, reviewing and challenging delivery of key public health funded and NHS delivered services such as immunisation and screening programmes.	Preventing sexually transmitted infections and under-18 conceptions HIV testing and prevention	**Published** Prevention of sexually transmitted infections and under-18 conceptions (NICE public health guidance 3) Increasing the uptake of HIV testing among black Africans in England (NICE public health guidance 33) Increasing the uptake of HIV testing among men who have sex with men (NICE public health guidance 34)

3 ABOUT THE SEXUAL HEALTH NEEDS ASSESSMENT METHODOLOGY

3.1 The Department of Health guidance on JSNA defined needs assessment as*: "A systematic method for reviewing the health and well-being needs of a population, leading to agreed commissioning priorities that will improve health and well-being outcomes and reduce inequalities."*

3.2 The methodology used in this West Sussex SHNA has followed *'Sexual Health Needs Assessment – A How to Guide', 2007* – that was commissioned by the Department of Health National Support Team. It includes 'epidemiological, corporate and comparative approaches as well as a prominent public voice' that aims to provide insight into existing inequalities in sexual health.

3.3 A mixed methodology with three core elements to support triangulation of evidence was used:

- Desk-based literature/data review and analysis
- Key Stakeholder/Key Informant interviews
- Service User engagement/consultation

Desk-based literature/data review and analysis

3.4 The project team reviewed and analysed literature and quantitative data from a range of national and local data sources. Analysis also mapped existing service provision and the characteristics of SUs.

3.5 To ensure confidentiality and anonymity of data, all identifiers were stripped prior to data transfer from WSCC to Nudge Associates Limited. Data was only used for the purpose of this SHNA and ownership remains with WSCC.

Key Stakeholder/Key Informant interviews

3.6 The purpose of this stakeholder engagement process was to elicit views from a wide range of providers (in health and LAs), commissioners, clinicians, primary care and other interested stakeholders, and to ensure that those views are incorporated into a decision making process for the future direction, planning and delivery of sexual health services in West Sussex.

3.7 KIs were identified in liaison with commissioners and Nudge Associates Limited gathered views from these KIs to bring a further level of intelligence to the SHNA. The stakeholder consultation element consisted of round table discussions, face-to-face, interviews, telephone interviews and a stakeholder survey.

3.8 A semi-structured question framework was employed as a method to collect qualitative data from KI interviews to ensure consistency in discussions. It was based on the 'Key Question Framework' that was developed by members of Nudge Associates Limited while members of the DH National Support Teams for Sexual Health, Response to Sexual Violence and Teenage Pregnancy.

3.9 In addition an online Stakeholder Survey was conducted between 1st April and 9th May 2014.

Service User engagement/consultation

3.10 A core component of the SHNA was the inclusion of views and experiences of both existing SUs, along with those not at present using sexual health services to help identify unmet need across West Sussex.

3.11 An online survey was conducted with SUs and non-SUs (between 1 April 2014 and 9 May 2014). In addition to this, with a view to gathering more detailed insight into the needs and experiences of people living and working in West Sussex, the following qualitative research was also undertaken:

- A facilitated discussion group with young people with experience of being in care
- Six in-depth discussions (1.5 hours each)
- Eight telephone interviews (20-30 minutes each)

3.12 Maps were created to provide an immediate, visual snapshot of service distribution and to enable and support the reader to make an assessment leading to decision-making.

4 A SEXUAL HEALTH REVIEW OF THE LITERATURE

Why good sexual health matters

4.1 While sexual relationships are essentially private matters, good sexual health is important to individuals and to society. It is therefore important to have the right support and services to promote good sexual health. The DH has developed guidance to provide the information and evidence base to enable everyone involved in sexual health to work collaboratively to ensure that accessible, high quality services and interventions are available.

4.2 Provision of sexual health services is complex and there is a wide range of providers, including general practice, community services, acute hospitals, pharmacies and the voluntary, charitable and independent sector.

4.3 All commissioners and providers need to work together to improve sexual health services and to ensure good-quality services and good outcomes. How commissioners implement and take forward work on sexual health at a local level will be influenced by the work of their health and well-being board.

4.4 Health and well-being boards assess current and future local health and care needs through Joint Strategic Needs Assessments (JSNAs), and develop Joint Health and Well-being Strategies to meet the identified needs. These inform local commissioning through the NHSE, CCGs and the LA.

4.5 Following the 2010 White Paper 'Equity and excellence: Liberating the NHS', LAs now lead the development of JSNAs, working with CCGs and other agencies. The White Paper set out how CCGs will have 'a duty' to promote equalities and to work in partnership with LA, for instance in relation to health and adult social care, early years services, public health, safeguarding, and the well-being of local populations.

4.6 This Sexual Health Needs Assessment forms part of the West Sussex JSNA.

4.7 More detailed reports / needs assessments have been completed within West Sussex for a number of other important areas of health and social care that have associated implications for sexual health.

4.8 This section presents a summary of key literature reviewed by Nudge Associates Limited (see Box B).

Box B: A summary of key literature reviewed

– West Sussex Alcohol and Drug Needs Assessment (2014)
– NHS Sussex – Military Veterans Health Needs Assessment (2012)
– OPM – Health and social care needs of Gypsies and Travellers in West Sussex (2010)
– ICPR – An assessment of the needs of detainees in West Sussex immigration removal centres (2012)
– West Sussex NHS PC Trust – Lifestyles of 16-24 year olds in HE and FE Colleges in West Sussex (2008)
– West Sussex NHS PC Trust – Needs Assessment of Vulnerable and Looked After Children in West Sussex (2008)
– West Sussex County Council – West Sussex Mental Health Needs Assessment (Adults) (2014)
– Therapeutic Solutions – Sussex Police Custody and SARC Health Needs Assessment (2013)
– Care Quality Commission Report – Worthing Sexual Health Clinic (2013)
– Adults with Autism (2013) – addition to commissioner list
– An Assessment of the Health Needs of Offenders in West Sussex – final report. (Institute of Criminal Policy Research, 2011)

West Sussex Alcohol and Drug Needs Assessment (2014)

4.9 The report found West Sussex is adequately resourced in relation to the provision of alcohol and drug services compared with other LAs. There are a wide variety of services that play an important role in responding to need. However, links and partnership working between specialist, non-specialists and community organisations/resources could be improved significantly.

4.10 The report points to concern at inconsistent data on the prevalence of injecting drug use, which does not match the data on the number of needles and syringes dispensed, nor the numbers of users presenting at clinics. There is also a lack of data in relation to current service provision for those with co-occurring disorders.

4.11 Mutual-aid and self-help groups are not well publicised or engaged with across the County, and services had not appeared to have grasped the shift in policy towards a recovery model which emphasises the importance of placing users of services as experts in their own recovery.

4.12 There were no specific findings or recommendations in relation to sexual health but the links between risk-taking behaviours are well recognised and alcohol and drug services have a role to play in delivering accessible services.

NHS Sussex – Military Veterans Health Needs Assessment (2012)

4.13 Using national prevalence assumptions it is estimated that there are approximately 66,405 military veterans in West Sussex - dominated by World War II veterans, or those who were subject to compulsory National Service. It is expected that the overall number of veterans will decline, and the average age of veterans will fall in future.

4.14 Under the Military Covenant[37] the Government has committed to ensure that veterans who have sustained serious genital injuries should be guaranteed three cycles of IVF treatment, and the report recommends that local Armed Forces Networks[38] should consider how they could ensure that all younger veterans are aware of this entitlement. CCGs should ensure that policies relating to IVF acknowledge this but there is no data available on the prevalence of serious genital injuries among military veterans.

4.15 Veterans are surviving more severe and complex injuries and are significantly more likely to report long-term health problems than their peers in the general population.

4.16 The most common mental health conditions are depression and anxiety (as for the general population) and alcohol misuse is much more frequent than in the general population, particularly for those that have been to combat zones in Iraq or Afghanistan.

4.17 This report does not make reference to sexual health, but given that the military is currently predominantly a young, sexually active and globally mobile population and that military personnel/veterans have a higher prevalence of risk-behaviour such as excessive drinking, sexual health should be an important aspect for WSCC to note for this population group.

OPM – Health and social care needs of Gypsies and Travellers in West Sussex (2010)

4.18 While the lack of systematic ethnic monitoring of Gypsies and Travellers makes accurate quantification difficult, the report makes a broad estimate that there are between 3,000 and 3,500 Gypsies and Travellers in West Sussex, living in a variety of permanent authorised LA sites, permanent authorised private sites, unauthorised developments and encampments, and in bricks and mortar housing.

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[37] Ministry of Defence. The Armed Forces Covenant: Today and Tomorrow. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/49469/the_armed_forces_covenant.pdf

[38] The South East Coast Armed Forces Network was launched in February 2011, and covers Kent, Surrey and Sussex.

4.19 The report draws significantly on previous research[39] examining the health of Gypsies and Travellers in England on behalf of the Department of Health, noting significantly poorer health outcomes than the general population, and in comparison to other English-speaking ethnic minorities.

4.20 Within the Gypsy and Traveller community there are culturally distinct beliefs and attitudes around health. These include: cultural taboos around the discussion of men's health, with men dismissing minor health complaints as insignificant and being reluctant embarrassed about going to see a doctor; strong belief in self-reliance, resulting in an aversion to seeking help from statutory services or others and a stoicism about poor health and pain with a fatalistic and nihilistic attitude to health.

4.21 Reproductive health issues such as miscarriages, stillbirths and neonatal deaths and premature deaths of older offspring, in part due to poor access to and uptake of maternity services are reported.

4.22 Accessibility of GPs and the need for better cultural awareness amongst health professionals was highlighted, as was the central importance of word-of-mouth and the reliance on trusted, established relationships in transmitting knowledge and information about health and social care services to members of the Gypsies and Travellers community.

The Institute for Criminal Policy Research (ICPR) – An Assessment of the Needs of Detainees in West Sussex Immigration Removal Centres (2012)

4.23 Within West Sussex there are two local Immigration Removal Centres (IRCs) (Brook House and Tinsley House) and pre-departure accommodation for children and families at Cedars. The report highlights particular mental health issues for detainees and notes a number of potential barriers including language, social deprivation and history of traumatic experiences.

4.24 Detention Services Operating Standards for initial health screening includes experiences of trauma or torture and HIV risk assessment with testing. For the calendar year 2011, six detainees were recorded as being HIV positive.

West Sussex NHS PCT – Lifestyles of 16-24 year olds in Higher Education (HF) and Further Education (FE) Colleges in West Sussex (2008)

[39] *The Health Status of Gypsies and Travellers in England*, report for the Department of Health, Parry et al, University of Sheffield, October 2004. https://www.shef.ac.uk/scharr/research/publications/travellers

4.25 2,672 students completed this survey, and 94% of students reported that they were heterosexual, 2.9% bisexual, 0.2% lesbian, 1.1% gay, 0.4% transsexual and 1.3% unsure.

4.26 It incorporated a series of questions about sexual behaviours and risk taking. Key points to note were:

- The proportion of the 16-19 age group who had first had sex before the age of 16 was higher than that reported in the 2001 National Survey of Sexual Attitudes and Lifestyles (NATSAL), suggesting young people are becoming sexually active at an earlier age
- A strong relationships between a number of lifestyle factors and the likelihood of students having had sexual intercourse, including smoking and drinking alcohol regularly
- Almost one in four females (36.9%) and just under a fifth (19.0%) of males thought that they should have waited longer before having sexual intercourse for the first time
- High non-use of contraception at first intercourse
- Among males, 19.9% had had a test for an STI and 6.1% had had an STI. The figures for females were 27.8% and 2.9% respectively. There was an association between the number of sexual partners and the likelihood of acquiring an STI; and Behavioural risk-taking was reported with one in three males and one in four females regularly consuming alcohol, and a quarter admitted to regularly binge drinking. Half of males and a third of females said they had tried cannabis, with 10.9% of males and 2.5% of females stating they were regular users. Around one in five students said they had tried Class A drugs, the majority of whom were occasional users (17.6%) rather than regular users (1.2%)

West Sussex NHS PCT – Needs Assessment of Vulnerable and Looked After Children in West Sussex (2008)

4.27 The report included any child or young person who was looked after (in public care), anyone who had left care in the last two years (under 20 years of age) and those under 18 years who were considered by health or social services to be 'high risk'.

4.28 Of particular note for this literature review, the needs assessment highlighted that children and young people who are looked after are vulnerable to risk taking behaviour, including substance misuse and unsafe sex.

4.29 At time of publication, there was also concern about increasing numbers of unaccompanied asylum seeking children (UASC).

4.30 Looked After Children (LAC) Nurses were seen as providing a valuable service and are viewed as being best placed to give teenagers in care advice about sexual health.

4.31 The report also stated, the Government's Care Matters White Paper and Children and Young Persons Bill recommends promoting health and well-being (including sexual health), and that *'ensuring that the individuals in day to day contact with children and young people in care are better able to provide sex and relationship education'* will be a priority.

West Sussex County Council – West Sussex Mental Health Needs Assessment (Adults) (2014)

4.32 This report does not make reference to sexual health, but given a wider definition of sexual health that encompasses emotional well-being, sexual health should be an important aspect for WSCC to note for this population group.

Therapeutic Solutions – Sussex Police Custody and SARC Health Needs Assessment (2013)

4.33 In Sussex the Sexual Assault Referral Centre (SARC) service is provided at SATURN Centre, which is based at Crawley Hospital and covers East Sussex, West Sussex and Brighton & Hove. The Centre has been operating since 2008, and provides a range of services for men and women aged 14 and above who have been sexually assaulted or raped in Sussex.

4.34 The Sussex Police Custody and SARC Health Needs Assessment conducted in 2013 reported that:

- The epidemiological analysis suggests that actual demand matches expected levels of need. The service uptake is within the estimates of reports to the police
- The introduction of a police champion for the SARC has facilitated engagement from the police and resulted in an increased number of referrals. However, the effect has since decreased
- The 10 key elements of a SARC services (see Appendix F) have mostly been met. However it was acknowledged that after a brief risk assessment by a Forensic Medical Examiner, the current provision of a three-day starter pack of PEPSE was possibly too short, especially over weekends and bank holidays, and should be extended to five days
- The report stated most users were white British female and 90% of referrals came via the police
- The needs assessment specifically recommended improving service uptake and referrals from other sources by raising awareness in relevant services such as primary care, accident & emergency and sexual health services

Care Quality Commission (CQC) Report – Worthing Sexual health Clinic (2013)

4.35 The Care Quality Commission inspected the following standards as part of a routine inspection in May 2013:

- Respecting and involving people who use services – Met this standard
- Consent to care and treatment – Met this standard
- Care and welfare of people who use services – Met this standard
- Safeguarding people who use services from abuse – Met this standard
- Cleanliness and infection control – Met this standard
- Assessing and monitoring the quality of service provision – Met this standard

4.36 The inspection report notes that they were unable to speak with any people who used the service, as the personal nature of the service meant that it was inappropriate to speak with people during the inspection, and contact details were confidential.

4.37 The report states that the staff team were passionate about their work, had very good specific subject knowledge and a wider understanding of how this could be applied in their everyday work. They understood the risks associated with working in the field of sexual health and family planning and took steps to mitigate against these risks.

Adults with Autism Needs Assessment (2013)

4.38 This assessment focuses on adults (people aged 18 years or over), with autism, however given the importance of provision in the early adult / teenage years, (14 years +) services at the transition period are also included. While there are a number of problems estimating the number of young people and adults who have autism, it is estimated that there are 7,100 people aged 18 and over living in West Sussex with Autism, with the majority of these being men.

4.39 The report notes that interviews with a group of local stakeholders (organisations) focusing on what was working well locally in terms of autism provision, suggested that targeted work to map sexual behaviour conducted by the sexual health team had been positively reviewed (no further details are given).

4.40 ***An Assessment of the Health Needs of Offenders in West Sussex – final report. (Institute of Criminal Policy Research, 2011)***

There is limited available research on the physical health needs of offenders in both prison and community settings. The available research shows that compared to the

general population, prisoners have *"higher rates of sexually transmitted infections, hepatitis B and C, and HIV."* [40]

[40] Referenced in Rennie et al. 2009

5 EPIDEMIOLOGICAL ANALYSIS

5.1 This section makes use of routinely available data sources to provide an overview of the epidemiology of sexual health in West Sussex, including trends and variations in HIV and STI prevalence, teenage pregnancy rates, contraceptive provision and abortion rates. The large majority of this information is residence based and is presented either for West Sussex as a whole or by the seven West Sussex districts of Adur, Arun, Chichester, Crawley, Horsham, Mid Sussex and Worthing. The data provides an overview of the sexual health needs for the population of West Sussex.

5.2 The districts of West Sussex can be mapped geographically to the three CCGs within the County, although the boundaries of Coastal West Sussex CCG do not match exactly with the boundaries of its constituent districts of Adur, Arun, Mid Sussex and Worthing. (Horsham and Mid Sussex districts cover the Horsham and Mid Sussex CCG area and Crawley district covers Crawley CCG.)

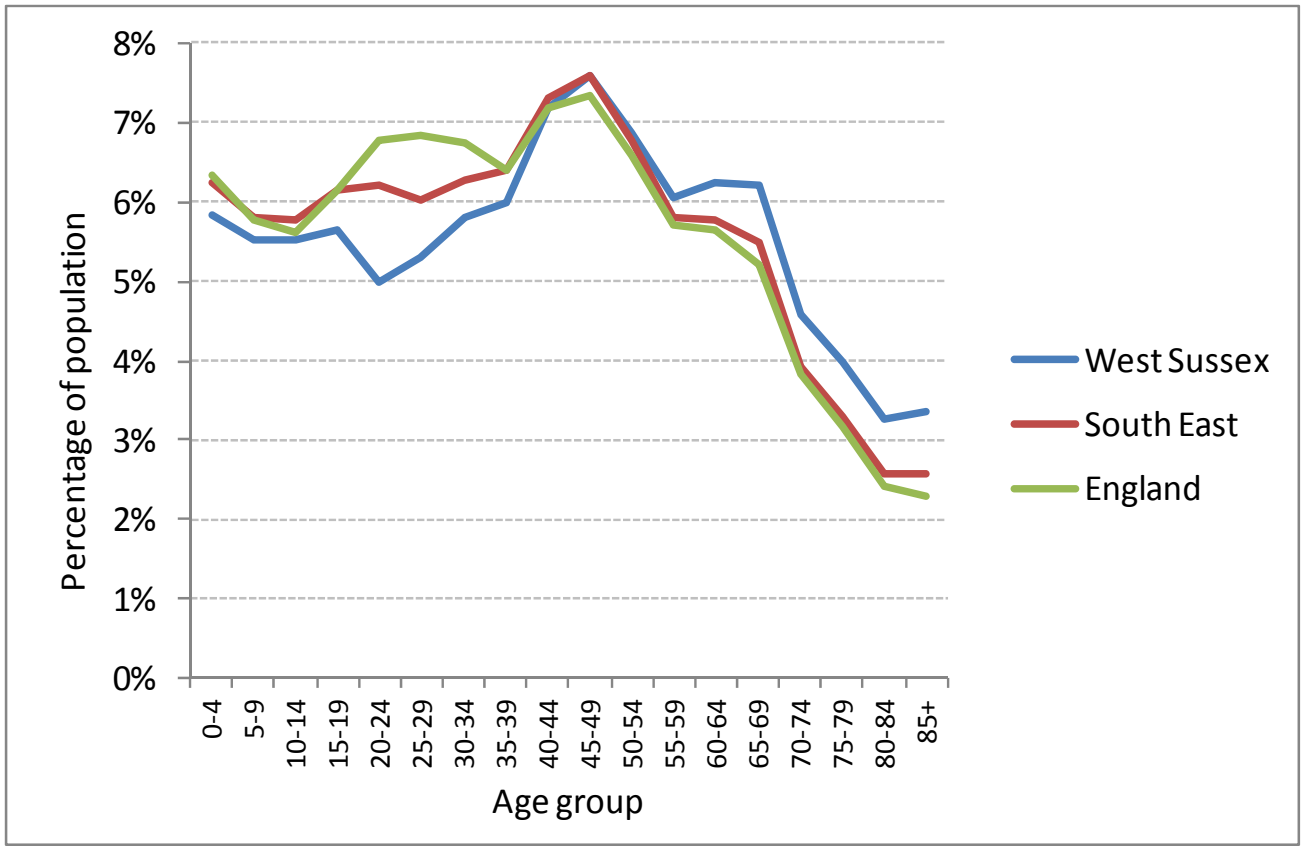
5.3 Analysis also includes Genito-Urinary Clinic Activity Dataset (GUMCAD) data, which relates specifically to patient attendances and diagnoses at the three GUM clinics in West Sussex at Crawley Hospital, The Warren Browne Unit (Worthing) and St Richard's Hospital (Chichester). This data gives an overview of activity at each clinic and includes both residents of West Sussex and clinic attendees living outside the West Sussex area.

West Sussex Sexual Health Profile

Demography

5.4 When compared with the population of England, West Sussex's population of around 815,000 has an older profile with a larger proportion of people in all age groups over 60 years and a smaller proportion of younger people aged 15-39 years (see Figure 1).

Figure 1: West Sussex, South East and England age profile, 2012



Source: ONS mid-2012 population estimates based on 2011 Census results

5.5 Across the seven county district areas in West Sussex, Arun has the largest population (151,000) followed by Mid Sussex (141,000) and Horsham (132,000). The remaining four districts have populations ranging between 62,000 and 115,000 (see Table 1).

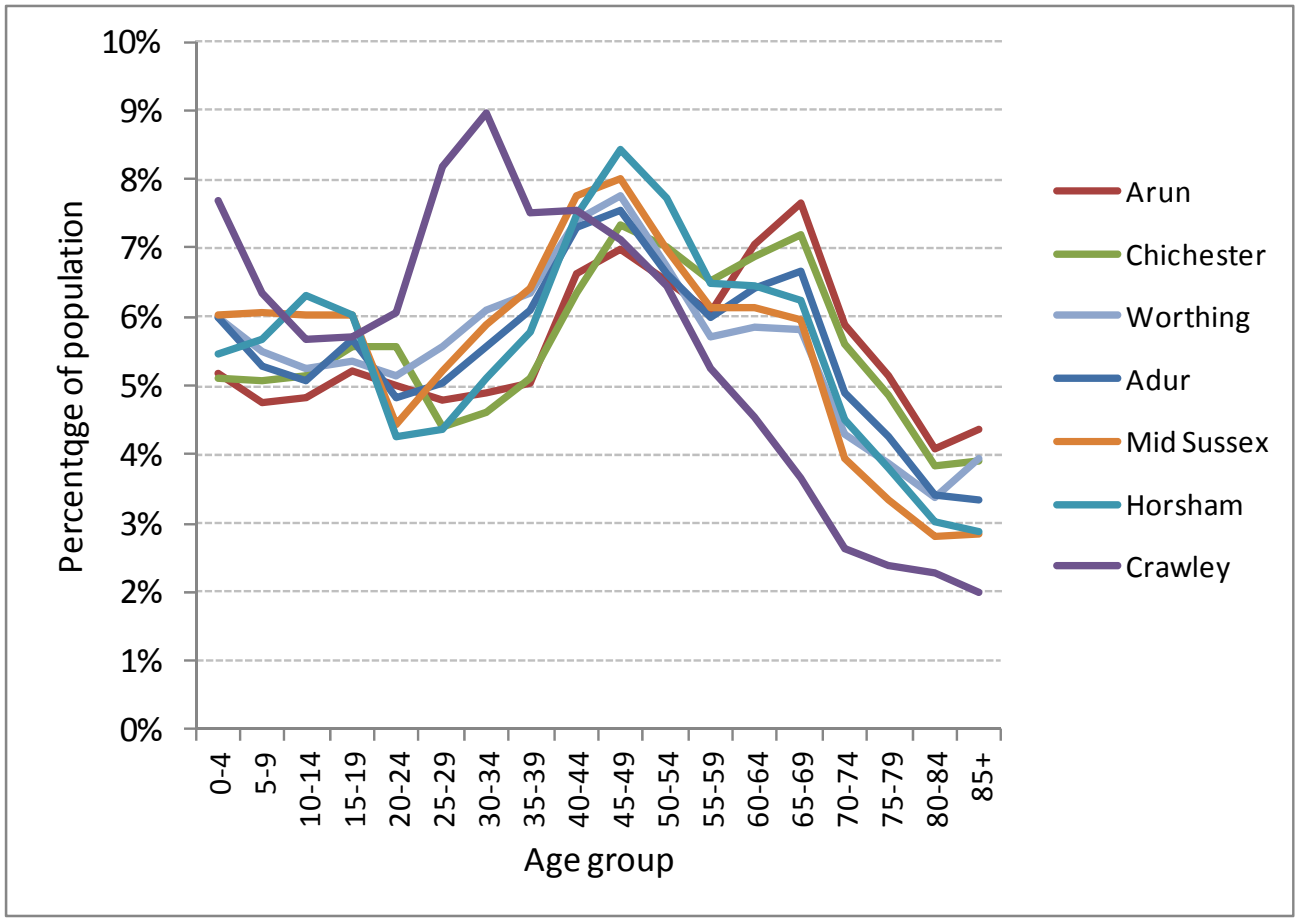
Table 1: Population by West Sussex district and age group, mid-2012

Age group	Adur	Arun	Chichester	Crawley	Horsham	Mid Sussex	Worthing	West Sussex
<15	10,110	22,310	17,540	21,320	23,040	25,530	17,660	137,510
15-29	9,620	22,690	17,780	21,620	19,330	22,100	17,010	130,150
30-44	11,750	25,070	18,350	26,040	24,320	28,330	20,960	154,820
45-64	16,470	40,250	31,760	25,290	38,420	38,470	27,520	218,180
65+	13,980	41,060	29,090	14,020	27,060	26,730	22,500	174,450
Total	61,930	151,380	114,520	108,300	132,160	141,160	105,660	815,120

Source: ONS mid-2012 population estimates based on 2011 Census results

5.6 Populations within each district have a similar age pattern (see Figure 2). The only exception is Crawley, which has a slightly younger population with 31% of the population aged 20-39, compared with between 20-23% in the other districts.

Figure 2: Population by West Sussex district and age group, mid-2012



Source: ONS mid-2012 population estimates based on 2011 Census results

Deprivation and health profile

5.7 West Sussex is among the least deprived areas in England, with around a third of the population living in areas classified among the 20% least deprived nationally, and over half living in the least deprived 40% of areas. However, there are pockets of deprivation across the County, most notably in Crawley and some coastal areas in Arun and Adur.

5.8 Overall, the health of residents in West Sussex is generally better than the England average across a wide range of health measures. Life expectancy, rates of early mortality from cancer and circulatory disease, smoking related deaths, alcohol-related admissions and physical activity rates are all better than the national average. On some health indictors, West Sussex residents have poorer outcomes that the national average, including rates of adult obesity, incidence of malignant melanoma and road traffic accidents.

5.9 For West Sussex as a whole, rates of sexually transmitted infections (STIs) and teenage pregnancy are below the national average, but across districts within West Sussex the picture is less uniform with some areas having rates of STIs and teenage pregnancy above the England average. In 2012/13, Crawley, Worthing and Arun also had pelvic inflammatory disease (PID) admissions and sexual offences rates above the national average and Adur, Worthing and Arun had under-18 alcohol-specific hospital stays higher than the England rate.

5.10 There are also significant health inequalities between the most and least deprived areas in West Sussex, as reflected in a difference in life expectancy of around seven years for men, and five year for women.

HIV

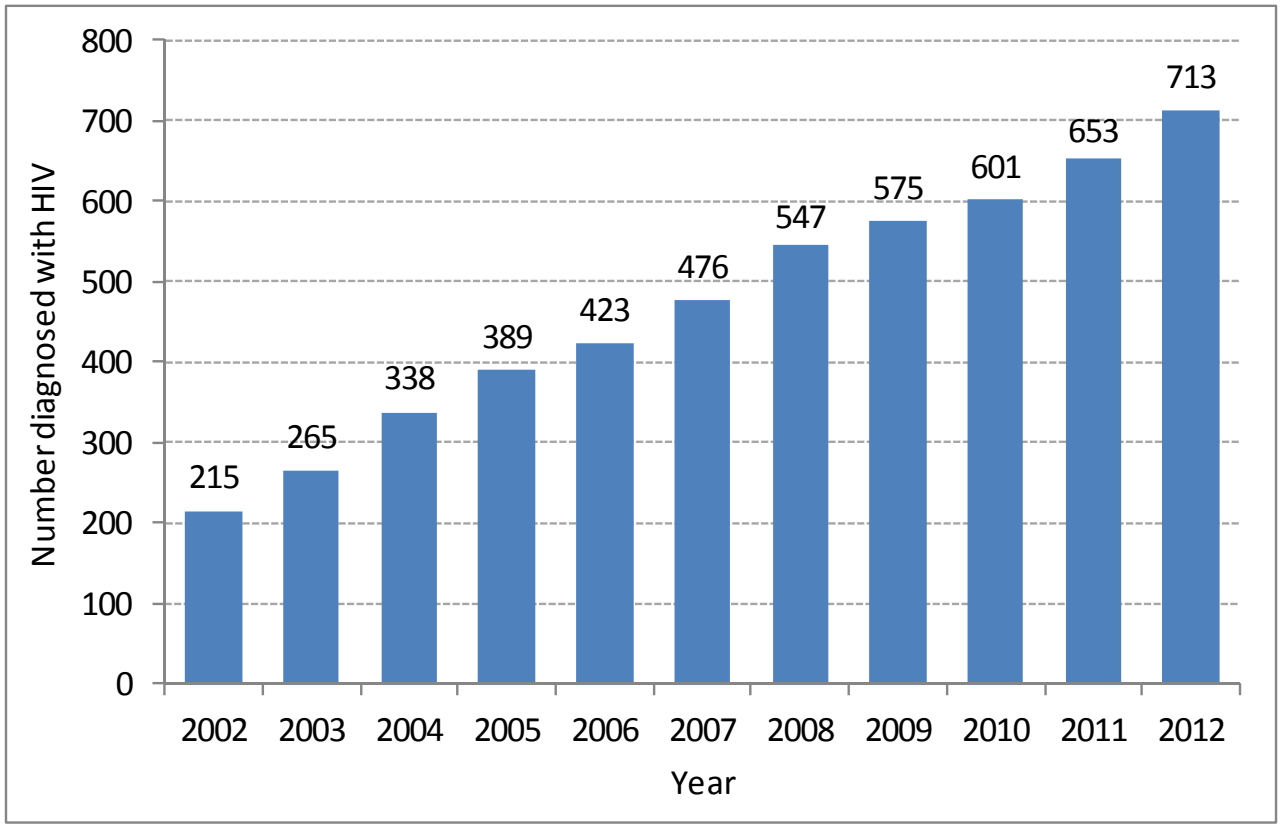
5.11 Statistics on HIV are collated and disseminated by Public Health England (PHE), which conducts the Survey of Prevalent HIV Infections Diagnosed (SOPHID) to record data on all individuals with diagnosed HIV infection receiving HIV-related care within the NHS. PHE also collects other survey data to estimate the number of individuals with undiagnosed HIV in the population and has reporting mechanisms in place to record uptake rates of HIV testing.

5.12 Whilst PHE data on HIV is both comprehensive and detailed, some caution is required when interpreting the data, especially at a local level, due to potentially considerable time lags between HIV infection and diagnosis and because of the mobility of individuals with HIV in and out of an area. Nevertheless, the available data on HIV can provide a robust picture of trends and should inform the provision of diagnostic and treatment services for HIV.

HIV Prevalence: numbers

5.13 The number of people with diagnosed HIV in West Sussex has increased year on year from 215 in 2002, to 713 in 2012 (see figure 3). The upward trend has been sustained over recent years, with a 19% increase in numbers between 2010 and 2012.

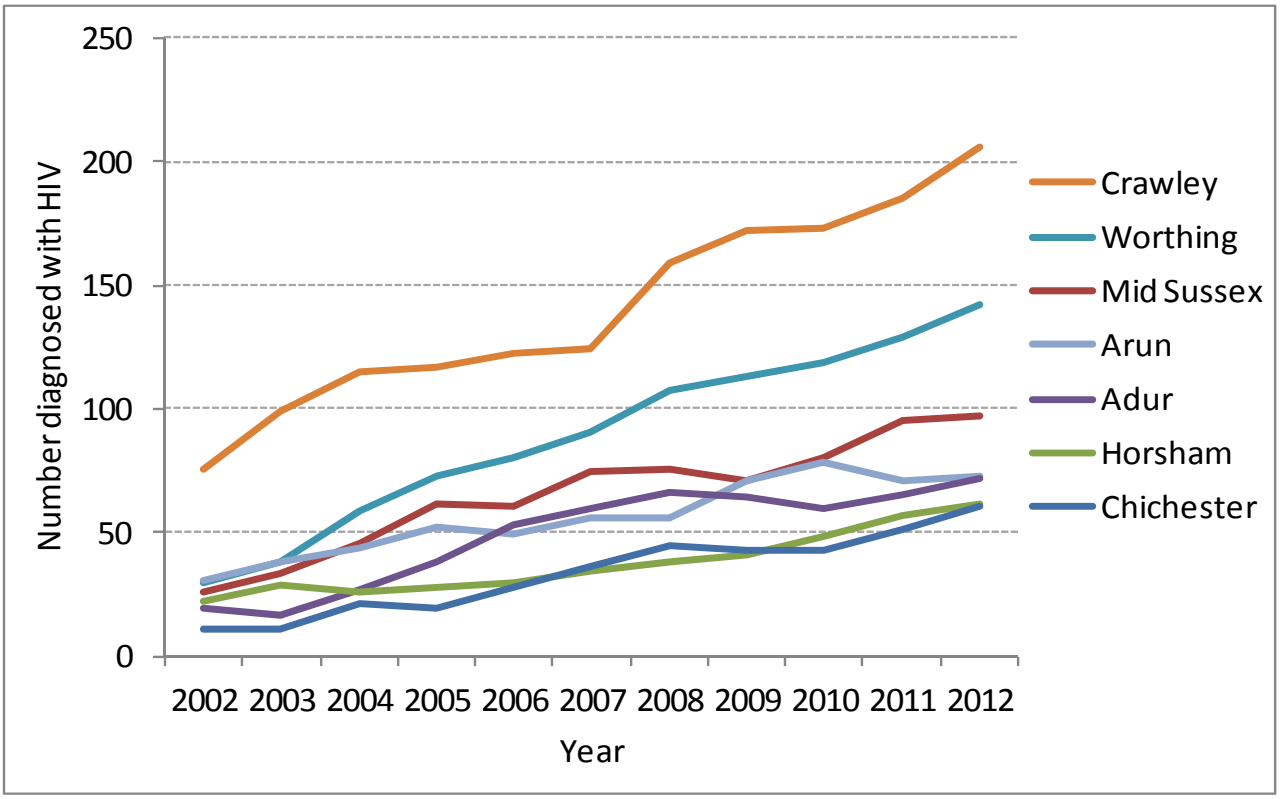
Figure 3: Number of people with diagnosed HIV in West Sussex, 2002-2012



Source: SOPHID (Survey of Prevalent HIV infections diagnosed)

5.14 HIV diagnosis numbers have increased across all UAs within West Sussex, with the highest numbers and greatest increases in Crawley and Worthing (see Figure 4).

Figure 4: Numbers of HIV diagnosed persons West Sussex UAs, 2002-2012



Source: SOPHID

HIV incidence

5.15 New HIV diagnoses among West Sussex residents averaged around 52 per year from 2008-2012. Males accounted for the large majority (70%) of new HIV diagnoses from 2008-20012. In 2009, 2010 and 2011, Crawley had the largest number of new diagnoses (with around 17 per year), but in 2012 there was a notable spike of 17 new HIV diagnoses among Arun residents – predominantly among males aged 35-64 years.

Undiagnosed HIV

5.16 Estimates of undiagnosed HIV infections from the Health Protection Agency's Multi-Parameter Evidence Synthesis (MPES) Model[41] indicate around 24% of individuals with HIV were undiagnosed in 2011.[42] This would equate to around 225 undiagnosed HIV cases in West Sussex in 2012.

[41] [41]The MPES model derives estimates of undiagnosed HIV by combining data from unlinked anonymous surveys of pregnant women, injecting drug users and sexual health clinic attendees and other surveillance and sexual behaviour data.

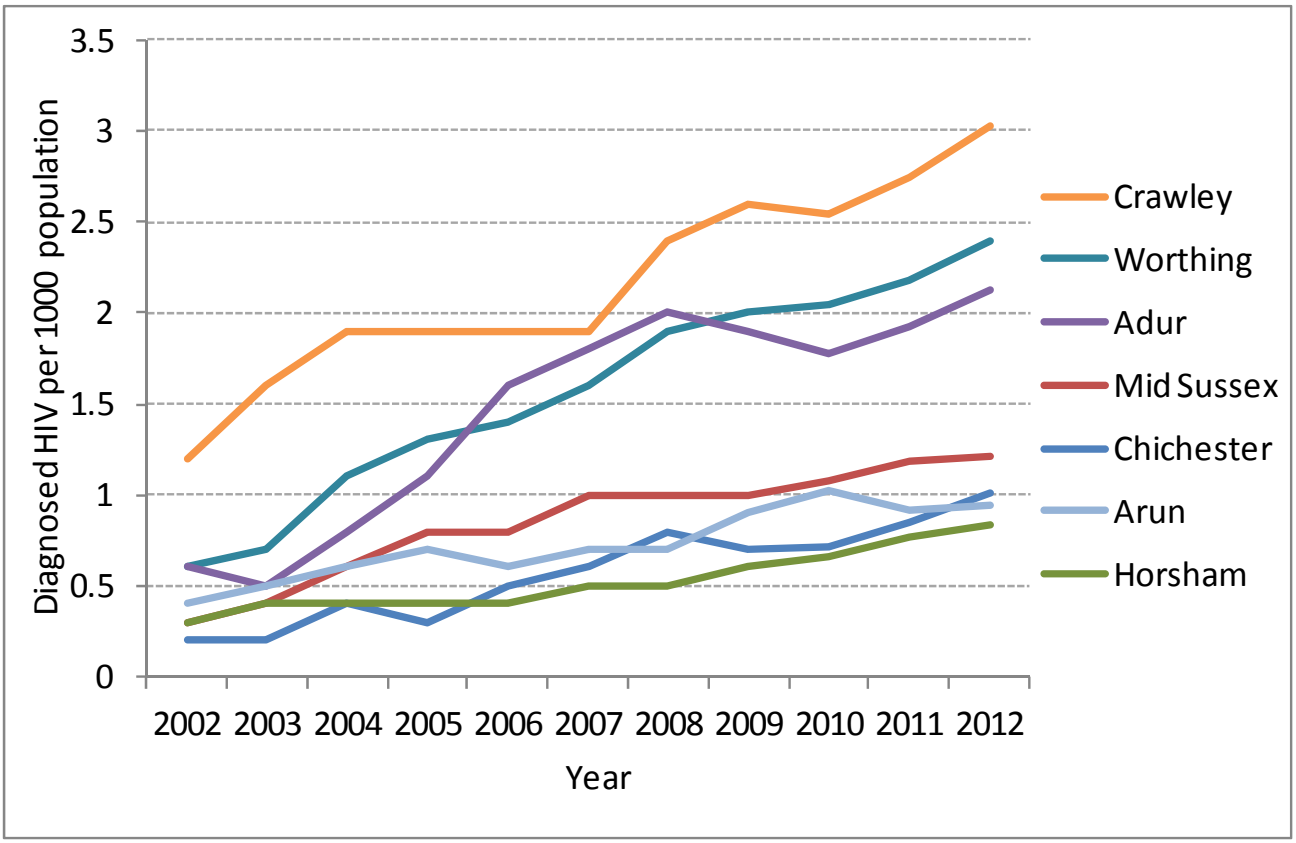
[42] Health Protection Agency. HIV in the United Kingdom: 2012 Report. London: Health Protection Services, Colindale. November 2012.

HIV Diagnosed Prevalence: rates

5.17 Rates of diagnosed HIV prevalence in West Sussex have increased in all districts since 2002. The highest rates are in Crawley, Worthing and Adur, which in 2012 had rates of 3.0, 2.4 and 2.1 per 1,000 population aged 15-59 respectively (see Figure 5). Other West Sussex districts had rates less than 1.2 per 1000-population aged 15-59 in 2012. Crawley, in particular, has experienced a marked increase in diagnosed HIV prevalence since 2007 with an overall increase of 60% from 2007-2012.

5.18 Rates of diagnosed HIV increased across all West Sussex UAs from 2002 to 2012, most notably in Crawley, Worthing and Adur (see Figure 4).

Figure 5: Diagnosed HIV prevalence per 1000 population aged 15-59 years, 2002-2012

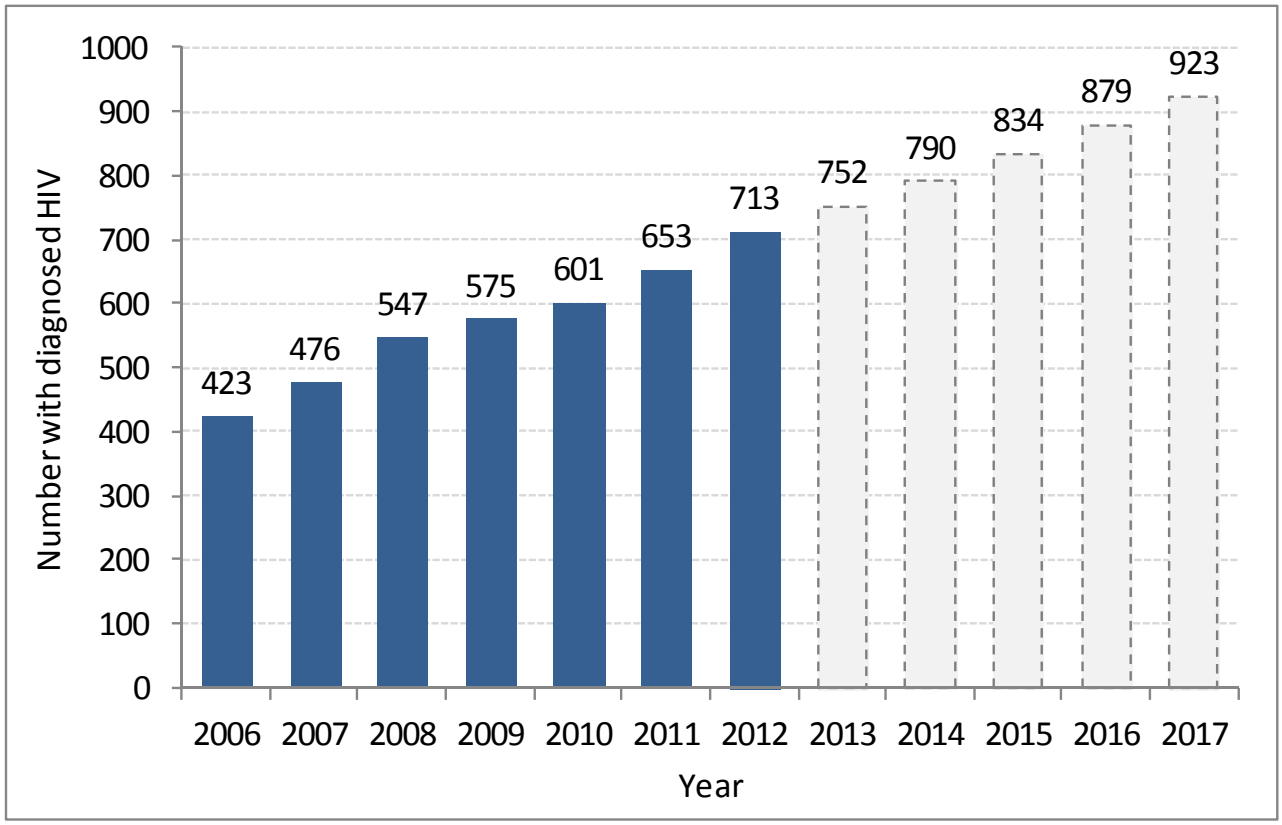


Sources: SOPHID; ONS mid-year population estimates

Forecasted numbers of diagnosed HIV and treatment costs

5.19 Although forecasted numbers should be interpreted with caution, a linear projection based on past trends suggests the number of HIV diagnosed persons in West Sussex could reach around 923 by 2017 – 209 more than diagnosed in 2012 (see Figure 6).

Figure 6: Diagnosed HIV prevalence numbers in West Sussex 2006-12 and forecast 2013-17



Sources: SOPHID and Nudge Associates Limited analysis

5.20 The Health Protection Agency (HPA) indicates that each HIV infection prevented would save between £280,000 and £360,000 in direct lifetime treatment costs. This means that if the 3,640 UK-acquired HIV cases diagnosed in 2010 had been prevented, between £1.0bn and £1.3bn in lifetime costs, would have been saved.

5.21 In addition to estimates of lifetime treatment cost, the HPA estimated that in 2010/11 the average annual health expenditure for each HIV patient accessing care in England (excluding the costs of testing or psychosocial care) was £13,900.

5.22 Based on the above figures and the current and forecasted prevalence of diagnosed HIV in West Sussex:

- The total annual treatment cost in 2012 for the 713 diagnosed HIV patients in West Sussex was around £9.9 million (£13,900 per patient).
- The forecast increase of 209 HIV diagnosed patients between 2013 and 2017 would add around £2.9 million to West Sussex's annual treatment costs by 2017 – an increase of 29%.

Late (and Very Late) Diagnosis of HIV

5.23 A late diagnosis is defined by PHE as having a CD4 count below 350 cells/mm³ within three months of diagnosis. Previously it meant having a CD4 count below 200 cells/mm³ within 91 days of diagnosis; this is now referred to as a very late HIV diagnosis.[43]

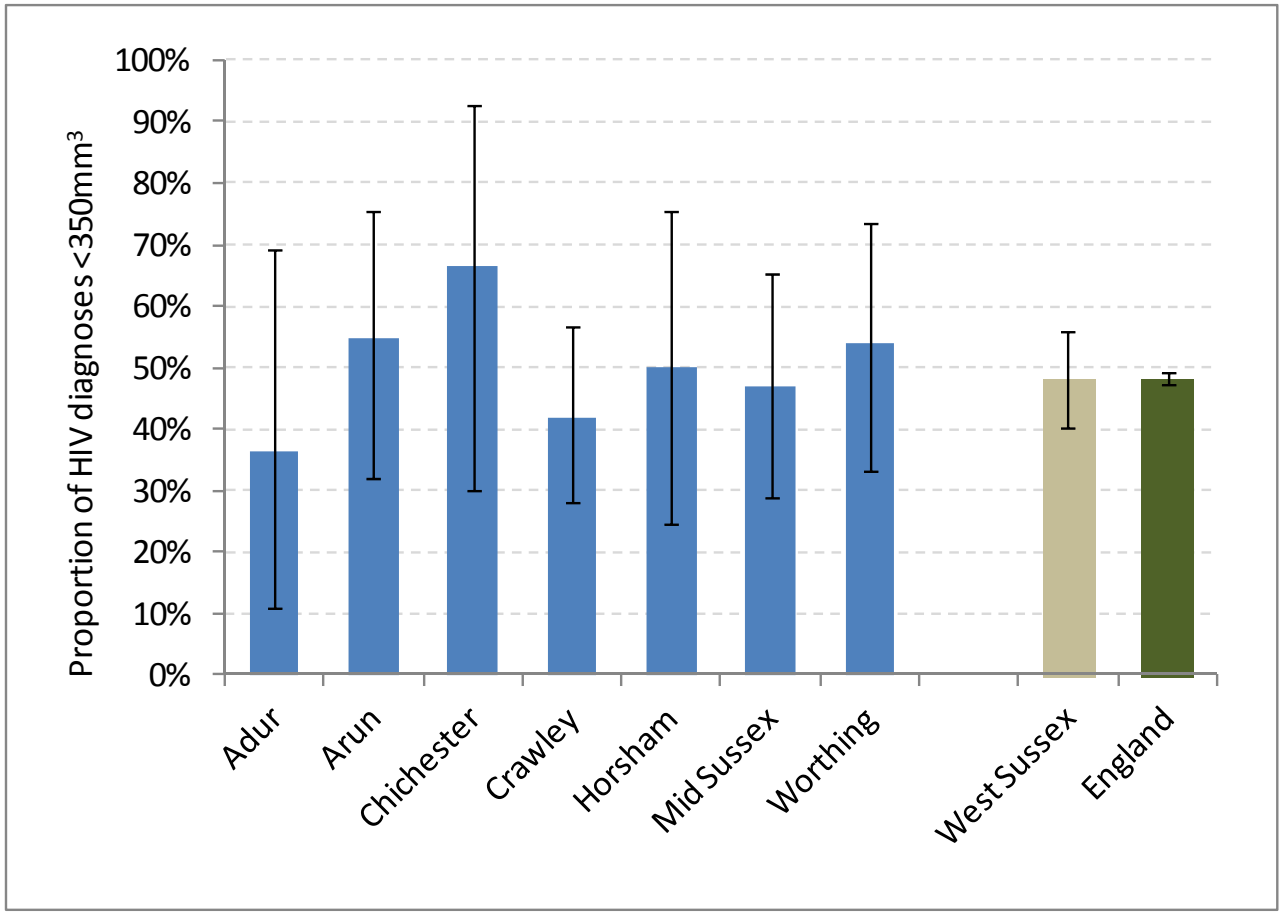
5.24 Individuals diagnosed at a late stage of infection have higher rates of morbidity and mortality. A quarter of deaths among HIV positive individuals in the UK are among those diagnosed too late for effective treatment, and individuals starting antiretroviral therapy with a CD4 count below 350 cells/mm^3 have a significantly increased risk of contracting opportunistic diseases.[44]

5.25 Over the three years 2010-12, there were 80 new HIV diagnoses in West Sussex residents with a CD4 count less than 350 cells/mm^3 at time of diagnosis. This number equates to just under half (48%) of new diagnoses – the same proportion as for England as a whole. Across West Sussex districts, the proportion of late diagnoses ranged from 36% in Adur to 67% in Chichester, although these figures should be interpreted with some caution as they are based on small numbers. (See Figure 7.) Crawley, with 21 diagnoses, had the highest number, but also a relatively low proportion of late diagnoses (42%).

[43] http://www.nat.org.uk/HIV-Facts/Statistics/Latest-UK-statistics/Late-diagnosis.aspx#sthash.UWfnePjA.dpuf

[44] HPA (April 2012) Evidence and resources to commission expanded HIV testing in priority medical services in high prevalence areas

Figure 7: Proportion of HIV diagnoses where CD4 cell count is <350 cells/mm^3 at time of diagnosis* (with 95% confidence intervals), West Sussex districts, 2010-12



*Source: PHE: Integrated HIV surveillance data: SOPHID, HIV and AIDS New Diagnoses Database (HANDD), and CD4 Surveillance *All adults (aged 15+ years) newly diagnosed with HIV infection with CD4 counts available within 91 days of diagnosis and with known residence based information.*

Uptake of HIV testing

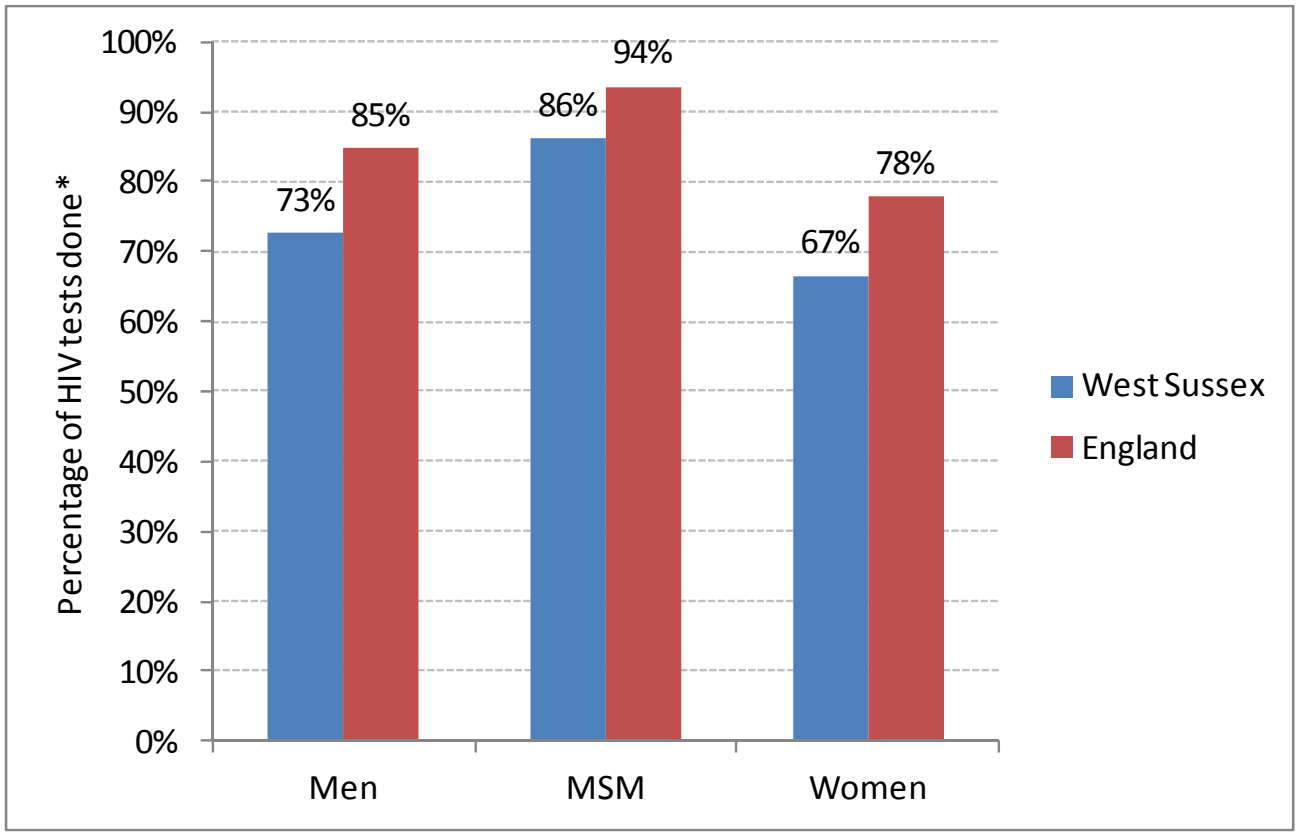
5.26 PHE recommends that any person presenting to a GUM clinic should be offered an HIV test regardless of symptoms and risk factors as individuals who are unaware of their positive HIV status have a rate of onward transmission that may be more than three times higher than those who know their status. [45]

5.27 In 2012, around 18,200 HIV tests were offered to West Sussex residents attending a new GUM episode, of which 12,900 (71%) accepted – a lower proportion than both the South East and England average of 79% and 82% respectively.

[45] The MPES model derives estimates of undiagnosed HIV by combining data from unlinked anonymous surveys of pregnant women, injecting drug users and sexual health clinic attendees and other surveillance and sexual behaviour data.

5.28 Uptake of HIV tests varies by sexual orientation, with the highest uptake rates among men who have sex with men (MSM) – 86% of MSM offered said yes among West Sussex residents and 94% for England as a whole (see Figure 8).

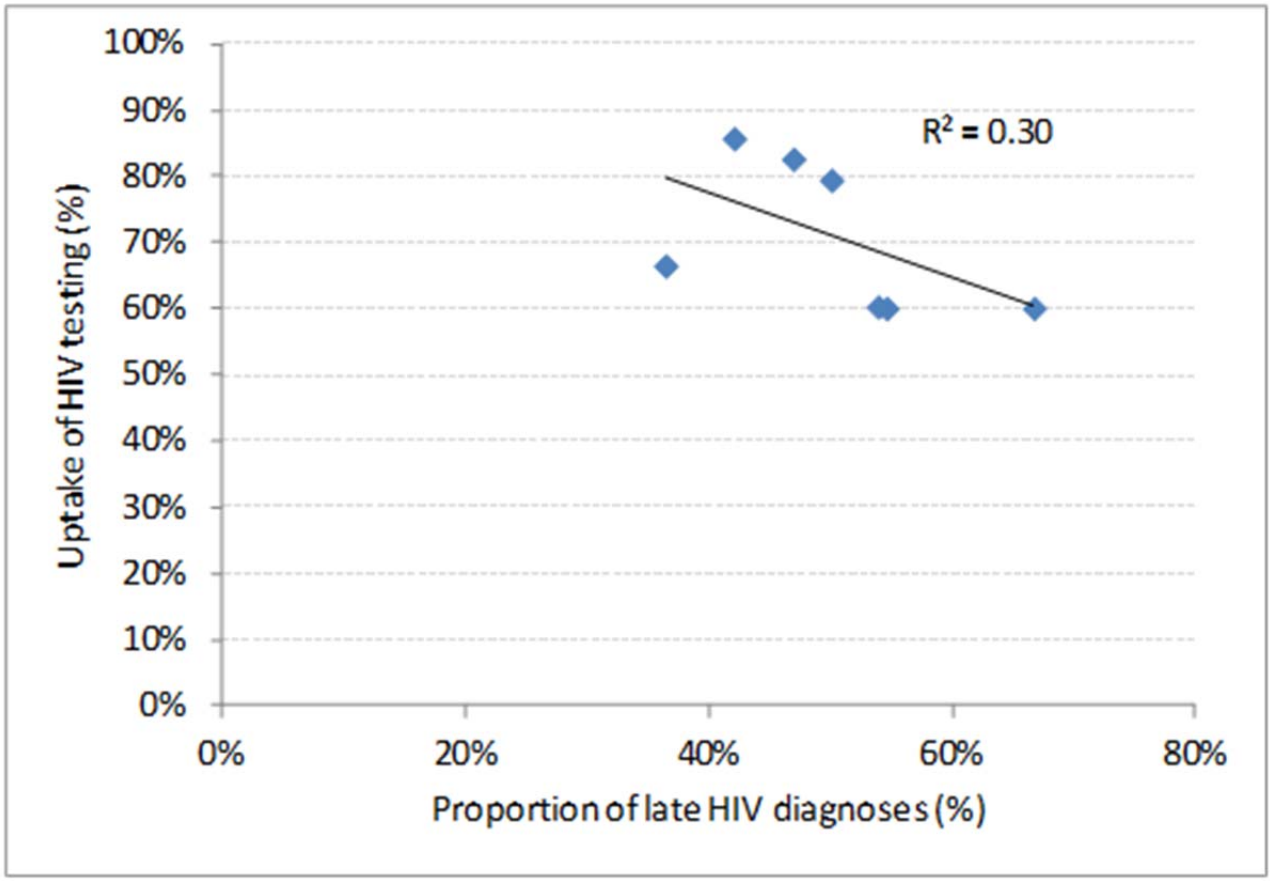
Figure 8: Uptake of HIV testing in GUM clinics by sexual orientation and gender, West Sussex residents, 2012



*As a proportion of tests offered
Source: GUMCAD, 2014

5.29 There is an association between rates of HIV testing and the proportion of late HIV diagnoses across West Sussex districts (for men and women combined), with those districts having higher uptake rates seeing a smaller proportion of late HIV diagnoses compared to those districts with lower uptake rates. Figure 9 suggests around 30% of the variation in late diagnoses across districts is 'explained' by differences in uptake rates of HIV testing (R^2=0.30). This relationship is also apparent when comparing HIV testing and late diagnosis for MSM or women.

Figure 9: Uptake of HIV testing and proportion of late HIV diagnoses (men & women combined), West Sussex districts, 2012



Source: GUMCAD, 2014

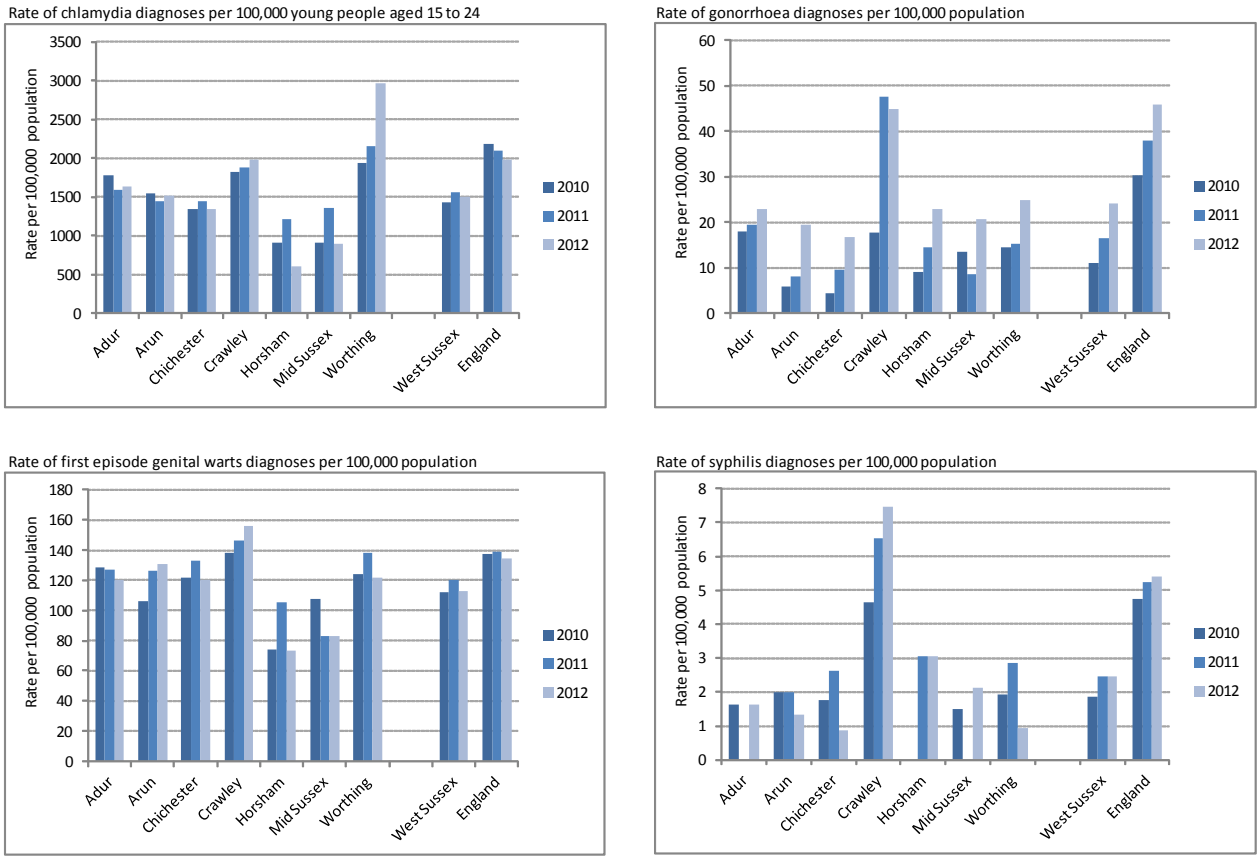
Sexually Transmissible Infections (STIs)

5.30 Genitourinary Medicine Clinic Activity Dataset (GUMCAD) collects disaggregated, patient-level information on all patients attending GUM clinics, including area of residence, diagnoses of sexually transmitted infections (STIs) and other services provided by GUM clinics.

STI diagnosis numbers and rates

5.31 Rates of STI diagnoses in West Sussex are below the England average, although rates vary across West Sussex districts, with both Crawley and Worthing having rates for some STIs above the national average (although differences are not statistically significant except for Worthing's high rate of diagnosed Chlamydia in 2012). From 2010-12 Crawley had high and increasing rates of gonorrhoea and syphilis, whilst Worthing had the highest rates of chlamydia among 15-24 year olds (see Figure 10.)

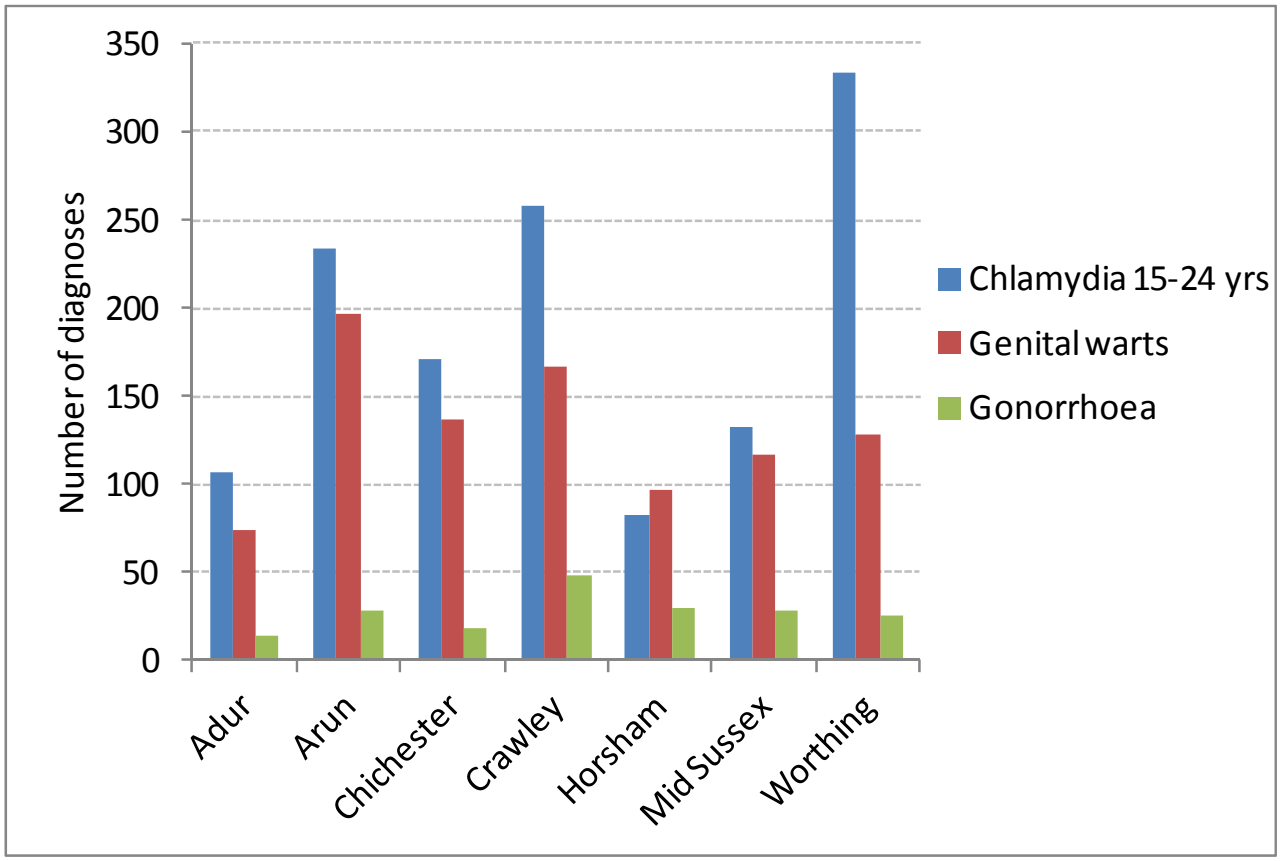
Figure 10: Rate of Chlamydia, Gonorrhoea, herpes, syphilis and genital warts diagnoses per 100,000-population, by West Sussex Districts, 2010, 2001 & 2012



Source: PHE GUMCAD, 2014

5.32 The number of new diagnoses in 2012 varied by STI and district (see Figure 11). In 2012, there were 2,488 new diagnoses of gonorrhoea, genital warts, syphilis or chlamydia (in people aged 15-24) among West Sussex residents. The largest numbers of new diagnoses were for chlamydia among 15-24 year olds, most notably in Worthing with 333 diagnoses in 2012.

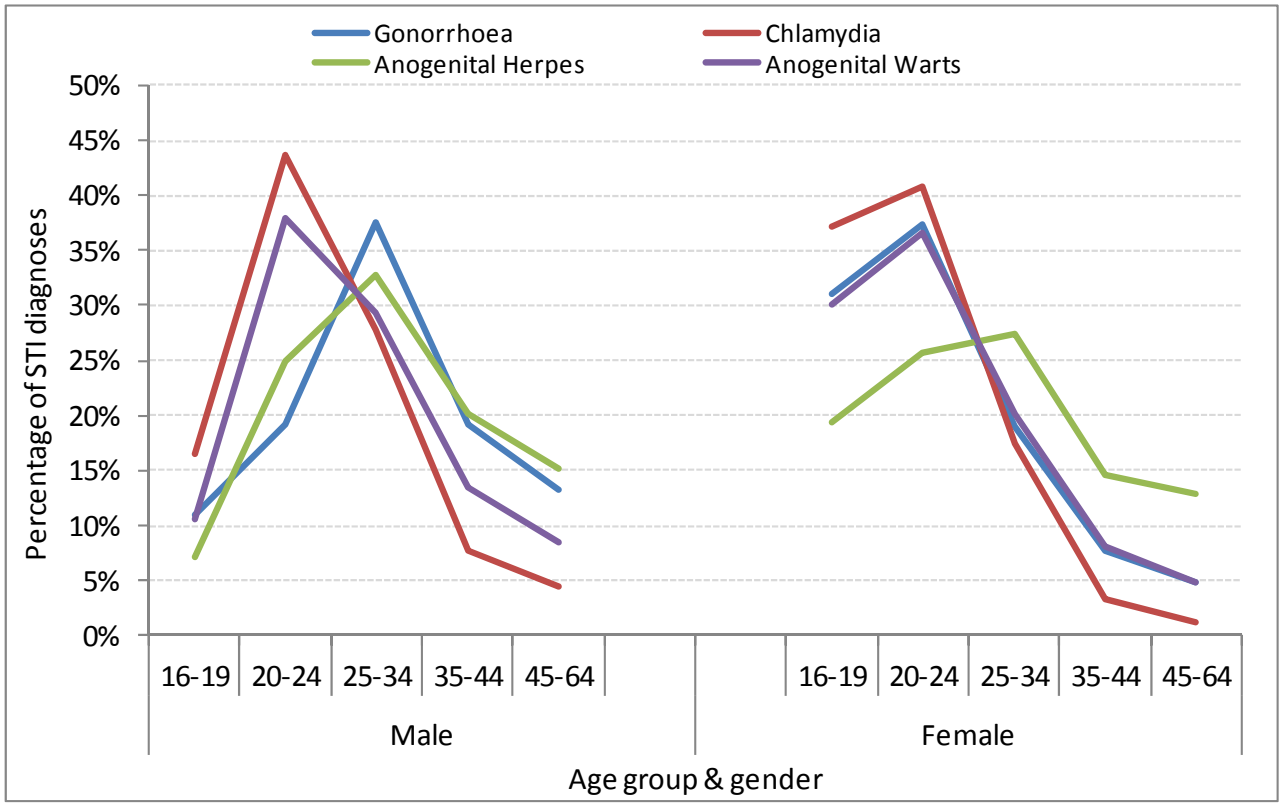
Figure 11: Number of new diagnoses by STI and West Sussex district, 2012



Source: PHE GUMCAD, 2014

5.33 Women with an STI diagnosis have a younger age profile than diagnosed men, with a larger proportion aged 16-19 and a peak in the 20-24 year age group for chlamydia, gonorrhoea and genital warts (see Figure 12). For men, chlamydia and genital warts diagnoses peak in the 20-24 age group, and gonorrhoea and herpes in the 20-34 age group.

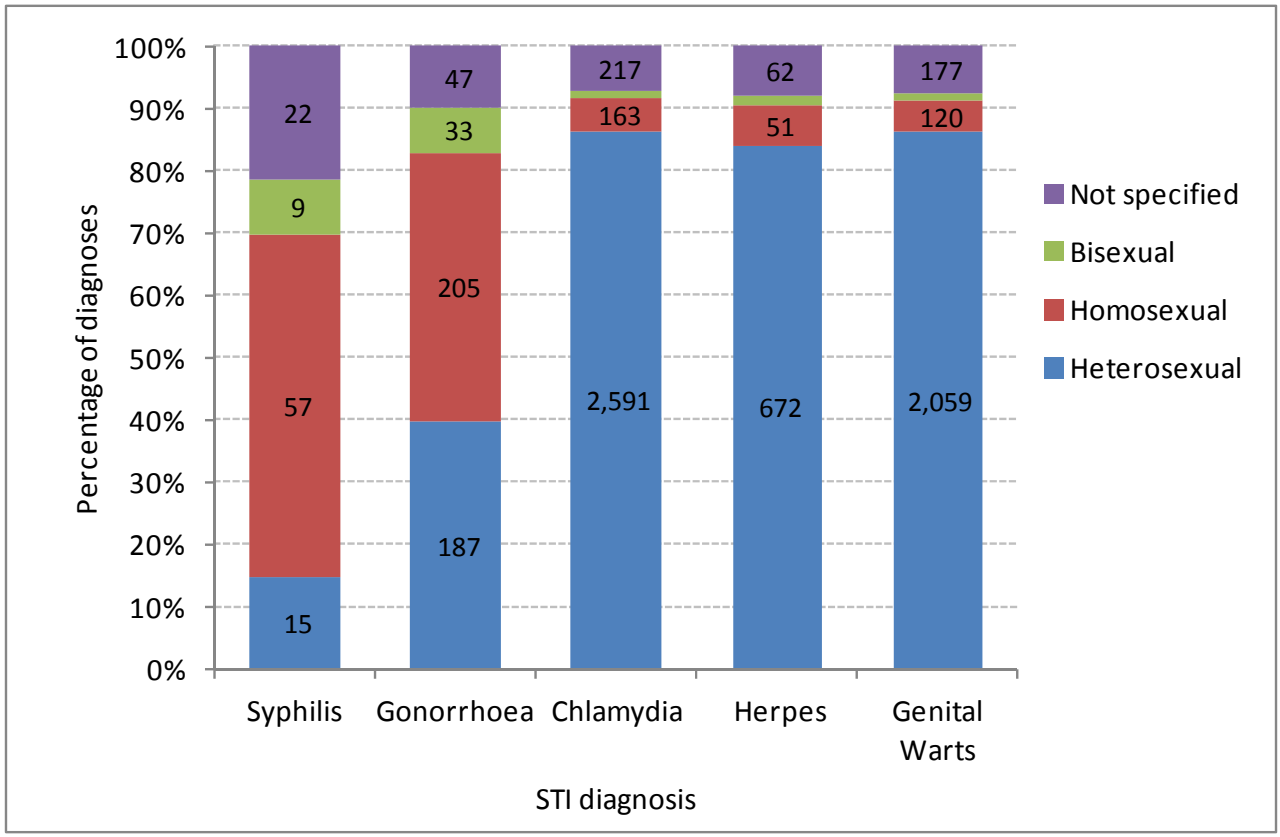
Figure 12: STI diagnoses by age group and gender in West Sussex, 2008-12



Source: PHE GUMCAD, 2014
Note: Under 16 and 65+ data excluded due to low numbers

5.34 Overall, the overwhelming majority of STI diagnoses are among heterosexual males and females – except for syphilis and gonorrhoea diagnoses among men, where homosexual men account for 55% and 43% of all diagnoses (see Figures 13 and 14).

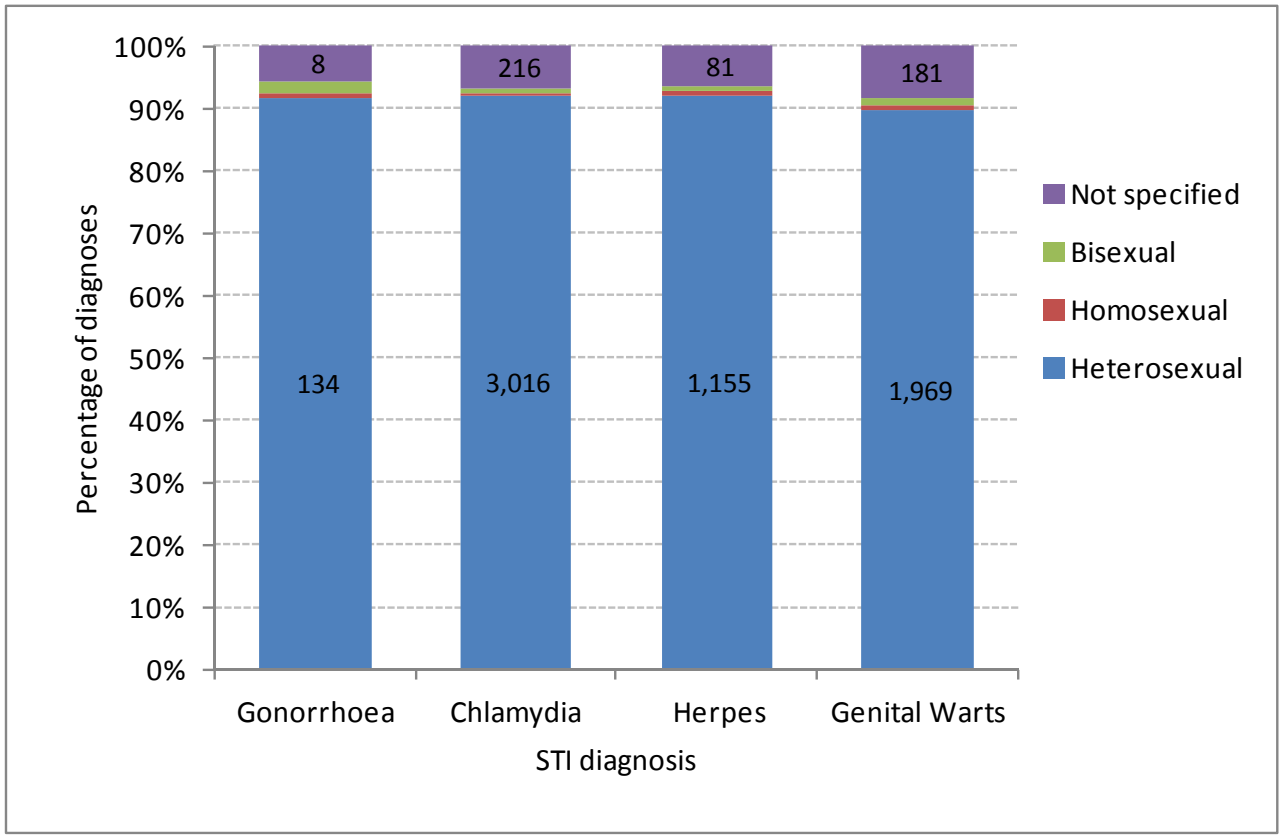
Figure 13: Male STI diagnoses by sexual orientation, West Sussex, 2008-12



Source: PHE GUMCAD, 2014

Note: Numbers within each column are the actual number of diagnoses

Figure 14: Female STI diagnoses by sexual orientation, West Sussex, 2008-12

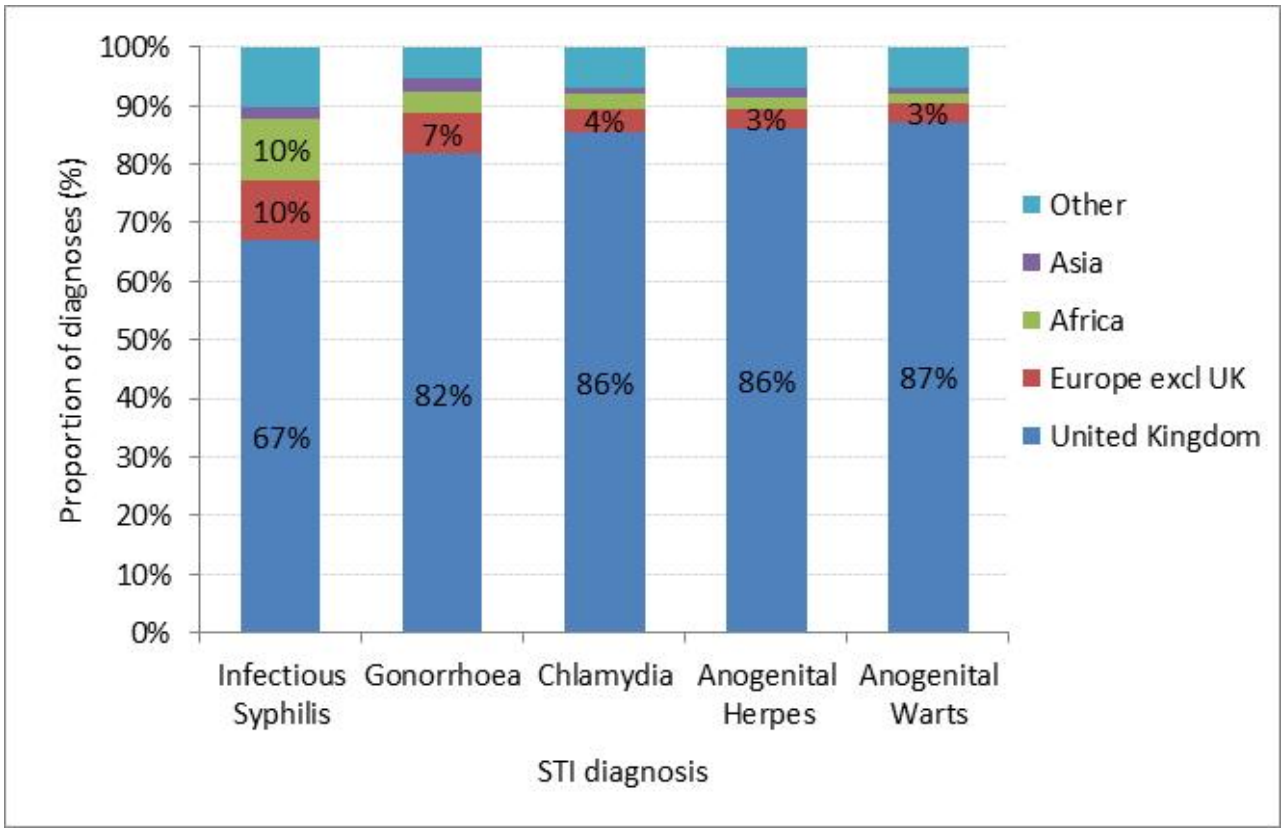


Source: PHE GUMCAD, 2014

Note: Numbers within each column are the actual number of diagnoses. Excludes Syphilis due to low numbers

West Sussex residents born in the UK account for between 82% to 87% of diagnosis for most STIs, except for syphilis where a third of diagnoses are among those born outside the UK (see Figure 15).

Figure 15: STI diagnoses by Country of birth, West Sussex, 2008-12

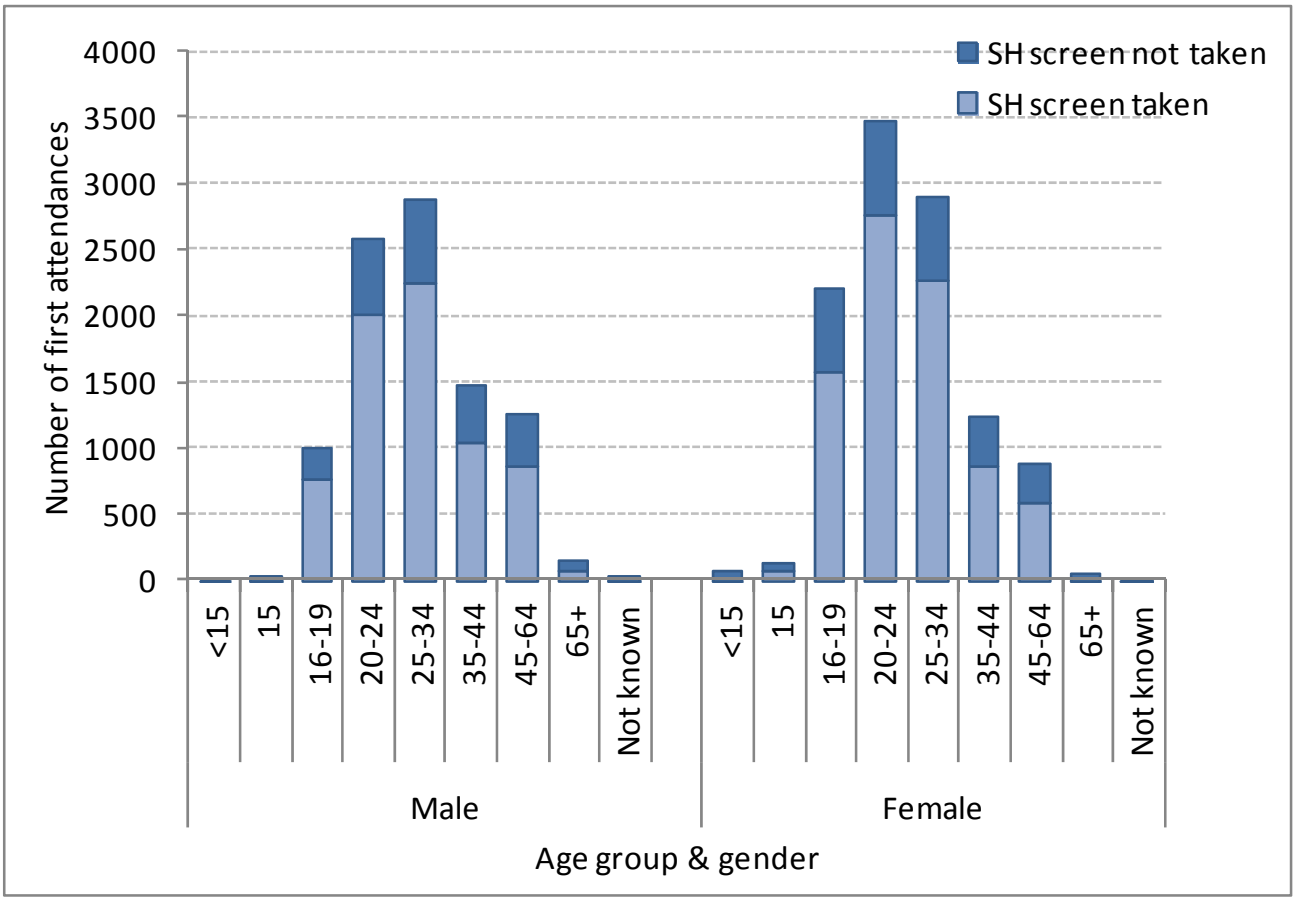


Source: PHE GUMCAD, 2014

Sexual Health Screens

5.35 In 2012, West Sussex residents had 20,400 first time attendances at a GUM clinic, of which 15,200 included a sexual health screen – an uptake rate of 75%. A majority of sexual health screens (around 60%) are taken in the 20-34 age groups for both men and women (see Figure 16.) Women have a larger number of sexual health screens under 20 years (around 20% compared with 11% for men), whereas men have a higher number over 35 years (28% compared to 18% for women).

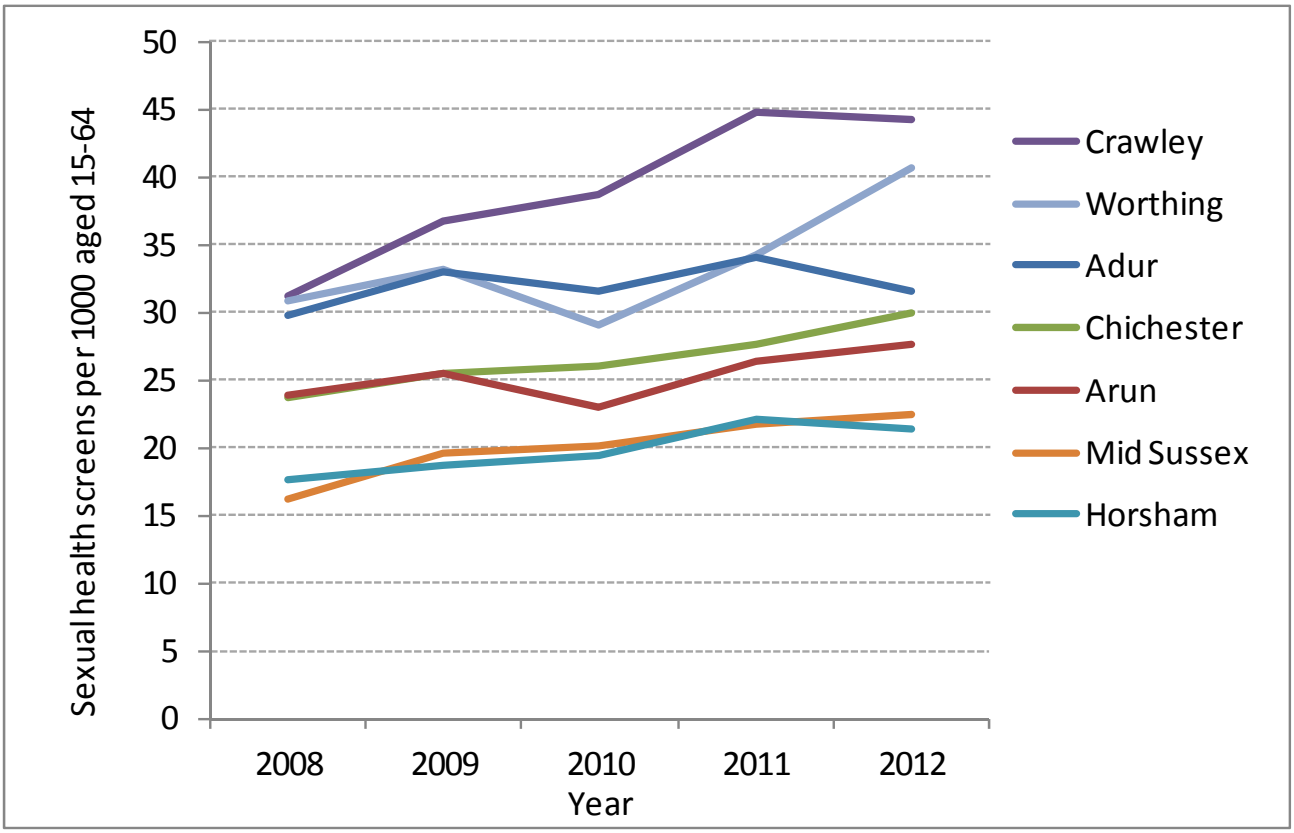
Figure 16: Sexual health screens by age group and gender, West Sussex residents, 2008-12



Source: GUMCAD, 2014

5.36 Across West Sussex districts, Crawley residents have the highest rate of sexual health screens per 1,000 population aged 15-64, followed by Worthing – both of which have seen an overall increase in the screening rate from 2008-2012 (see Figure 17).

Figure 17: Sexual health screening rate per 1,000 population, West Sussex residents, 2008-12



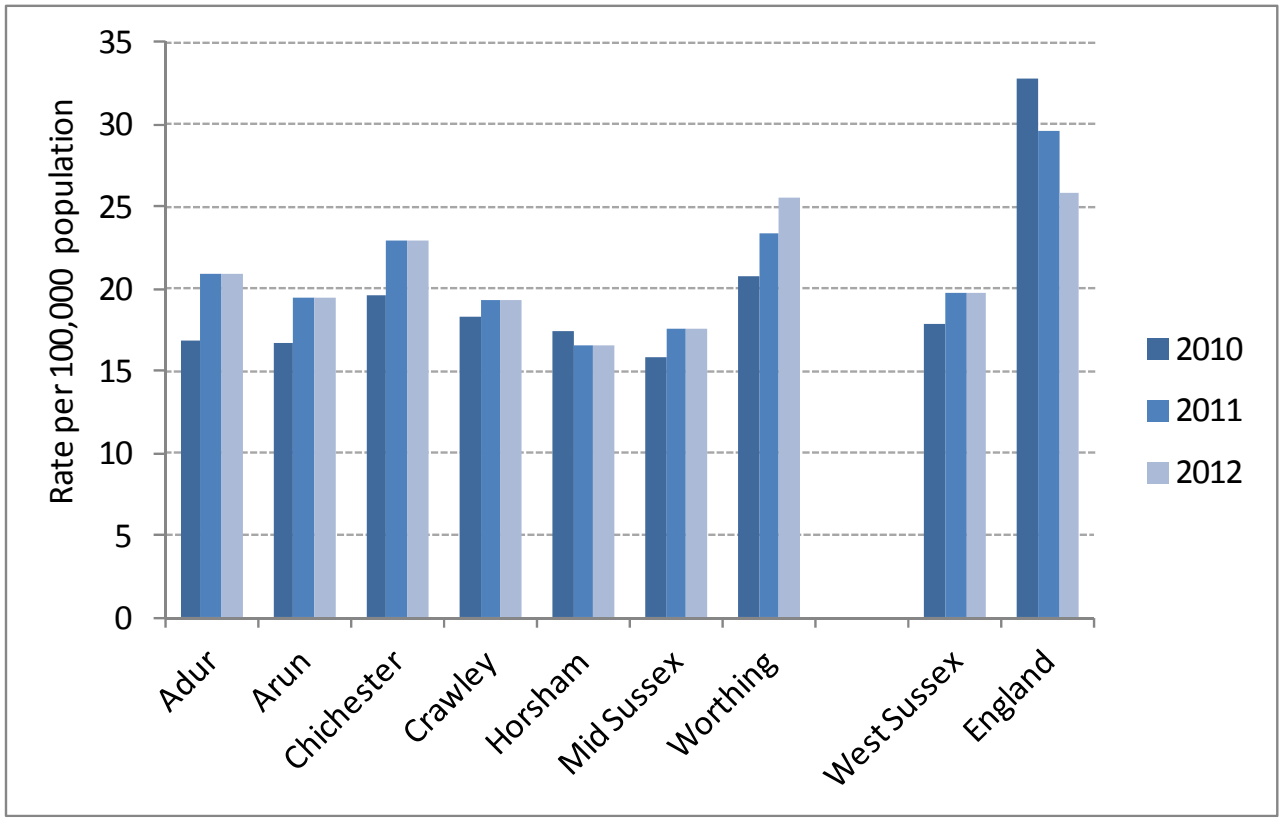
Source: GUMCAD, 2014

Chlamydia screening

5.37 Modelling strongly suggests that achievement of a diagnosis rate of 2,300/100,000 people aged 15-24 will lead to a national drop in the prevalence of chlamydia infection by about 2% of the prevalence the previous year, assuming that recommended standards of treatment and partner notification are met. Although the indicator includes symptomatic cases detected through testing, most of the diagnoses made will be asymptomatic cases ascertained through screening. Therefore, at this stage of disease control, the indicator should not be seen as a measure of disease where low rates would indicate success.

5.38 Around 16% of West Sussex residents aged 15-24 were screened for chlamydia in 2012, below the national average of 25%. The proportion screened is below the national average across all districts, except for Worthing, where the proportion screened has increased over recent years (see Figure 18).

Figure 18: Proportion of population aged 15 to 24 screened for chlamydia, 2010, 2011, 2012



Source: CTAD, 2014

Table 2: Chlamydia tests for 15-24 year olds, 2012

Area	Total tests	Total positive	% of population tested	% of tests positive	Diagnosis rate per 100,000
Adur	1,001	107	15.3%	10.7%	1,637
Arun	2,264	233	14.7%	10.3%	1,514
Chichester	2,092	171	16.4%	8.2%	1,340
Crawley	2,981	258	22.9%	8.7%	1,984
Horsham	1,456	83	10.7%	5.7%	608
Mid Sussex	1,618	133	10.9%	8.2%	894
Worthing	2,866	333	25.6%	11.6%	2,972
West Sussex	14,278	1,318	16.3%	9.2%	1,507
England	1,782,122	136,961	25.8%	7.7%	1,979

Source: CTAD, 2014

Vaccination coverage for HPV

5.39 West Sussex's population vaccination coverage for HPV was 87% in 2012/13 – above the South East and England averages of 83.6% and 86.1% respectively.

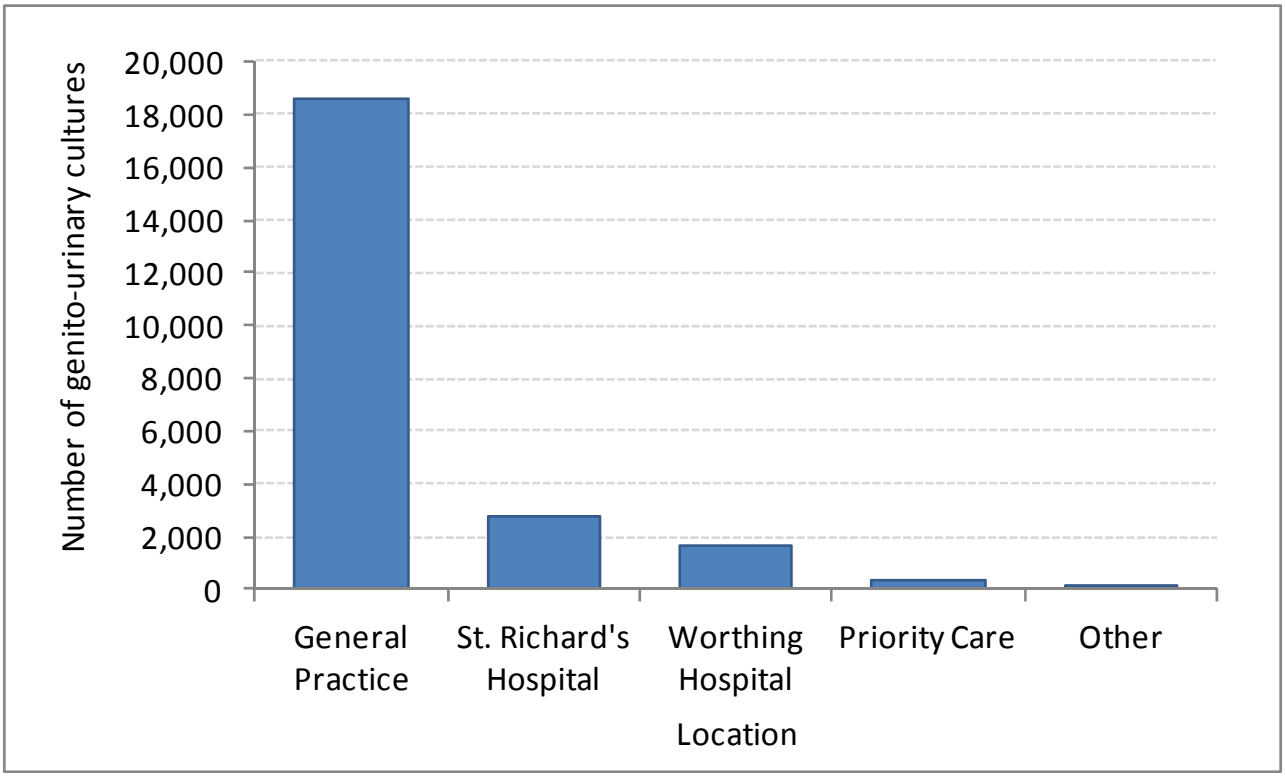
Microbiology laboratory data

Microbiology laboratory data from Western Sussex Hospitals on genito-urinary, syphilis and HIV tests undertaken outside GUM clinics provide an insight to testing across different locations in West Sussex. However, some caution is required in interpreting the data as Western Sussex Hospitals perform laboratory testing for the areas of Crawley, Worthing and Chichester only. The data therefore exclude tests undertaken by laboratories in Brighton and Crawley.

The data cover all tests undertaken and therefore will include some repeat and/or confirmatory tests.

The overwhelming majority of genitor-urinary tests (79%) are requested by GP practices. A further 12% are at St. Richard's Hospital and 7% at Worthing hospital (see Figure 19).

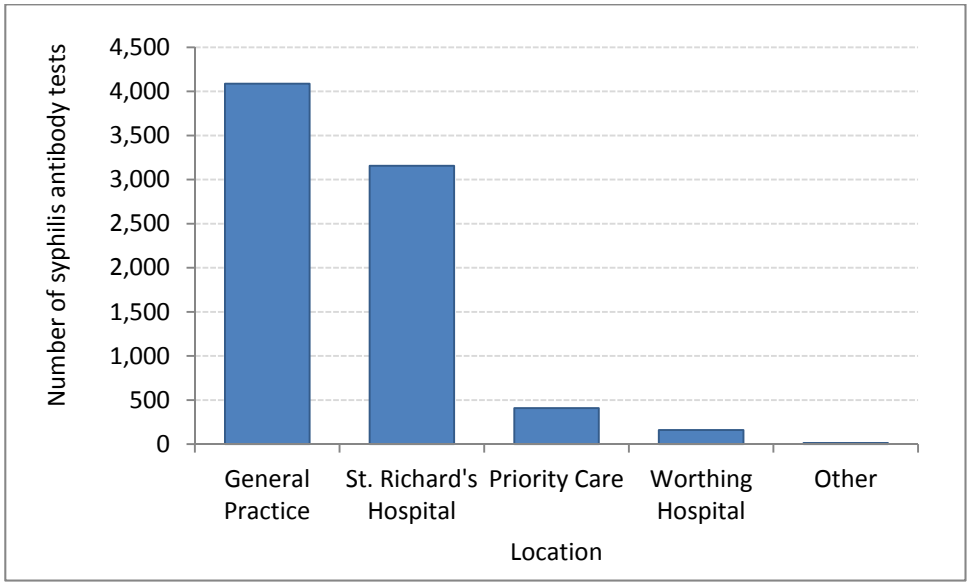
Figure 19: Number of Genito-urinary tests by location, 2013



Source: Western Sussex Hospitals microbiology laboratory data (excluding GUM clinics) 2013

Just over half (52%) of syphilis antibody tests are requested by GP practices, and 40% from St. Richard's Hospital (see figure 20).

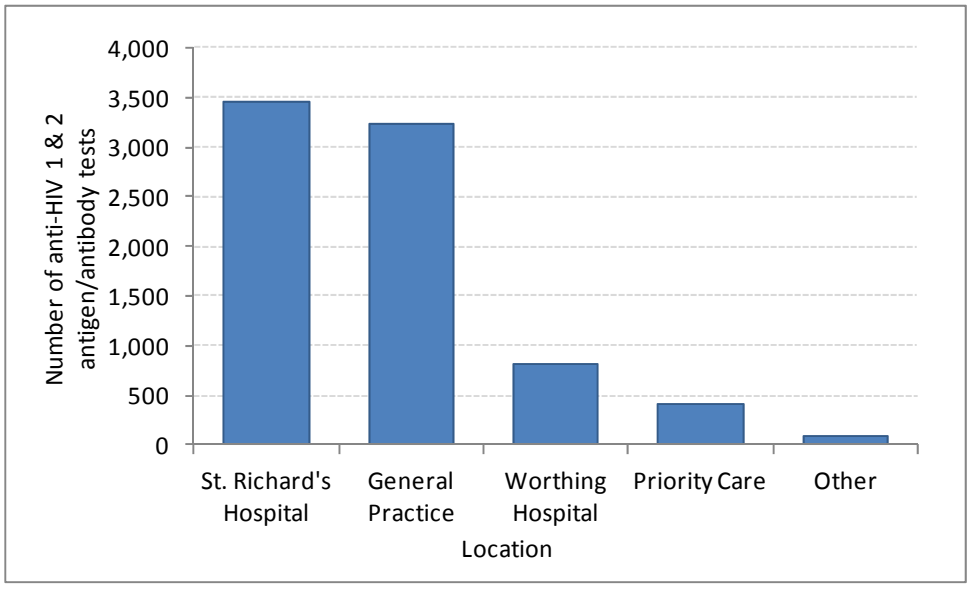
Figure 20: Number of syphilis antibody tests by location, 2013



Source: Western Sussex Hospitals microbiology laboratory data (excluding GUM clinics) 2013

Western Sussex Hospitals microbiology laboratory received around 8,000 HIV 1 and 2 Antigen/antibody tests requests from non-GUM clinics in 2013. St Richards Hospital accounted for 43% of these requests, general practice for 40% and Worthing Hospital 10%. Around 5% of requests were from Priority Care Community clinics (see Figure 21)

Figure 21: Number of Anti-HIV 1 & 2 Antigen/antibody tests by location, 2013

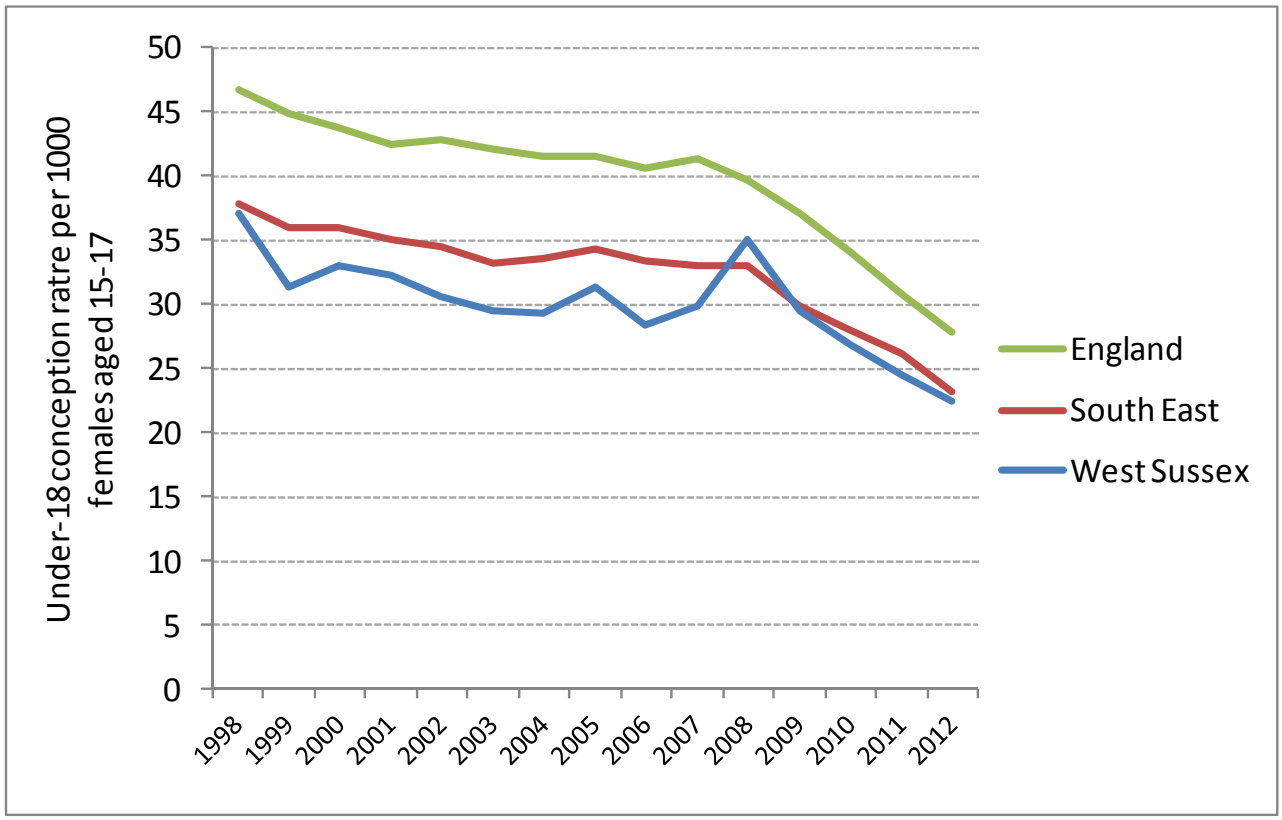


Source: Western Sussex Hospitals' microbiology laboratory data (excluding GUM clinics) 2013

Teenage Pregnancy

5.40 The 2012 under-18 conception rate for West Sussex, at 22.6 per 1,000 females aged 15-17, is lower than both the England rate (27.8 per 1000) and the South East rate (23.3 per 1000). See Figure 22. The downward trend in West Sussex's rate since 2008 has mirrored the reduction seen both nationally and regionally. In 2012, there were 308 under-18 conceptions in West Sussex – 191 fewer than in 2008. The latest data for the first quarter 2013 show a continuation of the falling rate with a 3% rate reduction compared with first quarter 2012.

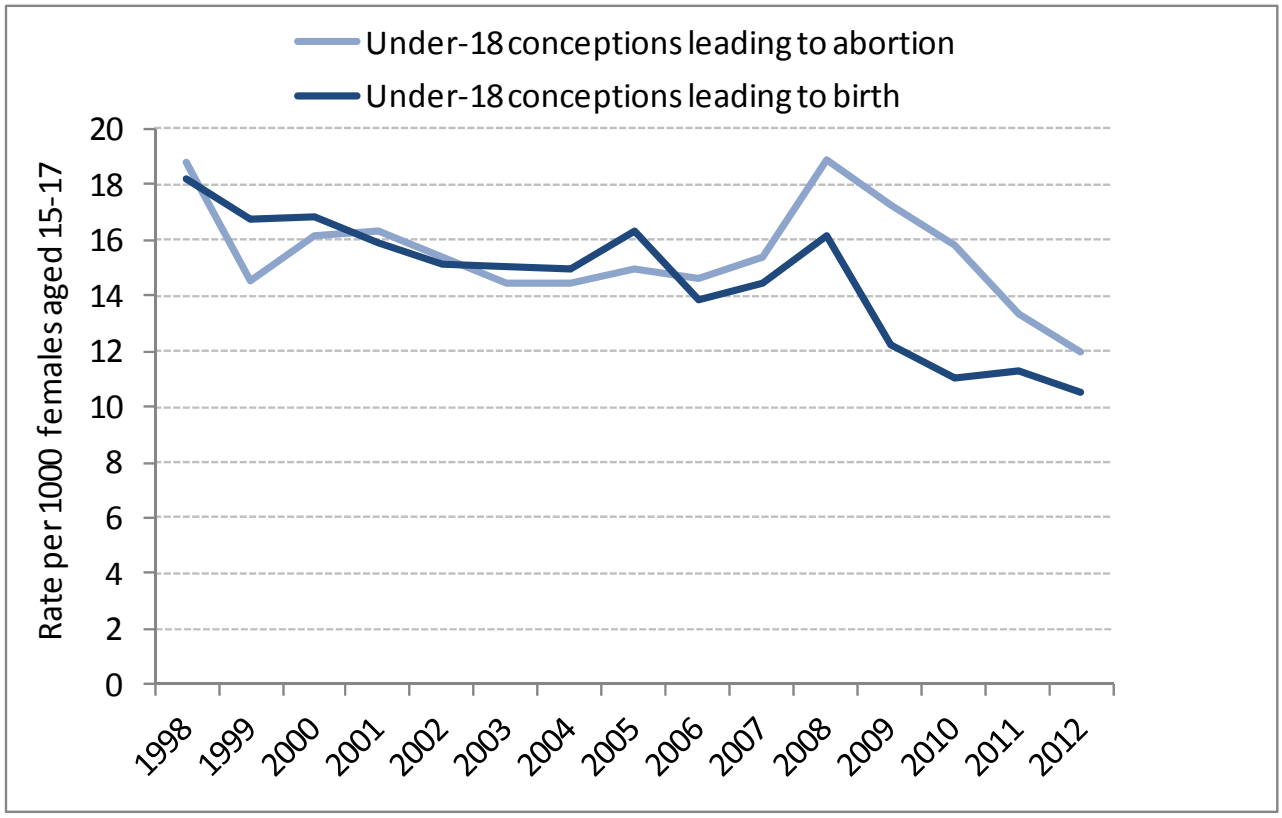
Figure 22: Under-18 conception rate trend 1998-2012



Source: ONS conception statistics, 2014

5.41 The reduction in West Sussex's teenage pregnancy rate since 2008 is reflected in reductions in both teenage birth and teenage abortion rates (see Figure 23.)

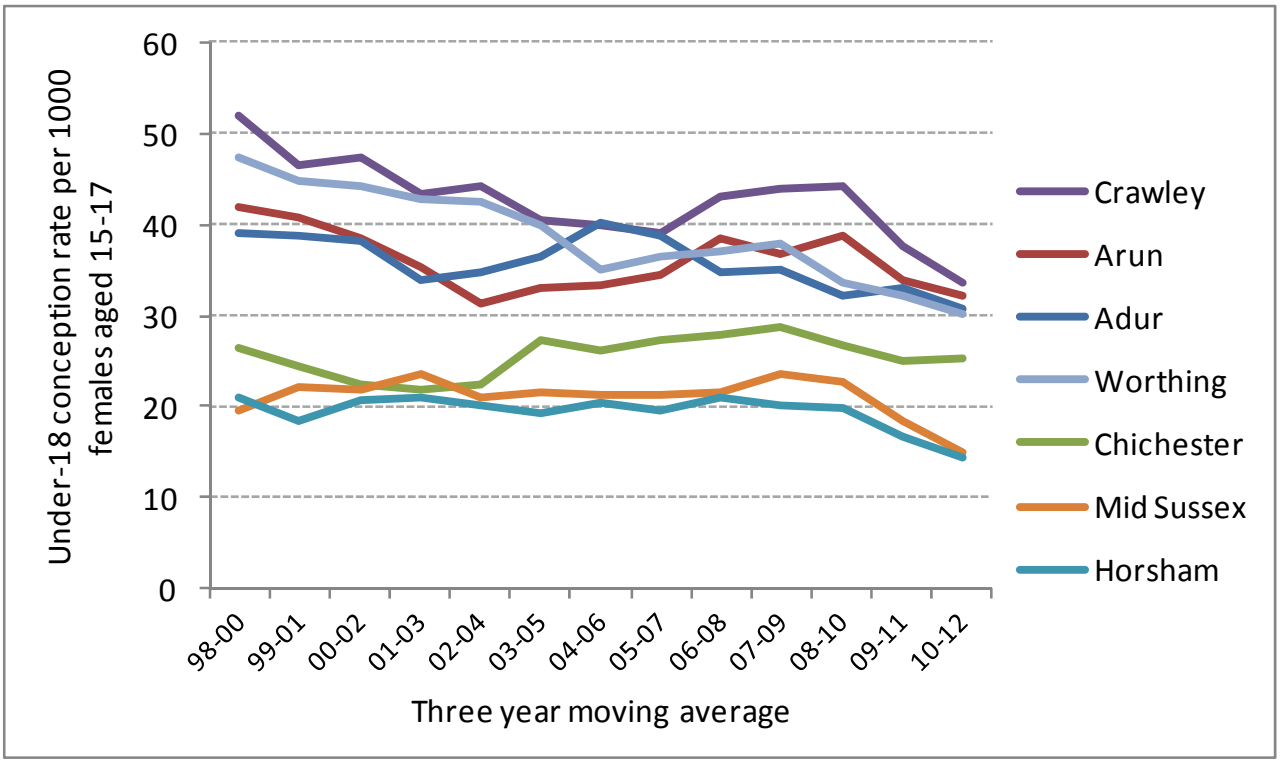
Figure 23: Rate of under-18 conceptions leading to abortion and birth, West Sussex, 1998-2012



Source: ONS conception statistics, 2014

5.42 Across West Sussex districts, under-18 conception rates vary between 13.3 and 32.6 per 1000 (see Figure 24.). The number of teenage conceptions in each district ranged from 33 to 55 in 2012.

Figure 24: Under-18 conception rates in West Sussex districts, 1998/00 – 2010/12

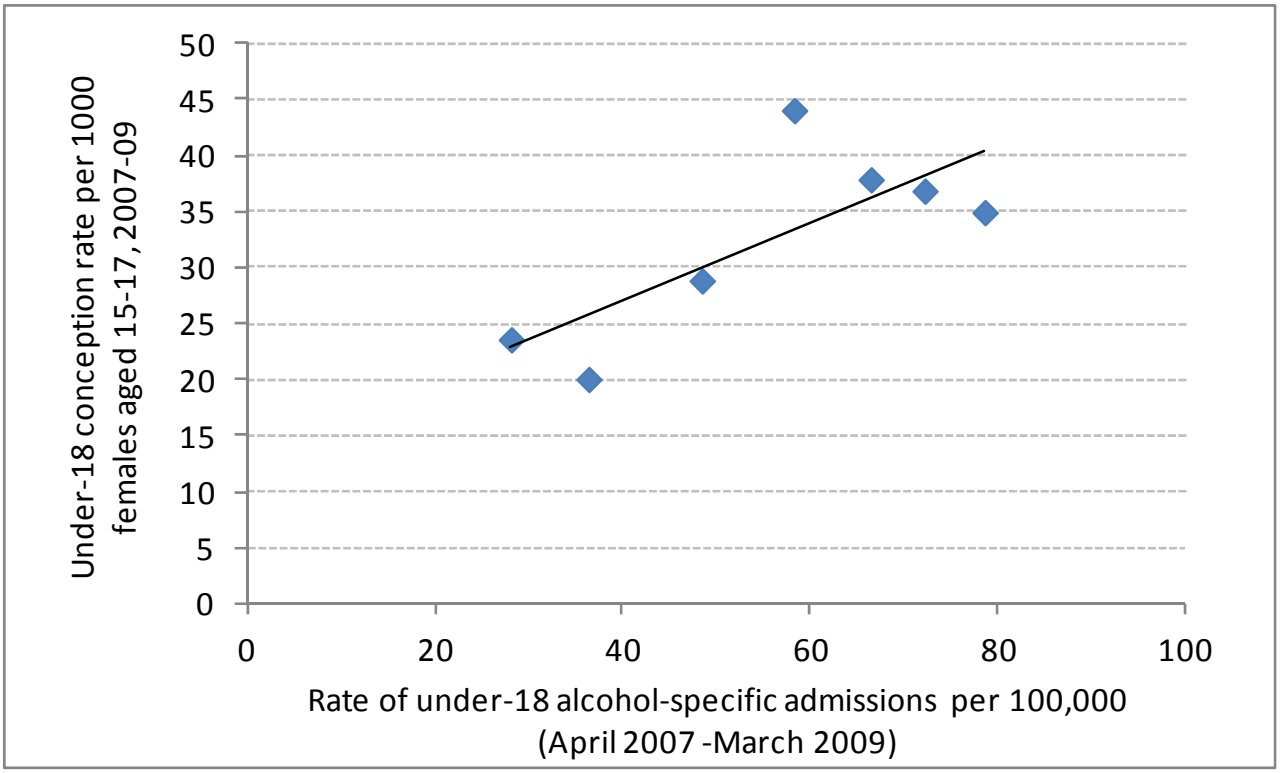


Source: ONS conception statistics, 2014

5.43 Research has shown an association between alcohol misuse by young people and teenage pregnancy[46]. Evidence includes a positive association, independent of deprivation, between district level under-18 conception rates and alcohol-related hospital admissions in young people aged 15-17 years. This association between alcohol-related admissions and teenage pregnancy is evident in West Sussex districts, with higher under-18 conception rates in those districts with a rate of under-18 alcohol-specific admissions around 60 per 1000 or higher (see figure 25).

[46] Bellis M, Morleo M, Tocque K *et al* (2009) '*Contributions of Alcohol Use to Teenage Pregnancy: An initial examination of geographical and evidence based associations*' North West Public Health Observatory Centre for Public Health, Liverpool John Moores University.

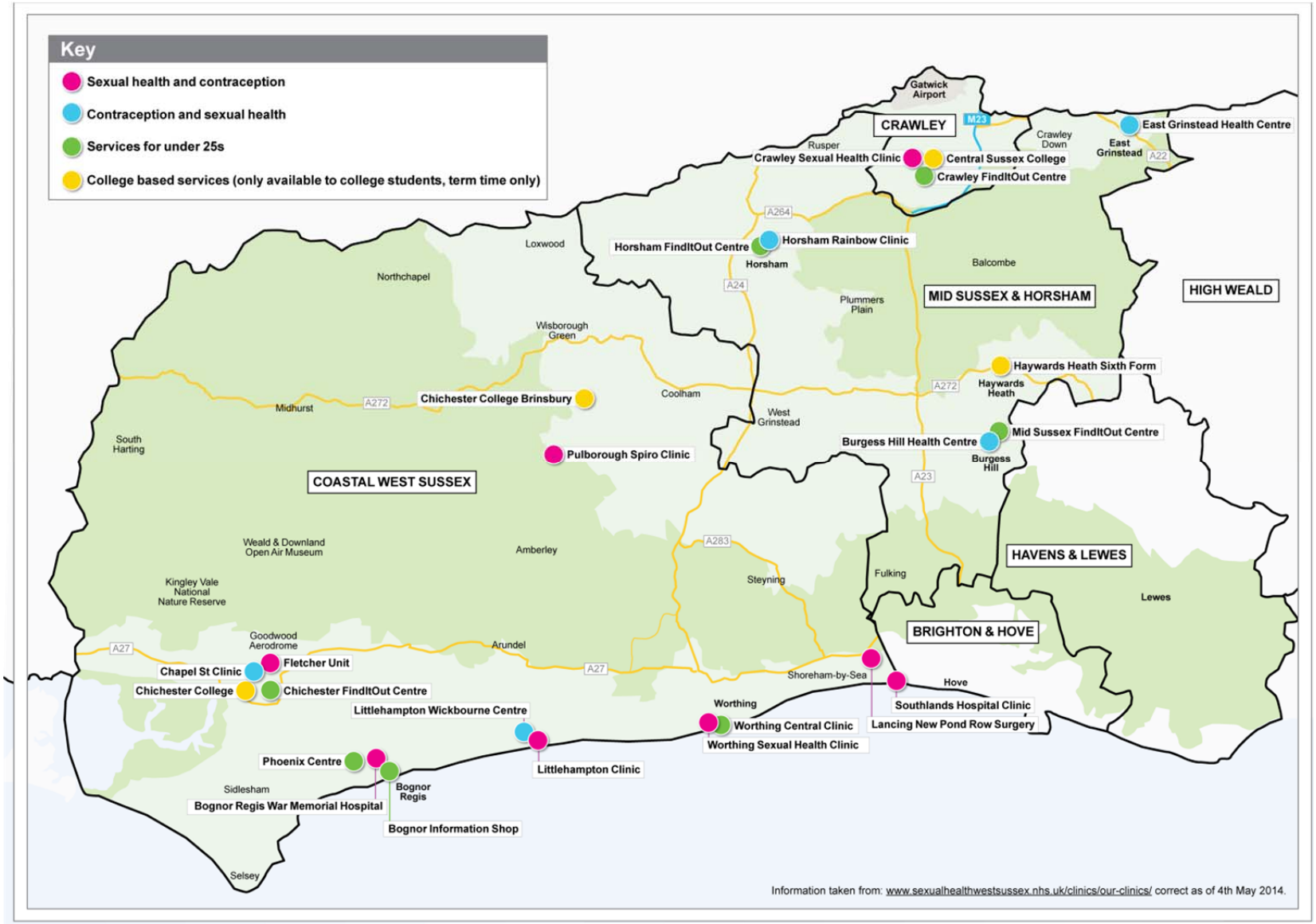
Figure 25: Association between rate of under-18 alcohol-specific admissions (2007/8 – 2008/9) and under-18 conception rates (2007-09) by West Sussex district



Source: PHE Sexual Health Profiles indicator data, 2014

Contraception

Map A: West Sussex Sexual Health Services

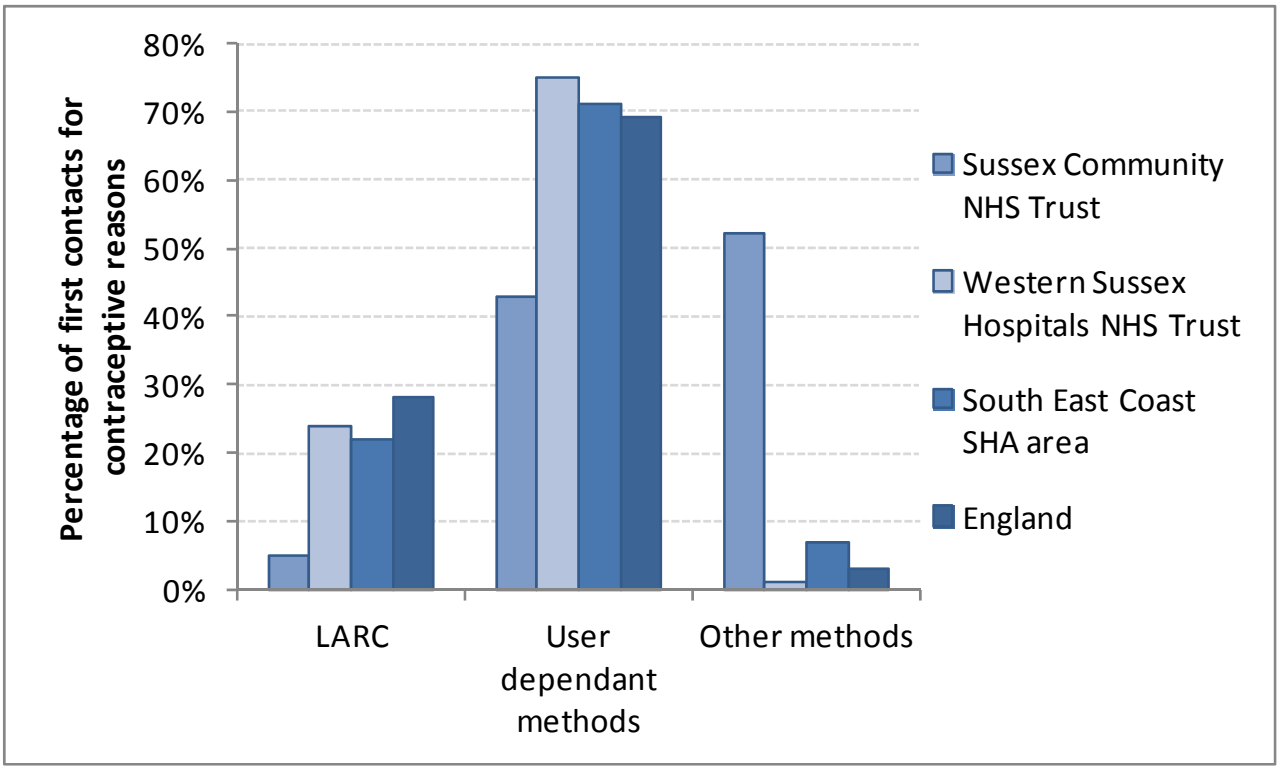


Community contraceptive clinics

5.44 Information on NHS community contraceptive clinics, which include data for family planning clinics and clinics run by voluntary organisations, show there were around 17,400 first attendances for contraceptive reasons only – 6,400 at Sussex Community NHS Trust and 11,000 at Western Sussex Hospitals NHS Trust. These 17,400 attendances equate to around 12% of West Sussex's female population aged 15-44 years. This is higher than the England proportion of 8.7%, although caution is required when interpreting these data as attendances are not based on residence and do not account for first attendances at more than one clinic in a year.

5.45 The majority of first contacts for contraceptive reasons at Western Sussex Hospitals NHS Trust are for user dependant methods, which account for over 70% of contraceptive first attendances - similar to the regional and national average (see figure 26). In contrast, first contraceptive attendances at Sussex Community Trust are predominantly for 'other methods'.

Figure 26: Percentage of first contacts for contraceptive reasons by method, NHS community contraceptive clinics, 2011/12



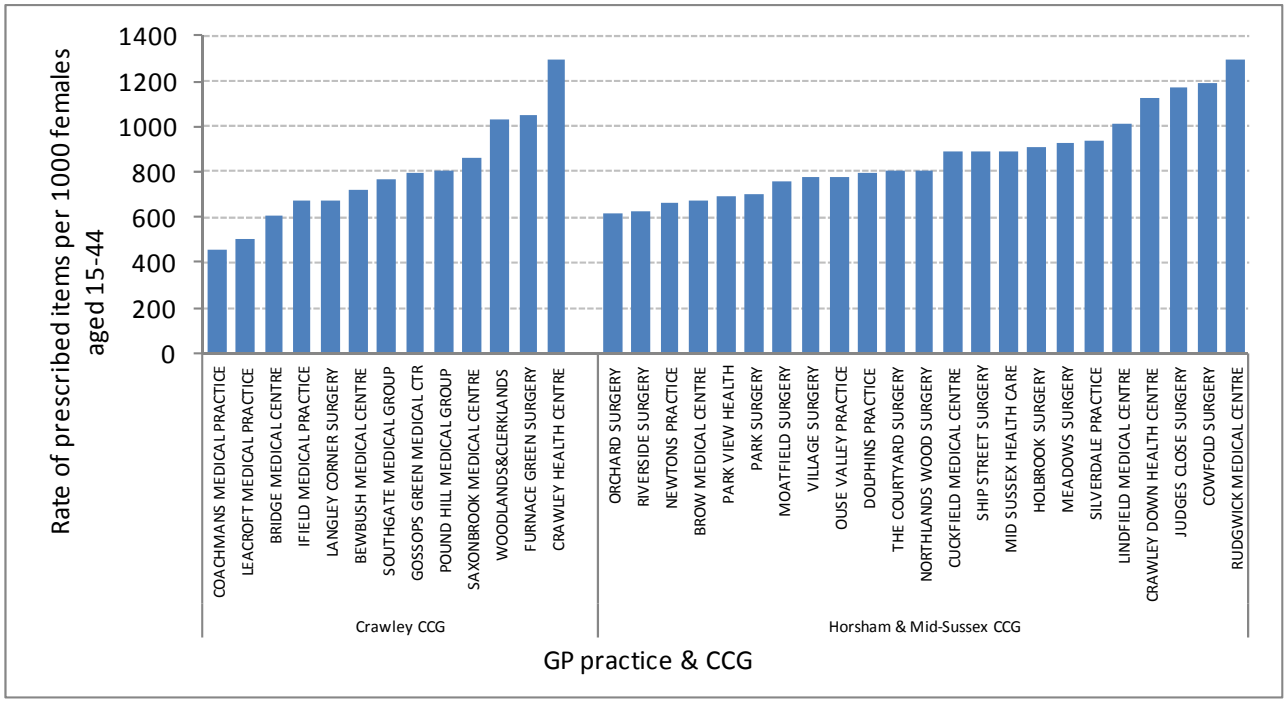
Source: The NHS Information Centre, 2013
Note: Excludes services provided in out-patient clinics and by General Practitioners

5.46 Rates of GP prescribed LARC in West Sussex were above the national average in 2012/13. West Sussex has a rate of 60.0 per 1000 registered female population aged 15-44 years, compared with 52.4 and 49.0 per 1000 for the South East and England respectively.

GP contraceptive prescribing – ***Note: Crawley and Horsham & Mid-Sussex CCGs only***

5.47 Rates of contraceptive prescribing vary widely across GP practices. In Crawley CCG there is a 2.8 fold difference between the GP practices with the lowest and highest prescribing rates, and a 2.1 fold difference in Horsham & Mid-Sussex CCG. (See figure 27.)

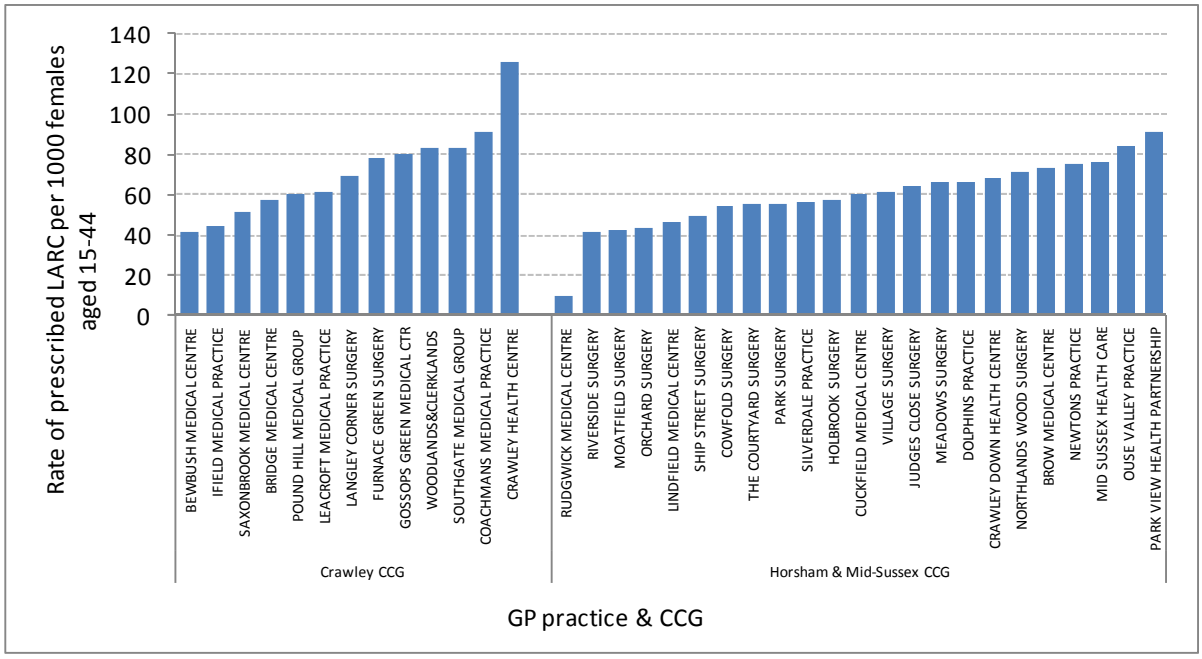
Figure 27: Rate of contraceptive items prescribed per 1000 women aged 15-44 by GP practice, ***Crawley and Horsham & Mid-Sussex CCGs only,*** *2013/14*



Source: NHS Business Authority ePACT data by GP practice
Note Number of prescribed injectable contraceptives (Depo-provera) divided by 4.3 to estimate annual injections per year for each woman

5.48 Rates of long acting reversible contraceptive (LARC) prescribing show a marked variation across GP practices, most notable in Crawley CCG where there is a three fold variation across practices (see figure 28.)

Figure 28: Rate of LARC items prescribed per 1000 women aged 15-44 by GP practice (Crawley and Horsham & Mid-Sussex CCGs only), *2013/14*



Source: NHS Business Authority ePACT data by GP practice
Note Number of prescribed injectable contraceptives (Depo-provera) divided by 4.3 to estimate annual injections per year for each woman

Abortions

5.49 West Sussex residents had 1,896 abortions in 2013,equating to an age-standardised all age abortion rate of 13.2 per 1000 females aged 15-44; lower than the England rate of 16.1 per 1000. Nearly four in five abortions (79%) in West Sussex were less than 10 weeks gestation, the same as the national average, and 91% were less than 13 weeks gestation.

5.50 Abortion data by CCG in West Sussex show all age abortion rates are below the England average in each CCG. Compared to England, West Sussex CCGs have a higher proportion of surgical abortions (between 72% to 76%; see Table 3). Across CCGs, repeat abortions are highest in Crawley CCG with 27% of abortions for women under 25 years and 49% of abortions for women aged 25 and over being repeat abortions.

Table 3: Method of abortion and repeat abortion rates by CCG, 2013

	Total number of abortions	Age-standardised rate per 1000 females aged 15-44	Method of Abortion		Repeat abortions all ages	Repeat abortions in women aged under 25	Repeat abortions in women aged 25 and over
			Medical	Surgical			
			%	*%*	*%*	*%*	*%*
England	**177,016**	**16.1**	***48***	***53***	***37.0***	***26.7***	***45.3***
NHS Coastal West Sussex	1,055	15.0	*24*	*76*	*34*	*24*	*43*
NHS Crawley	405	13.6	*27*	*73*	*40*	*27*	*49*
NHS Horsham and Mid Sussex	423	11.2	*28*	*72*	*37*	*26*	*46*

Source: Department of Health Abortion Statistics, 2013

5.51 A large majority of abortions in each CCG are in the independent sector. Both NHS Coastal West Sussex and NHS Crawley have a slightly lower proportion of abortions under 10 weeks gestation (77%) compared to the England average. See Table 4.

Table 4: Abortion by purchaser and gestation by CCG, 2013

	Purchaser (%)			Gestation weeks (%)					
	NHS Funded		Privately Funded				Total NHS funded abortions	NHS funded abortions at under 10 weeks	Percentage of all NHS funded abortions under 10 weeks
	NHS Hospital	Indep-endent Sector		3-9	10-12	13+			
England	***32***	***66***	***2***	***79***	***12***	***8***	**173,043**	**137,348**	***79.0***
NHS Coastal West Sussex	*5*	*94*	*1*	*77*	*15*	*8*	1,042	803	*77*
NHS Crawley	*2*	*96*	*2*	*80*	*12*	*9*	398	315	*79*
NHS Horsham and Mid Sussex	*3*	*96*	*1*	*78*	*10*	*12*	418	323	*77*

Source: Department of Health Abortion Statistics, 2013

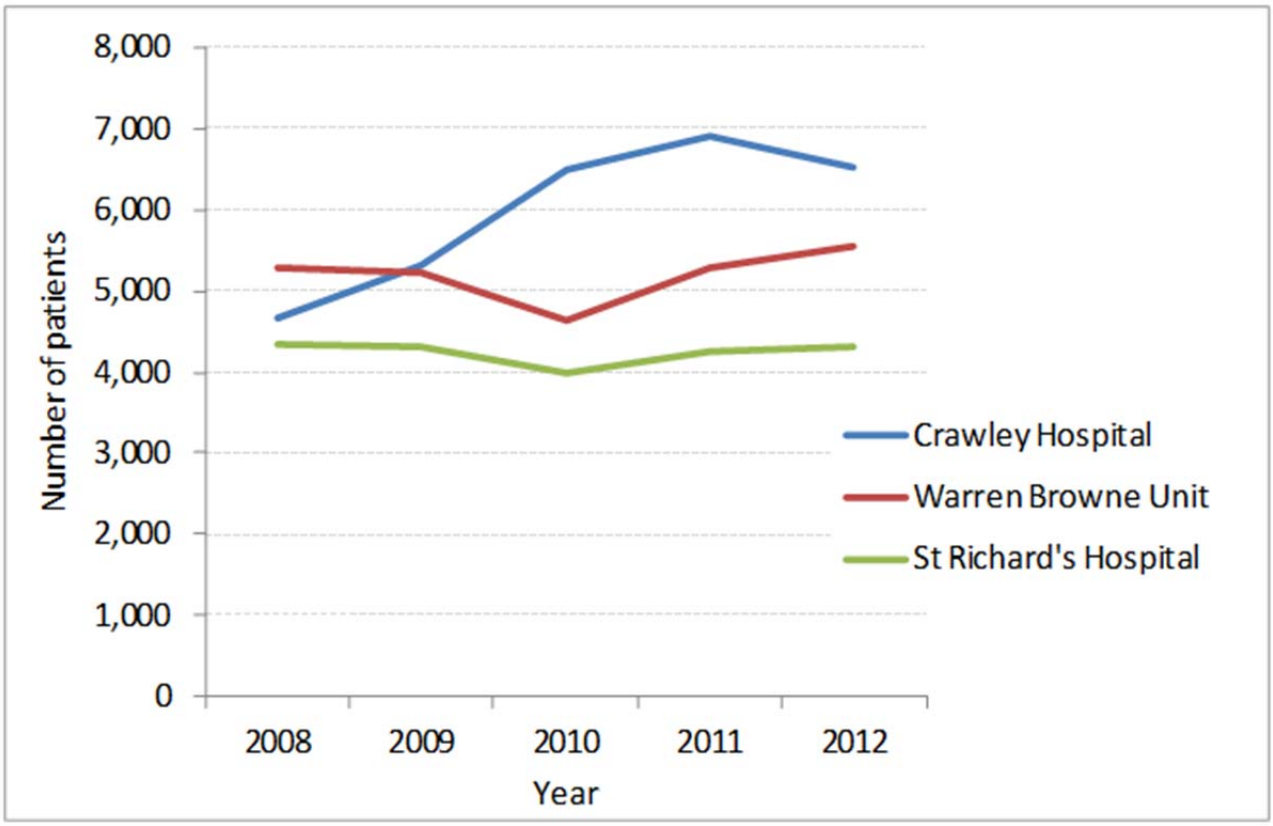
GUM clinic activity data

5.52 This section makes use of Genitourinary Clinic Activity Dataset (GUMCAD) collected at the three GUM clinics in West Sussex – Crawley Hospital, the Warren Browne Unit (Worthing) and St. Richard's Hospital (Chichester). The data gives an overview of activity at each clinic and includes both residents of West Sussex attendances and clinic attendees living outside the West Sussex area.

Patient attendances

5.53 In 2012, a combined total of 16,400 patients attended Crawley Hospital, the Warren Browne Unit and St. Richard's Hospital. The largest proportion (40%) of these were Crawley Hospital which saw 6,500 patients in 2012, followed by 5,600 at Warren Browne Unit (34%) and 4,300 (26%) at St. Richard's Hospital. (See Figure 29.) A further 4,000 West Sussex residents attended a clinic outside the County.

Figure 29: Number of patients by year, 2008-2012



Source: GUMCAD, 2014

5.54 Of the 16% of West Sussex GUM attendances at clinics outside the County, the majority attended the Royal Sussex County Hospital (7.8%), followed by just under 2% at the Earnsdale GUM clinic in Surrey (see Table 5).

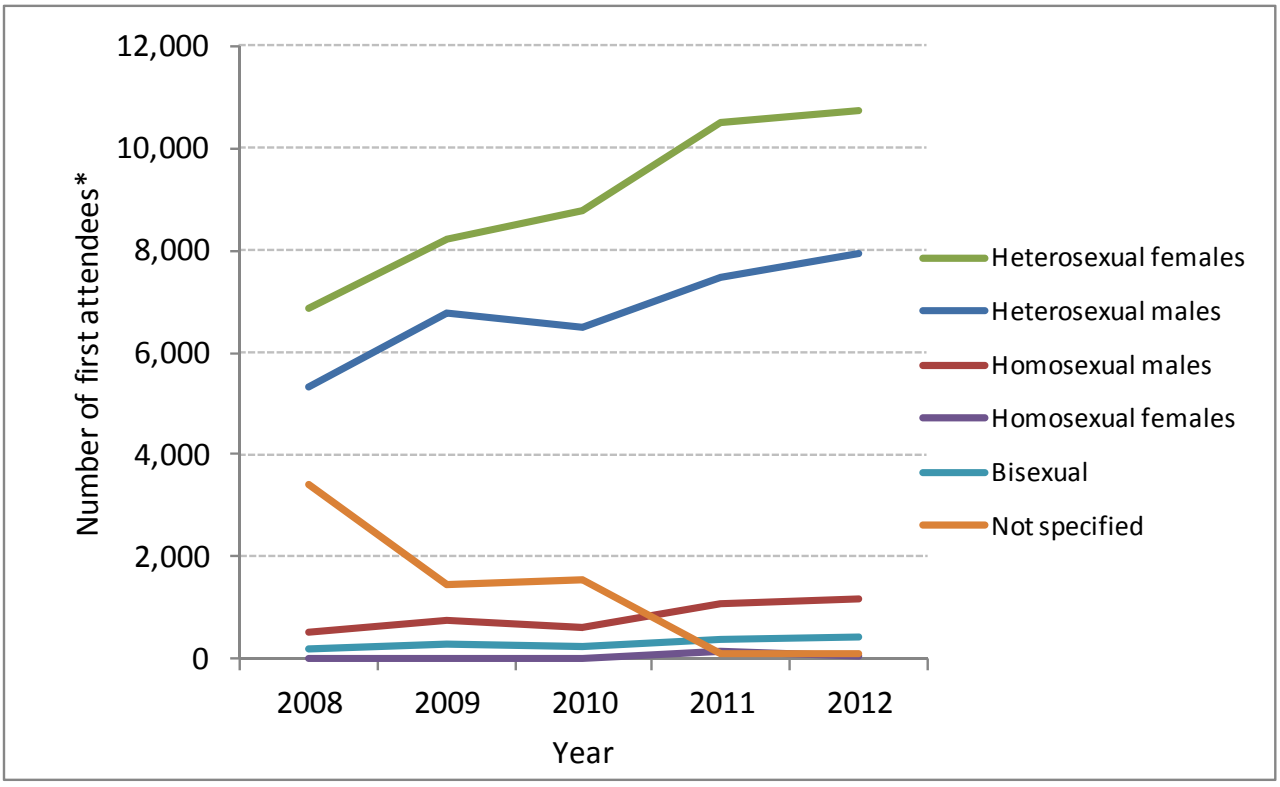
Table 5: Clinics attended by patients residing in West Sussex, 2008-2012

Area of clinic	Clinic attended	Number of patients	*% of total patients*	New Attendances	Follow-up Attendances	Total Attendances
West Sussex	Crawley Hospital	18,175	*30.4*	33,909	8,817	42,726
West Sussex	Warren Browne Unit	17,310	*29*	26,535	13,835	40,370
West Sussex	St Richard's Hospital	14,573	*24.4*	25,866	10,468	36,334
Brighton & Hove	Royal Sussex County Hosp	4,638	*7.8*	8,370	7,706	16,076
Surrey	Earnsdale GUM Clinic	1,050	*1.8*	1,632	706	2,338
Portsmouth	St Mary's Hospital	658	*1.1*	981	465	1,446
Surrey	Farnham Road Hospital	530	*0.9*	736	319	1,055
Other LA	Other clinic	2,810	*4.6*	3,918	1,744	5,662
Total		**59,744**	***100***	**101,947**	**44,060**	**146,007**

Source: GUMCAD, 2014

5.55 In 2012, female patients accounted for 53% of West Sussex patients attending a GUM clinic either in or outside the County. Heterosexual males accounted for a further 39% of patients and homosexual males 6% (see Figure 30.)

Figure 30: West Sussex residents attending any clinic, by sexual orientation, 2008 – 2012

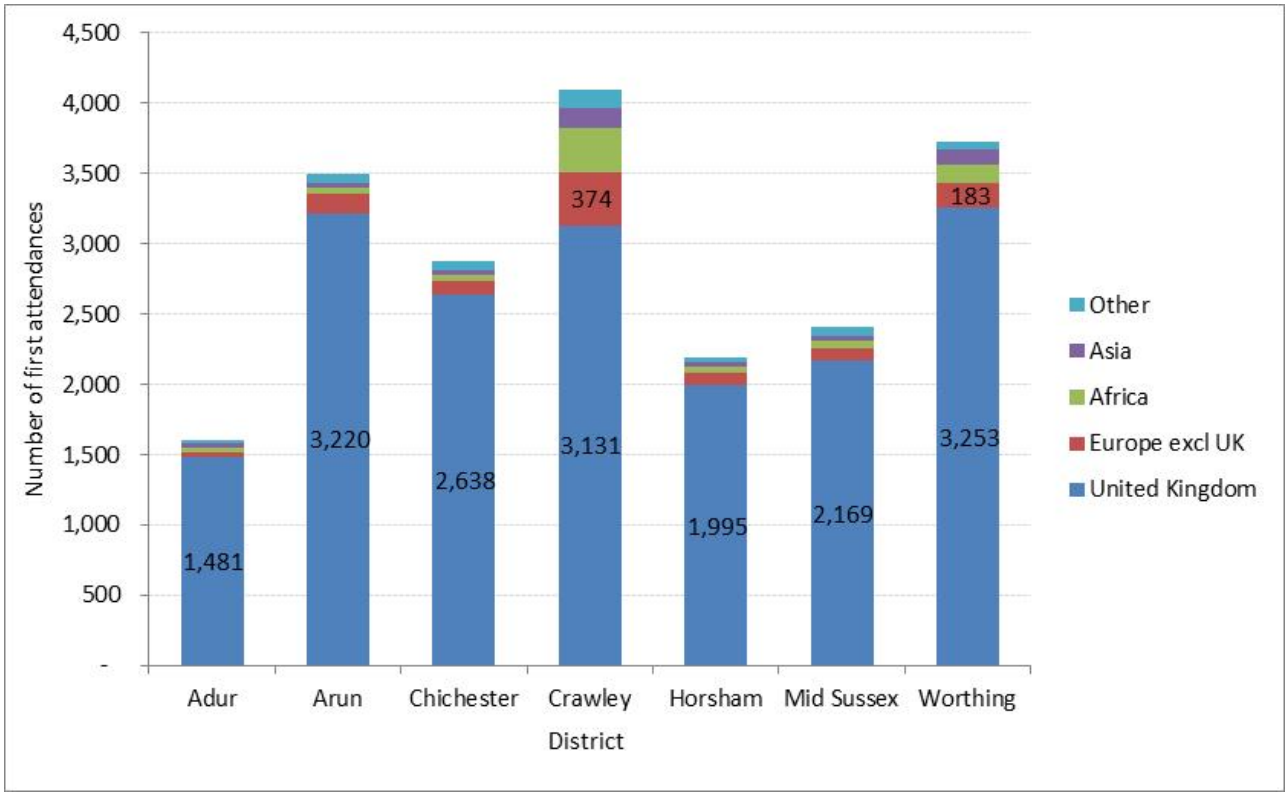


Source: GUMCAD, 2014

5.56 People born in the UK make up the large majority of clinics attendees among residents of West Sussex districts, accounting for over 90% of clinic attendees in each district, except for Crawley and Worthing where 34% and 13% of clinic attendees were

born outside of the UK (predominantly on the European continent and Africa). See figure 31.

Figure 31: West Sussex residents attending any clinic, by country of birth, 2008 – 2012

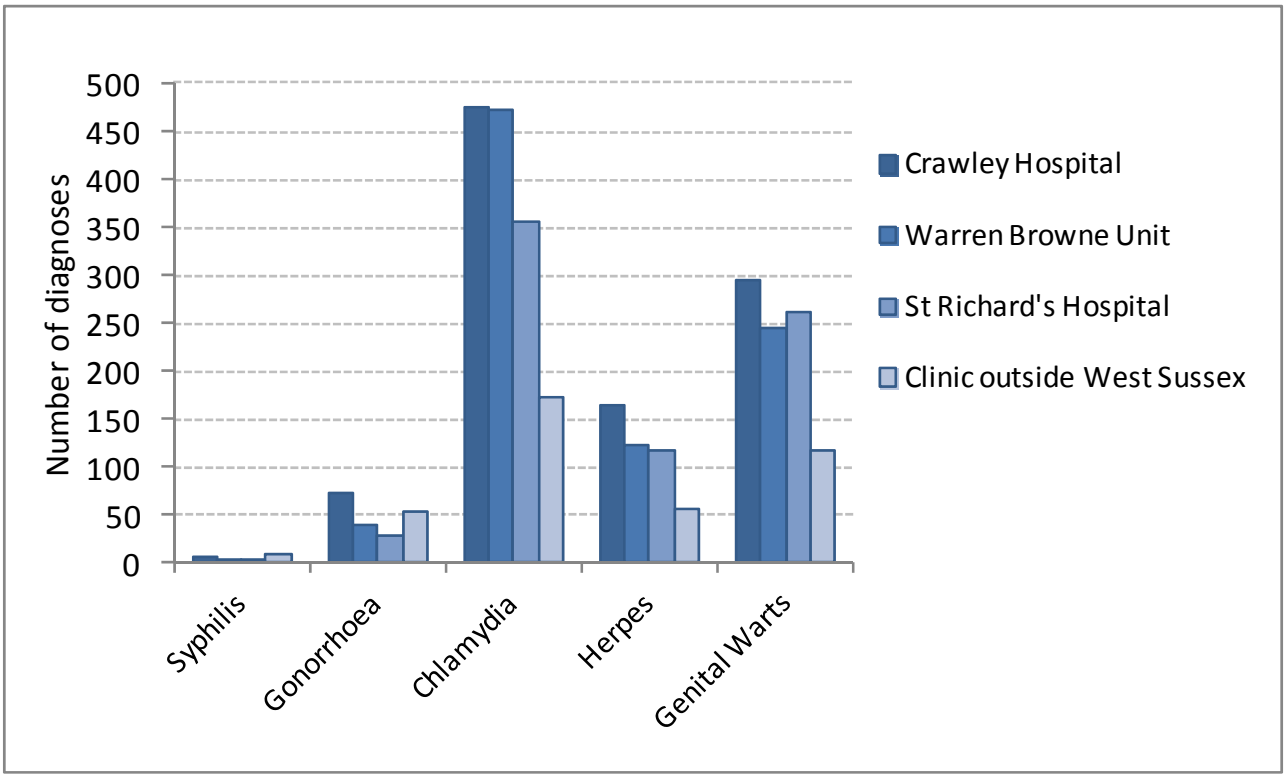


Source: GUMCAD, 2014

STI Diagnoses by Clinic

5.57 The distribution of STI diagnoses across the three clinics in West Sussex is broadly similar for chlamydia, herpes and genital warts, with around 88% of all diagnoses at a West Sussex clinic. In contrast, a larger proportion of diagnoses for gonorrhoea and syphilis were made at a clinic outside West Sussex (28% and 45% respectively; see Figure 32).

Figure 32: Number of diagnoses for the five main STIs, 2012



Source: GUMCAD, 2014

Attendances at West Sussex Clinics by local authority of residence

5.58 From 2008-12, around 85% of all attendances at West Sussex clinics were for West Sussex residents. A further 4% of attendances were residents of Brighton & Hove and 3% residents of Surrey (see Table 6).

Table 6: Patient attendances at West Sussex Clinics by local authority of residence, 2008-2012

Area of patient residence	Number of patients	*% of total patients*	New Attendances	Follow-up Attendances
West Sussex	50,058	*85*	86,310	33,120
Brighton & Hove	2,581	*4*	3,773	1,829
Surrey	1,928	*3*	3,059	767
Not Known	1,109	*2*	1,536	430
Hampshire	675	*1*	1,024	389
East Sussex	618	*1*	890	267
Other LA	1,807	*3*	2,580	811
Total	**58,776**	***100***	**99,172**	**37,613**

Source: GUMCAD, 2014

6 VIEWS OF KEY INFORMANTS

The following Key Informant (KI) views provide a snapshot of opinions and perceptions gathered during this population focused sexual health needs assessment. Although they may not represent the actual views of a majority of KIs, it is likely that they indicate the need for improvement in certain areas such as, better communication or signposting to services, etc.

The Nudge Associates Limited delivery team acknowledges that some KIs may not have been able to participate at the time of this consultation.

6.1 This population focused needs assessment consultation asked KIs questions on what they thought of the current model of sexual health service delivery, and views on what the future of sexual health services in West Sussex should look like.

6.2 The overall objective of this KI engagement process was to listen, record and collate these responses. There was semi-structured framework with views collated into sections based on the government's five key objectives for improved sexual health outcomes (see Box C), with an additional initial section on commissioning, contracting and procurement.

Box C: Themed Responses from Key Informants (KIs)

The following responses include all verbal and survey response inputs, including provider and commissioner staffing, and are reported under the following themed sections:

- Commissioning, contracting and procurement
- Access to information
- Preventative Interventions
- Rapid open access to integrated sexual health services - including free STI testing and treatment, HIV testing, partner notification, free contraception and reasonable access to all methods
- Early accurate diagnoses and treatment
- Joined up provision

6.3 All interviews were confidential to facilitate open discussions and collaboration in the SHNA. All responses in this report are therefore anonymised.

6.4 There is some cross over in stakeholder responses as many KIs saw the five key objectives as interchangeable. One KI stated:

> ***"Rapid access should mean that any service user be seen in a timely fashion, is diagnosed and treated promptly, and is provided with the necessary information on their queries and goes away fully aware of how to access provision for any future health care needs. Seamless, joined up pathways and provision should be our big aim."***

6.5 This section of the report reflects the views and opinions of KIs and adds value to the evidence provided from the epidemiology/quantitative analysis.

Commissioning, contracting and procurement: Background and context

6.6 The commissioning structures in West Sussex have experienced change. Prior to Public Health transition from the NHS to LA, the county was split across multiple health commissioners with PCGs becoming PCTs, which only merged into one for the County in 2007/8.

6.7 The Department of Health's National Support Team (NST) for Sexual health visited in 2007 as a response to the Crawley GUM service being found to be in the bottom five counties in England for overall performance against the 48-hour GUM access target. At the time there were 3 GUM providers, two community based family planning organisations, and two contracted abortion services.

6.8 A review was initiated, and work was done to move towards integration. As part of the procurement process one provider emerged, integrating provision and ensuring seamless pathways for patients where referrals were necessary. Finances remained an issue year on year, with block payment systems in place, and the commissioners acknowledge that this was never fully resolved.

> ***"At the heart of providing public services is finding and maintaining a balanced state of tension in which the best outcomes are achieved for the best value investment. In reality, the tension is more like a tug of war! (HSJ 25.4.14)***

6.9 West Sussex County Council spends in excess of £6 million for the provision of Integrated Sexual Health Services for its population. In addition to this funds are required for the provision of sexual health services for residents seeking services outside of the county. This is demand-led and activity based and costs around £600,000 per year. Additional sexual health services provided through Primary Care

and Community Pharmacies are also activity based and demand-led and account for approximately £900,000 per year.

6.10 Section 7 of this report provides further information about the contracting and procurement of sexual health services including, initiatives and procurement actions (2010-2014), current contracting arrangements, and details of performance management arrangements and shaping of service supply.

Commissioning, Contracting and Procurement

Key issues and challenges identified by KIs:

6.11 It is important to acknowledge that there were major challenges identified by many KIs in restoring confidence in the commissioning process following the recent decommissioning and recommissioning process (see Section 7 of this report). Whilst a line has been drawn, a substantial number of KIs felt that the commissioning process had been ***"flawed and weak"*** and there was some residual anger, distress and a potential lack of confidence in this needs assessment process. Some were also concerned that this was another exercise to destabilise the integrated sexual health services and ***"provide another excuse to go back out to tender".***

> ***"It was a bad time. We all really struggled with what was going on. I know we have to move on now but I'm just not sure we can recover the trust."***

6.12 With the budget for sexual health now lying with WSCC, the public health commissioners are faced with a real cultural shift in thinking, and recognition that the financial pathways in local government are complex, often with wider conditions attached. LAs are use to managing complex financial environments – Some KIs stated that LAs have been looking after the health and well-being of populations for over 125 years, and some expressed surprise at the pace of change and "pop up organisations" which have been managing money in the NHS.

> ***"How long were PCTs around...Five to six years tops? How long are CCGs going to be here…until the next government? They are not a permanent organisation, another 'pop - up'. We (WSCC) have been managing the health of our population for 125 years. To the rest of public health, it's a big deal having a ring-fenced grant. To us (LAs)...it's the norm, and it depends what you mean by ring fenced. It does not mean we have to provide mandated services the NHS way. We have different methods and we can use them".***

6.13 As stated, some KIs expressed negative views on the previous tender process, but many were also keen to ***"leave the bad experience behind and move on",*** and embrace the future potential for improving the situation across the range of sexual health provision.

"That was then - this is now. Let's just get on with it. I think we have made serious progress and improved the services enormously. We had a lot to do and we have a lot more to do - but we are definitely going in the right direction".

6.14 Some KIs expressed a real sense of increased optimism, and a feeling that commissioners wanted to really support the service improvements and work closely with providers to make changes where appropriate.

6.15 Others however, felt that commissioners have been ***"too reliant on the perceived wisdom of current providers",*** and that this needs to be addressed to reassure partners and providers that there will be strong accountability for decision making and governance arrangements. Some also felt that commissioning needs to address the ***"broader determinants of ill-health"*** and work less as a silo. Links to drugs, alcohol and tobacco were mentioned on many discussions with KIs, and the impact they have on many of their SUs, and the ways in which misuse can affect judgement in relation to having safer sex.

"We've all had these discussions with patients …you know …the story of being too drunk to remember really what happened. And all the stuff about 'chemsex' now out there - we need to be able and equipped to deal with all these things."

6.16 Nationally, sexual health provider organisations have to deal with the realities of an open market place, and competing priorities, which may lead to very different decisions than those they have worked with previously. There are also now a variety of commissioners where they previously dealt primarily with one commissioning body (the Primary Care Trust). Contracts and models of procurement in the NHS were considered by some KIs to be nowhere near as rigorous as LA processes, and big procurements are deemed to be a ***"way of life"*** for LAs. Concerns were also expressed about the longer term commissioning plans of LAs in relation to sexual health services, the realities of the open market place and the possibility that WSCC could still go out to tender.

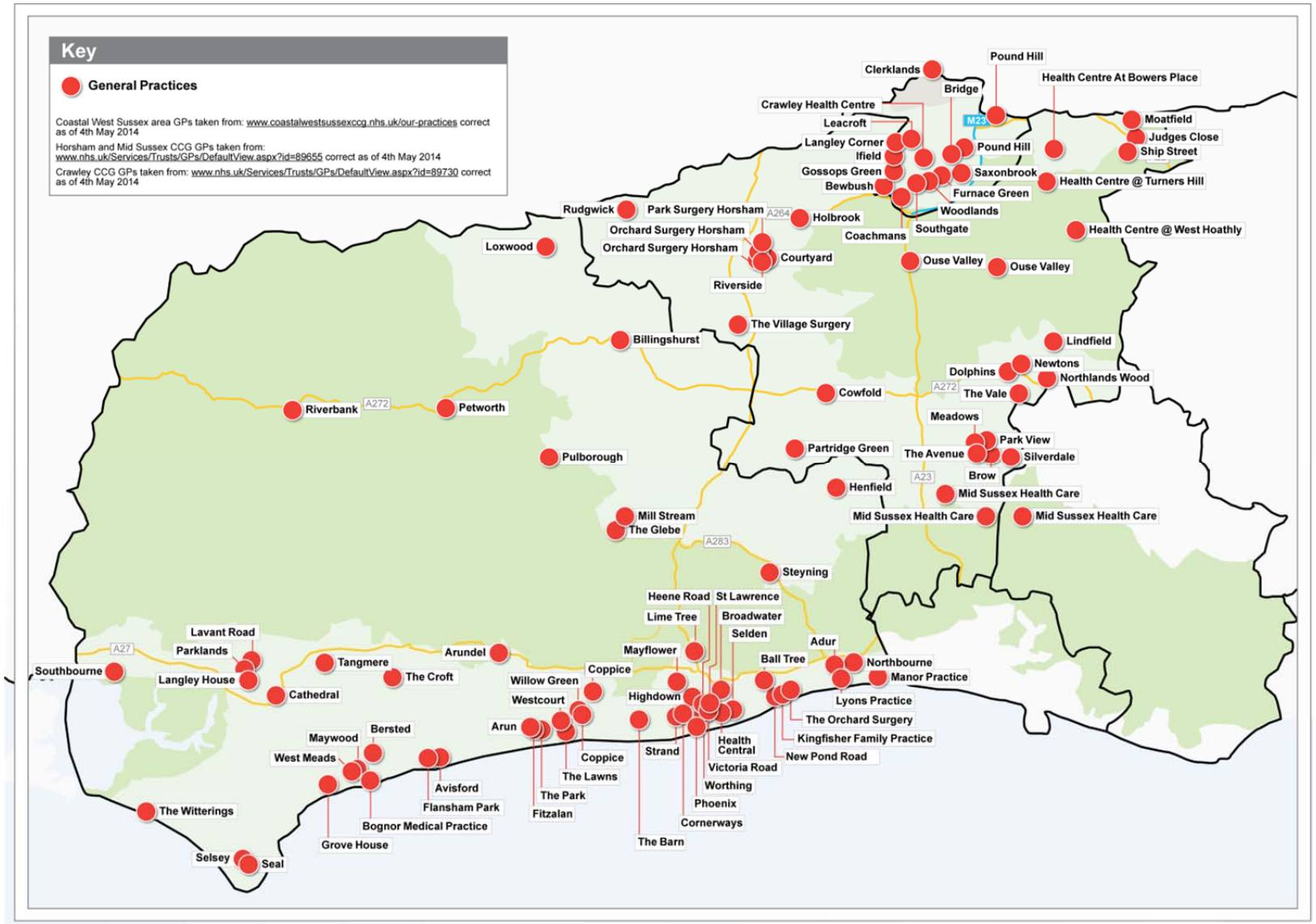
6.17 Primary care was highlighted as being a ***"bit of a gap in the commissioning process",*** with some KIs identifying a real need for increased involvement with GPs and pharmacy colleagues across the county. It was perceived to be ***"somewhat piecemeal"*** with only limited involvement from those interested, and not enough co-commissioning to really increase their contribution.

"They've got good access in the main towns, but there are loads of rural areas with nothing - just nothing - and we (GPs/pharmacists) could be doing more. We need to up our role and get more involved to increase access in some areas. We've got patients with drug and alcohol problems and we need to be better at joining this up in terms of what we offer across all our practices".

6.18 GPs in West Sussex seem well placed to engage with providers in innovative ways such as collaborating with specialist colleagues in sexual health to deliver services in alternative settings. These innovations however, are often dependent on local relationships, access to specialist training and require considerable know how to navigate around complexities, inflexibilities and the limitations of all the different funding streams and contracts. One GP described his profession as being at ***"saturation point"***.

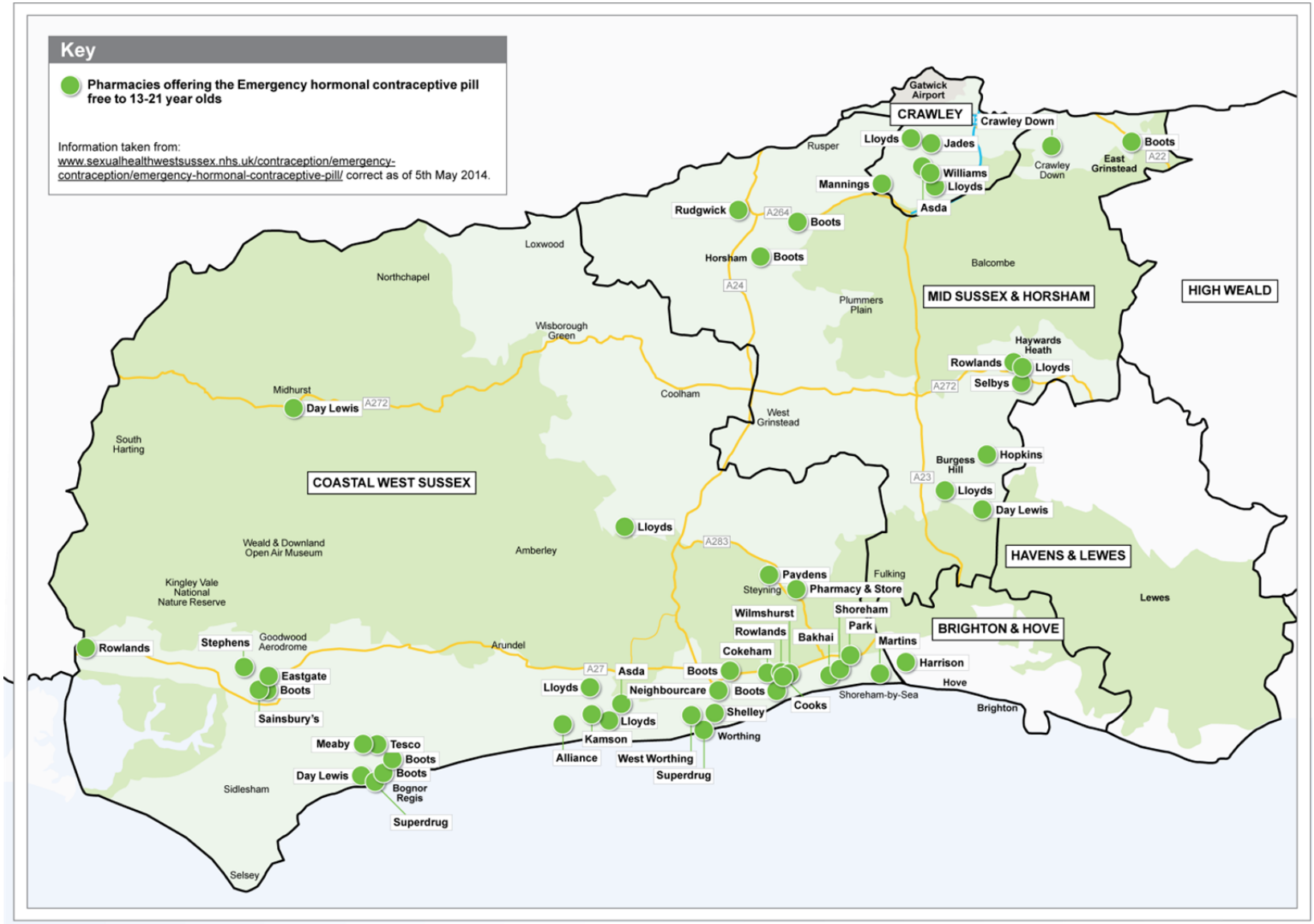
> ***"We have a whole heap of issues coming through clinic doors - we should be able to offer much more advice and info on those (e.g. drugs, alcohol) and spend more time with people. But it's hard when you have a full waiting room of people waiting to be seen."***

Map B: Local GP Practices



6.19 There was a sense that pharmacists could be commissioned to provide more sexual health services, however lack of designated time from commissioners to actively engage with them has led to a lack of enthusiasm and a piecemeal approach – especially in more rural areas where there is a need for more engagement and provision (e.g. chlamydia screening and the provision of EHC).

Map D: Local pharmacies offering emergency contraception to under 21s



6.20 Recent King's Fund research[47] has identified a major issue with the current contractual and funding context which is deemed inadequate to truly support innovative GPs and pharmacists to reach their full and desired potential in a range of specialities, not just sexual health. Fragmented payment mechanisms, different types of contracts, locally commissioned service contracts and performance payments add to a complex set of mechanisms to navigate. KIs identified a major issue with the perverse payment incentives offered to GPs in West Sussex who are trained in delivering a range of contraceptive services, including LARC, and perceive they are not paid fairly for the service. Different payment processes dependent on where the service is being offered are seen to be a major barrier for more open access and increased interest in broader provision.

6.21 Another potential commissioning complication identified by some KIs, is that two or more bodies now often commission services that patients may expect to receive in one consultation or one episode of care. For example, a woman seeking a termination who also requires an STI test and contraception; or an HIV patient receiving treatment and care who may also needs STI testing and treatment. In West Sussex STI testing and contraception are part of the ToP pathway however some KIs seemed concerned about what they see as fragmented commissioning arrangements. The commissioning of services for people living with HIV is shared amongst LAs, CCGs and NHS England.

6.22 Some KIs believe that those involved in the new commissioning arrangements now need to develop methods for collaboration to ensure clinical and cost effective services, which meet local needs and protect public health. The policy intention of a tariff based payments system and a competitive market place for health is that the money will follow the patient but this has never been introduced across sexual health as it inherited Contraception and Sexual Health services on block contracts and GP services that are often not open access. Clearly these fragmented commissioning relationships are challenging both commissioners and providers alike.

6.23 Provider KIs were in consensus that they were making every effort to manage their resources within budget. Their policies and procedures feed into divisional groups all believing they are responding to commissioners' requirements and agreed key performance indicators (KPIs). However, all expressed concerns that they are not open as much as they should be, mainly due to resource limitations and the dilution of specialist dual trained staff across several hub and spoke services. Insufficient

[47] Commissioning and Funding General Practice, King's Fund 2014

resources with stretched staff were cited as a barrier to increased opening times – especially in the evenings.

Commissioning, Contracting and Procurement

Summary of key issues and challenges identified by KIs:

6.24 The transition of commissioning responsibilities from the NHS to different organisations, namely LAs but also NHSE and CCGs, has been challenging. This experience from KIs is supported by a recent survey conducted by the Royal Society of Public Health (RSPH) that reported 'Low opinions of local authority health integration revealed' because, 'public health workforce within local authorities in England are continuing to bed in following the official shift from the NHS on 1st April 2013.'[48]

6.25 Other KIs however believe that transition in relation to HIV treatment & care went ***''pretty smoothly''***, and certainly better than for some. Nevertheless, continued confusion **(*"poor communications"*)** around the intentions of NHSE **(*"there's more change ahead"*)** as the specialised commissioner, and discussions of a model designed for London being applied to the system of the South Coast mean that concentration is easily given to this continuing saga debate rather than the immediate job at hand of addressing sexual health care services.

6.26 This, coupled with the lengthy transition process from NHS to Local Authority commissioning and the troubled procurement process of (2011), mean fears continue across the system.

6.27 There is seen to be a major cultural and organisational disconnect across the whole of sexual health as a result of the new commissioning arrangements however, West Sussex commissioners and providers have set in place a three year contract with an agreed move towards an integrated sexual health tariff.

6.28 There are perceptions that there is no one organisation that can hold the strategic and accountable overview for a whole system approach, mainly due to different roles and expectations within the organisations.

6.29 There is perceived to be a lack of clarity on leadership and accountability for the whole service user pathway, and for the funding streams across all the commissioning organisations, which will benefit patient care.

[48] 'The views of public health teams working in local authorities Year 1', Royal Society for Public Health Report, February 2014.

6.30 This concern over a lack of strategic leadership and lack of clarity over service user pathways was also reflected in the stakeholder survey, with 'Pathways' and 'Leadership' having among the lowest ratings on the extent to which the current service model is working well.

6.31 Some KIs feel GPs are not appropriately engaged in providing a full range of contraceptive service provision due to perverse funding incentives and difficulties for some in accessing the necessary training.

6.32 Some KIs believed that the ***"so-called sovereignty of"*** WSCC does not lend itself to collaborative financial partnership working – particularly across different organisations, including NHSE (LATs), CCGs and providers. It was said that WSCC struggles with the concept of open access services as they are funded for their own residents and not those from out of area. NHS commissioner ***"naivety"*** in LA ways of working and procurement are causing confusion and remain challenging. Some KIs believe that open access is now under threat.

6.33 There is a perception among some providers to deliver more services for less money.

6.34 Some KIs consider that there is too much emphasis on HIV and GUM – contraceptive services are perceived to be marginalised.

6.35 There are some issues in relation to cross charging. WSCC has an agreed interim tariff with the Trust and should cross charge at the agreed rates it pays its own services. Accurate data reporting is required to assure out of area commissioners that this is an accurate record of activity.

6.36 Although the contraceptive offer is part of the ToP contract in West Sussex, service pathways are seen to be tangled as providers and commissioners alike are trying to negotiate the fragmented funding streams (e.g. TOPs lie with CCGs and WSHNHST and yet community contraceptive services are with LAs).

6.37 There is no universal agreement on a definition for an integrated service, or what is meant by prevention. KIs agree that calling the sexual health services ***"integrated"*** is problematic as not all sessions will have the dual trained staff available to provide a fully comprehensive level of service in all its Spoke (and sometimes Hub) services as required.

6.38 There is lack of clarity between what HIV care services are delivered within GUM services and the costs of treatment. Who is meant to be paying for the actual care element as they administer treatment, and how is this being disaggregated within service budgets?

6.39 There is lack of clarity as to who is paying for HIV ***"treatment as prevention"***.

6.40 The role of elected members is perceived to be unclear.

Commissioning, Contracting and Procurement

SUGGESTED APPROACHES/RECOMMENDATIONS raised by KIs:

6.41 It was suggested that a lead commissioning role is identified to lead on the three elements of commissioning across WSCC Public Health, CCGs and LATs. This would help avoid fragmentation, and provide an environment for seamless pathways for patients. The lead can act as conduit to the bodies responsible for the different elements and ensure robust and transparent processes are in place. Section 75 or other appropriate arrangements could be put in place to manage these arrangements on behalf of all partners.

6.42 NHSE are exploring how to pool its primary care budgets with other commissioners, this work includes co-commissioning and combining budgets. The PHE whole-system commissioning framework (out for consultation at the time of writing) is due in summer 2014 and may help WSCC decide on appropriate arrangements across the county for sexual health.

6.43 A small, high level commissioning sexual health group should be developed by Public Health to support the commissioning lead and have formal delegated responsibility to facilitate the commissioning processes across all the financial partnerships in WSCC, CCGs, and NHSE (LATs). A robust membership will be necessary to ensure that all key decision makers are equally represented (see Appendix I)

6.44 Commissioning intentions need to be clearly outlined setting out KPIs and expectations on providers for what is required to provide HIV and integrated sexual health services for WSCC, maintaining the indicators for the Public Health Outcome Framework (PHOF) and local response to epidemiological evidence. These commissioning intentions should be developed in line with a sustainable commissioning strategy that is developed through partnership working and commissioning cycles across the county. It will be essential to utilise local evidence

from the JSNA, user feedback, provider data etc. The PHE Sexual and Reproductive Health Profiles[49] will be a useful tool to facilitate this.

6.45 There was universal consensus across KIs on the need for an integrated tariff, especially now that there are major opportunities to address sexual health at one clinical intervention point. Whilst the interim tariff has been agreed for 2014-2015, it is recognised as flawed, and work needs to be done in year to address the shortfalls. Local implementation of an interim integrated tariff arrangement will begin in earnest and will help WSCC know they are paying like for like, although the rate will not be mandatory. A reduction in income to the providers may however impact detrimentally on provision and care pathways for patients, and given the apparent stress on their capacity to meet demand, any implementation of an integrated tariff will need rigorous collation and monitoring of accurate data to progress.

6.46 KIs agree that commissioners should be clearly defining their expectations, identifying excellence and setting the parameters for providers. This will require excellent communication channels and use of robust service contracts to monitor and evaluate the purpose, outputs and outcomes of a range of interventions. Service contracts will need to encompass identified vulnerable communities, which takes account of the cultural norms within those communities (e.g. MSM, BME and young people). The service contract could also include an element of evaluation development as well as a baseline evaluation framework.

6.47 WSCC commissioners may wish to consider the benefit of completing a pathways risk analysis across all disciplines in relation to HIV, sexual and reproductive health. That is, an analysis of a set of sequential events along the sexual and reproductive health pathway that may affect a patient's journey and the risk management options adopted that can mitigate risks related to finance, workforce etc.

6.48 Commissioners will remain unsure of the current and future demand, need and capacity for appropriate HIV, sexual and reproductive health services until services are robust enough to undertake, complete and pass a risk analysis based on evidence of need and epidemiology.

6.49 The majority of provider KIs appeared unsure of the total allocation for sexual and reproductive health service provision, and some wanted to understand the totality of the resource for sexual health. KIs would like to play an equal role in determining the

[49] http://fingertips.phe.org.uk/profile/sexualhealth

needs and priorities for investment and expenditure. Sharing the responsibility for the allocated budgets may also be beneficial, as all elements of provision will be clear on their designated investment.

6.50 A robust performance management framework with transparent access to data should be developed across the three commissioning elements (LA/CCG/NHSE) to ensure equity of access and seamless pathways for SUs. There was also a clear message from KIs that the data collated should be used to inform any future commissioning intentions, and that a transparent process would be welcomed to allow for flexibility and programme development on a county wide basis. Service user voices should be actively encouraged as part of the data collection, and providers should foster a culture, which encourages and enables those voices to contribute and be heard.

6.51 The lead commissioning role within WSCC could ensure that champions are identified and nurtured and that the championing of all related issues expressed as part of this consultation are incorporated into the new commissioning intentions and provider practice.

6.52 Service contracts should specify that clinical providers engage with third sector providers, and include joint working with accessible and seamless referral pathways.

6.53 Respondents to the stakeholder survey were in favour of the Voluntary and Community Organisation (VCO) sector having a role in delivery of sexual health services, with 57.1% saying it should to some extent, 28.6% a significant extent and 10.7% a great extent.

6.54 GPs across West Sussex could consider signing up to a single local enhanced service contract for sexual health outlining the expected service delivery and impact at practice and group level. KPIs accompanied by variable funding to share overall investment would then be dependent on achieving the KPIs (e.g. LARC fitting, HIV testing, Chlamydia screening). This may strengthen the role of GPs, particularly in more rural areas, and stimulate a more collaborative environment brought together through a population based capitation contract. It would also allow GPs to develop a more integrated model of sexual health provision centred on primary care and targeted at more vulnerable communities.

6.55 Pharmacists should be proactively involved and could be commissioned through local agreements to increase access to EHC, condoms and chlamydia screening.

6.56 Prior to the challenging process of agreeing any future service models for sexual health services across the range of partners and new commissioning arrangements, the Sexual Health Strategy Group should identify initial overarching priorities for how the commissioning partnerships should proceed. These priorities should include:

- Deciding what they decide to keep
- Deciding what they decide to share
- Agreeing on what they decide to delegate (e.g. to Third sector)
- Agreeing the vision and shift towards both an integrated commissioning model and integrated care for patients
- Supporting self management
- Increasing productivity of all service provision
- Looking at new technologies including social media
- Mastering sexual health procurement spending
- Ensuring staff and service user engagement at all levels

6.57 Providers need to be explicitly engaged in this process so sorting out the specific roles and responsibilities will be crucial at the outset.

6.58 Should commissioners intend to go out to tender at a point in the future they should ensure transparency of intent with clear outcome measures. The key to success is going to be with transparent and effective methods which demonstrate to the SUs that decisions have been made that puts their needs at the heart of the decision making process.

6.59 It will be essential that commissioners and providers work together to ensure elected members are provided with accurate health economic arguments in support of open access HIV, and sexual and reproductive health service provision.

6.60 It will also be important to ensure elected members are made aware of and informed of action taken to prevent local HIV, sexual and reproductive health associated stigma and discrimination experienced by service users in NHS primary care providers (including GPs, dentists and general hospital clinicians).

6.61 Public health has a key role in providing leadership for HIV, sexual and reproductive health and in championing multi-agency partnership working, particularly in relation to services for young people, older people living with HIV, BMEs and MSM in West Sussex.

6.62 Commissioners would benefit from undertaking site visits periodically, to observe service delivery and gain a first hand understanding of issues on the frontline. This will

help and inform their decision-making processes in relation to service development and future commissioning.

6.63 It is essential that the different commissioners reach an operational understanding. Sharing the challenges and accepting that sexual health is everybody's business and a joint responsibility offers opportunities to enable joint solutions. This can only be good for patients and service users.

6.64 The changing environment of the LA/NHS commissioning landscape, including the move to more social enterprise involvement, with other qualified providers waiting to join the new market opportunities, presents challenges to both providers and commissioners. These emerging opportunities are embryonic and for effective partnerships to work in the future, each will need to feel confident in their roles and understand their responsibilities in order to achieve the best possible outcome for patients.

Commissioning, Contracting and Procurement

Summary of priorities raised by Key Informants (KIs) for commissioners to consider:

6.65 There should be a lead accountable commissioner for all funding streams with risk sharing arrangements agreed between commissioning bodies and providers. In the absence of government intervention, there is an urgent need for formal delegated responsibility to an individual role, based in WSCC, for all the commissioning streams at local level to ensure seamless service delivery and patient pathways. The mechanism to link those commissioning responsibilities need to be agreed locally.

6.66 Clinical and service user engagement should be managed at local level to ensure that services are meeting needs.

6.67 Commissioners should be resourced and supported to manage the complexity currently in place.

6.68 CCGs could be persuaded to be more engaged with HIV, sexual and reproductive health provision at local level, and clear on what they are prepared to offer within their core contracts and as additional services. It offers commissioners and GPs an opportunity to provide a broader range of provision in alternative settings.

6.69 Proactive partnerships should be encouraged to ensure best use of finite resources and to help create solutions applicable to local area challenges (as illustrated in WSHT's development of a sexual health service based in Bognor).

6.70 Skills development and education should to be prioritised, both for commissioners to address the new challenges they face and for dual trained nurse led service delivery in primary and secondary care settings to increase capacity and meet increasing demand.

6.71 The role of local prevention should be proactively incorporated into service contracts (for clinical and third sector providers), with KPIs developed to ensure a consistent approach across West Sussex.

6.72 An integrated service model definition should be agreed for West Sussex.

6.73 Community contraceptive service provision should be reviewed to ensure appropriate levels of investment and based on local need - similarly to that of GUM and HIV.

6.74 Work with elected members should be proactive, informative and supportive.

6.75 Open access for all to HIV, sexual and reproductive health services in West Sussex, should be maintained.

Access to accurate, high-quality and timely information that helps people to make informed decisions about their relationships, sex and sexual health

Access to Information

Key issues and challenges identified by KIs:

6.76 Access to information was seen as falling into two categories by KIs during this stakeholder engagement process. Some saw the access to information issue as one which identified where services/free condoms/health promotion literature etc. were available, and how that was communicated to the general public and advertised.

> ***"Where are we getting on things like Facebook/Twitter to advertise our services? Are providers using those means to advertise? If so - why isn't it all out there - really clearly for everyone to see?"***

Others believed it to be about a whole range of information, including access points for services (where services actually are), the availability of EHC and LARC, sex and relationship education (SRE) in schools and colleges and access to the more holistic information and literature available on STIs/HIV/chlamydia screening etc. Some agreed that it was all-important.

"People come from such varied places and backgrounds now. We have split and blended families, and safe spaces to really get quality information are hard to find - especially as the Internet is so easily available. Often people are alone in their rooms with access to porn and thousands of so-called 'friends' on 'Facebook'. We really need to be in there with them - making sure we make use of 'free media' opportunities - counteracting the weird with the facts and information they need to be safe and have healthy sexual relationships. People need where to go to get this info".

6.77 WSHT has a website which is updated regularly and signposts potential service users to all its sexual health 'Hub and Spoke' services across the county, including information on opening times, venues and what sexual health service is provided. Some KIs felt that the website, although linked to the council's 'Your Space' website, is not young people friendly, as it is overly wordy and could be targeted more appropriately.

6.78 The availability of consistent, quality information and resources is universally regarded as central to health and wellbeing, including for STI/HIV prevention. There was a sense that access to information on where sexual health services are actually situated, and information on proactive prevention work with individuals in West Sussex is failing to evolve at the same speed as societal changes. Embracing technology was seen to be far too slow and ad hoc.

6.79 It was acknowledged that some people like to access information about health and available services in an anonymous and confidential manner. Technology can facilitate this. Without some form of co-ordination however, the potential for duplication is great. The majority of KIs consider some strategic planning and development of countywide mass and social media resources necessary.

6.80 Interestingly respondents to the stakeholder survey and SU surveys had fairly similar views on preferred locations for information on sexual and reproductive health services, with schools/colleges/universities, GPs and pharmacies featuring in the top five for each. However stakeholders also included social media and in local bars and clubs, whereas SUs other priorities were NHS Direct and community health services.

6.81 While social media was not in the top five for SUs (perhaps due to the profile of respondents, which had relatively few young people), this was mentioned 113 times by SUs, and those that had mentioned it were asked both why and how it should be used. The main reasons that SUs felt social media should be used were it can reach a lot of people quickly and cheaply, particularly young people, and that it offers a level of anonymity/discretion. The most common suggestion of how it should be used was to

promote sexual and reproductive health services, with the next most common suggestion being to provide information (promotion was suggested almost twice as frequently as providing information).

"We used to have a whole heap of stuff going on for chlamydia screening and young people understood it. Where's it all gone now?"

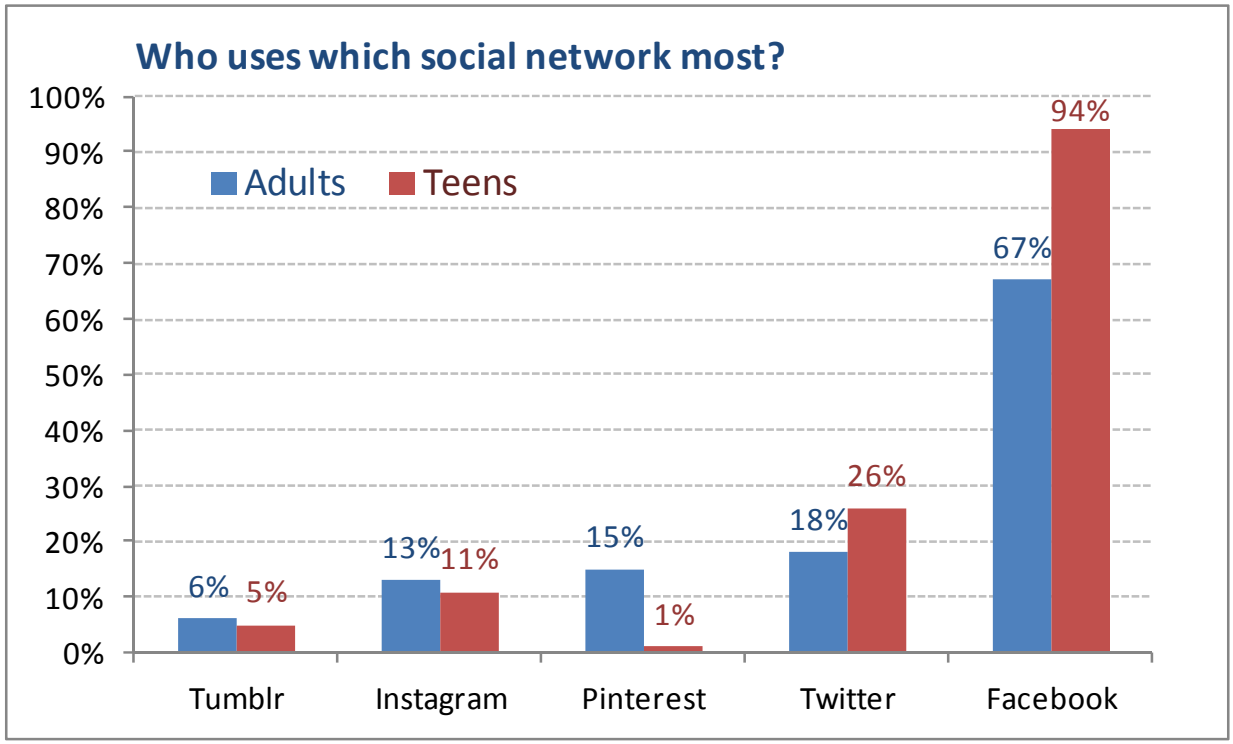
6.82 There were different views expressed on the HIV Prevention England (HPE) mass media campaign. Some considered it relevant and valued; whereas others felt it is not branded in a way that speaks to the populations it needs to reach in West Sussex. HPE has been commissioned to complement local provision as part of key HPE priority geographical areas (such as Brighton - not necessarily in West Sussex) however resources are available and can be used as highlighted elsewhere in this report. There is a view that, in the future, there needs to be more collaboration with SUs and other key stakeholders in West Sussex about the messages to be relayed. Branding for West Sussex was discussed by some KIs who felt that this might be relevant for young people in particular.

6.83 Some KIs also believe there to be a total disinvestment in Lesbian, Gay, Bisexual, (LGBT) targeted work - especially for young people. In the stakeholder survey respondents were asked whether there are any particular groups that need more outreach/targeting work, and young people, LAC care leavers/looked after young people and LGBTI groups were mentioned most frequently.

"Most of our LGBTIs have to go to Brighton to get their information and support - that's if they can afford to go there - we've got nothing now."

6.84 There was consensus that all West Sussex public health messages need to be "up there in that digital space." The majority of KI's acknowledge high-level use of social media amongst young people, gay men and African communities, although patterns of usage were different across these groups. MSM/gay men tend to use smart phone apps and websites to meet other men, primarily for sex. African communities usage is more varied, and includes general use of social sites and reading news from home countries. Young people use Facebook/Twitter to communicate (see Figure 33). There was no consensus expressed on the effectiveness of sexual health prevention media campaigns. The reach of campaigns is seen to be limited by size of budget, but most KIs felt that there had been a major reduction in budgets for proactive prevention and messages on safer sex, overall support for vulnerable communities, and that there were missed opportunities to actively engage more broadly because of this reduction.

Figure 33: Social media use by adults and teenagers



Source: Pew Research Center

6.85 This was reflected in the stakeholder survey, with respondents rating promotion of services to vulnerable groups as the area of current service delivery working least well, and various gaps in terms of targeted work identified as an area for improvement.

6.86 Access to consistent Sex and Relationships Education (SRE) in schools and colleges was a concern for many KIs. They were particularly concerned that WSCC did not have comprehensive guidance in place to support young people's sexual health needs in schools and colleges. Access to age appropriate relevant sexual health information and literature is therefore seen to be limited or dependent on individual schools policies.

> ***"Young people are using porn sites to find out about sex. This is really sad and definitely puts them at risk - not only do they remain ignorant about safe sex, but where's the respect and dignity afforded to young women if the boys believe that's what sex is all about? We really need consistently good SRE in our schools. The young people I see want to talk about their relationships as well as sex."***

6.87 Although the provision of SRE in WSCC schools was not a key part of this needs assessment, the lack of appropriate SRE in schools was also highlighted by the stakeholder survey.

6.88 The specific needs of Looked After Children (LAC) were also highlighted as a concern by some KIs, especially those children placed outside of their home areas, and where

peer groups and friendships were new, so discussions and shared information on sensitive and difficult personal issues were seen to be a challenge.

6.89 The lack of services for LAC and the need for more outreach/targeted work with LAC were also features of responses to the stakeholder survey.

6.90 Some KIs views are that advertising in the press reaches smaller audiences, as smart phone applications take over. Nationally, young people, BME, and MSM are reported to be using this technology as it enables them to access services, information, and for some, the opportunity to meet other sexual partners with more anonymity.

6.91 Whilst there has been extensive promotion of STI/HIV testing via some of the gay 'hook-up' smart phone apps (e.g. Gaydar/Scruff/Grindr), there has been almost no reported prevention campaign work, with KIs believing this is primarily due to the costs of advertising.

6.92 Most KIs felt that access to information and more innovative prevention ideas should be advertised through social media, however there was a difference in opinion as to what they think will work. Some felt that factual information would have more of an impact on people, for example, increased information on the consequences of late HIV diagnosis could prompt people to take action. Others felt it was more about directing people to services, and ensuring that those services are clearly signposted and accessible to all. Where there was almost universal consensus was the need for a proactive consistent SRE policy that offers young people the right to access appropriate information that meets their needs, keep them safe and helps them make informed choices (see above section about views on use of social media).

Access to Information

SUGGESTED APPROACHES/RECOMMENDATIONS raised by KIs:

6.93 Given the current lack of a formal West Sussex sexual health network, which appears to be negatively impacting on good communication across the county, many KIs would like to see an open communication strategy introduced by commissioners of sexual health services. This would ensure transparency of consistent information across the county for all providers and commissioners.

6.94 The planned Sexual Health Forum should be re-introduced to increase and improve communication, with representatives across the provider and commissioning spectrum, including with the third sector and service user representatives.

6.95 An annual sexual health event, perhaps as part of a broader Public Health event to share information and provide updates and opportunities for a question and answers session would be beneficial as new ways of improving access to information and service provision are shared. All key stakeholders could be invited and providers could update on service improvements, updated data analysis on sexual health, availability and relevant information to share across a range of stakeholders and providers.

6.96 Increased use of public spaces, such as libraries, swimming pools, pubs, hairdressers etc. should be used to provide relevant and appropriate information about sexual health service availability and health promotion literature. Consideration should also be given to whether community facilities could also be used to host services.

6.97 All service providers and commissioners in partnership with colleagues in Children's services should consider the specific needs of Looked After Children (LAC) in relation to their sexual health needs.

6.98 There should be an increase in proactive engagement and information sharing on the sexual health needs of young people with school governors to ensure a more consistent approach to SRE across West Sussex.

6.99 Increased use of IT and social networking sites to increase access to integrated sexual health services was viewed as essential by many KIs. This should be developed as an effective means of communicating for a range of age groups and target populations, with the added bonus of confidentiality for all, e.g. www.tht.org.uk/myhivww.myhiv.org

6.100 Increasing the use of "podcasts" or YouTube was also highlighted as an excellent tool and should be encouraged in schools and colleges to offer a range of information on sexual and reproductive health services.

6.101 The sexual health services website of Western Sussex NHS Hospital Trust should be reviewed, in light of the general criticism that 'it is not very user friendly", to ensure that it offers up to date information and access points for all service users, and identifies clearly the specific type of services available, opening times and information about what to expect. Providers should identify a lead to ensure that this information is kept up to date and communicated consistently across the county. The lead should ensure that the information is regularly updated, relevant, timely and proactively advertised on the *"Your Space"* WSCC website.

6.102 These sites should also provide the information in a range of languages that meet the needs of the diverse population of West Sussex, and ensure access to the information for more vulnerable and hard to reach populations.

6.103 Given the emergence of new treatment technologies, including PEPSE and Pre-Exposure Prophylaxis (PrEP), some KIs believed that SUs need to be clearly signposted to relevant sources of HIV treatment information online. This would be hugely beneficial in supporting those living with HIV to maintain their health and reduce onward transmission. Point of Care Testing (POCT) should be widely advertised as this would increase early diagnoses of HIV and should be available across WSCC.

6.104 KIs unanimously supported a central booking line for all sexual health services across West Sussex.

6.105 In summary, there were a range of views expressed (which broadly mirror the findings of both the stakeholder and SU surveys) as to what and how information should be relayed for sexual health SUs in West Sussex but notably, the key messages from KIs were:

- Increase the use of social media to engage, inform and educate
- Increase access to information on where services are, opening times and what they offer in a range of communal settings
- Ensure appropriate web links between WSCC and all its service providers across all Hub and Spoke services provided by the WSHT and Voluntary Sector Organisations (VCOs)
- Provide a consistent PSHE support across all schools through evidence based programmes, good practice and advice
- Link in with HIV Prevention England (HPE) more proactively and use their resources (http://www.hivpreventionengland.org.uk/Resources)

Preventative Interventions

6.106 Sexual health is an area where considerable health gain can be achieved by proactive health promotion and advice, access to a full range of contraception, relevant information, proactive prevention interventions, timely access to testing, and early diagnoses of all STIs and HIV. Preventative interventions which increase self-esteem, resilience and help support individuals to manage their health by providing them with

the necessary information to make informed choices is an aspiration that most KIs agreed is a priority.

Preventative Interventions

Key issues and challenges identified by KIs:

6.107 Concerns were often expressed as to how to better align clinical service provision with the prevention agenda. KIs widely recognise the role of GUM and community contraceptive clinics in STI/HIV prevention and in reducing unintended pregnancies, and are keen to see this role increased. However capacity issues, lack of specific commissioned activity for prevention, funding pressures, lack of relevant training, and some reduced skills and competencies are often cited as reasons why there was too little proactive prevention work incorporated into sexual health service contracts.

> ***"Why are clinics not really addressing the prevention needs of those going in through their doors? What's that document...'Every Contact Counts'…***
>
> ***"Well, we need to make sure it does and it should be embedded in their (provider) contracts."***

6.108 Time is also highlighted as a major challenge.

> ***"If we actively challenged everyone who came into the clinics and got them talking about why they are here in the first place, we'd be here all day and probably half the night!"***

6.109 KIs commented that merely providing negative diagnoses are "missed opportunities" to proactively engage with an individual, suggesting that more attention needs to be given to health promotion interventions and supporting individuals to remain negative. However it was recognised that the role, skills and competencies of health and other professionals are variable, and some identified the need to incorporate much broader risk factors into their intervention portfolio (including alcohol and drug use).

> ***"There are just so many times that we see people who have got multiple problems –booze/fags/drugs...you name it and we just often don't have the time to address all that in one go. We need more time to spend with people and to help with all their issues, otherwise you just know they will be back."***

6.110 As stated in the previous section on access to information, there is no countywide SRE programme, consistently applied across all schools in West Sussex. Although WSCC teenage pregnancy rates have decreased, KIs highlighted the potential for negative impact on teenage pregnancy and STI rates were a school head to block the sexual health element of SRE. KIs also expressed concerns that they lack the capacity to provide a robust training programme and follow up mentorship for those teachers who

complete the programmes available. This lack of consistent SRE provision in schools was cited by almost all KIs as representing a major gap in health education and prevention work. Young people in WSCC are learning about sex from the Internet and therefore there is no way to ensure that they are getting factual information. The need to educate young gay men and Looked After Children (LAC) about safer sex, in particular, was a recurrent theme.

6.111 There are a significant number of KIs that felt messages about promoting condom use had faded and that there needs to be more high profile promotion of their use.

6.112 Concern was also expressed about the increase in "chemsex" amongst young gay men and a need to ensure that those who are involved have access to the relevant support as a priority. This concern is supported by the recent South London Chemsex Study[50], which explored perceived norms about drug use in the gay scene.

6.113 In addition, some KIs highlighted the fact that the C-card scheme (that allows young people to obtain free condoms once they have had a talk with a trained worker) only had limited distribution points.

6.114 Many KIs are frustrated by the lack of a coordinated response to STI/HIV prevention, despite the evidence of effectiveness and need. *Unprotected Nation*, a report from Brook and FPA[51], was cited by some stakeholders. It models how sexual health promotion and service cuts and restrictions will lead to a significant rise in STIs, HIV infection, and unintended pregnancies across all ages, with onward costs that will impact on local government services. There was particular concern that this evidence would be ignored in a bid to reduce costs.

6.115 The 'Find it Out' services for young people were highly commended, but there was increased frustration that there was only limited sexual health outreach provision available in the seven wellbeing hub services across county, and that there were missed opportunities to really address the sexual health needs of those young people who attend. KIs would like to see the outreach teams offer far more sessions, and offer EHC, LARC, pregnancy testing, asymptomatic screens and chlamydia screening as well as information on sexual health, where appropriate.

"The outreach team are amazing - we need so much more of them, and they can really help young people get a sense of perspective about sexual health –

[50] http://www.sigmaresearch.org.uk/files/report2014a.pdf

[51] http://www.fpa.org.uk/sites/default/files/unprotected-nation-sexual-health-full-report.pdf

practical and real help. They are a great resource but we need more, more, more."

6.116 A small number of KIs expressed concern that there was little incentive for WSCC to prioritise sexual health promotion and prevention, as they will not be responsible for the lifetime drug costs for those living with HIV. This was an interesting perspective as HIV treatment and care costs are the responsibility of NHSE. KIs also expressed concerns at the lack of proactive prevention work, arguing that spiralling clinical costs could be curbed with a reduction in repeat attendance through more proactive prevention messages. STI/HIV testing as the means to an end is seen as a limited approach without the back up of behavioural change interventions to add value and support to the individual.

6.117 It was also felt that repeat termination rates should be vigorously addressed, with all offered access to LARC and STI testing, especially targeting young women. Despite the county reductions, KIs also felt the current proactive prevention work on teenage pregnancy was not rigorous and effective enough to really address the unintended conception rates and repeat abortions.

6.118 The national push to increase STI/HIV testing as a prevention tool was seen as potentially undermining to individual 'one to one' interventions. 'Warm referrals' (where SUs are actively introduced to other services, not merely referred on) are suggested as a solution to the lost of follow-up; stipulating this and joint working arrangements in service contracts between clinical and third sector organisations could facilitate better patient pathways and KIs felt this was not common enough practice.

6.119 Access to resources, including the wide availability of condoms and relevant and culturally appropriate literature has been reduced. KIs expressed concerns that the reduction in those "essential helpers" would lead to an increase in STIs and HIV.

Preventative Interventions

SUGGESTED APPROACHES/RECOMMENDATIONS raised by KIs:

6.120 Given that WSCC are now responsible for commissioning a major share of Sexual Health services, there are opportunities to improve the role of services in unplanned pregnancies/HIV/STI prevention and to identify additional and alternative settings to provide relevant information and increase uptake of HIV/STI and pregnancy testing. KIs felt that this could be agreed as a priority requirement between public health commissioners and providers. There was recognition that a standardised tool was not

applicable to every aspect of delivery but that service contracts could account for this in any local area deemed appropriate. As stated, a sexual health balanced scorecard has been developed by PHE and could be introduced as a standardised tool with local metrics to account for variations.

6.121 There is the potential to increase co-commissioning with other public health initiatives. In terms of the future model, some KIs cited the Marmot Review[52] into health inequalities stating that it gave a broader, and more relevant context to risk, including drug and alcohol and smoking behaviours, and the majority of KIs were clear that there were missed opportunities by having such a narrow definition of prevention.

6.122 There was interest in aligning clinical service provision with the prevention agenda and incorporating it into service contracts. KIs felt that multi-disciplinary models of prevention and care, provided by appropriately skilled professionals, would support provision of prevention advice but would also provide support in a range of other public health issues, including alcohol, substance misuse, and smoking. KIs would like to see a consistent methodology used to evaluate the effectiveness of prevention. Models offering a potential solution, for example the BASK (Behaviour, Attitudes, Skills and Knowledge), need to be appropriately and consistently monitored before their use is agreed strategically. WSCC could consider a pilot on evaluating this model with a range of Third Sector providers who are currently commissioned to provide sexual health services.

> ***"They need to invest in interventions that will create sustained behavioural change. It's about winning over hearts and minds. What is going to create a culture of sustained change? To create a sustained solution is about engaging people meaningfully – email, follow-up, support groups, people who can lead service users through all the journey and point them to the right services - not just clinical interventions."***

6.123 A combination approach, rather than one universal approach to STI and HIV prevention, recognises the range of factors that influence an individual's relationships and safer sex behaviour. It also offers a menu of interventions with clear patient pathways and strong referral processes needed to enable providers meet the different need of individuals. STI/HIV testing is an effective primary clinical prevention initiative, and treatment is an effective secondary clinical prevention initiative; however, they cannot be delivered in isolation. The division between primary and secondary prevention work is seen by KIs to be unhelpful, and should be universally provided.

[52] http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

6.124 KIs perceive that there is now an opportunity to introduce STI/HIV testing in a broader range of community and primary care settings, and a need to incorporate much broader risk factors into the intervention portfolio (including alcohol and drug use).

6.125 Interpersonal (face-to-face) interventions can help people make healthier life choices, including reducing risk-taking behaviours. Interpersonal interventions acknowledge the complexities of individual lives, however they are time consuming and expensive.

6.126 SRE should be accepted as a serious and relevant participative subject by all schools and academies as an important part of what is offered young people. There were strong and consistent views from KIs that WSCC should address this as a matter of urgency with school heads and governors. Commissioners and providers should be aware of the latest guidance such as *'Sex and Relationships Education (SRE) for the 21st Century'* (Brook, PSHE Association and the Sex Education Forum 2014)

6.127 WSCC have an opportunity to advise that all SRE programmes inform and educate young people. There is also an opportunity through youth work in schools, and in provision for young gay men, vulnerable young women and LAC.

6.128 Stigma and discrimination should be addressed vigorously and SRE education in schools should encourage "normalising" STI/HIV testing and chlamydia screening.

6.129 Work with young women in particular was highlighted as a priority by many KIs working with young people across youth and children's services. Offering proactive support and counselling, especially to young mothers who have repeated pregnancies and abortions, and ensuring they have access to LARC was deemed a real priority.

6.130 There was consensus that the availability of condoms is crucial as an effective part of an effective prevention strategy. Improving the C-Card scheme further, by expanding the scheme, providing more updates on it and training other professionals (non-NHS) to help promote/administer the scheme was highly recommended.

6.131 In addition there were a significant number of KIs who felt that messages about promoting condom use had faded and that there needed to be more high profile promotion of their use.

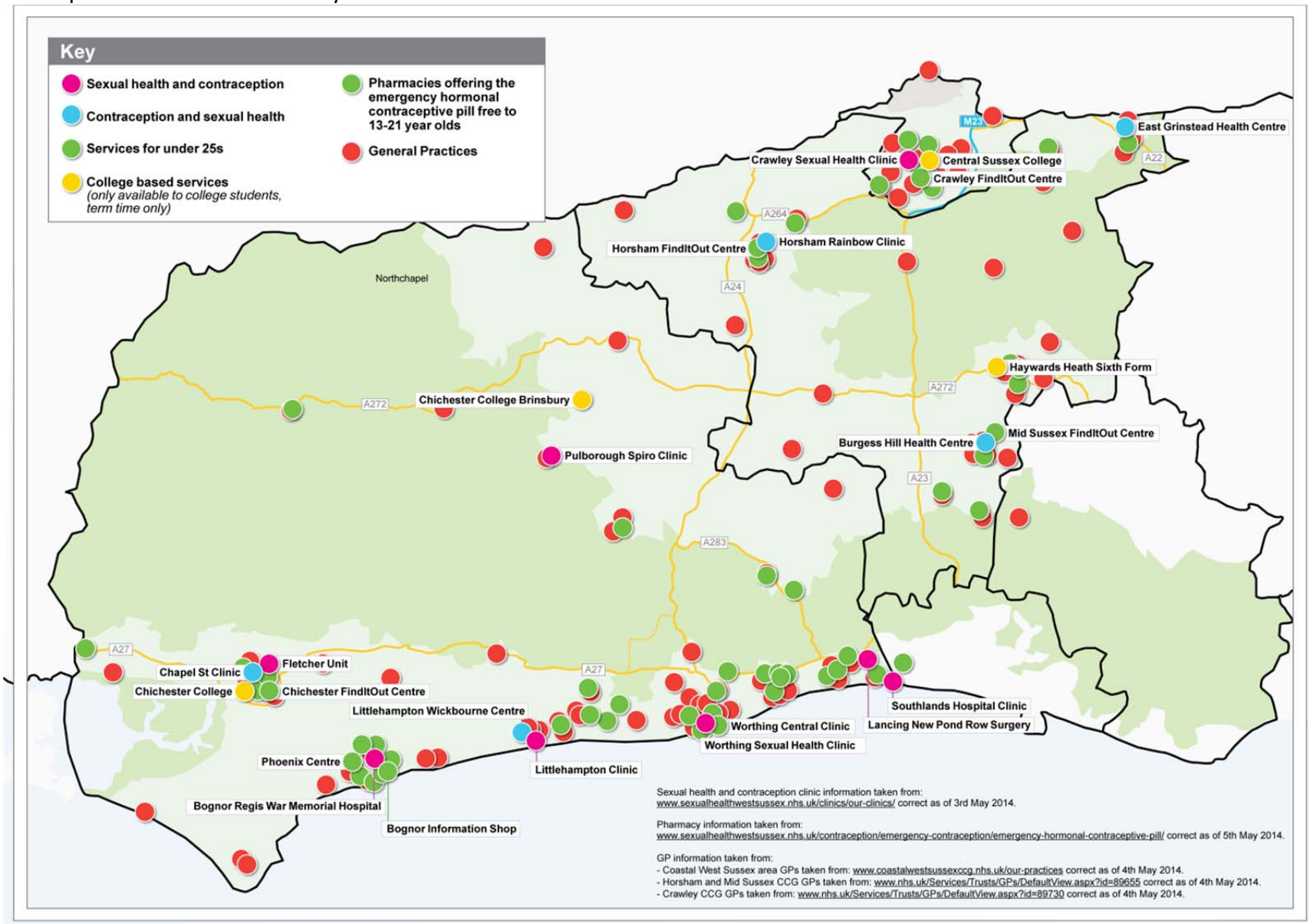
Rapid open access to integrated sexual health services - including free STI testing and treatment, HIV testing, partner notification, free contraception and reasonable access to all methods

Rapid open access to sexual health services

Key issues and challenges identified by KIs:

6.132 There was widespread recognition that a large amount of work had been done since the recommissioning of WSHT to provide integrated sexual health services in West Sussex. There was also agreement that this had been achieved by close working relationships with the commissioners, that much of the 'damage done' during the tendering process was now in the past, and that commitment was evident to improve relationships and service delivery across the patch.

Map D: West Sussex Pharmacy and General Practice locations



6.133 There are however some agreed gaps in provision, with efforts being made to identify appropriate premises to increase access by providing a level 3 integrated sexual health service in Bognor.

6.134 There was also praise and positive recognition of the proactive work of the outreach team and many KIs welcomed their efforts and identified the need for increased access to that team, particularly for young people. They are seen to be providing much needed support to more vulnerable communities and there was a clear regard for their skills and competencies.

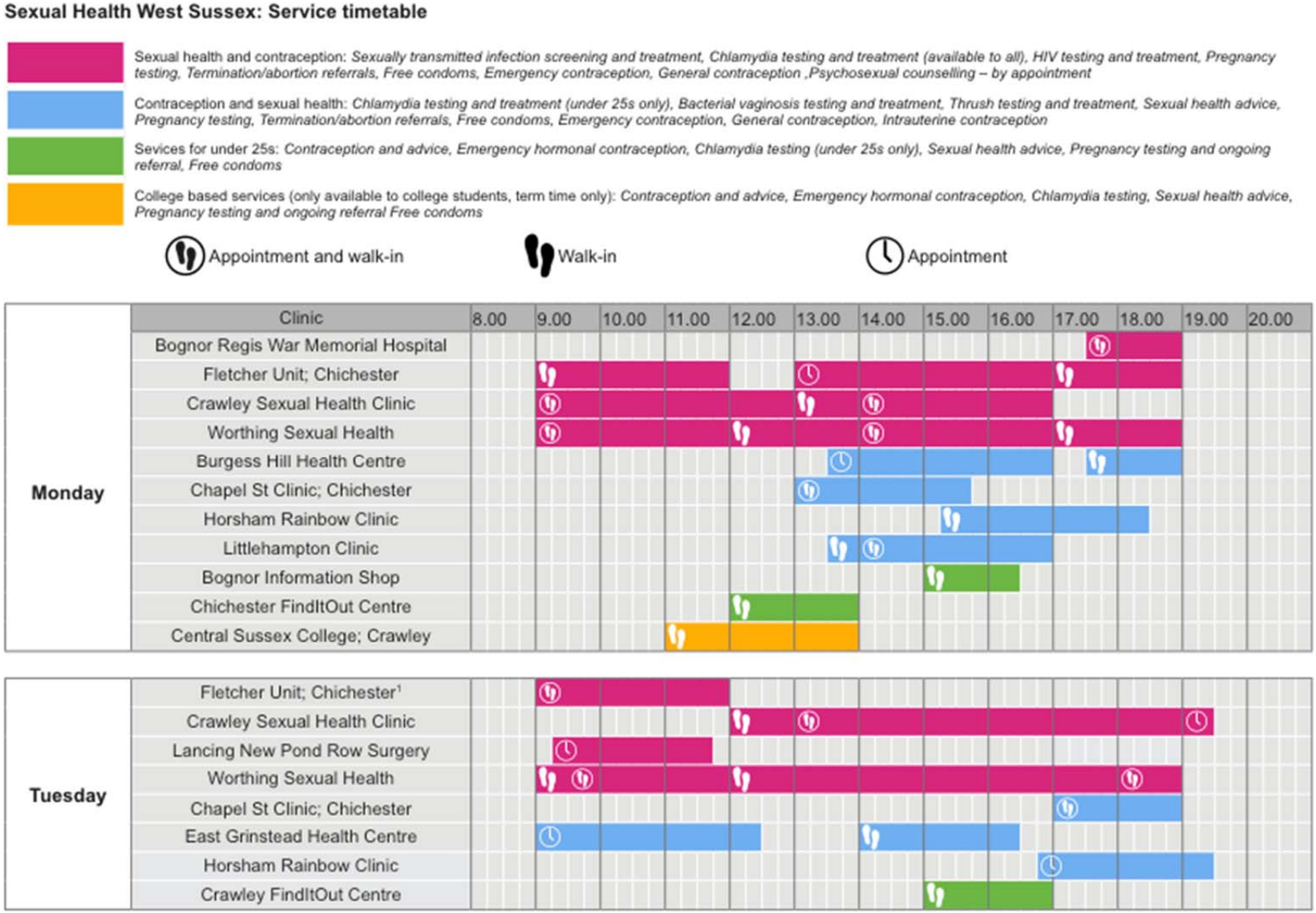
6.135 Abortion services are provided by bpas (British Pregnancy Advisory Service) in centres based in Crawley and Chichester. They are commissioned directly through WSHT as part of an integrated sexual health service with the money allocated by the CCGs. bpas also provide chlamydia screening and the provision of LARC post termination with the take-up rates in West Sussex above their organisational average. bpas abortion services were widely commended by KIs with most stating that easy access and swift appointments benefited those seeking a termination. It was also highlighted that the bpas service offers a range of STI tests and LARC after termination - this practice was highly commended. The service provided by bpas is well regarded and meets demand, with no problems in access for women presenting for abortion across various access points in West Sussex.

6.136 There are discrepancies in equal access across the county due to differing opening times in all three hubs and spokes, e.g. Crawley Hub is only open on 3 evenings a week beyond 5.30pm. While Nudge Associates Limited recognises that staffing levels are a priority, some KIs expressed opinions suggesting that it was staff rather than service need that was taking priority, and that much more needed to be done to increase "out of hours" access across the range of provision - not merely traditional office hours. One KI said:

> ***"It really is a tale of tail wagging dog! We are constantly surprised at how little is being done to actively manage the staff so that the service is open at times convenient for the public - not them!"***

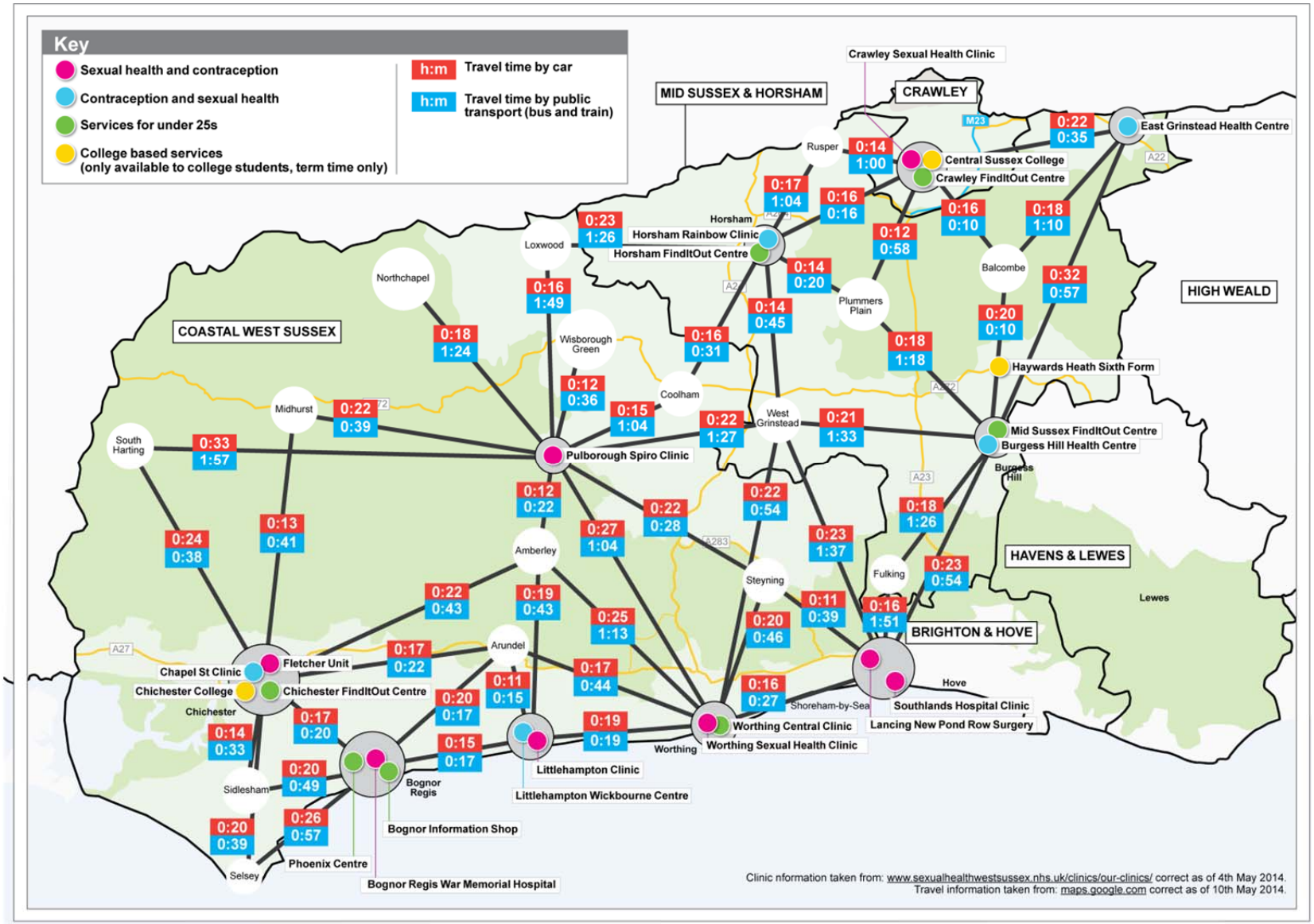
6.137 This was also mentioned by respondents to the stakeholder survey, with comments that opening hours could be improved, and that there should be more uniform opening hours across services.

Figure 34: West Sussex Sexual Health Services timetable excerpt (see Appendix H for the full six day sexual health services timetable)



6.138 Some KIs also felt that the current range of provision had “too much emphasis on coastal regions”, and that not enough had been done to address the gaps in rural areas. There is no one access point for patients to navigate their way around fragmented service provision across geographically challenged WSCC. Poor transport links were often identified as a major challenge for residents, especially as public transport fares are expensive and ad hoc travelling times and distances eat into limited time and household budgets.

Map E: West Sussex Transport Travel Times Sexual Health Services



6.139 In the SU survey 22.5% of respondents said that it would take them between 30 minutes to an hour to travel to the nearest Integrated Sexual Health Service (ISHS).

6.140 There is no central booking system for patients to review and access the options available to them across the county based on their need, no online/text based provision for booking appointments, obtaining results, or for navigating complex opening times for services across the county.

6.141 There were mixed messages from service providers about the level of engagement with GPs. Some felt that the ongoing education and training programmes developed and delivered by the specialities were a means for effective communication. Others felt that GPs were not engaged.

6.142 Based on local demographics, lack of sexual health provision rurally, potentially ignores the needs of c 50% of the population, particularly those that live more than 40mins travel away (the measure used by Monitor based on survey of acceptable distance) or further even as it seems people are happy to travel further for specialist care so long as general/basic care is available closer to home.

6.143 Although c 50% of pharmacies are engaged in broader sexual health provision there were concerns that many were not. This included the lack of access to EHC, condoms and chlamydia screening. Some KIs were unclear as to what the consistent role of pharmacists was for West Sussex.

Rapid open access to sexual health services

SUGGESTED APPROACHES/RECOMMENDATIONS raised by KIs:

6.144 Whilst there has been considerable work done to improve the situation across the county, most KIs acknowledge that there is still a long way to go.

"We know how far we have come...but we also know how much further we need to go!"

6.145 There is a need to increase the number of STI/HIV tests in the community. Earlier diagnosis saves lives and reduces treatment costs. WSCC have the opportunity to introduce STI/HIV/Chlamydia testing in a broader range of community and primary care settings. Stakeholders believe there are opportunities to work in much closer partnership with Third Sector and other community services to provide Point Of Care Testing (POCT) in a variety of settings - especially in the Crawley area where the majority of more vulnerable African communities live.

6.146 A few KIs were under the impression that that GPs may benefit from WSCC introducing the "Buddy Scheme" adopted in Surrey where GPs trained in sexual health are able to initiate and support the training and competencies for their colleagues offering a service whereby neighbouring surgeries will carry out Contraceptive Implants and IUCD Public Health Agreements for patients registered at neighbouring practices. Practices could work to enable the scheme to offer a choice of provider to patients but will also help to maintain services in a Primary Care setting without increasing activity in Secondary Care services.

6.147 It is recommended that the site in Bognor is agreed and refurbished to meet the gap in sexual health service provision as a priority. KIs believe that the conversations between providers and commissioners have been protracted and that action to provide the service should be prioritised.

6.148 Youth workers could expand collaborative work with sexual health service providers and ensure that the respected outreach nurses can visit and provide much needed information and other supportive resources for young people to improve their sexual health.

6.149 Discrete services for young people should be provided as a larger package in community settings, including a more collaborative approach with drug and alcohol services, pregnancy testing, POCT, condoms and EHC. The outreach team could provide this with nurse prescribers if necessary. The opportunities to proactively engage with young people in this type of setting could really support their broader health and emotional wellbeing needs. This would quickly identify safeguarding and other challenging issues if the nurses and youth workers were adequately skilled.

6.150 Opening times across all services should be reviewed to ensure that there is consistent access across the county.

6.151 Staffing levels and the necessary resources required to maintain open access and improve opening times should be considered across the range of provision, with a view to prioritising locations of greatest need.

6.152 Any re-assessment of clinical service points may require reviewing nursing headcounts whilst maintaining the whole time equivalent, withdrawing services where other providers should and could undertake the role and assessing fitness for purpose.

6.153 Integrated network teams with a consistent delivery model will be crucial as will utilising technology such as perpetual patient feedback processes, both paper and online such as Survey Monkey®, as this would offer evidence of SU's opinions. This will allow rapid engagement and ensure that services maintain the values and principles outlined in the Health and Social Care Act - specifically ***"nothing about us without us"***.

6.154 Good QIPP (Quality, Innovation, Productivity and Prevention) outcomes and meeting the PHOF should be priorities, so integrated sexual health provision will need to be organised efficiently, and funds allocated accordingly. All the elements will need to be aligned with commissioning as just one of the levers, with clinical leadership and engagement another key part of the new commissioning process.

6.155 WSCC will be monitoring the numbers of local residents tested for HIV and be monitored on the numbers of residents diagnosed late for HIV. Whilst NHSE is responsible for the treatment and care costs of people living with HIV, KIs would support a case for the money allocated for sexual health (which includes testing for HIV) to be maximised and encompass the breadth of interventions required to tackle the increasing numbers of people living with HIV. Further discussion between relevant commissioners and providers should take place to ensure this is appropriately established and managed.

6.156 Sexually acquired Hepatitis, HPV (human papilloma virus) and other STIs are universally recognised co-infections associated with HIV infection and as such should be tackled in a coordinated manner within an integrated sexual health service.

6.157 West Sussex should continue to support the *HalveIt* Campaign[53] (halve the proportion of people diagnosed late with HIV (CD4 count <350mm3), and halve the proportion of people living with undiagnosed HIV, by 2015).

6.158 The role of nursing and health advising should be working to a standard that is within the national guidance available from recognised professional bodies such as BASHH[54] and FSRH[55] (both updated 2014), thus ensuring that robust clinical governance is evident in all the hub and spoke services across the county, and provides the public with assurances of quality.

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[53] http://www.halveit.org.uk

[54] http://www.medfash.org.uk/uploads/files/p18dtqli8116261rv19i61rh9n2k4.pdf

[55] http://www.fsrh.org/pdfs/FSRHQualityStandardContraceptiveServices.pdf

6.159 Educational development utilising the national programs such as BASHH – STIF Sexual Health - Course of Five & BHIVA / NHIVNA competencies in tandem with local HEI support will allow the workforce to be educated to a standard that the professions deem as required. This, underpinned with routine and regular audit of practice, will demonstrate the importance of Multi-Disciplinary Team (MDT) working whilst providing the commissioners with assurance of quality with patient focused outcomes.

6.160 Health Advisors (HAs) should continue to play a pivotal role in the management of on-going risk, screening and crucially partner notification management. These skills along with enhanced behavioural interventions such as 'Motivational Interviewing' would enable the team to robustly support the clinical services. Cross working and being independent in core skills such as phlebotomy, asymptomatic screening would enable the HA team to further embed their skills into the MDT across a range of settings in West Sussex.

6.161 **In summary;** to meet demand, the commissioners, in partnership with WSHNHST, should agree a process which identifies the broader gaps in current provision, expands capacity and utilises other existing providers more effectively, particularly GPs, pharmacists and VCO sector providers.

Early accurate diagnosis and treatment

Key issues and challenges identified by KIs:

6.162 Early accurate diagnoses of STIs and HIV are essential in reducing escalating infection rates, and of reducing a broader pool of infection. Given the positive impact of early diagnoses on HIV/STI related morbidity and onward transmission, there was consensus that HIV/STI testing is an effective intervention. Testing, and getting those who test positive onto effective treatment, is an essential and evidence based treatment and prevention intervention.

6.163 Most KIs (outside of clinical provider settings) were unsure of whether SUs were getting early accurate diagnoses and treatment. Most were however satisfied that access to services in urban areas was adequate, and believed that once into the services, SUs would be diagnosed and treated accordingly. This was not however the case for more rural areas, and where access to integrated sexual health provision was patchy.

"I'm never sure what day of the week its open in (town), but I suppose I could find out if I had to - the question is if I can't, and it's not in my face, then how

does 'Joe Public' know when to go – or where for that matter? It's all a bit confusing."

6.164 Opening hours of all the different hub and spoke clinics across the county were unknown by many KIs, although most KIs acknowledged that they had not tried to find them out. This often led to discussions on how accessible and well advertised the services are in order to get an early diagnosis, and it raised questions as to how the services are marketed by WSCC and the providers.

6.165 The Clinical Nurse HIV Specialist team that works across West Sussex, Brighton and Hove is a highly respected resource, offering a high level of treatment and care in the home environment of people living with HIV, alleviating the need for in-patient treatment and care in acute hospital settings. Currently funded by CCGs, referrals to the team are made by the clinics and GPs, and are well utilised, although some concerns were expressed that referral rates in the north of the county were lower than the county average.

Early accurate diagnosis and treatment

SUGGESTED APPROACHES/RECOMMENDATIONS raised by KIs:

6.166 A single menu of sexual health screening based on the most specific and sensitive testing platforms available (which should include Point of Care Tests) should be prioritised.

6.167 Economies of scale through purchasing and single site laboratory testing may also be of benefit to West Sussex and may reduce costs. This, linked to electronic downloading of results into clinic IT systems, would facilitate rapid return of results to patients and clinical staff. Technology exists where all negative test results are batched and sent with minimal HA or administrative input, leaving only reactive or positive results to be person managed.

6.168 'People attending health care services (primary, secondary and tertiary care) should be offered diagnostic tests for HIV in accordance with current national guidance'[56]. Testing for HIV infection across West Sussex in both general practice and A&E departments should lower the rates of undiagnosed HIV. Other venues could be considered based on epidemiology e.g. faith based settings for BME communities.

[56] http://www.bhiva.org/documents/Standards-of-care/BHIVAStandardsA4.pdf

6.169 WSCC and the providers have a single IT network for Electronic Patient Records across the county which enables enhanced clinical care, minimises duplication of records, facilitates partner notification and lowers on infection rates. This is excellent practice, and was commended highly by KIs.

6.170 Electronic downloading of results into clinic IT systems facilitates rapid return of results to patients and clinical staff, it will be important to ensure this is a core part of ongoing service provision.

6.171 The development of agreed and monitored outcome measures that show increased rates of HIV testing, vaccination and prompt treatment of STIs would be of benefit to commissioners and providers alike, and ensure progress on performance and benefits to the population of West Sussex.

6.172 Some KIs mentioned patient IT systems for self-booking, triage and then rapid transmission of confidential results from laboratory to patient, minimising third party handling would be a key investment for integrated sexual health services.

6.173 West Sussex has a limited self-managed clinical network, however it is resource poor and existing clinical commitments prohibit it from being able to sustain significant countywide support to other primary and secondary care providers. In order to facilitate improvements, KIs noted a formal clinical network led by a dedicated coordinator would be needed to create a culture of change required in the new sexual health commissioning environment.

6.174 A coordinated engagement process with GPs, voluntary and other statutory services to enhance education and testing of vulnerable communities at venues and times outside of traditional clinical services should be reviewed and strengthened. Outcome measures that show increased rates of testing, vaccination and prompt treatment of STI infection would be an integral part of any 'joined up' partnership working.

6.175 All sites for screening and care need to continue to ensure access to the latest cost effective screening platforms such as urine based NAATs (Nucleic Acid Amplification Tests) technology for minimally invasive screening. POCT for HIV and other infections is available, and would allow outreach STI/HIV testing in alternative settings.

6.176 Increasing the referral rates as necessary to the clinical nurse HIV specialist team would benefit patients who require additional support at home. It was suggested that increased numbers of referrals from the Crawley clinic would be an appropriate use of

HIV Sp. Nurse service resources, especially because they have the highest number of people living with HIV in the county. Reducing inpatient treatment and care costs should be a major incentive.

6.177 A website for West Sussex that directs people to a central call centre with access to all integrated sexual health hub and spoke clinics and other sexual health provision would promote an efficient use of resources while offering information and choice to SUs. This call centre could provide for self-triage. This degree of self-management enables the public to self-assess the severity of their symptoms and reduce unnecessary attendance.

6.178 Timely and easy access to EHC (Emergency Hormonal Contraception) in rural areas with poor transport and limited pharmacy services is deemed essential.

Joined Up Provision

6.179 As WSHT has the overall clinical contract for the provision of integrated sexual health services (ISHS) in West Sussex, there was a sense from KIs that delivery should remain/be coordinated seamlessly across the county, and that the services should be easily accessible and offering equitable access.

Joined Up Provision

Key issues and challenges identified by KIs:

6.180 Apart from the providers who understood the links between their own services and the pathways made available for patients and service users, there was an overall sense that KIs believe that SUs are ***'travelling seamlessly'*** between the different services required, due to the interventions of those providing the services.

> ***"We have to assume that wherever a patient ends up, those seeing them know where else they need to go, and send them there?"***

6.181 Some KIs were concerned that people got lost between services, and that there was an assumption that because they are told where to go they will make it there. GPs were singled out as their referrals on to sexual health services are not recorded or monitored, and so there was not necessarily uptake.

> ***"So many of them (GPs) just send people to the clinics as they are not wanting to screen for sexual diseases in house - they refer on as they think it needs more specialist treatment, but what if they (patients) are too scared to go?"***

6.182 In some discussions, KIs were unclear as to the totality of sexual health service provision, and were concerned that they were not well informed about the provision. This lack of awareness of the range of sexual and reproductive health service provision among service providers was also mentioned in the stakeholder survey.

> ***"I'm not sure where to send anyone I think might need help and support these days. It's never just about their diseases - they have other things going on too and there isn't a one stop shop I don't think anymore."***

Joined Up Provision

SUGGESTED APPROACHES/RECOMMENDATIONS raised by KIs:

6.183 Steps should be taken to prioritise the development and promotion of a West Sussex Sexual Health Services Communications Strategy that would raise awareness about the range and availability of sexual health service provision across West Sussex.

6.184 Commissioners should consider funding the development of a West Sussex Clinical /Support Group which incorporates the HIV clinical nurse specialist team. Even meeting costs with some back up locum costs would be welcomed and supportive. This would ensure that services are all aware of their specific roles, and will increase the opportunities for joint collaboration, seamless transition for patients and excellent communication.

6.185 Most KIs would like to see a dedicated role manage the network - not necessarily a clinician or commissioner but someone to coordinate the services, delivery across county and monitor effectiveness and appropriateness against the government key objectives. SW London's SWAGNET is an excellent example.

6.186 Pathways between provision need to be better understood by all professionals, advertised on a website and endorsed by all health and other professionals, so that SUs can receive the most appropriate care pathway for their needs.

6.187 It was recommended that there should be more support for skills development and education of health and other professionals due to some SU experiences of stigma and discrimination. Some KIs felt that further training on confidentiality should be provided to all key stakeholders and service providers. The majority of KIs requested a specific HIV and sexual health training and development programme for all LA partners, GPs with a special interest and Third Sector organisations.

6.188 Respondents to the stakeholder survey were asked if they were aware of any particular staff training needs or workforce issues, and suggestions included:

- Conducting child protection assessments
- Cultural awareness
- Drug cultures for young people
- Implant/removal training
- MSM issues
- PSHE within schools
- Sexual Health for people with disabilities
- SRE training
- Training staff in children centres on C-Card
- Treating under 18s
- Understanding and knowledge of domestic and sexual abuse
- Working with vulnerable children
- 'You're welcome' quality criteria

6.189 GPs with a Special Interest (GPsSI), with the relevant training, should be advertised so that anyone can approach those surgeries with their sexual health needs with full confidence.

6.190 In addition, some KIs felt that education and skills development about the overall complexity of sexual health and SU's needs (emotional and medical) should be identified as a priority for:

- GPs
- Nurses in non-specialist services
- Dentists
- Teachers and youth workers
- Maternity services - in particular, midwives
- Some Voluntary and Community Organisations (VCOs)

6.191 Overall, improving the communication and relationships between service users and the health and other professionals with whom they come into contact would improve pathways, increase access and develop trust and co-operation.

7 CONTRACTS AND PROCUREMENT

Initiatives and procurement actions 2010 - 2012

7.1 With the publication of the Health White Paper on 12 July 2010 the commissioner worked with the incumbent providers and developed a single, integrated service specification across sexual health and ToP. During the financial year 2011-12 a procurement process was initiated, however this had to be paused and changes made to the service specification against which providers were tendering, due to a decision of Secretary of State to sit the responsibility for commissioning ToP with NHS CCGs as opposed to LAs.

7.2 A preferred provider was announced (not the incumbent), however during the contract negotiation process issues arose between the potential provider and the commissioner that could not be resolved. As a consequence the commissioner withdrew the offer and offered preferred provider status to their second choice, the incumbent.

7.3 Setting-out this previous procurement here could give the impression of a process that, even with the outcome of the preferred provider having their offer withdrawn, went smoothly overall as no gap in service occurred due to the commissioner taking the necessary steps to ensure continuity of provision.

7.4 However, the adverse impact on all stakeholders of this, ultimately, unsuccessful procurement process should not be underestimated.

7.5 The management of a procurement process requires a significant amount of commissioner time and concentration. So too, the incumbent provider understandably concentrate their efforts on retaining the service(s) in question. Often these two diversions on capacity mean that continued development of the services at stake pause and communications between the parties, due to concerns on competition and the risk of perceived or actual conflicts of interest, cease.

7.6 This pause in progress is an adverse impact for service users, though with the justification that the commissioner is seeking the best placed provider going forwards.

7.7 For the incumbent to then be told they've been unsuccessful, to begin planning for the handover of service delivery to a new provider and the potential transfer of key staff, only to be told that in actual fact they are to retain the service can have some obvious impacts on momentum and the morale of service staff and organisational managers.

7.8 The commissioner expressed empathy with the incumbent that progress is not where it may have been without this period of delay having occurred. The commissioner also

voiced appreciation of the provider organisation and its staff, and was clear that their reliability to provide consistent, good quality services, and to engage with the commissioner, had never ceased.

7.9 That said, the rules around public sector procurements and contracting remain in place and as such the commissioner cannot allow the fact that they've had their 'hands burnt' to restrict their options and opportunities going forwards. Similarly, the incumbent would be mistaken in believing that a previous unsuccessful procurement process means that the challenge of potential competitors to gain the service from them has either receded or vanished entirely.

Initiatives and procurement actions 2012 to 2014

7.10 The core aims of the procurement process initiated by the commissioner in 2011 was to find the best placed provider where by both quality and sustainability of provision could be assured.

7.11 With the final selection of their second preferred provider as the successful organisation, these aims remained and work commenced to progress further the development work that had taken place and to ensure that the pricing mechanisms in place were the best possible.

7.12 The provider was invited to develop a suite of prices across their service offer, and once accepted by the commissioner these were adopted. From February 2013, and for the following financial year, the block contract; the mechanism that had been used for many years for payment of both the specialist GUM, and community based contraceptive and sexual health (CASH) elements of service; was adjusted to take into account case mix/ activity expectations and the newly adopted pricing structure.

7.13 From 1 April 2014 all core areas of sexual health have moved to being paid for on a 'per episode of care' basis, using the local tariffs of West Sussex. There are exceptions - Chlamydia testing has attracted its own tariff for many years, which remains in place, whilst the outreach service for young people and vulnerable groups remains on block. The commissioner expects their spending in the financial year 2014-15 to rise.

7.14 Further changes in pricing are planned, with the commissioner expecting the provider to begin delivering under a developed national tariff model for integrated sexual and reproductive health from 1 April 2015. This follows independent work carried-out on behalf of the commissioner, aligned to the national indicative tariff clinical pathway models, which clearly evidences that WSCC is paying significantly more than the actual cost of delivering many of the areas of care involved. As such the commissioner is confident that the national tariff model, already adopted by their

neighbours in Hampshire[57], will offer an actual cost reduction ensuring longer term sustainability for the service.

7.15 Risk to the provider has already been voiced within this assessment, and so it is of course vital that parties communicate well and plan together so that a sustainable, reasonable approach can be taken that is in the best interests of all stakeholders, not least patient's and taxpayers, in West Sussex.

7.16 Commissioners are aware that anxieties still exist about ongoing sexual health service provision along with associated posts, and staff morale remains delicate.

7.17 Recently the commissioner, along with the other six upper tier authorities of the South Coast held a 'Market Stimulation' event. Such events are not necessarily directly linked to a new statement of commissioning intentions or an intended procurement process, which indeed, for West Sussex at least, is the case in this instance.

7.18 However, such events do provide an important role in ensuring that commissioners are aware of innovations and best practices beyond that of their incumbent providers; and that said providers remain engaged in the wider system and aware that they operate in a contestable market.

Current contracting arrangements

7.19 The commissioner has a range of contracts in place across their providers. The Integrated Sexual Health Service contract was awarded whilst in the NHS, before the move of Public Health into the Local Authority. The contract moved over to WSCC as part of the Transfer Order from the NHS to the Local Authority.

7.20 The 2013-14 financial year offered just a twelve-month window where local authority commissioners were able to contract with primary care, and community pharmacies, where practitioners are commissioned to deliver elements of public health services over and above that expected of them within their core contract. NHS England, as the responsible commissioner for primary care, had made it clear that this contracting option would not be available to Local Authorities after the first year.

7.21 In West Sussex commissioners met this challenge head-on and in 2014-15 moved all of their current providers to a local authority contract, and in doing so maintained a 'status quo' in terms of services commissioned. This is to be commended, as there are

[57] Hampshire adopted specific elements of the national tariff as deemed appropriate for their area. However, for those services and pathways reflected within the national indicative tariff for sexual health the prices recommended have been put in place with no adjustments or other local prices used.

160 community pharmacies and 94 GP practices, of which some 60 to 80% respectively, delivering public health services across the County.

7.22 These contracts now require work to ensure equity and measurable quality of services for both patients and taxpayers. Commissioners acknowledge that they do not understand whether the prices they are paying are 'fair' to all parties, and a process of benchmarking needs to commence.

Performance management and shaping supply

7.23 The commissioner acknowledges that in the years immediately before transition, and in this first year of local authority control, energies have centred on improving secondary care and community based services, and ensuring integration, and as such sexual health services procured from Primary Care are yet to be addressed.

7.24 The commissioner meets monthly with representatives from the Trust and, it seems from the information given from both parties, that both have a good sense of current provision, capacity and the immediate plans ahead.

7.25 Parties have in place an activity and pricing schedule developed beyond that of many secondary care/ GUM contracts. It has some ten classifications of activity, and includes areas such as psychosexual counselling and differentiates between 'STI/ GUM services' and 'Reproductive Health'.

7.26 The contract has specified a number of quality metrics within it, and in addition the commissioner requires monitoring returns on a range of other measures. The commissioner acknowledges that some metrics remain from previous iterations of the contract, and others applied without perhaps a robust consideration of the application and purpose. That said, the commissioner is acutely aware that ***"too many metrics"*** exist and of the need for purposeful monitoring, i.e. that metrics gathered have a direct purpose of informing the commissioner of the quality and outcomes of services so as to best inform them of gaps and need for change, and a review is ongoing.

7.27 Changes have already taken place from 2013-14, used as a benchmarking year, to 2014-15 with a core 'Top 8' measures in place and differentiation made between performance measures (KPIs) and metrics in place for validation purposes, and the commissioner expects further iterations to be forthcoming. The commissioner is keen to ensure the use of metrics that will have a direct bearing on the local authorities' real-time view of the service and the decisions they make going forwards.

7.28 Nevertheless, work to date has been measured and monitored, including public/ patient feedback, with the provider seen as having worked hard to develop the three

hubs at Crawley, Worthing, and Chichester. Although provision at the spoke locations is, at times, patchy (with the elements of care available dependent upon specific staff being on shift as all are not as yet universally trained) the commissioner felt that it is improving, with both recruitment and training addressed, albeit perhaps slower than all would like.

7.29 The provider has also shown initiative beyond areas requested of them or mutually agreed between the parties (e.g. in requiring all Level 2/spoke based staff to complete one clinic session each month within the specialist hub service).

7.30 Bognor is an area identified by parties involved as being of specific need, with the provider stating that current provision is insufficient for the level of need and the type of care required by the attending population, but the commissioner appreciates the efforts being made by the provider in addressing the issue. Indeed, new premises have been sourced and a plan for the commencement of services at a new Bognor site were being finalised as this report was completed.

7.31 Outreach services, funded through block at the present time, provide some essential services and support to young people and other hard to reach groups. Although both the provider and commissioner acknowledge that this service would struggle ever to provider Level 2 care within its settings, due to the clinical suitability of the buildings concerned, both believe that the service is critical to those who use it.

7.32 That said, respondents to the stakeholder survey stated that 'promotion of services to vulnerable groups' was the area of the current service model working least well, and only a small number of respondents stated that they felt services are meeting the needs of a wide range of vulnerable groups to a significant or great extent. However, and slightly contradictorily, when asked what the most successful aspects of the current system are, outreach work was in the top three aspects mentioned, along with accessibility of services and walk-in/drop-in clinics.

7.33 This links directly with representations made from many quarters over the years, and indeed voiced in this report too, about what is meant by the term 'integration' given the significant logistical difficulties, and indeed costs, that would be realised in attempting to provide access to consultant led, Level 3 specialist GUM in every setting.

7.34 So too at the new Bognor site previously mentioned, the provider and commissioner have a difficult choice to make in either attempting to build capacity to as to deliver a fully integrated 'hub' from the site, which undoubtedly could serve the people of Bognor well, or to make a logistical decision to establish it as a spoke with some, specific clinics offering a consultant presence such as in a supra-spoke.

7.35 The commissioner has identified funds to extend HIV testing for newly registered patients to primary care. This will assist in the reduction of HIV prevalence rate and help identify late diagnosis of HIV as per the governments PHOF outcome measure.

7.36 The commissioner seeks to carry out an annual review with each GP and pharmacy provider, and has made an undertaking to review each and every provider in 2014-15. Although the commissioner has communication lines with both the Local Medical Committees (LMC) and Local Pharmacy Committees (LPC) there is no forum for direct communication with providers other than on a 1:1 basis. The local CCG holds an enhanced services group and the LA attends as necessary.

7.37 Internally the sexual health, public health team remain responsible for the sourcing and dissemination of resources around STI and HIV prevention, and contraception information. The coordination of provision such as chlamydia screening and the C-Card scheme has passed to the WSHT now.

7.38 The commissioner is part of the development of public health promotions, with the communication teams of all parties, including the CCG, working very closely in developing joint campaigns. The commissioner described these processes as 'very tight' and stated that the provider was 'excellent' at briefing [the commissioner] on events and issues.

8 VIEWS OF SERVICE USERS AND THE LOCAL POPULATION

The following Service User (SU) views provide a snapshot of opinions and perceptions gathered during this population focused sexual health needs assessment. Whilst they may not represent the actual views of a majority of stakeholders, it is likely that they indicate the need for improvement in certain areas such as, better communication or signposting to services, etc.

The Nudge Associates Limited delivery team acknowledges that some stakeholders may not have been able to participate at the time of this consultation.

8.1 This population focused needs assessment consultation asked SUs and the local population questions on what they thought of the current model of sexual health service delivery, and views on what the future of sexual health services in West Sussex should look like.

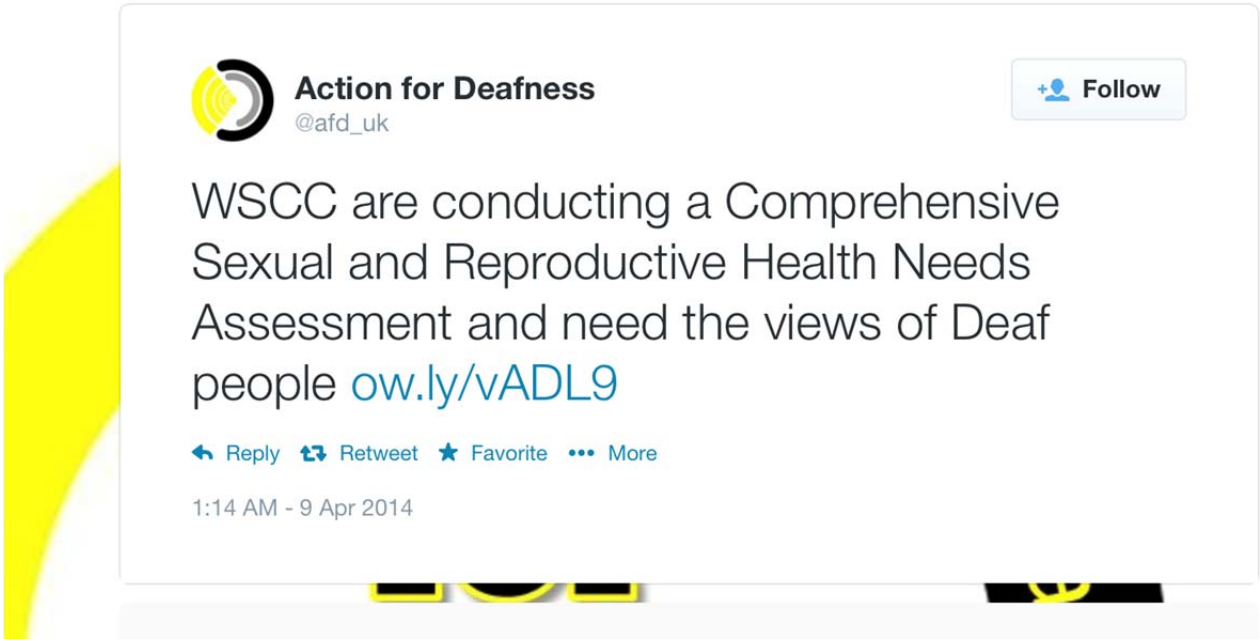
8.2 The overall objective of this service user (SU) engagement process was to listen, record and collate these responses. There was no formal framework but views are collated into sections based on the government's five key objectives for improved sexual health outcomes sexual health, with additional sections such as commissioning, contracting and procurement etc.

Service User and Local Population Views

Key issues and challenges identified by SUs:

8.3 In order to gather the views of both service users and non-service users in West Sussex, an online survey was conducted between 1st April and 9th May 2014. This was circulated via Twitter/Facebook to local target groups (see those contacted in Appendix D).

Figure 35: Screen shot: Survey Promotion to Action for Deafness Stakeholders



8.4 In total there were 540 respondents to the local population survey. Full details of the survey results can be found in Appendix G, however the key findings included:

- Just over half of respondents said they would know where to go to access sexual and reproductive health services, with slightly more saying they would know where to access emergency contraception;
- 15.6% of respondents stated that they could not reach sexual and reproductive health services by public transport;
- For those that could, 73.5% said it would take them up to 30 minutes, 22.5% said between 30 minutes and one hour and 4.3% said it would take over an hour;
- Only 12.9% of respondents had used sexual and reproductive health services in West Sussex in the last 12 months – consequently some caution needs to be taken when interpreting findings about direct experience of local sexual and reproductive health services;
- Of those that had used services, the most common locations were Chichester (32.8%) and Worthing (31.1%), followed by Crawley (16.4%), 'Other' (9.8%) and Bognor Regis (8.2%)
- Only 25.6% of survey participants had previously had an HIV test at some time, and 22.0% had had a chlamydia test
- Generally service users that had visited a sexual and reproductive health service rated their experience quite positively (against the location, opening hours, quality of service and confidentiality of service). Opening hours were the lowest rated of these aspects
- A large majority of those that had accessed services in the last 12 months agreed that they would recommend the service to a family member

- Suggested improvements to services included reducing waiting times, improving the booking system and providing clearer information on opening times/increasing opening times
- The majority of respondents said that they would prefer to attend services with their GP if their GP offered a full range of sexual and reproductive health services
- Service users preferred locations for information on sexual and reproductive health services were GP surgeries, pharmacies, schools / colleges / universities, NHS Direct and community health services
- Those that suggested social media should be used said so because of its reach with young people, ability to reach people quickly and cheaply and level of anonymity; they felt it should be used to promote services and provide information.
- A large majority of respondents stated that they would not follow sexual and reproductive health services if they were on Facebook/Twitter
- Respondents identified 'privacy/confidentiality', 'location / distance / accessibility' and 'helpful / respectful staff' as the most important aspects of a sexual and reproductive health service

Figure 36: Screen shot: Survey Promotion to West Sussex Community Stakeholders

8.5 In addition to this, and with a view to gathering more detailed insight into the needs and experiences of people living and working in West Sussex, the following qualitative research was also undertaken:

- A facilitated discussion group with young people with experience of being in care
- Six in-depth discussions (1.5 hours each)

- Eight telephone interviews (20-30 minutes each)

8.6 In total, 19 individuals took part, including representatives and community champions of specific communities as follows:

- Male and female
- Bisexual (females), Gay, Heterosexual (males and females)
- Individuals in age ranges: 15-19; 25-34; 35-44; 45-64; 65-70; Over 70
- African, 'multi-cultural' (young people's group) and white British
- Living with HIV
- Learning disabilities
- Young people

8.7 A summary of service user views (with comparison to the general population survey), is reported in the following areas:

- ***Commissioning, contracting and procurement***
- ***Access to information***
    - Awareness of sexual health services and knowing where to go
    - Promotion of sexual health services
    - Normalisation of sexual health services (including for older people)
    - Sources of information
- ***Preventative interventions***
- ***Rapid open access to sexual health services***
    - Emergency contraception
    - Post-Exposure Prophylaxis after Sexual Exposure (PEPSE)
    - Confidentiality in practice and use of GP for sexual health services
    - Accessibility of services
    - Respect in practice
    - Expert staff
    - Convenient opening times
- ***Early accurate diagnosis and treatment***
- ***Joined up provision***

Commissioning, contracting and procurement

Key issues and challenges identified by SUs:

8.8 One SU mentioned the better outcomes of the German health system and the attitude of spending money to keep people well because it is cheaper than paying for them in hospital. It was suggested that rather like taking a car for an MOT each year, people of any age should be invited for an annual sexual health MOT.

8.9 The lack of integration between health and social care was highlighted by a number of participants.

8.10 Amongst gay men and people affected by HIV, there was particular concern about services being put out to tender. A number of individuals talked about their worries around splitting off sexual health.

> ***"If services get split off, how are co-infections treated? HIV is mostly sexually transmitted and late presentation of HIV is very serious – life threatening. Deaths are due to late presenters. People are brought in because they are very ill. We want to avoid this at all costs."***

8.11 Some people expressed opinions that services should not be delivered by private companies and that whilst there are private clinics, it is important to have free services to encourage people to use them.

> ***"Private contractors may end up employing existing staff. Private firms only want to do testing to make money. The easy stuff."***

8.12 A number of people mentioned the importance of maintaining free access across county boundaries.

8.13 People who took part in the interviews were pleased to be able to give their opinions. One individual pointed out that it wasn't easy to have patient representatives, particularly in relation to sexual health, as interactions with patients were relatively short. With HIV and reproductive health, longer-term relationships are possible.

8.14 One person felt that user feedback should be part of commissioning so that service users could give their views through surveys and questions to people in clinics to find out how they are treated.

8.15 People said that better communication was needed about sexual health and services. Perhaps a Communications Plan was needed and marketing materials produced on an on-going basis.

Access to information

Key issues and challenges identified by SUs:

Awareness of sexual health services and knowing where to go

8.16 Just under half (49.3%) of the people who completed the service-user questionnaire stated that they would not know where to go to access sexual and reproductive health services.

> ***"I did ask my girls after the survey. They didn't know either."***

8.17 Respondents were also shown a list of sexual and reproductive health services provided in West Sussex, and asked whether they knew where any of them were, and over half of respondents said they did not (57.7%).

8.18 The individuals taking part in the interviews discussed the survey results. Most were not surprised to hear that many people did not know where to go.

8.19 Some people who worked in London, Brighton and other out of county locations said it was ironic that they knew where sexual and reproductive health services were in the place where they worked, but not in West Sussex where they lived.

"I don't know what happens at the Spiro clinic – whether I could go there (as a gay man)."

8.20 Male, female, bisexual, gay and straight people participating in the qualitative research, all mentioned that travelling to Brighton in the adjoining county felt like going to another country, as sexual health information in that city is much more visible.

8.21 To find out where clinics are, most people talked about using Google and probably searching for the words 'sexual health clinic' or 'STD clinic'. However some people did say they were in an informed position and knew the language to use. Young people said the names were too long (sexual and reproductive health services).

8.22 Some participants said that there are sufficient sexual and reproductive health services, but people just don't know about them. This meant having to be very pro-active to seek out services, establish what they do and where, and which one is right for you as an individual. The need to let people know where services are not a one-off, as changes can and do occur. An example was given:

"I went to Chapel Street in December. I go every four months. They said they would be moving and to come back in March so they could give me more details. I went back in March and they still didn't know when but it would be to the hospital. I went last week (May) as I needed more pills. It was closed. There was a poster on the door. It had a website called Sexual health West Sussex. I'd never heard of this before. That's how I found out where to go. I hope other people get to see the poster."

8.23 A community representative of people with learning disabilities said that to her knowledge there are not any specialist services for people with learning disabilities and she did not know where those who are sexually active should go. Some people with learning disabilities have support workers who may help them access general medical services, but it is not clear whether this is happening with sexual and reproductive health services.

8.24 The group of young people with experience of being in care who took part in the group discussion knew where to go to access sexual health services. They had used services in Bognor Regis, Chichester, Littlehampton, Shoreham and Worthing. Parents interviewed had also asked children in the household if they knew.

"My foster daughter knew. There's a little troupe of them go down there. I got the impression that it's a rite of passage"

8.25 People with learning disabilities were mentioned in a number of interviews with participants saying that they were aware of people in sexual relationships, some had children and others didn't. Participants felt that it was possible that they wouldn't know where to go for emergency contraception and that support workers may not be helping with this, or available at the time it is needed.

8.26 Individuals and community representatives affected by HIV all mentioned the HIV clinic.

"Where would I go? The hospital? But they are very busy."

Promotion of sexual health services

8.27 In many interviews people highlighted the lack of posters in male and female toilet cubicles in a variety of settings: public facilities, gay bars, schools, council buildings, restaurants etc.

"When I was at school there was a poster in the loo. 10 years later when I needed to go to a clinic I remembered it."

8.28 Participants mentioned that other initiatives had been publicised well across the county using this approach, such as the Worth Project about domestic abuse and sexual violence.

8.29 Respondents to the SU survey were asked where they thought information on local sexual and reproductive health services should be located, and the most popular locations were GP surgeries, pharmacies, schools/colleges/universities, NHS Direct and community health services.

8.30 During the interviews, people of all ages talked about reaching people of school age with sexual and reproductive health services and information through schools, pastoral managers, school hubs and GP surgeries linked to the schools rather than in the location of residence.

Normalisation of sexual health services (including for older people)

8.31 Participants highlighted the need to normalise good sexual health throughout life, starting with conversations when people are aged 11-12 and continuing into old age.

People aged over 25 were keen to point out that sexual health needs don't stop at age 25 or 30 or 40 or 50 or 60 or 70.

8.32 Some participants said there was a lot of emphasis on sexually transmitted infections and preventing pregnancy and less around all the other aspects of sexual and reproductive health.

8.33 The word normalisation was used a lot in the discussions. People pointed out that sexual health seemed to be treated differently than other health needs and not included in general health check-ups. For example, participants mentioned the way in which 'Boots' encourages people over 40 to come for a health check (diabetes, cholesterol, blood pressure, etc.), but makes no mention of sexual health.

8.34 Normalising to some participants meant ensuring that people just know where to go, in the same way that they know to go to Accident and Emergency if they break a leg.

8.35 West Sussex County Council, and Chichester in particular, were thought to adopt a conservative approach (with a small 'c') by some participants who felt that this might be the reason why there is not as much openness or public information about sexual health.

"Chichester – a pretty pink bow. It's a different mind-set than you'll find in East Sussex or Gatwick."

8.36 Older people thought that there were missed opportunities to engage with their age ranges to have conversations about good sexual health. One individual mentioned that there was an advert in the Connexions newsletter for a wellness check but again no mention of sexual health or where sexual health clinics are.

"My partner strayed and I got an infection. I went to my GP but I was told that as I was over 25 I needed to go to Warren Brown. Age is irrelevant – it should be based on need."

8.37 As people get older, they may want to seek information and treatment for menopausal symptoms, erectile dysfunction and urological problems[58]. Some people said that they would prefer not to go to the GP but were not sure where they could go for specialist support in these areas.

"If it was a physical or psychological issue, I'd be reluctant to go to a GP."

[58] *Nudge Associates Limited note:* Each of these is the commissioning responsibility of the CCG, and not all sit under sexual health.

An SU aged over 70 said:

> ***"Sexual and reproductive health can and does concern anyone of any age – don't ignore it."***

Sources of information

8.38 Participants were asked where they, their children, family or members of the community would go to get answers to questions about sexual and reproductive health, particularly if they didn't want to go to a clinic, or didn't know whether they needed to.

8.39 Those interviewed talked about the fact that when they were young they got information from their peers. For those who are parents they see the same happening with their sons and daughters. Sometimes information misunderstood by one young person was passed along and could have consequences.

8.40 In relation to online information, participants talked about using 'Google'. When asked what reputable websites they might look at some people mentioned, NHS Direct (now closed), NHS Choices, Patient.co.uk and BootsWebMD.

8.41 The importance of search 'Meta Tags' (descriptions and words that help search engines understand what the webpage is about) was highlighted in relation to ensuring that people using lots of different words and spellings should be able to get to the information.

8.42 People affected by HIV and gay men mentioned NAM, Terrence Higgins Trust, the British HIV Association, and British Association for Sexual Health and HIV.

8.43 An app for young people was mentioned and a number of people talked about Your Space.

8.44 Although people participants in the qualitative interviews talked about FPA as a service provider in the past, none mentioned FPA or Brook as sources of information.

8.45 Participants said that not everyone has access to a computer or uses English as a first language. The range of adult literacy levels was also discussed.

8.46 One person talked about using the Twitter feed for Worthing Directory as a way of enabling young people to ask and get answers to questions in an anonymous way. The young people in care group said they would not follow anything to do with sexual health on Twitter.

8.47 Similarly 84.1% of respondents to the SU survey stated that they would not follow local sexual and reproductive health services if they were on social media such as Facebook or Twitter.

8.48 The seven FindItOut Centres (formerly known as Connexions or The Information Shop) were mentioned, although some people were not sure whether it was only for certain age groups or restricted to youth networks.

8.49 Although some people may see a leaflet written in their language, people speak many different languages and dialects. People from African communities may want to get information by word of mouth.

"In my culture I have to talk to my daughter and be an auntie to my friends' daughters. We talk to our sons about the dangers. We have to teach them what is right and wrong."

8.50 The Citizens Advice Bureau and churches were also cited as sources of information.

8.51 All the parents who took part in the interviews had talked to their children and foster children about sex and relationships. They recognised that not all parents are confident and able to this and some young people do not have parental guidance and can miss out.

Preventative interventions

Key issues and challenges identified by SUs:

8.52 People taking part in the interviews highlighted the need to provide integrated health and social care services, which promoted good sexual health. All the young people who took part in the group discussion (aged 15-19) said they had had a chlamydia test over a year ago. However less than half of the respondents to the SU survey in this age category had done so, and only 22.0% of all respondents had had a chlamydia test (of those that had, 29.3% had done so in the last year).

8.53 Missed opportunities to have conversations about sexual health occur in all age groups and settings. A number of participants said that there had been a focus on gay men and African communities in relation to HIV prevention. They questioned whether this was leading to complacency that if people were not in these groups they were not at risk.

8.54 People taking part in the interviews who had not had an HIV test said that they knew they did not need one, mostly because they were in long-term relationships.

8.55 Only 25.6% of SU survey respondents had previously had an HIV test at some time.

8.56 There was also a discussion about the balance between making people aware about the risks of having unprotected sex with people from high prevalence HIV countries whilst not appearing racist.

8.57 Issues around the use of drugs and alcohol increasing vulnerability and impairing decision-making were discussed as well as vulnerable communities.

"My family planning doctor was uncomfortable when I said my 15 year old daughter would be coming to the clinic. She has a right to be seen. I have encouraged her to do these things on her own."

"My daughter hasn't been in the UK long. She's 18. Her friends tell her all about the free contraceptives (the pill and implants) but if you don't do protected sex there's STIs. Those are the things that are not being taught. It's not only about not being pregnant."

"I know my son had a chlamydia test at University – he got a pair of boxer shorts, which he still wears!"

"I'd been drinking. For me not being a virgin was the most important thing. She wanted to have sex without a condom. I thought what are the odds? It was Russian Roulette. I was incredibly lucky that I was diagnosed with HIV at a time when there was treatment. I was aged 20 then, I'm 40 now."

"To my knowledge there is no material to use with people with learning disabilities. There is no easy to read material. How do we help them know what is acceptable and what isn't for example?"

"When I think about trips to Kenya as a young man and what sailors got up to... There is now much more recognition and training. Partly because as an employer, your men are very expensive resources and you don't want anything to happen to them."

"There are an increasing number of people in their late forties and fifties actually exploring their sexuality after having been in heterosexual relationships for several decades."

"People start new relationships in older age and don't use condoms because contraception for them was all about not having children. I met a guy recently infected with HIV who is in his 70s."

"You hear more about loneliness, particularly men who could be vulnerable."

"The issues that come up for over 70s like me are hypertension, diabetes, coronary heart disease, weight management. Sexual health is rarely mentioned."

8.58 Participants emphasised the importance of keeping momentum going with preventative interventions. It was felt that there had been some successful initiatives, but often these are projects that come to an end and there is nothing else to replace it. People fall through the net as a result.

Rapid open access to sexual health services

Key issues and challenges identified by SUs:

Emergency contraception

8.59 From the SU survey 42.8% of participants said they would not know where to go to get emergency contraception. During the interviews participants were asked to say where they would go, or where they would tell a friend, relative or someone new to the area to go. The places mentioned were GP, onsite pharmacy, GUM, chemist, clinic and family planning.

8.60 Most people who took part in the discussion said that emergency contraception was free and that under-16s can get it. Participants were asked to say how much they thought it cost someone if it was not free. Most thought it would be the price of a prescription and were surprised that it could cost up to £30. Some individuals had experience of using emergency contraception and had paid for it. For one woman, at the time it was needed, it was too much out of the weekly budget.

> ***"I was a single mum on family tax credits at the time. It didn't cover emergency contraceptive. I either had to pay or wait for the GP to open on Monday. I didn't have the money so I took the risk."***

8.61 Following an interview in which access to emergency contraception was discussed, one participant subsequently conducted their own research to find out more about charging for emergency contraceptive, and emailed the Nudge Associates Limited team with their findings:

> ***"According to the NHS Choices website and the sexual health West Sussex, emergency contraception may be available free from some pharmacies (but doesn't say which ones) others may charge up to £30. It seems very vague so might be worth including in your report."***

8.62 For the group of young people in care who took part knowing there was emergency contraception was one of their three most important things.

Post-Exposure Prophylaxis (PEPSE)

8.63 Gay men and people affected by HIV talked about PEPSE and the fact that GPs cannot prescribe this. It means that in an emergency it is only available during the opening hours of a sexual health clinic or possibly at a family planning clinic. Nobody talked about accessing PEP at A&E.

Confidentiality in practice and use of GP for sexual health services

8.64 Some SUs had no option to go anywhere other than a GP surgery. In association everyone interviewed highlighted the lack of privacy and concerns about confidentiality that arose from having to go through a GP receptionist system to access sexual and reproductive health services.

8.65 Privacy/confidentiality was clearly rated as the most important aspect of a sexual and reproductive health service by respondents to the SU survey.

8.66 The GP receptionist as a gatekeeper was felt to be a barrier. Some people questioned the ethics of having to inform a receptionist about the reason for a sexual and reproductive health appointment. Everyone highlighted this as an important factor. One individual expressed disappointment about not being able to just email the surgery.

8.67 In a local GP setting participants were concerned that they were more likely to bump into people they knew who may overhear conversations, with young people, especially those aged under 16, most concerned about this.

8.68 The difference in the process between GP delivered sexual and reproductive health services and specialist clinics was highlighted by a number of people. There was specific reference to the fact that in the specialist services, numbers are used, or first names.

8.69 Interestingly however, the majority of respondents (68.1%) to the local population survey stated that they would prefer to attend services with their GP if they offered a full range of sexual and reproductive health services (rather than a specialist service).

8.70 Problems getting a GP appointment quickly and not being able to request a female or male doctor were highlighted by most interviewed, with one participant giving an example of having to wait 3 weeks to see a female doctor.

> ***"If I phone they say 'is it life threatening?' They just cut you off and send you off."***

> ***"They tick all the boxes to say you can be seen the same day but only if you say it is an emergency and you are prepared to go through those hoops."***

8.71 Highly qualified GP practice nurses who were able to prescribe were valued and it was felt that they should be able to provide contraception services.

8.72 For younger people, going to the GP service where their parents and other family members attend may create concern. Young people may not understand what confidentiality means in practice. They may have received mixed messages from

professionals interpreting confidentiality in different ways, for example teachers, pastoral managers, school nurses, social workers.

8.73 GP records and data sharing were a concern for some people, who had not agreed for their records to be shared online. People with HIV mentioned the fact that their records were computerised in the GUM system but kept separately, however there were times when information had to be shared and examples were given such as when starting medication or becoming ill and being admitted to hospital.

"I expect them to keep all my details with them. I don't want to share my data with anyone. I've been asked to fill in a form to share data across the UK – like for Manchester or Scotland. I'll never go to those places so why do they need my data?"

8.74 Some people with HIV chose to be treated out of the county, due to concerns about confidentiality, especially those that work in the health service.

8.75 On participant said:

"I had to have an HIV test because I needed to work in the US. I was told not to talk about it."

8.76 All participants talked about the importance of discussions remaining in the consulting room. Some people wanted to emphasise that conversations should remain private. Information should only be used for the purpose of treatment, care and research.

8.77 The design of the physical space is important to enable confidentiality to happen. People interviewed talked about going to services in the past that had curtained off areas only. People said that consulting rooms should be private.

8.78 Young people in care, who had used services scored confidentiality as two on the scale, lower than the majority of respondents. One young person explained:

"I didn't want to have the conversation in the reception area."

8.79 Older people were also concerned about the reception area:

"I don't want to be sat in the 'something sexually wrong' section."

8.80 Some people mentioned job centre type booths so that more private conversations with receptionists can take place. Getting the personal welcome and the physical space right was important to encourage people to return to services. One person said, "In the end I suppose we could argue that getting the waiting room right could save the NHS money."

"My GP goes to my church. It's a Catholic church. I want to talk about contraceptive needs."

8.81 A number of people talked about having to go to their GP because there was no option, whilst recognising that this was not ideal. Some people emphasised that they would not expect the GP to treat them in other specialist areas of medicine.

"I went to see the GP who wouldn't prescribe me the pill anymore because I was too fat. The GP didn't give me any advice or offer any options."

"If I was a teenager and I thought I was in the wrong body or I thought I was gay I wouldn't dream of going to a GP but where would I go?"

"A nurse told me she had removed an implant from a woman she later found out to have HIV. She was angry that the woman hadn't told her, as she hadn't worn gloves. When I asked why, she said she didn't like wearing them. They are the rules. Universal procedures should be taken, as out of 100,000 people with HIV a third don't know they have it. It's about training and good practice."

Accessibility of services

8.82 Whilst over 80% of people who completed the survey could reach the main services by public transport, 15.6% said they could not, and for 26.5%, journeys to their nearest service would take over 30 minutes.

8.83 A number of people who took part in the interviews, particularly those aged under 17, rely on public transport and public transport maps do not always tell the whole story.

"I live in Littlehampton and I work in Chichester. I don't drive. I was going to the Chapel Clinic for contraceptive services before it closed. It was convenient as it was in the town centre. I now have to go to the Fletcher Clinic at the main hospital. There is a bus that leaves every 30 minutes".

"In relation to HIV, there is no clinic in Hayward's Heath so people with HIV have to travel to Crawley. There is a bus but this doesn't go as far as the hospital. Someone with HIV in Bognor has to get a train to Three Bridges, then from Three Bridges to Brighton. Once arriving in Brighton, the station is some way from the hospital."

8.84 Participants in the interviews also felt that people in more rural areas, especially those without cars, have less opportunity to access comprehensive sexual and reproductive health services.

"I live in a very rural area. I would have to walk two miles to the bus stop. I'm not aware of any sexual health outreach in the area. I have to go to my GP for everything."

8.85 Participants said that although it was common for people to travel to Chichester from Midhurst, it was an area that has grown a lot, with a college and new school. They

were surprised that there was not a service there; especially as surrounding areas are very rural with poorer transport links.

8.86 It was acknowledged that people in the North West of the County would be more likely to access services out of the County. People were surprised that there seemed to be little provision in between Brighton and Crawley where populations were assumed to be much larger.

8.87 People with physical or sensory disabilities may need additional support and more pro-active engagement to facilitate access to the type of sexual and reproductive health services they wish to access. This could include assistance with travel, translators, visual communication for those hard or hearing and private areas for blind and partially sighted people to give and receive information verbally.

8.88 Interview participants pointed out that University students seemed to be poorly served compared to college students, as there are no sexual health services on the campus sites in Chichester or Bognor.

8.89 Links with pharmacies are also important. People who had attended services in Brighton talked about the advantage of having a well-stocked pharmacy adjacent to the clinic that dispensed prescriptions almost immediately.

Respect in practice

8.90 People want to be listened to and not to feel like they are just part of a process or part of somebody's job. They want staff to be professional but empathetic.

"I expect to respect the staff and them to respect me as a patient."

8.91 Men in particular talked about the intimate nature of examinations and the need to be treated with confidence and the need to feel comfortable from the moment they walked in. Everyone who took part in the interviews mentioned not wanting to feel judged.

"The GP looked at me and made a judgement. I don't want to be judged about STIs, how many partners I have had etc. They are there to help, not to judge."

8.92 This was reflected in the SU survey, with respondents rating both 'helpful/respectful staff' and 'privacy/confidentiality' in their top three priorities for a sexual and reproductive health service.

8.93 The welcome people get when arriving at any provider of sexual and reproductive health service is important.

"You just want a friendly face with a smile that's not going to make you feel like you're in the wrong place or you've done something wrong."

"When I went to have my coil fitted I wanted to feel as comfortable in the waiting room as I did in the consulting room and to walk out feeling that I had been looked after."

"It's like when I arrived here today (County Hall, Chichester). It's an individual but somebody can make you feel unwelcome and a nuisance."

8.94 Most people said the specialist sexual health and reproductive services gave a good welcome.

"The receptionist at Chapel Street always said hello with a smile. They're here to help."

8.95 There was an exception:

"The receptionist is frosty…very abrupt. A clipboard is thrust at you. You almost feel like a burden. I expect it now."

8.96 Systems of registration vary. One person who attends a reproductive service regularly expressed frustration about having to fill in a lengthy form each time, which included details that she gave every time and should be on the system, like her GP name and address, her own address etc. There were also quite personal questions on the form and everyone who took place in the interviews felt that receptionists didn't need to know everything.

8.97 People taking part felt that an important element of specialist sexual and reproductive health services was that young people could attend in their own right. Staff should be confident and trained to help them make their own decisions and not be influenced by parental pressure.

"When I phoned the clinic to say I was bringing my foster daughter, I said can you give her a real stern talking to. She said, 'no we don't do that because otherwise it might put her off coming back the next time and we want to encourage that.' So they've got a good ethos already."

Expert staff

8.98 People highlighted the importance of having specialist and experienced staff, regardless of the setting. No matter where sexual and reproductive health information, treatment and care was being provided, people expected the quality to be the same (in a GP setting, at school, at specialist services).

8.99 This wasn't always the case and examples were given which showed that the advice and treatment received could have been improved.

"I don't think I associate my GP with sexual health advice."

"My GP is good generally but family planning advice is rubbish."

"Sometimes you wonder whether their values will be the same."

"I had a coil fitted by the GP. I've had 3 children but this was more painful. I couldn't sit down properly for a month. The GP referred me to Stoke Abbott family planning. They took the coil out straight away. It had been fitted too low."

"My daughter asked me to arrange an appointment with the GP as she thought she was pregnant. She has an implant. She said the pregnancy test from the pharmacy wouldn't work because of the hormones in the implant. She had heard this from friends."

8.100 Some people who were interviewed emphasised the need for people to have good communication skills. To be able to explain what's wrong and how they are going to help.

"It's relaxed and the language used is non-medical. It's open and easy to understand."

8.101 People affected by HIV talked about the need to maintain expertise for HIV and co-infections like hepatitis. All those living with HIV attended a specialist clinic for treatment of HIV. Whilst being able to cater for other sexual and reproductive health needs, HIV clinics were often not sited near where people lived. People would prefer to get everything in one place but also plan for emergency situations.

Convenient opening times

8.102 Drop-in services were highly rated by interviewees, especially those open in the evenings.

"I quite like the drop in. Sometimes it's been a long wait and the waiting room is small. I've been told to leave and come back in two hours. I went for a coffee. I'd prefer to get a text when a slot is available."

8.103 The people interviewed wanted clinics to be open after school hours, later in the evenings and at weekends. Some people said that opening on both Saturday and Sunday was important.

"I gave low scores on location and opening hours. The opening is one day per week for family planning between 3-6pm. I can just about make it if I'm working locally."

8.104 It was felt important to have services available when people need it, for when people pluck up the courage and walk through the door.

8.105 For the young people in care, being open at night was one of their three most important things.

Early accurate and effective diagnoses and treatment

Key issues and challenges identified by SUs:

8.106 Gay men who took part mentioned the fact that there is HIV testing in some gay bars and clubs but this is not happening in all areas. Worthing was mentioned as an area that did not seem to have any outreach HIV testing.

8.107 Young people in care had used services a number of times in Bognor Regis, Chichester, Littlehampton, Shoreham and Worthing. They rated the services lower than most people who completed the survey[59].

8.108 Most people who took part in the interviews had used sexual and reproductive health services rated the services at the higher levels. In the interviews people had very positive experiences of specialist sexual health clinics.

> ***"At Chapel Street it was always very positive. I had all my up to date smears and screening. Having said that the system of reminding probably didn't work – it was a proactive thing."***
>
> ***"I'm very happy with the service in Worthing. Worthing should be proud. The counsellors, doctors and nursing staff are fantastic."***
>
> ***"I have a high confidence in HIV and sexual health services. From the early basements they came upstairs with carpet, appointments and soundproofing. We have come a long way."***

8.109 For people diagnosed with HIV, there was a concern that changes in the way that services were delivered meant that when someone was diagnosed there was no one for them to talk to. People could be very isolated. The good care received at Brighton as a hub for HIV and hepatitis was emphasised.

8.110 For African people living with HIV, there have been changes in the way services are provided.

> ***"Before you could phone the community people but now you can't phone them. We used to have a phone and if there were a problem they would drive and come and see you. Next minute they are receiving treatment. Now we're not allowed to do that."***

[59] Services were rated on the following aspects: location; opening times; quality of the service; and confidentiality. Ratings were on a scale of 1-5, where 1 = very poor and 5 = excellent.

The young people in care rated services as follows: location (2); opening hours (2): quality (3); and confidentiality (4). These scores were generally lower than those given by respondents to the local population survey.

Joined up provision

Key issues and challenges identified by SUs:

8.111 Everybody that took part in the interviews thought that there should be 'one stop shops' for sexual and reproductive health. These should deliver a full range of sexual and reproductive health services to promote good sexual health. People from all communities and ages were clear that they did not want to separate communities, ages and groups. Some people said that rather than try and deliver lots of small services and mobile clinics, it would be better if there were a few comprehensive services, open in the evenings and at weekends and strategically placed with good transport links.

"In my culture, dividing people, we would think that we are being selected or singled out."

"The clinic is mixed (gay, straight, male, female, any age). It works well. People are there for many different reasons. I would feel uncomfortable attending a gay only clinic. I like the balance and mix."

"It should be adaptable and flexible to provide space for all. It should encompass all demographic – like Worthing Leisure Centre. It should be more like Weight Watchers than Alcoholics Anonymous!"

"You're making it easier for someone to go in and say I'm not well down there. It normalises it."

"There's got to be concern for where people have their opening sentence so you can tell them where to go – not just a big sign saying STIs this way."

8.112 A discussion about mobile and outreach services raised concerns about the expense of providing this type of service, whether the equipment and expertise is available, what happens when people have a more complicated or serious infection and whether the mobile clinic is going to be open on the right day at the right time.

8.113 There was also discussion about parity of services if mobile clinics were set up in some rural areas and not in others – it may be worth exploring the option of mobile facilities in every village, although Nudge Associates recognises the finacial challenges and cost implications of such a venture.

"The access for everybody should be fair, consistent and appropriate".

8.114 Some participants felt that when someone needs the service they can need it quickly. There are some issues that are not possible to wait for another week. People felt it was better to let people know about the good and existing services and improve their hours and transport links, than to try and meet needs by either sending specialists out to rural areas or expecting GPs to deliver specialist services.

8.115 An individual working with people with learning disabilities said there are service users that would help to produce and comment on learning materials. My Network and MyNetwork Plus reach hundreds of people with learning disabilities throughout West Sussex. There is a need to link sexual health, social care and learning disability support teams to provide an integrated sexual and reproductive health service to people with learning disabilities.

8.116 Some participants discussed how peer support worked really well for breast-feeding, for people with HIV and for parents in FPA's Speakeasy programme. There may be opportunities to use peer support more in sexual health.

> ***"I'd like to be a Doula (supporting women and their families during pregnancy, childbirth and early parenthood). I'd have benefited from that when I was a young mum."***

Box D: What would put people off using sexual and reproductive health services?:

- *Inaccessible opening times so I can't get there if I'm at work or I'm at school*
- *I have to make an appointment*
- *It's part of an environment where I don't feel safe - in its widest sense*
- *I don't know what to expect*
- *I'm going to be judged - I've done something wrong*
- *It's too embarrassing*
- *I'm not going to be treated like a human being*
- *There's probably going to be people I know*
- *I'm going to have to pay for it*
- *I'm going to have to go somewhere else to activate the advice*
- *I'm going to be pushed around the system*
- *Big queues*
- *Some people are shy*
- *The welcome*
- *Isolation*
- *Being in denial about infection – especially HIV*
- *Staff*
- *Lack of discretion*
- *Poor advice*
- *If its' focus was particularly on school kids or a sort of yob culture it would become an inaccessible place as far as I am concerned*
- *I am confident enough to go to a sexual health clinic but there's still stigma attached*

9 RECOMMENDATIONS AND CONCLUSION

9.1 It was evident during this stakeholder engagement process that WSCC, its provider partners and other colleagues, have worked exceptionally hard to improve sexual health service provision in the County, and have developed relationships to progress matters in all aspects of both commissioning and delivery.

9.2 There were a range of views expressed by the KIs with differing perspectives, and what is reported in this SHNA offers an overview of the main messages with a full range of opinions.

9.3 The commissioning partners across public health and LAs have relatively new roles that are fundamentally different to the providers. Commissioners need to be stating the "what" and providers, the "how". This is why commissioner and clinical leadership and engagement are deemed so important. Commissioners can set their expectations, define excellence and outline the parameters for delivery from providers.

9.4 Excellent communication channels need to be opened and regularly used. The WSCC Health and Well Being Board (HWB) could play a major part in this

9.5 In the new organisational structures and across the partnerships, it is commissioners, who need to examine the evidence of local population need and from this dictate the change in culture, determine the mechanisms and describe clearly what it is they want from providers. Commissioners need to decide how they allocate the resources, what they select and promote and what the organisational structures and processes if change is to occur for the benefit of patients.

9.6 The following recommendations draw on the key themes identified by key informants, service users and the local population. They outline suggested approaches for change that West Sussex may wish to consider in any future commissioning and provision of sexual health services for the population of West Sussex.

Commissioning, contracting and procurement (Recommendations 1-24)

9.7 ***Recommendation 1:*** It was suggested that a lead commissioning role is identified to lead on the three elements of commissioning across WSCC Public Health, CCGs and LATs. This would help avoid fragmentation, and provide an environment for seamless pathways for patients. The lead can act as conduit to the bodies responsible for the different elements and ensure robust and transparent processes are in place. Section

75 or other appropriate arrangements could be put in place to manage these arrangements on behalf of all partners.

9.8 ***Recommendation 2:*** NHSE are exploring how to pool its primary care budgets with other commissioners, this work includes co-commissioning and combining budgets. The PHE whole-system commissioning framework (out for consultation at the time of writing) is due in summer 2014 and may help WSCC decide on appropriate arrangements across the county for sexual health.

9.9 ***Recommendation 3:*** A small, high level commissioning sexual health group should be developed by Public Health to support the commissioning lead and have formal delegated responsibility to facilitate the commissioning processes across all the financial partnerships in WSCC, CCGs, and NHSE (LATs). A robust membership will be necessary to ensure that all key decision makers are equally represented.

9.10 ***Recommendation 4:*** Commissioning intentions need to be clearly outlined setting out KPIs and expectations on providers for what is required to provide HIV and integrated sexual health services for WSCC, maintaining the indicators for the Public Health Outcome Framework (PHOF) and local response to epidemiological evidence. These commissioning intentions should be developed in line with a sustainable commissioning strategy that is developed through partnership working and commissioning cycles across the county. It will be essential to utilise local evidence from the JSNA, user feedback, provider data etc. The PHE Sexual and Reproductive Health Profiles[60] will be a useful tool to facilitate this.

9.11 ***Recommendation 5:*** There was universal consensus across KIs on the need for an integrated tariff, especially now that there are major opportunities to address sexual health at one clinical intervention point. Whilst the interim tariff has been agreed for 2014-2015, it is recognised as flawed, and work needs to be done in year to address the shortfalls. Local implementation of an interim integrated tariff arrangement will begin in earnest and will help WSCC know they are paying like for like, although the rate will not be mandatory. A reduction in income to the providers may however impact detrimentally on provision and care pathways for patients, and given the apparent stress on their capacity to meet demand, any implementation of an integrated tariff will need rigorous collation and monitoring of accurate data to progress.

9.12 ***Recommendation 6:*** KIs agree that commissioners should be clearly defining their expectations, identifying excellence and setting the parameters for providers. This will require excellent communication channels and use of robust service contracts to monitor and evaluate the purpose, outputs and outcomes of a range of interventions.

[60] http://fingertips.phe.org.uk/profile/sexualhealth

Service contracts will need to encompass identified vulnerable communities, which takes account of the cultural norms within those communities (e.g. MSM, BME and young people). The service contract could also include an element of evaluation development as well as a baseline evaluation framework.

9.13 ***Recommendation 7:*** WSCC commissioners may wish to consider the benefit of completing a pathways risk analysis across all disciplines in relation to HIV, sexual and reproductive health. That is, an analysis of a set of sequential events along the sexual and reproductive health pathway that may affect a patient's journey and the risk management options adopted that can mitigate risks related to finance, workforce etc.

9.14 ***Recommendation 8:*** Commissioners will remain unsure of the current and future demand, need and capacity for appropriate HIV, sexual and reproductive health services until services are robust enough to undertake, complete and pass a risk analysis based on evidence of need and epidemiology.

9.15 ***Recommendation 9:*** The majority of provider KIs appeared unsure of the total allocation for sexual and reproductive health service provision, and some wanted to understand the totality of the resource for sexual health. KIs would like to play an equal role in determining the needs and priorities for investment and expenditure. Sharing the responsibility for the allocated budgets may also be beneficial, as all elements of provision will be clear on their designated investment.

9.16 ***Recommendation 10:*** A robust performance management framework with transparent access to data should be developed across the three commissioning elements (LA/CCG/NHSE) to ensure equity of access and seamless pathways for SUs. There was also a clear message from KIs that the data collated should be used to inform any future commissioning intentions, and that a transparent process would be welcomed to allow for flexibility and programme development on a county wide basis. Service user voices should be actively encouraged as part of the data collection, and providers should foster a culture, which encourages and enables those voices to contribute and be heard.

9.17 ***Recommendation 11:*** The lead commissioning role within WSCC could ensure that champions are identified and nurtured and that the championing of all related issues expressed as part of this consultation are incorporated into the new commissioning intentions and provider practice.

9.18 ***Recommendation 12:*** Service contracts should specify that clinical providers engage with third sector providers, and include joint working with accessible and seamless referral pathways.

9.19 ***Recommendation 13:*** Respondents to the stakeholder survey were in favour of the Voluntary and Community Organisation (VCO) sector having a role in delivery of sexual health services, with 57.1% saying it should to some extent, 28.6% a significant extent and 10.7% a great extent.

9.20 ***Recommendation 14:*** GPs across West Sussex could consider signing up to a single local enhanced service contract for sexual health outlining the expected service delivery and impact at practice and group level. KPIs accompanied by variable funding to share overall investment would then be dependent on achieving the KPIs (e.g. LARC fitting, HIV testing, chlamydia screening). This may strengthen the role of GPs, particularly in more rural areas, and stimulate a more collaborative environment brought together through a population based capitation contract. It would also allow GPs to develop a more integrated model of sexual health provision centred on primary care and targeted at more vulnerable communities.

9.21 ***Recommendation 15:*** Pharmacists should be proactively involved and could be commissioned through local agreements to increase access to EHC, condoms and chlamydia screening.

9.22 ***Recommendation 16:*** Prior to the challenging process of agreeing any future service models for sexual health services across the range of partners and new commissioning arrangements, the Sexual Health Strategy Group should identify initial overarching priorities for how the commissioning partnerships should proceed. These priorities should include:

- Deciding what they decide to keep
- Deciding what they decide to share
- Agreeing on what they decide to delegate (e.g. to Third sector)
- Agreeing the vision and shift towards both an integrated commissioning model and integrated care for patients
- Supporting self management
- Increasing productivity of all service provision
- Looking at new technologies including social media
- Mastering sexual health procurement spending
- Ensuring staff and service user engagement at all levels

9.23 ***Recommendation 17:*** Providers need to be explicitly engaged in this process so sorting out the specific roles and responsibilities will be crucial at the outset.

9.24 ***Recommendation 18:*** Should commissioners intend to go out to tender at a point in the future they should ensure transparency of intent with clear outcome measures. The

key to success is going to be with transparent and effective methods which demonstrate to the SUs that decisions have been made that puts their needs at the heart of the decision making process.

9.25 ***Recommendation 19:*** It will be essential that commissioners and providers work together to ensure elected members are provided with accurate health economic arguments in support of open access HIV, and sexual and reproductive health service provision.

9.26 ***Recommendation 20:*** It will also be important to ensure elected members are made aware of and informed of action taken to prevent local HIV, sexual and reproductive health associated stigma and discrimination experienced by service users in NHS primary care providers (including GPs, dentists and general hospital clinicians).

9.27 ***Recommendation 21:*** Public health has a key role in providing leadership for HIV, sexual and reproductive health and in championing multi-agency partnership working, particularly in relation to services for young people, older people living with HIV, BMEs and MSM in West Sussex.

9.28 ***Recommendation 22:*** Commissioners would benefit from undertaking site visits periodically, to observe service delivery and gain a first hand understanding of issues on the frontline. This will help and inform their decision-making processes in relation to service development and future commissioning.

9.29 ***Recommendation 23:*** It is essential that the different commissioners reach an operational understanding. Sharing the challenges and accepting that sexual health is everybody's business and a joint responsibility offers opportunities to enable joint solutions. This can only be good for patients and service users.

9.30 ***Recommendation 24:*** The changing environment of the LA/NHS commissioning landscape, including the move to more social enterprise involvement, with other qualified providers waiting to join the new market opportunities, presents challenges to both providers and commissioners. These emerging opportunities are embryonic and for effective partnerships to work in the future, each will need to feel confident in their roles and understand their responsibilities in order to achieve the best possible outcome for patients.

Access to information (Recommendations 25-37)

9.31 ***Recommendation 25:*** Given the current lack of a formal West Sussex sexual health network which appears to be negatively impacting on good communication across the county, many KIs would like to see an open communication strategy introduced by commissioners of sexual health services. This would ensure transparency of consistent information across the county for all providers and commissioners.

9.32 ***Recommendation 26:*** The planned Sexual Health Forum should be re-introduced to increase and improve communication, with representatives across the provider and commissioning spectrum, including with the third sector and service user representatives.

9.33 ***Recommendation 27:*** An annual sexual health event, perhaps as part of a broader Public Health event to share information and provide updates and opportunities for a question and answers session would be beneficial as new ways of improving access to information and service provision are shared. All key stakeholders could be invited and providers could update on service improvements, updated data analysis on sexual health, availability and relevant information to share across a range of stakeholders and providers.

9.34 ***Recommendation 28:*** Increased use of public spaces, such as libraries, swimming pools, pubs, hairdressers, etc. should be used to provide relevant and appropriate information about sexual health service availability and health promotion literature. Consideration should also be given to whether community facilities could also be used to host services.

9.35 ***Recommendation 29:*** All service providers and commissioners in partnership with colleagues in children's services should consider the specific needs of Looked After Children (LAC) in relation to their sexual health needs.

9.36 ***Recommendation 30:*** There should be an increase in proactive engagement and information sharing on the sexual health needs of young people with school governors to ensure a more consistent approach to SRE across West Sussex.

9.37 ***Recommendation 31:*** Increased use of IT and social networking sites to increase access to integrated sexual health services was viewed as essential by many KIs. This should be developed as an effective means of communicating for a range of age groups and target populations, with the added bonus of confidentiality for all, e.g. www.tht.org.uk/myhivww.myhiv.org

9.38 ***Recommendation 32:*** Increasing the use of 'podcasts' or YouTube was also highlighted as an excellent tool and should be encouraged in schools and colleges to offer a range of information on sexual and reproductive health services.

9.39 ***Recommendation 33:*** The sexual health services website of Western Sussex NHS Hospital Trust should be reviewed, in light of the general criticism that "it is not very user friendly", to ensure that it offers up to date information and access points for all service users, and identifies clearly the specific type of services available, opening times and information about what to expect. Providers should identify a lead to ensure that this information is kept up to date and communicated consistently across the county. The lead should ensure that the information is regularly updated, relevant, timely and proactively advertised on the 'Your Space' WSCC website.

9.40 ***Recommendation 34:*** These sites should also provide the information in a range of languages that meet the needs of the diverse population of West Sussex, and ensure access to the information for more vulnerable and hard to reach populations.

9.41 ***Recommendation 35:*** Given the emergence of new treatment technologies, including PEPSE and Pre-Exposure Prophylaxis (PrEP), some KIs believed that SUs need to be clearly signposted to relevant sources of HIV treatment information online. This would be hugely beneficial in supporting those living with HIV to maintain their health and reduce onward transmission. Point of Care Testing (POCT) should be widely advertised as this would increase early diagnoses of HIV and should be available across WSCC.

9.42 ***Recommendation 36:*** KIs unanimously supported a central booking line for all sexual health services across West Sussex.

9.43 ***Recommendation 37:*** In summary, there were a range of views expressed (which broadly mirror the findings of both the stakeholder and SU surveys) as to what and how information should be relayed for sexual health SUs in West Sussex but notably, the key messages from KIs were:

- Increase the use of social media to engage, inform and educate
- Increase access to information on where services are, opening times and what they offer in a range of communal settings
- Ensure appropriate web links between WSCC and all its service providers across all hub and spoke services provided by the WSHNHST and Third Sector organisations
- Provide a consistent PSHE support across all schools through evidence based programmes, good practice and advice
- Link in with HIV Prevention England (HPE) more proactively and use their resources (http://www.hivpreventionengland.org.uk/Resources)

Preventative interventions (Recommendations 38-50)

9.44 ***Recommendation 38:*** Given that WSCC are now responsible for commissioning a major share of sexual health services, there are major opportunities to improve the role of services in unplanned pregnancies/HIV/STI prevention and to identify additional and alternative settings to provide relevant information and increase uptake of HIV/STI and pregnancy testing. KIs felt that this could be agreed as a priority requirement between public health commissioners and providers. There was recognition that a standardised tool was not applicable to every aspect of delivery, but that service contracts could account for this in any local area deemed appropriate. As stated, a sexual health balanced scorecard has been developed by PHE and could be introduced as a standardised tool with local metrics to account for variations.

9.45 ***Recommendation 39:*** There is the potential to increase co-commissioning with other public health initiatives. In terms of the future model, some KIs cited the Marmot Review61 into health inequalities stating that it gave a broader, and more relevant context to risk, including drug and alcohol and smoking behaviours, and the majority of KIs were clear that there were missed opportunities by having such a narrow definition of prevention.

9.46 ***Recommendation 40:*** There was interest in aligning clinical service provision with the prevention agenda and incorporating it into service contracts. KIs felt that multi-disciplinary models of prevention and care, provided by appropriately skilled professionals, would support provision of prevention advice but would also provide support in a range of other public health issues, including alcohol, substance misuse, and smoking. KIs would like to see a consistent methodology used to evaluate the effectiveness of prevention. Models offering a potential solution, for example the BASK (Behaviour, Attitudes, Skills and Knowledge), need to be appropriately and consistently monitored before their use is agreed strategically. WSCC could consider a pilot on evaluating this model with a range of Third Sector providers who are currently commissioned to provide sexual health services.

9.47 ***Recommendation 41:*** A combination approach, rather than one universal approach to STI and HIV prevention, recognises the range of factors that influence an individual's relationships and safer sex behaviour. It also offers a menu of interventions with clear patient pathways and strong referral processes needed to enable providers meet the different need of individuals. STI/HIV testing is an effective primary clinical prevention initiative, and treatment is an effective secondary clinical prevention initiative; however, they cannot be delivered in isolation. The division between primary and secondary prevention work is seen by KIs to be unhelpful, and should be universally provided.

[61] http://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

9.48 ***Recommendation 43:*** KIs perceive that there is now an opportunity to introduce STI/HIV testing in a broader range of community and primary care settings, and a need to incorporate much broader risk factors into the intervention portfolio (including alcohol and drug use).

9.49 ***Recommendation 44:*** Interpersonal (face-to-face) interventions can help people make healthier life choices, including reducing risk-taking behaviours. Interpersonal interventions acknowledge the complexities of individual lives, however they are time consuming and expensive.

9.50 ***Recommendation 45:*** SRE should be accepted as a serious and relevant participative subject by all schools and academies as an important part of what is offered young people. There were strong and consistent views from KIs that WSCC should address this as a matter of urgency with school heads and governors. Commissioners and providers should be aware of the latest guidance such as 'Sex and Relationships Education (SRE) for the 21st Century' (Brook, PSHE Association and the Sex Education Forum 2014).

9.51 ***Recommendation 46:*** WSCC have an opportunity to advise that all SRE programmes inform and educate young people. There is also an opportunity through youth work in schools, and in provision for young gay men, vulnerable young women and LAC.

9.52 ***Recommendation 47:*** Stigma and discrimination should be addressed vigorously and SRE education in schools should encourage 'normalising' STI/HIV testing and chlamydia screening.

9.53 ***Recommendation 48:*** Work with young women in particular was highlighted as a priority by many KIs working with young people across youth and children's services. Offering proactive support and counselling, especially to young mothers who have repeated pregnancies and abortions, and ensuring they have access to LARC was deemed a real priority.

9.54 ***Recommendation 49:*** There was consensus that the availability of condoms is crucial as an effective part of an effective prevention strategy. Improving the C-Card scheme further, by expanding the scheme, providing more updates on it and training other professionals (non-NHS) to help promote/administer the scheme was highly recommended.

9.55 ***Recommendation 50:*** In addition there were a significant number of KIs who felt that messages about promoting condom use had faded and that there needed to be more high profile promotion of their use.

Rapid open access to sexual health services (Recommendations 51-67)

9.56 Recommendation 51: Whilst there has been considerable work done to improve the situation across the county, most KIs acknowledge that there is still a long way to go.

"We know how far we have come ...but we also know how much further we need to go!"

9.57 ***Recommendation 52:*** There is a need to increase the number of STI/HIV tests in the community. Earlier diagnosis saves lives and reduces treatment costs. WSCC have the opportunity to introduce STI/HIV/chlamydia testing in a broader range of community and primary care settings. Stakeholders believe there are opportunities to work in much closer partnership with Third Sector and other community services to provide Point Of Care Testing (POCT) in a variety of settings - especially in the Crawley area where the majority of more vulnerable African communities live.

9.58 ***Recommendation 53:*** A few KIs were under the impression that that GPs may benefit from WSCC introducing the 'Buddy Scheme' adopted in Surrey where GPs trained in sexual health are able to initiate and support the training and competencies for their colleagues offering a service whereby neighbouring surgeries will carry out Contraceptive Implants and IUCD Public Health Agreements for patients registered at neighbouring practices. Practices could work to enable the scheme to offer a choice of provider to patients but will also help to maintain services in a Primary Care setting without increasing activity in Secondary Care services.

9.59 ***Recommendation 54:*** It is recommended that the site in Bognor is agreed and refurbished to meet the gap in sexual health service provision as a priority. KIs believe that the conversations between providers and commissioners have been protracted and that action to provide the service should be prioritised.

9.60 ***Recommendation 55:*** Youth workers could expand collaborative work with sexual health service providers and ensure that the respected outreach nurses can visit and provide much needed information and other supportive resources for young people to improve their sexual health.

9.61 ***Recommendation 56:*** Discrete services for young people should be provided as a larger package in community settings, including a more collaborative approach with drug and alcohol services, pregnancy testing, POCT, condoms and EHC. The outreach team could provide this with nurse prescribers if necessary. The opportunities to proactively engage with young people in this type of setting could really support their broader health and emotional wellbeing needs. This would quickly identify safeguarding and other challenging issues if the nurses and youth workers were adequately skilled.

9.62 ***Recommendation 57:*** Opening times across all services should be reviewed to ensure that there is consistent access across the county.

9.63 ***Recommendation 58:*** Staffing levels and the necessary resources required to maintain open access and improve opening times should be considered across the range of provision, with a view to prioritising locations of greatest need.

9.64 ***Recommendation 59:*** Any re-assessment of clinical service points may require reviewing nursing headcounts whilst maintaining the whole time equivalent, withdrawing services where other providers should and could undertake the role and assessing fitness for purpose.

9.65 ***Recommendation 60:*** Integrated network teams with a consistent delivery model will be crucial as will utilising technology such as perpetual patient feedback processes, both paper and online such as Survey Monkey®, as this would offer evidence of SU's opinions. This will allow rapid engagement and ensure that services maintain the values and principles outlined in the Health and Social Care Act – specifically stated by the former Secretary of State for Health, Rt. Hon. Andrew C. Lansley, "nothing about us, without us".

9.66 ***Recommendation 61:*** Good QIPP (Quality, Innovation, Productivity and Prevention) outcomes and meeting the PHOF should be priorities, so integrated sexual health provision will need to be organised efficiently, and funds allocated accordingly. All the elements will need to be aligned with commissioning as just one of the levers, with clinical leadership and engagement another key part of the new commissioning process.

9.67 ***Recommendation 62:*** WSCC will be monitoring the numbers of local residents tested for HIV and be monitored on the numbers of residents diagnosed late for HIV. Whilst NHSE is responsible for the treatment and care costs of people living with HIV, KIs would support a case for the money allocated for sexual health (which includes testing for HIV) to be maximised and encompass the breadth of interventions required to tackle the increasing numbers of people living with HIV. Further discussion between relevant commissioners and providers should take place to ensure this is appropriately established and managed.

9.68 ***Recommendation 63:*** Sexually acquired Hepatitis, HPV (human papilloma virus) and other STIs are universally recognised co-infections associated with HIV infection and as such should be tackled in a coordinated manner within an integrated sexual health service.

9.69 ***Recommendation 64:*** West Sussex should continue to support the 'HalveIt' Campaign62 (halve the proportion of people diagnosed late with HIV (CD4 count <350mm3), and halve the proportion of people living with undiagnosed HIV, by 2015).

9.70 ***Recommendation 65***: The role of nursing and health advising should be working to a standard that is within the national guidance available from recognised professional bodies such as BASHH63 and FSRH64 (both updated 2014), thus ensuring that robust clinical governance is evident in all the hub and spoke services across the county, and provides the public with assurances of quality.

9.71 ***Recommendation 66:*** Educational development utilising the national programs such as BASHH – STIF Sexual Health - Course of Five & BHIVA / NHIVNA competencies in tandem with local HEI support will allow the workforce to be educated to a standard that the professions deem as required. This, underpinned with routine and regular audit of practice, will demonstrate the importance of Multi-Disciplinary Team (MDT) working whilst providing the commissioners with assurance of quality with patient focused outcomes.

9.72 ***Recommendation 67:*** Health Advisors (HAs) should continue to play a pivotal role in the management of on-going risk, screening and crucially partner notification management. These skills along with enhanced behavioural interventions such as 'Motivational Interviewing' would enable the team to robustly support the clinical services. Cross working and being independent in core skills such as phlebotomy, asymptomatic screening would enable the HA team to further embed their skills into the MDT across a range of settings in West Sussex.

Early accurate diagnosis and treatment (Recommendations 68-80)

9.73 ***Recommendation 68:*** A single menu of sexual health screening based on the most specific and sensitive testing platforms available (which should include Point of Care Tests) should be prioritised.

9.74 ***Recommendation 69:*** Economies of scale through purchasing and single site laboratory testing should be continued in West Sussex and may reduce costs. This, linked to electronic downloading of results into clinic IT systems, would facilitate rapid return of results to patients and clinical staff. Technology exists where all negative test

62 http://www.halveit.org.uk
63 http://www.medfash.org.uk/uploads/files/p18dtqli8116261rv19i61rh9n2k4.pdf
64 http://www.fsrh.org/pdfs/FSRHQualityStandardContraceptiveServices.pdf

results are batched and sent with minimal HA or administrative input, leaving only reactive or positive results to be person managed.

9.75 ***Recommendation 70:*** 'People attending health care services (primary, secondary and tertiary care) should be offered diagnostic tests for HIV in accordance with current national guidance'[65]. Testing for HIV infection across West Sussex in both general practice and A&E departments should lower the rates of undiagnosed HIV. Other venues could be considered based on epidemiology (e.g. faith based settings for BME communities).

9.76 ***Recommendation 71:*** WSCC and the providers have a single IT network for Electronic Patient Records across the county which enables enhanced clinical care, minimises duplication of records, facilitates partner notification and lowers on infection rates. This is excellent practice, and was commended highly by KIs.

9.77 ***Recommendation 72:*** Electronic downloading of results into clinic IT systems facilitates rapid return of results to patients and clinical staff, it will be important to ensure this is a core part of ongoing service provision.

9.78 ***Recommendation 73:*** The development of agreed and monitored outcome measures that show increased rates of HIV testing, vaccination and prompt treatment of STIs would be of benefit to commissioners and providers alike, and ensure progress on performance and benefits to the population of West Sussex.

9.79 ***Recommendation 74:*** Some KIs mentioned patient IT systems for self-booking, triage and then rapid transmission of confidential results from laboratory to patient, minimising third party handling would be a key investment for integrated sexual health services.

9.80 ***Recommendation 75:*** West Sussex has a limited self-managed clinical network, however it is resource poor and existing clinical commitments prohibit it from being able to sustain significant countywide support to other primary and secondary care providers. In order to facilitate improvements, KIs noted a formal clinical network led by a dedicated coordinator would be needed to create a culture of change required in the new sexual health commissioning environment.

9.81 ***Recommendation 76:*** A coordinated engagement process with GPs, voluntary and other statutory services to enhance education and testing of vulnerable communities at venues and times outside of traditional clinical services should be reviewed and strengthened. Outcome measures that show increased rates of testing, vaccination and

[65] http://www.bhiva.org/documents/Standards-of-care/BHIVAStandardsA4.pdf

prompt treatment of STI infection would be an integral part of any 'joined up' partnership working.

9.82 ***Recommendation 77:*** All sites for screening and care need to continue to ensure access to the latest cost effective screening platforms such as urine based NAATs (Nucleic Acid Amplification Tests) technology for minimally invasive screening. POCT for HIV and other infections is available, and would allow outreach STI/HIV testing in alternative settings.

9.83 ***Recommendation 78:*** Increasing the referral rates as necessary to the clinical nurse HIV specialist team would benefit patients who require additional support at home. It was suggested that increased numbers of referrals from the Crawley clinic would be an appropriate use of HIV Specialist Nurse service resources, especially because they have the highest number of people living with HIV in the county. Reducing inpatient treatment and care costs should be a major incentive.

9.84 ***Recommendation 79:*** A website for West Sussex that directs people to a central call centre with access to all integrated sexual health hub and spoke clinics and other sexual health provision would promote an efficient use of resources while offering information and choice to SUs. This call centre could provide for self-triage. This degree of self-management enables the public to self-assess the severity of their symptoms and reduce unnecessary attendance.

9.85 ***Recommendation 80:*** Timely and easy access to EHC (Emergency Hormonal Contraception) in rural areas with poor transport and limited pharmacy services is deemed essential.

Joined up provision (Recommendations 81-89)

9.86 ***Recommendation 81:*** Steps should be taken to prioritise the development and promotion of a West Sussex Sexual Health Services Communications Strategy that would raise awareness about the range and availability of sexual health service provision across West Sussex.

9.87 ***Recommendation 82:*** Commissioners should consider funding the development of a West Sussex Clinical /Support Group which incorporates the HIV clinical nurse specialist team. Even meeting costs with some back up locum costs would be welcomed and supportive. This would ensure that services are all aware of their specific roles, and will increase the opportunities for joint collaboration, seamless transition for patients and excellent communication.

9.88 ***Recommendation 83:*** Most KIs would like to see a dedicated role manage the network – not necessarily a clinician or commissioner but someone to coordinate the services, delivery across county and monitor effectiveness and appropriateness against the government key objectives. SW London's SWAGNET is an excellent example.

9.89 ***Recommendation 84:*** Pathways between provision need to be better understood by all professionals, advertised on a website and endorsed by all health and other professionals, so that SUs can receive the most appropriate care pathway for their needs.

9.90 ***Recommendation 85:*** It was recommended that there should be more support for skills development and education of health and other professionals due to some SU experiences of stigma and discrimination. Some KIs felt that further training on confidentiality should be provided to all key stakeholders and service providers. The majority of KIs requested a specific HIV and sexual health training and development programme for all LA partners, GPs with a special interest and Third Sector organisations.

9.91 ***Recommendation 86:*** Respondents to the stakeholder survey were asked if they were aware of any particular staff training needs or workforce issues, and suggestions included:

- Conducting child protection assessments
- Cultural awareness
- Drug cultures for young people
- Implant/removal training
- MSM issues
- PSHE within schools
- Sexual Health for people with disabilities
- SRE training
- Training staff in children centres on C-Card
- Treating under 18s
- Understanding and knowledge of domestic and sexual abuse
- Working with vulnerable children
- 'You're welcome' quality criteria

9.92 ***Recommendation 87:*** GPs with a Special Interest (GPsSI), with the relevant training, should be advertised so that people can approach those surgeries with their sexual health needs with full confidence.

9.93 ***Recommendation 88:*** In addition, some KIs felt that education and skills development about the overall complexity of sexual health and SU's needs (emotional and medical) should be identified as a priority for:

- GPs
- Nurses in non-specialist services
- Dentists
- Teachers and youth workers
- Maternity services – in particular, midwives
- Some Voluntary and Community Organisations (VCOs)

9.94 ***Recommendation 89:*** Overall, improving the communication and relationships between service users and the health and other professionals with whom they come into contact would improve pathways, increase access and develop trust and co-operation.

Nudge Associates Limited would like to thank all those who participated in this Sexual Health Needs Assessment.

10 APPENDICES

Appendix A: Key Informant Survey Analysis

10.1 This appendix provides analysis of the Key Informant (KI) survey that was conducted as part of this review.

Summary

10.2 In total there were 39 respondents to the KI survey, with the majority having a role in which sexual and reproductive health was a priority.

10.3 Key findings:

- The areas of current service delivery viewed as working best were 'Partnership working/local partnerships', 'Equality of access to services' and 'Promotion of sexual and reproductive health services'
- The areas with the lowest ratings were 'Promotion of services to vulnerable groups', 'Pathways' and 'Leadership'
- Generally respondents did not feel that services were meeting the needs of vulnerable groups particularly well
- The most successful aspects of the service were seen as 'Accessibility of services', 'Walk-in/drop-in clinics' and 'Out-reach work'
- There were a range of suggested areas for improvement, gaps in services, barriers to accessing services, opportunities for prevention work and training needs
- Respondents felt the three most important aspects of a sexual and reproductive health service were 'Helpful/respectful staff', 'Privacy/ confidentiality', and 'Location/distance/ accessibility' (this broadly matched those suggested by service users, which were 'Privacy/ confidentiality', 'Location/distance/accessibility' and 'Helpful/ respectful staff')
- Respondents felt that 'Young people', 'LAC Care Leavers/Looked after young people' and 'LGBT groups' were particularly in need of more outreach/targeting work;
- Respondents were in favour of the Voluntary and Community Organisation (VCO) sector having a role in delivery of sexual and reproductive health services
- They were also in favour of community assets being used for the promotion and hosting of services
- Respondents' preferred locations for information on sexual and reproductive health services were schools/colleges/ universities, GP surgeries, through social media, pharmacies and in local bars and clubs.

Survey respondents

10.4 In total there were 39 respondents to the KI survey. Of these respondents 47.4% stated that sexual and reproductive health is a priority in their role to a great extent, 23.7% to a significant extent, 21.1% to some extent and 7.9% to no extent.

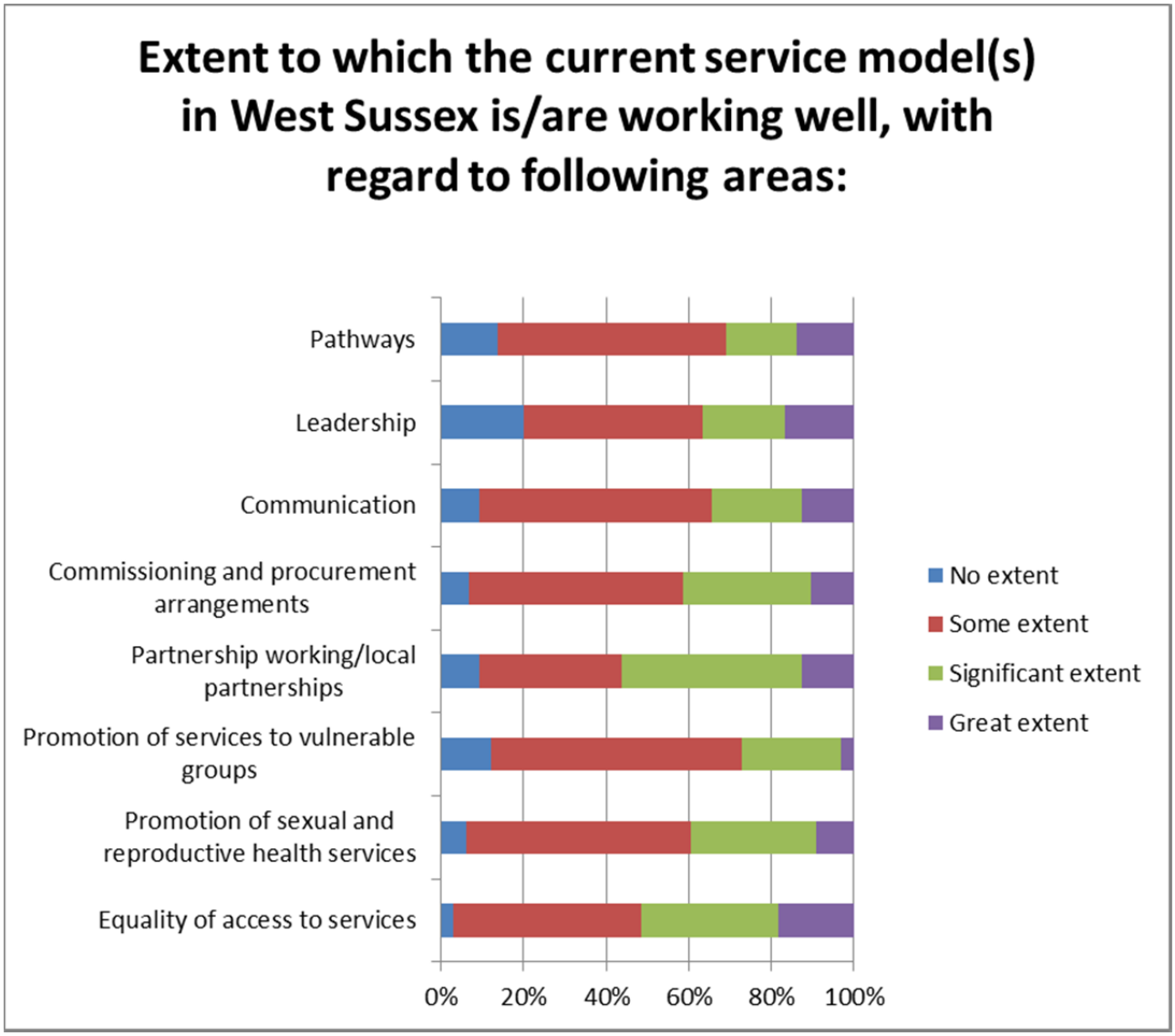
10.5 Of the 39 respondents 22 chose to remain anonymous. Those respondents that were willing to be identified stated they were from the following organisations:

- Coastal West Sussex CCG
- Horsham & Mid-Sussex CCG
- Sussex Community NHS Trust
- Terrence Higgins Trust
- West Sussex County Council
- West Sussex Integrated Sexual Health
- Western Sussex Hospitals NHS Foundation Trust
- Youth Support & Development Service
- Youth Support and Development Service Intensive Support Team (WSCC)

Views on current service delivery

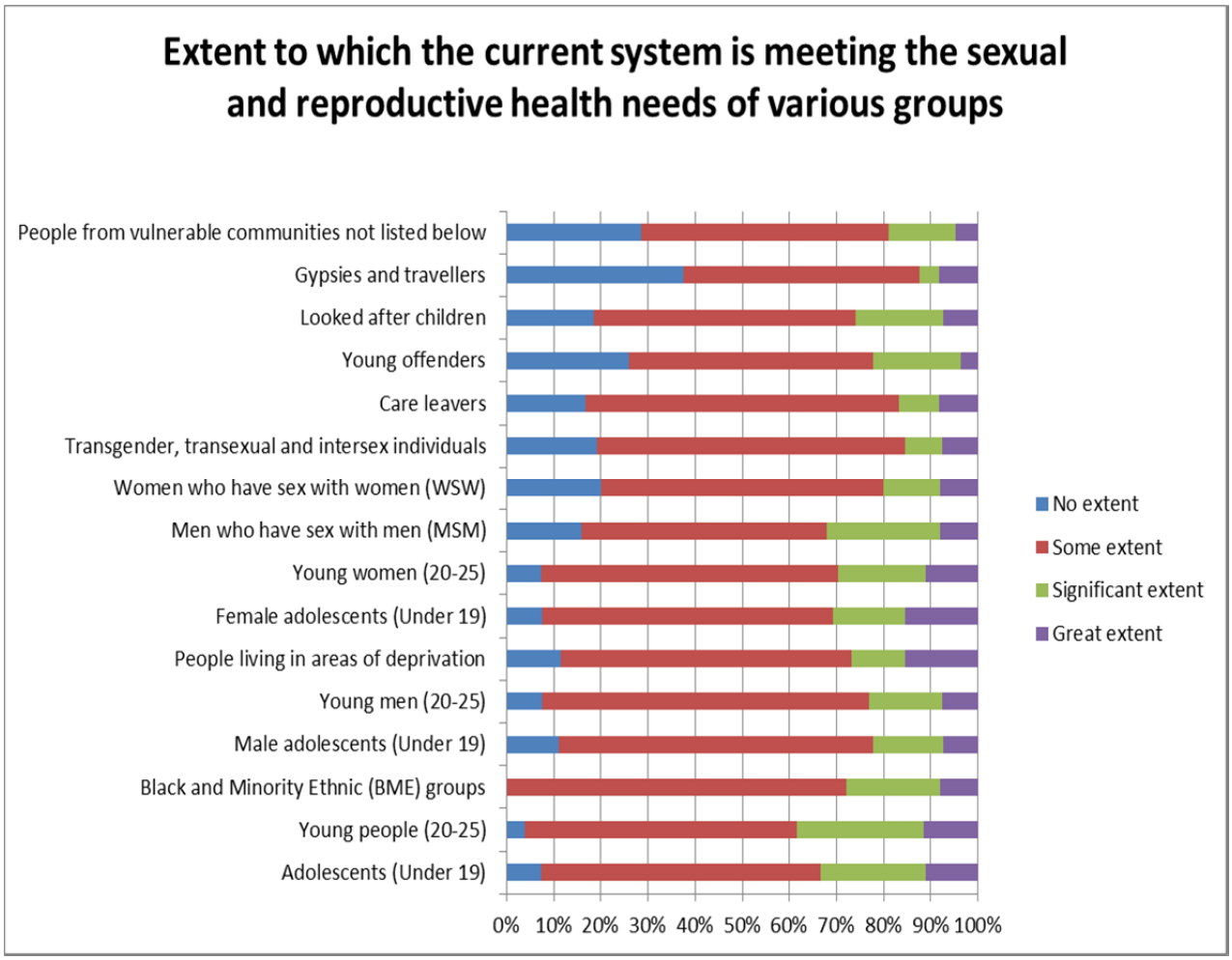
10.6 Survey respondents were asked the extent to which they felt the current service model/s in West Sussex is/are working, with regard to various areas. As Appendix A Figure 1 shows, the area with the highest rating (combining either 'significant' or 'great' extent) was 'Partnership working/local partnerships', followed by 'Equality of access to services' and 'Promotion of sexual and reproductive health services'. The areas with the lowest ratings were 'Promotion of services to vulnerable groups', 'Pathways' and 'Leadership'.

Appendix A Figure 1: Extent to which the current service model(s) in West Sussex is/are working well



10.7 Survey respondents were then asked the extent to which they felt the current system is meeting the sexual and reproductive health needs of various vulnerable groups. As Appendix A Figure 2 shows across the groups the ratings were relatively low, with only a small number of respondents rating services as meeting the needs of any of the groups to a 'significant' or 'great' extent. The groups with the highest levels of 'no extent' were 'Gypsies and travellers' (37.5% of responses gave a rating of 'no extent'), 'People from vulnerable communities not listed below' (28.6%), 'Young offenders' (25.9%) and 'Women who have sex with women (WSW)' (20.0%).

Appendix A Figure 2: Extent to which the current system is meeting the sexual and reproductive health needs of various groups



10.8 Respondents were asked to state what they consider to be the three most successful aspects of the system as it currently operates. As Appendix A Table 1 below shows, the aspects most commonly mentioned were 'Accessibility of services' and 'Walk-in/drop-in clinics' (both with 14.6% of responses), 'Out-reach work' (12.5% of responses), 'Fully integrated services' and 'Joint-working with partners' (both with 8.3%) and 'Privacy/confidentiality of services' with 6.3%.

Appendix A Table 1: Most successful aspects of sexual and reproductive health system as it currently operates

Most successful aspects	Count	Percentage
Accessibility of services	7	14.6
Walk-in/drop-in clinics	7	14.6
Out-reach work	6	12.5
Fully integrated services	4	8.3
Joint-working with partners	4	8.3
Privacy/confidentiality of services	3	6.3

Awareness of where local sexual health services are	2	4.2
Chlamydia testing programme	2	4.2
Operating from young person friendly centres (such as Find It Out)	2	4.2
C-Card condom scheme	1	2.1
Convenient opening times	1	2.1
Counselling for victims of sexual assault	1	2.1
Independent Sexual Violence Advisors	1	2.1
Promotion of services	1	2.1
Sexual Assault Referral Centre	1	2.1
Skill mix of staff	1	2.1
Successful outcomes	1	2.1
Targeted work	1	2.1
Timely access	1	2.1
Welcoming/respectful staff	1	2.1

10.9 KIs were then asked what three aspects of the service(s) they would most like to see improve/change. Suggestions included:

- Provide more outreach/walk-in/drop-in services (mentioned six times) – including more outreach nurses, outreach/walk-in clinics both in rural areas and easily accessible in town centres, and point of care HIV testing
- Partnership working (mentioned four times) – better links to the Sexual Assault Referral Centre (SARC), with primary care, with community groups, better referral pathways into other health services
- CPD and training for other professionals on SRE issues
- C-Card scheme – expand the scheme, provide updates on the scheme generally, train staff in children and family centres in C-Card
- LARC – better data collection, reduce waiting times (or signposting to other services if wait over 10 days) and promotion of LARC to teenage population
- More focus/better links to vulnerable/hard-to-reach
- Better publicity of services, including online
- Better mapping of services and inter-service awareness of services across the county
- Opening hours – having uniform opening hours across hubs, improving opening hours
- Reduce waiting times
- CPD and training for other professionals on SRE issues
- Improve confidentiality
- Better support for victims of sexual assault
- Communication/networking opportunities to be improved
- Provide an expert advice line for other health care professionals
- Extend existing clinical care provided in non-conventional settings
- For West Sussex to have a clear strategy for SRE/Teenage Pregnancy, including setting out the role of other organisations
- GPs to have better knowledge of treating STIs/HIV and more information on sexual health services provided

- Improvements to acute paediatric assessments
- Include young people in quality assurance
- More welcoming reception staff in GP surgeries
- A national campaign to destigmatise sexual health
- Specific branding for young people's sexual health services; and
- To be commissioned to carry out Cytology as part of a one-stop-shop framework

10.10 They were also asked to state whether they felt there are any particular gaps in current sexual and reproductive health services. Areas identified included:

- Advice for parents/carers
- Being unable to give mirena for menorrhagia
- Better training around sexual health for health professionals working with vulnerable children
- Geographical inequalities
- Lack of enough educational work with boys and young men
- Lack of quality SRE education in school settings
- Promotion of IUD/IUS as a good form of contraception for teenage parents;
- Provision for over 25s
- Reaching out to children who do not attend school/truant;
- Services for gay young men
- Services for Gypsies and Travellers
- Services for looked after and vulnerable children
- Services for special educational needs and disabilities people
- Services for young offenders
- Young people in hostels and supported accommodation finding it harder to access services

10.11 In addition KIs were asked whether there are any particular barriers to accessing services. Those identified were:

- Accessibility generally
- Accessibility for disabled clients
- Choice of appointments
- Difficult to access hard-to-reach groups
- Geographic barriers
- Lack of clarity over roles and responsibility for SRE
- Lack of publicity
- Lack of SRE in schools
- Opening times
- Sexual and reproductive health not being a high priority for young people
- Stigma
- Travel links between services
- Waiting times

10.12 Respondents were asked what they thought are the three most important aspects to people who use sexual and reproductive health services. In total 25 stakeholders responded to this question, and Appendix A Table 2 provides a summary of the responses, coded to different themes. As the table shows, the most commonly mentioned aspects were 'Helpful/respectful staff' (20.0% of comments), 'Privacy/confidentiality' (20.0%), 'Location/distance/ accessibility' (15.4%) and 'Timely access/service' (13.8%).

Appendix A Table 2: Most important aspects of sexual and reproductive health services

Most important thing	Count	Percentage
Helpful/respectful staff	13	20.0
Privacy/confidentiality	13	20.0
Location/distance/accessibility	10	15.4
Timely access/service	9	13.8
Convenient opening times	6	9.2
Clear/reliable information	3	4.6
Free	3	4.6
Full range of services	3	4.6
Safety	2	3.1
Availability and quality of follow-up appointments	1	1.5
Joined-up care pathways	1	1.5
Specialist/knowledgeable staff	1	1.5

Views on further improving service delivery

10.13 Respondents were asked whether there are any particular opportunities for prevention or building resilience that are not currently being taken, and suggestions included:

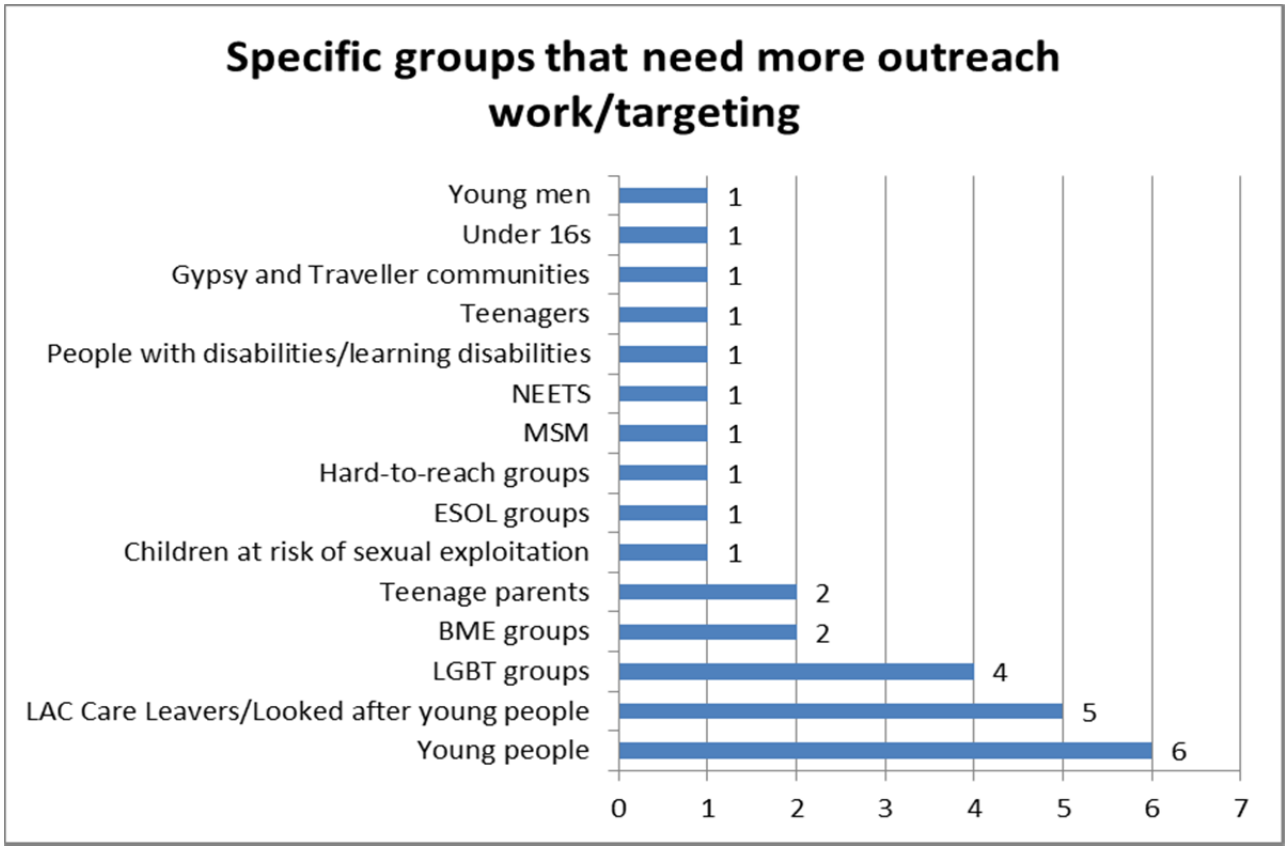
- Advertising in pubs/clubs
- Advertising through media campaign
- Advice on self-management of patients
- Agreeing pathways for awareness raising with young people in schools and colleges
- Being clear about what services are available and how to access them
- Early identification of risk factors to support young people to make the right choices
- Gaps in the education of school children (both primary and secondary) and university students
- Health promotion campaigns review
- HIV prevention and the importance of HIV as a long term condition;
- Multi-agency working
- Peer educator programmes - young people working with young people;
- Prioritising young people who are Looked After or are Leaving Care
- SRE/PHSE education in schools needing improvement

10.14 They were also asked whether there are any particular staff training needs or other workforce issues, and responses included:

- Conducting child protection assessments
- Cultural awareness
- Drug cultures for young people
- Implant/removal training
- MSM issues
- PSHE within schools
- Sexual health for people with disabilities
- SRE training
- Training staff in children centres on C Card;
- Treating under 18s
- Understanding and knowledge of domestic and sexual abuse
- Working with vulnerable children
- 'You're welcome' quality criteria

10.15 Following this respondents were asked whether there are there any specific groups that they thought need more outreach work/targeting, and as Appendix A Figure 3 shows, the groups most commonly mentioned were 'Young people' (mentioned six times), 'LAC Care Leavers/Looked after young people' (five times) and 'LGBT groups' (four times).

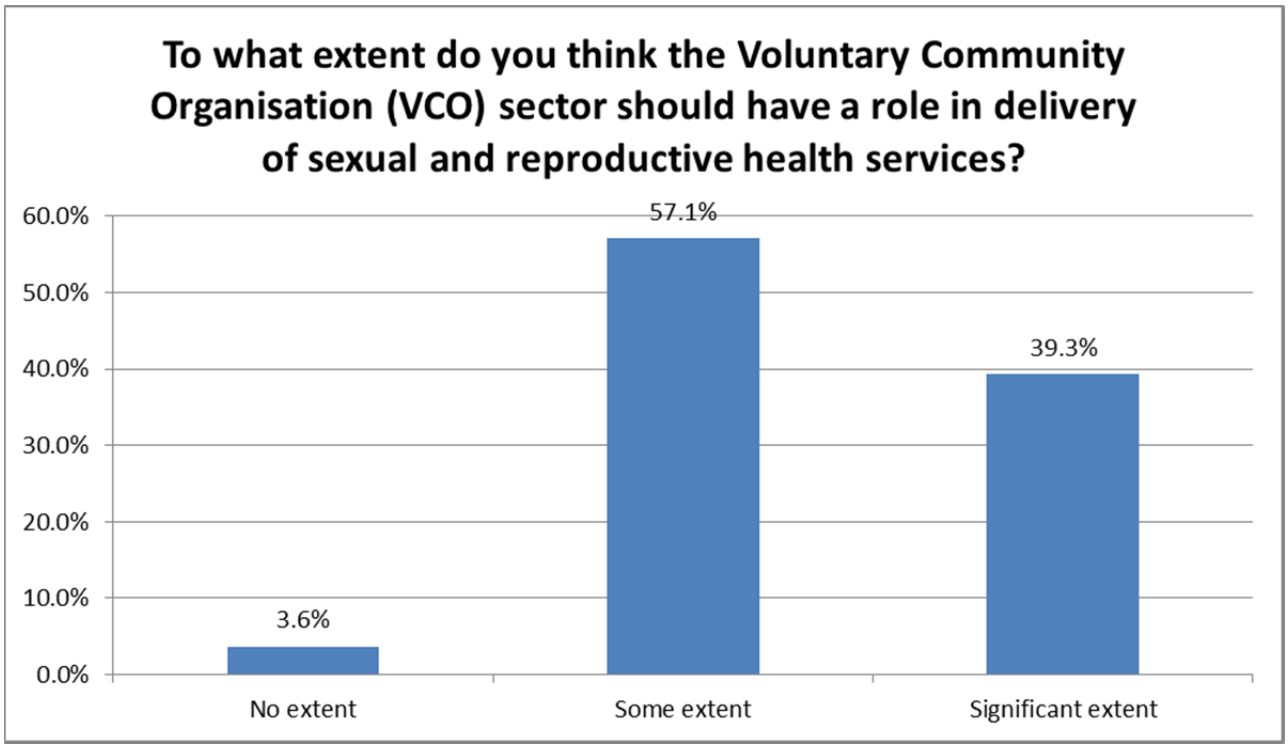
Appendix A Figure 3: Specific groups that need more outreach work/targeting



10.16 KIs were asked whether they felt the Voluntary Community Organisation (VCO) sector should have a role in delivery of sexual and reproductive health services. As

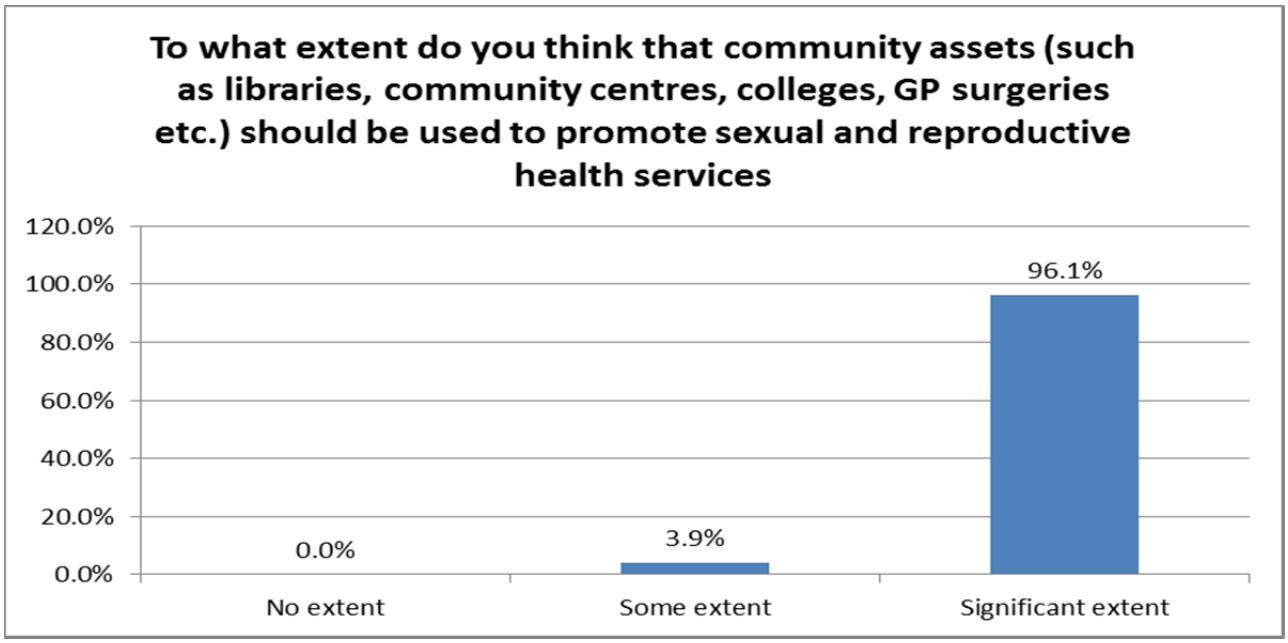
Appendix A Figure 4 shows, almost all respondents felt they should be involved (only 3.6% said 'no extent'), with 57.1% stating to 'some extent', 39.3% a 'significant extent'.

Appendix A Figure 4: Extent that the Voluntary Community Organisation (VCO) sector should have a role in delivery of sexual and reproductive health services

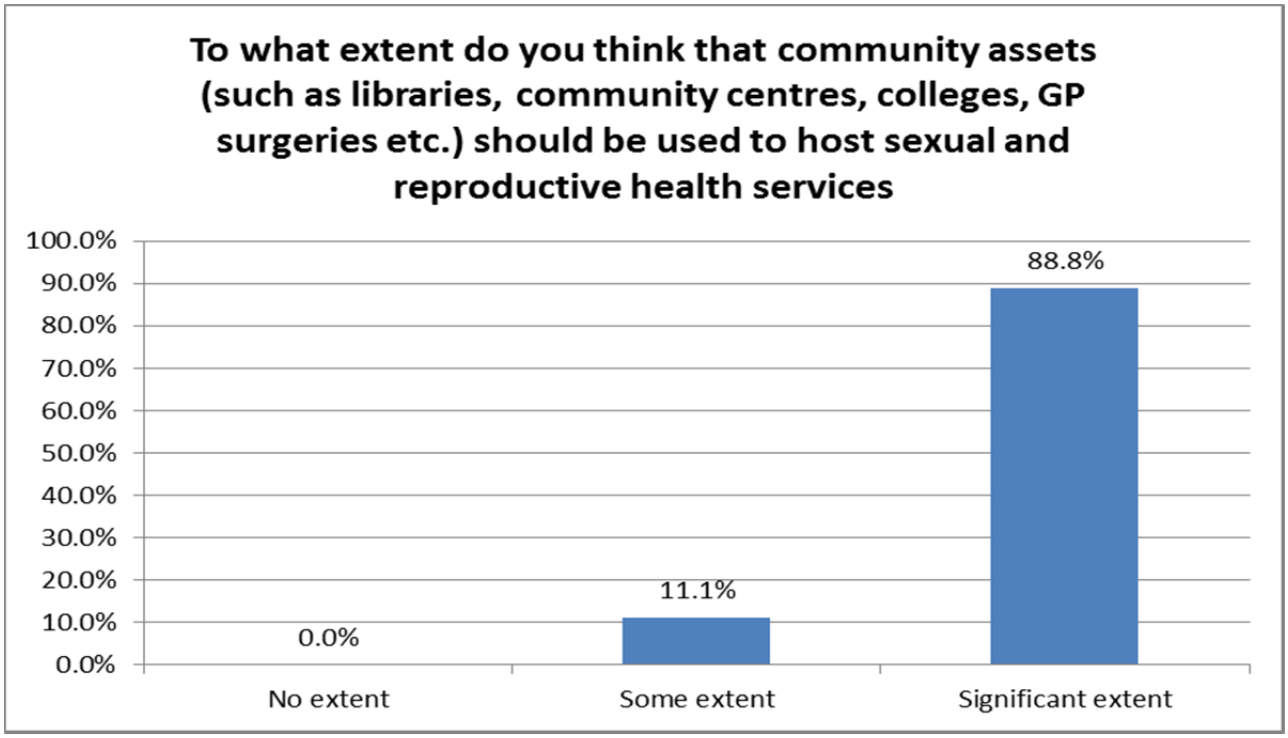


10.17 Respondents were asked for their views on whether community assets (such as libraries, community centres, colleges, GP surgeries etc.) should be used to promote and/or host sexual and reproductive health services. As Appendix A Figures 5 and 6 show, the vast majority of respondents were in favour of community assets being used for both of these purposes, with 96.1% agreeing to a 'significant' extent for promotion and 88.8% agreeing to a 'significant' extent for hosting.

Appendix A Figure 5: Extent to which community assets (such as libraries, community centres, colleges, GP surgeries, etc) should be used to promote sexual and reproductive health services



Appendix A Figure 6: Extent to which community assets (such as libraries, community centres, colleges, GP surgeries, etc) should be used to host sexual and reproductive health services



10.18 Finally respondents were then asked where they thought information on local sexual and reproductive health services should be located (allowing them to choose up to five options). As Appendix A Table 3 shows, the most popular location was

Schools/Colleges/ Universities (a count of 27), followed by GP surgeries (23), through social media (such as Facebook and Twitter) (19), Pharmacies (18) and in local bars and clubs (17).

Appendix A Table 3: Preferred locations for information on sexual and reproductive health services

Location	**Count**
School/Colleges/Universities	27
GP surgeries	23
Through social media (such as Facebook and Twitter)	19
Pharmacies	18
In local bars and clubs	17
Community health services (NHS services provided outside a hospital)	13
NHS Direct	10
Job Centre Plus	10
In bus and train stations	10
In sports centres	10
In other community locations	10
Local library (e.g. on notice boards)	9
Council Website	8
Local community organisations	8
Local hospital website	6
Anywhere else	5

Appendix B: Service User And Local Population Survey Analysis

10.19 This appendix provides analysis of the local population survey that was conducted as part of this review.

Summary

10.20 In total there were 540 respondents to the Service User survey. The age profile of respondents was relatively old, with a low number of responses from those aged under 25.

Key findings:

- Just over half of respondents said they would know where to go to access sexual and reproductive health services, with slightly more saying they would know where to access emergency contraception
- 15.6% of respondents stated that they could not reach sexual and reproductive health services by public transport
- For those that could, 73.5% said it would take them up to 30 minutes, 22.5% said between 30 minutes and one hour and 4.3% said it would take over an hour
- Only 12.9% of respondents had used sexual and reproductive health services in West Sussex in the last 12 months – consequently some caution needs to be taken when interpreting findings about direct experience of local sexual and reproductive health services
- Of those that had used services, the most common locations were Chichester (32.8%) and Worthing (31.1%), followed by Crawley (16.4%), 'Other' (9.8%) and Bognor Regis (8.2%)
- Only 25.6% of survey participants had previously had an HIV test at some time, and 22.0% had had a chlamydia test
- Generally service users that had visited a sexual and reproductive health service rated their experience quite positively (against the location, opening hours, quality of service and confidentiality of service) and opening hours were the lowest rated of these aspects
- A large majority of those that had accessed services in the last 12 months agreed that they would recommend the service to a family member
- Suggested improvements to services included reducing waiting times, improving the booking system and providing clearer information on opening times/increasing opening times
- The majority of respondents said that they would prefer to attend services with their GP if their GP offered a full range of sexual and reproductive health services
- Service users preferred locations for information on sexual and reproductive health services were GP surgeries, pharmacies, schools/colleges/ universities, NHS Direct and community health services

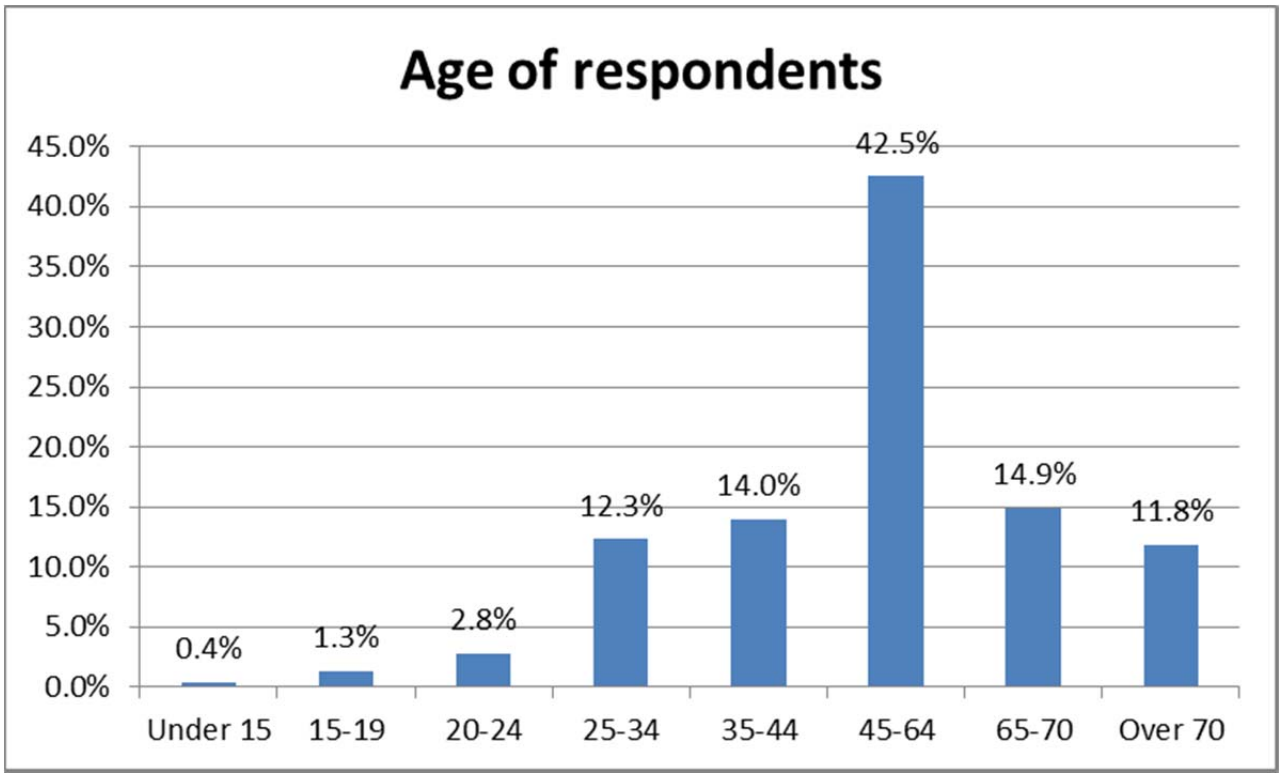
- Those that suggested social media should be used said so because of its reach with young people, ability to reach people quickly and cheaply and level of anonymity, felt it should be used to promote services and provide information
- A large majority of respondents stated that they would not follow sexual and reproductive health services if they were on Facebook or Twitter
- Respondents identified 'privacy/confidentiality', 'location/distance/ accessibility' and 'helpful/respectful staff' as the most important aspects of a sexual and reproductive health service

Survey respondents

10.21 In total there were 540 respondents to the survey, of which 57.2% were female and 41.2% were male (1.5% preferred not to give their gender).

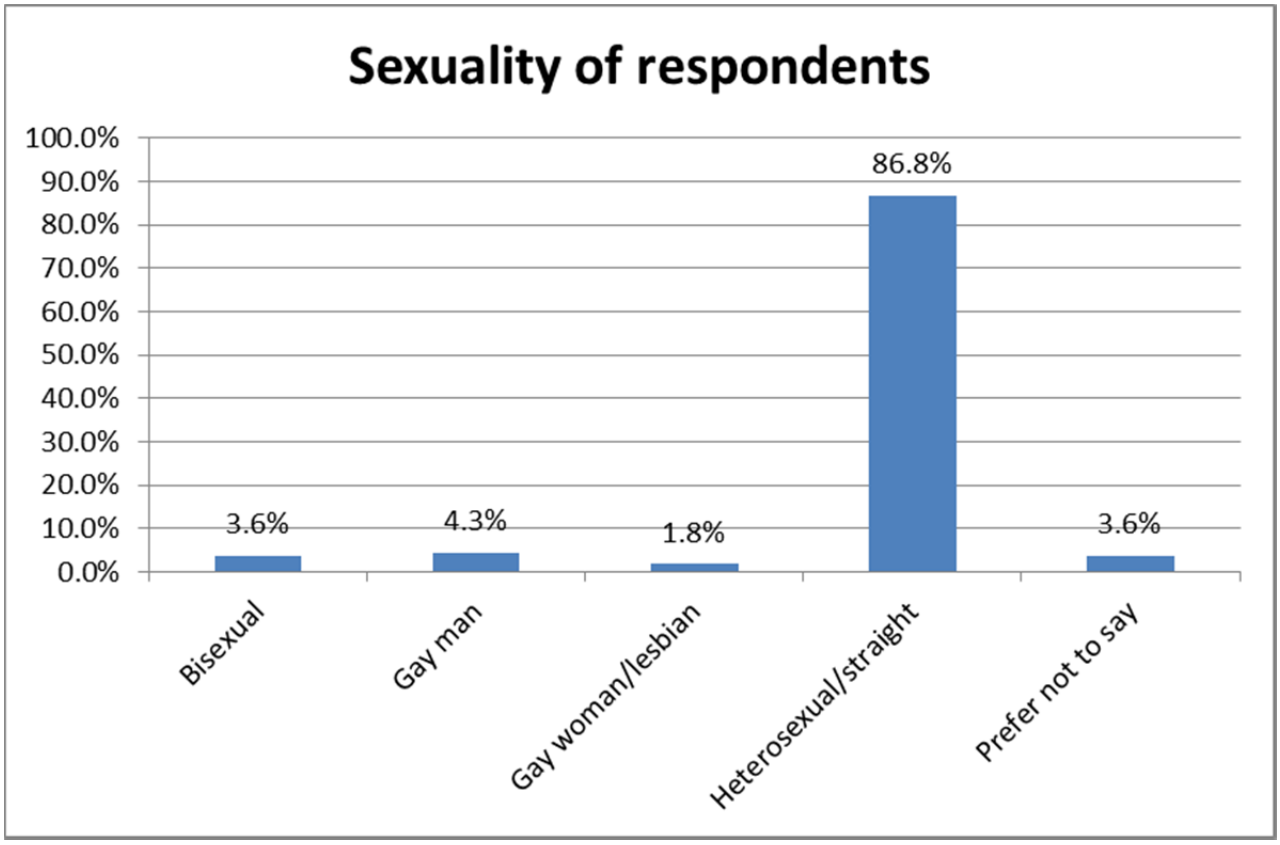
10.22 As Appendix B Figure 1 shows, the largest age group of respondents were those aged 45-64 (42.5%), followed by those aged 65-70 (14.9%), 35-44 (14.0%), 25-34 (12.3%), those over 70 (11.8%), those aged 20-24 (2.8%), 15-19 (1.3%) and those aged 15 and under (0.4%).

Appendix B Figure 1: Age of respondents



10.23 As Appendix B Figure 2 shows, 86.8% of respondents described their sexuality as 'Heterosexual/straight', while 4.3% said 'Gay man', 3.6% said they were 'Bisexual', 1.8% said 'Gay women/lesbian' and 3.6% preferred not to say.

Appendix B Figure 2: Sexuality of respondents



10.24 Appendix B Table 1 shows the ethnicity of survey respondents – the vast majority were 'White British' (91.5%), with the largest other groups being 'White – any other White background' (3.6%) and 'White – Irish' (1.3%). The largest non-White group was 'Asian/Asian British – Indian' (0.7%).

Appendix B Table 1: Ethnicity of respondents

Ethnicity	Percentage
White - British	91.5%
White - Any other White background	3.6%
White - Irish	1.3%
Asian / Asian British - Indian	0.7%
Asian / Asian British - Any other Asian background	0.2%
Black or Black British - Caribbean	0.2%
Chinese - Chinese	0.2%
Mixed/Multiple ethnic groups - White and Black African	0.2%
Not stated	2.0%

Awareness of sexual health services

10.25 Respondents were asked if they needed to use sexual and reproductive health services in West Sussex whether they would know where to go. Just over half of respondents (50.7%) said they would, while 49.3% said they would not.

10.26 Slightly more respondents stated that they would know where to go for emergency contraception, with 57.2% of all respondents, compared to 42.8% who said they would not.

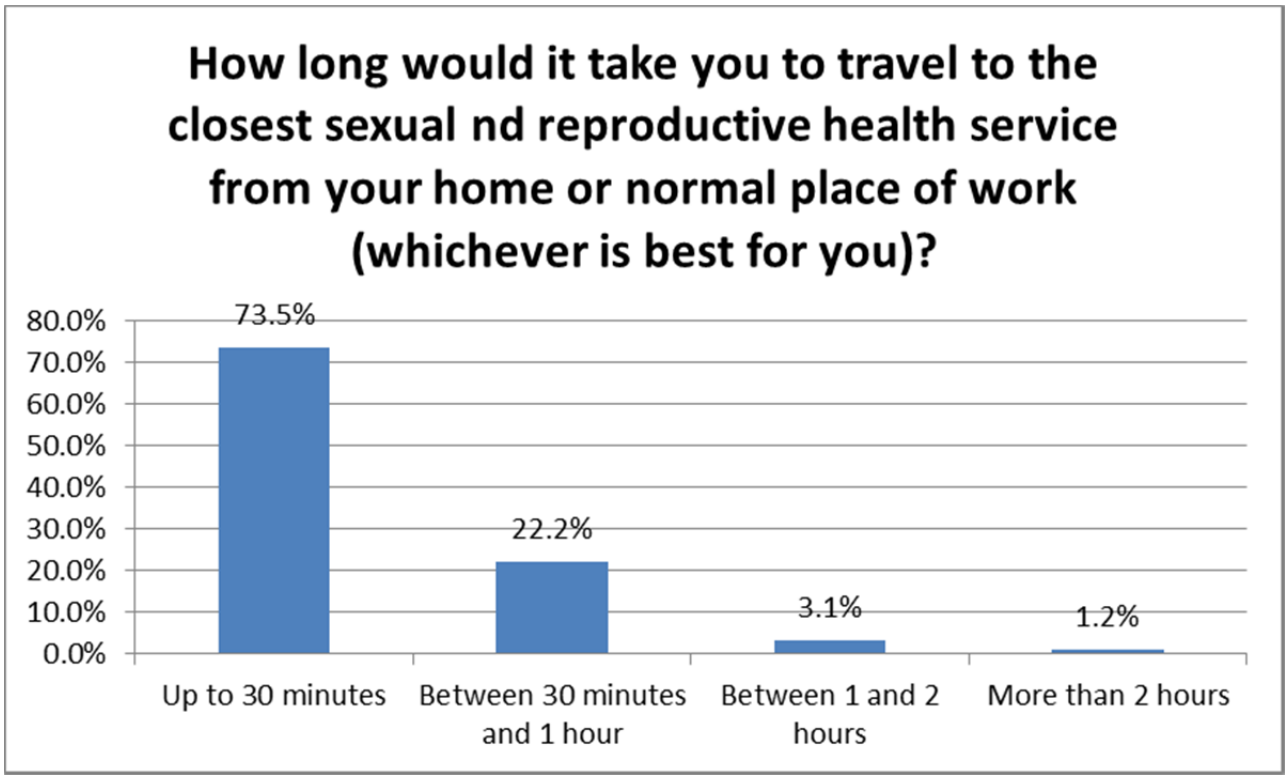
10.27 Respondents were shown a list of sexual and reproductive health services provided in West Sussex[66], and asked whether they knew where any of these services were. Over half of respondents (57.7%) said they did not, while 42.3% said they did.

10.28 Participants were then asked whether they could reach any of these services by public transport. While the majority of respondents (84.4%) said that they could, there were 15.6% of respondents who said they could not.

10.29 They were then asked how long it would take to travel to the closest service to their home or place of work (whichever was most convenient for them). As Appendix B Figure 3 shows, 73.5% of respondents said that it would take them up to 30 minutes, while 22.5% said between 30 minutes and one hour. Only 3.1% of respondents stated that it would take them between one and two hours, and 1.2% said it would take them more than two hours.

[66] The list stated that specialist services for sexual infection screening (including HIV) and advice and provision of contraception (including emergency contraception) are currently provided in Bognor Regis, Burgess Hill, Chichester, Crawley, East Grinstead, Haywards Heath, Horsham, Lancing, Littlehampton, Pulborough, Shoreham and Worthing.

Appendix B Figure 3: Time taken to travel to closest sexual and reproductive health service

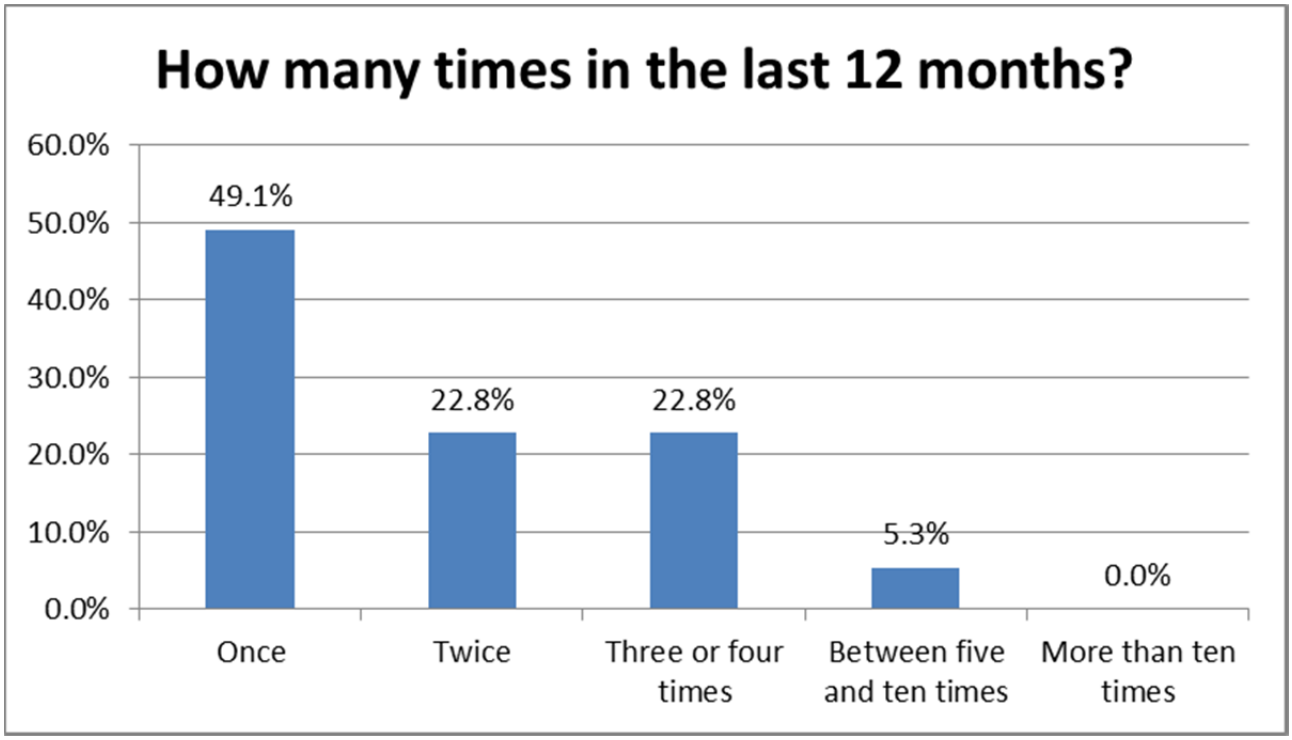


Use of sexual and reproductive health services

10.30 Respondents were asked whether they had ever used sexual and reproductive health services anywhere, and just under half (49.7%) said they had, while 50.3% had not (n=497). They were then asked whether they had used any sexual and reproductive health services in West Sussex within the last 12 months, and only 12.9% of respondents had done so, while 87.1% had not.

10.31 Those that had used services in the last 12 months were asked how many times they had done so. As Appendix B Figure 4 shows, almost half of those that had used a service had done so only once (49.1%), while just under a quarter had used it either twice or three times (22.8% for each). A small number of participants had used services between five and 10 times (5.3%).

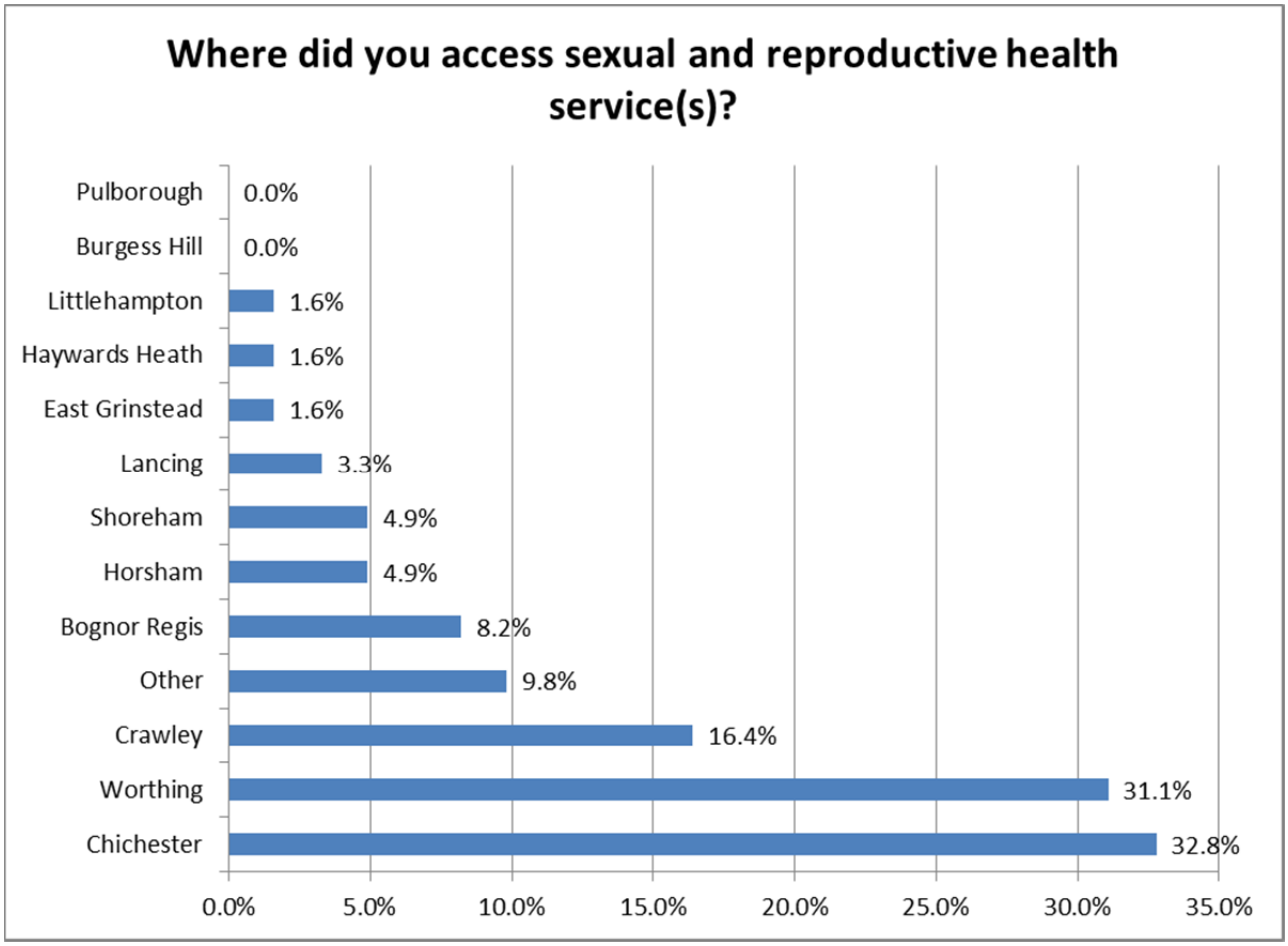
Appendix B Figure 4: Number of visits to sexual and reproductive health services in West Sussex within the last 12 months



10.32 Respondents to this question were asked to state where the service(s) they had accessed were (respondents could select multiple locations if they had visited various services). As Figure 5 shows, the most common locations were Chichester (32.8%) and Worthing (31.1%), followed by Crawley (16.4%), 'Other'[67] (9.8%) and Bognor Regis (8.2%). Horsham and Shoreham had each been visited by 4.9% of respondents, and Lancing by 3.3%. East Grinstead, Hayward's Heath and Littlehampton had been visited by 1.6% of respondents (one individual) respectively.

[67] The only other location given was Brighton (3 respondents). The other three responses to 'Other' stated that they had visited their 'local' GP surgery or Health Centre.

Appendix B Figure 5: Location of sexual and reproductive health services accessed in last 12 months



HIV and chlamydia testing

10.33 Only 25.6% of survey participants had previously had an HIV test at some time, and of those that had, 29.7% said they had done so within the last 12 months.

10.34 Only 22.0% of all survey respondents had had a chlamydia test, and of those that had, 29.3% had done so in the last 12 months.

Experiences of existing services

10.35 Respondents who had accessed sexual and reproductive health services in West Sussex in the last 12 months were asked to rate the service(s) they had visited in terms of the location, opening hours, quality of service and confidentiality of service.

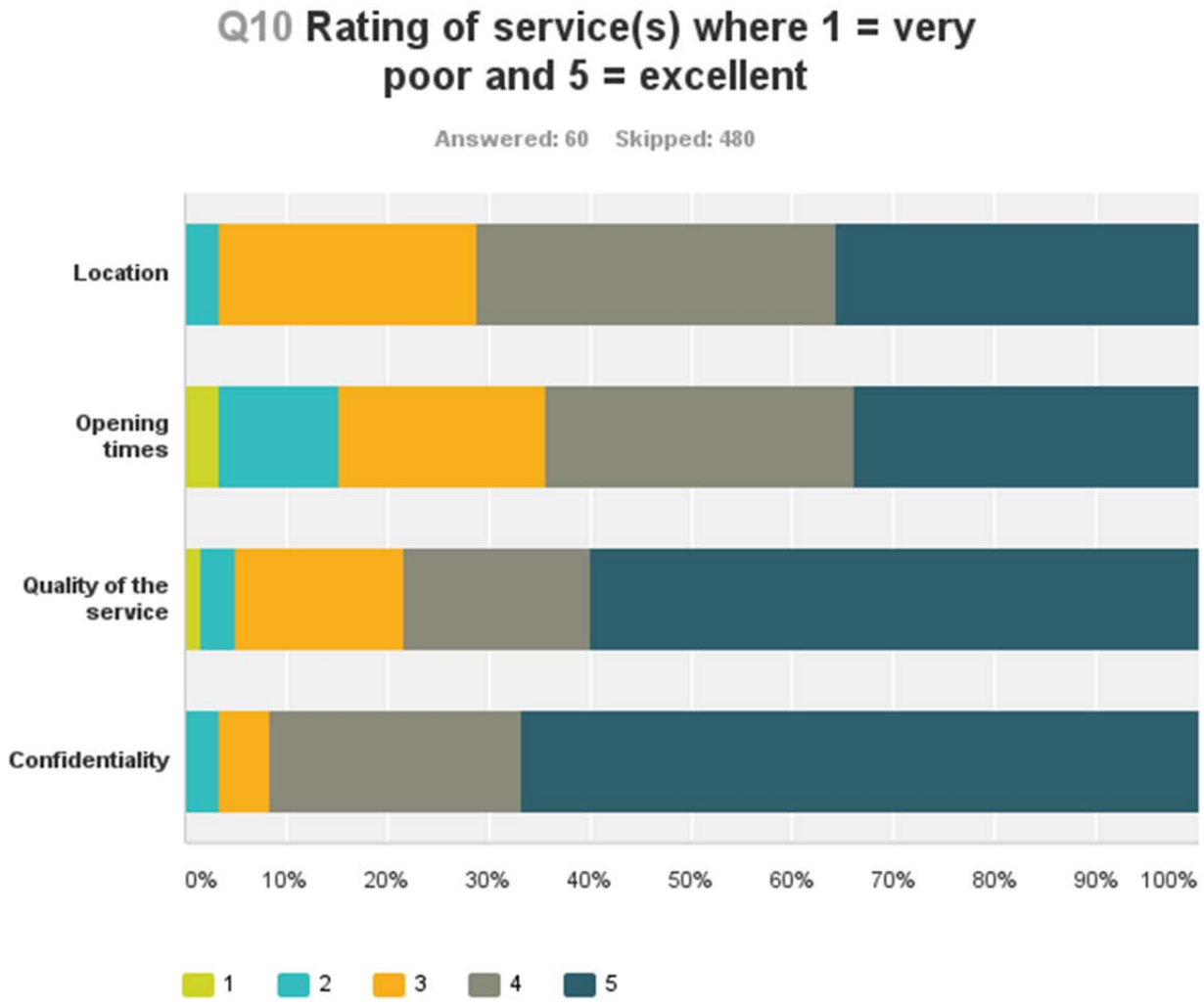
10.36 As Appendix B Figure 6 and Appendix B Table 2 show, generally service users that had visited a sexual and reproductive health service rated their experience quite positively (n=60). In terms of location, 71.2% of respondents rated this as either four or five on the scale (where 1=very poor and 5=excellent), while only 3.4% rated it at the

lower end of the scale (at two, as there were no responses for one). When rating the quality of the service(s) visited, 78.3% of respondents gave a score of four or five, with only 5% giving a low rating of either one or two. Ratings for the confidentiality of the service were the highest, with 91.7% of respondents rating this either a four or five on the scale, while only 3.3% rated this at the lower end of the scale. Ratings for the opening hours of services were the lowest rated aspect of services, with 64.4% of respondents giving a four or five rating, while 15.3% rated this aspect of the service as one or two.

Appendix B Table 2: Rating of sexual and reproductive health services by location, opening times, quality of service and confidentiality

	Rating scale (Where 1 = very poor and 5 = excellent)				
Area of service	**1**	**2**	**3**	**4**	**5**
The location	0.0%	3.4%	25.4%	35.6%	35.6%
The opening times	3.4%	11.9%	20.3%	30.5%	33.9%
The quality of the service	1.7%	3.3%	16.7%	18.3%	60.0%
The confidentiality of the service	0.0%	3.3%	5.0%	25.0%	66.7%

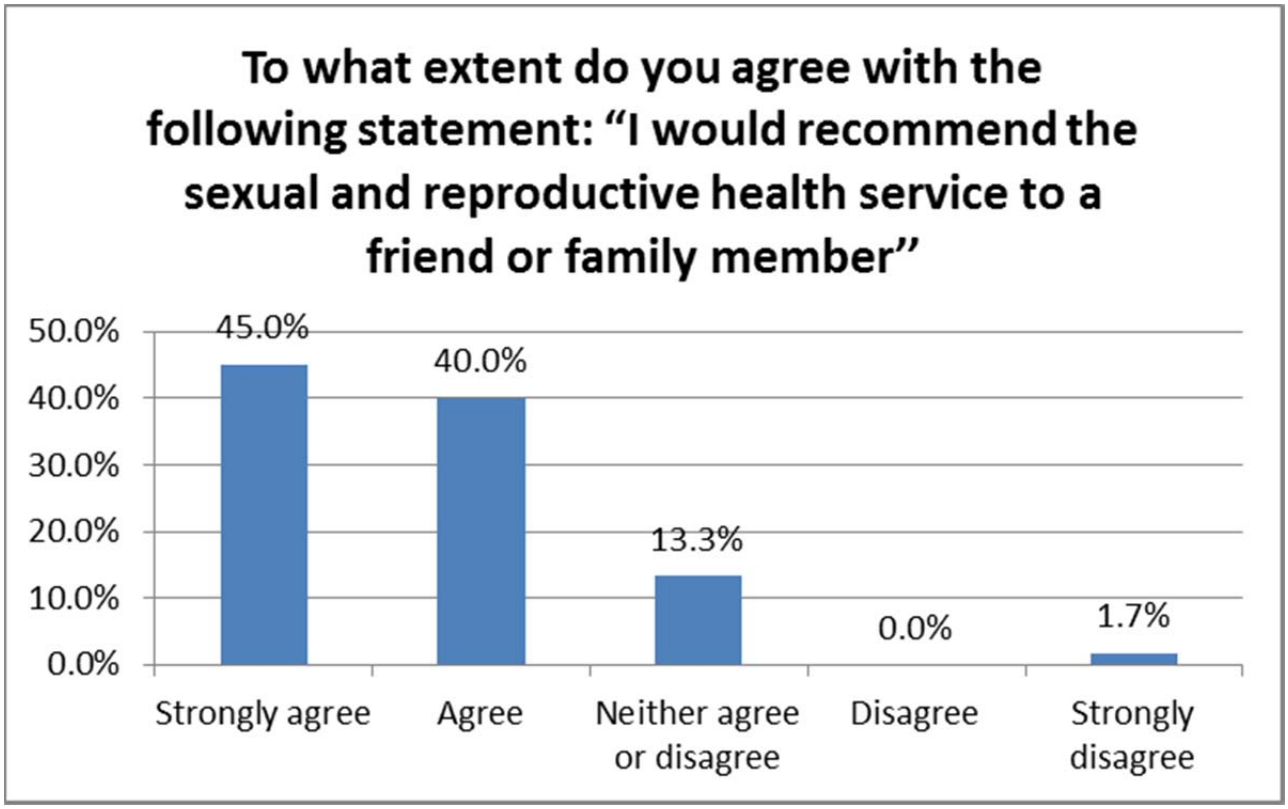
Appendix B Figure 6: Rating of sexual and reproductive health services by location, opening times, quality of service and confidentiality



10.37 Respondents who had accessed services in the last 12 months were then asked the extent to which they agreed with the following statement: 'I would recommend the sexual or reproductive health service to a family member'.

10.38 As Appendix B Figure 7 shows, the large majority of respondents (n=60) agreed with this statement (with 45% strongly agreeing and 40.0% agreeing), while only one respondent (1.7%) either disagreed or strongly disagreed with the statement (in this case strongly disagreed). There were 13.3% of respondents who stated they neither agreed nor disagreed with the statement.

Appendix B Figure 7: Extent of agreement with statement recommending sexual and reproductive health services to a friend or family member



Improvements to services

10.39 Respondents who had accessed a sexual or reproductive health service in the last 12 months were asked to comment on anything that could have been improved about the service. Suggestions for areas of improvement included:

- Accessibility
- Attitude of staff
- Awareness of dangers of syphilis
- Booking system (mentioned twice)
- Clearer information from doctors
- Clearer information on opening hours
- Clearer information on STI testing
- Clearer information on test result waiting times
- Doctors competence in inserting coil
- Flexible and longer appointments
- Information on new service locations
- Keep at Chapel Street rather than hospital
- Keeping drop-in clinics open
- Level of supplies in consulting room
- More drop-in sessions
- Only having to see one staff member
- Privacy

- Speed of test results
- Waiting times (mentioned four times)

Views on the future of sexual and reproductive health services

All survey respondents were asked if their GP offered a full range of sexual and reproductive health services whether they would prefer to attend services with their GP, and the majority (68.1%) said that they would (448).

Respondents were then asked where they thought information on local sexual and reproductive health services should be located (allowing them to choose up to five options). As Table 3 shows, the most popular location was GP surgeries (a count of 423), followed by pharmacies (349), Schools/Colleges/ Universities (330), NHS Direct (257) and community health services (205).

Appendix B Table 3: Preferred locations for information on sexual and reproductive health services

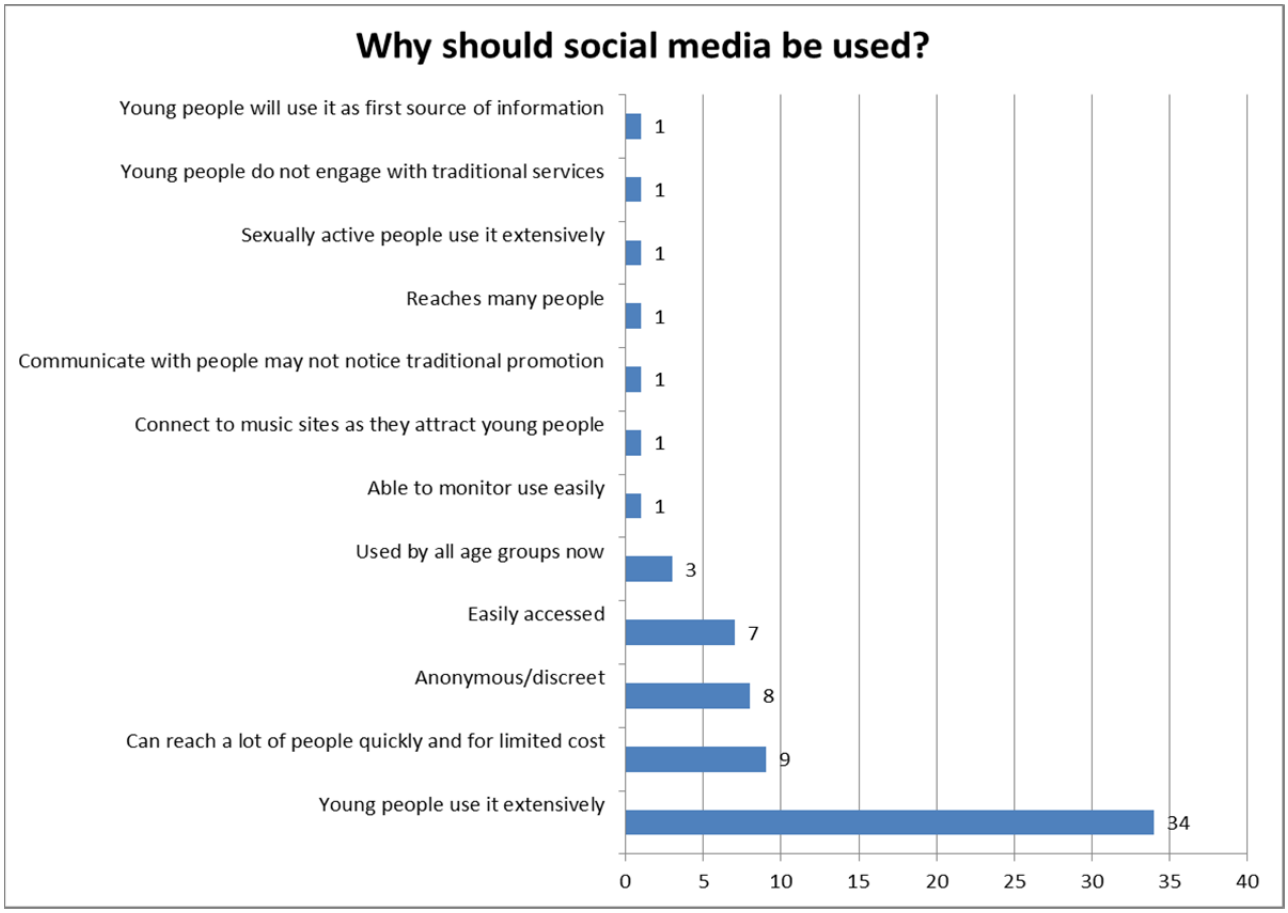
Location	Count
GP surgeries	423
Pharmacies	349
School/Colleges/Universities	330
NHS Direct	257
Community health services (NHS services provided outside a hospital)	205
Local hospital website	182
In local bars and clubs	146
Local library (e.g. on notice boards)	136
Through social media (such as Facebook and Twitter)	113
Council Website	104
Local community organisations	87
In sports centres	81
In other community locations	71
In bus and train stations	62
Job Centre Plus	45
Anywhere else	18

10.40 Those that had suggested social media should be used were asked to state both why and how it should be used.

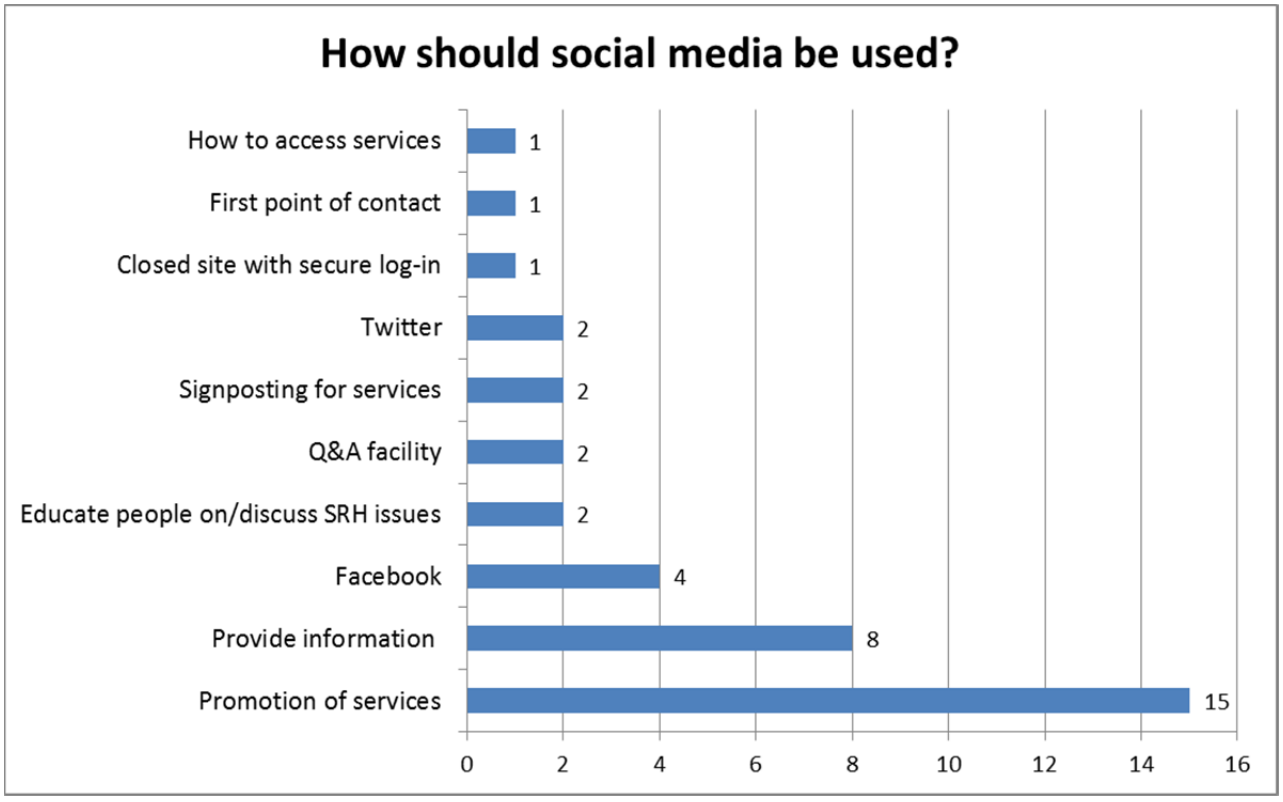
10.41 As Appendix B Figures 8 and 9 show, the main reason people felt it should be used were that young people use social media extensively (mentioned 34 times), that it can reach a lot of people quickly and relatively cheaply (mentioned 9 times), that it is anonymous/discreet (8 times) and that it is easily accessed (7 times).

10.42 The main ways they felt it social media should be used were to promote sexual and reproductive health services (mentioned 15 times), to provide information (8 times) and to have a Facebook presence (4 times).

Appendix B Figure 8: Why social media should be used to provide information on sexual and reproductive health services



Appendix B Figure 9: How social media should be used to provide information on sexual and reproductive health services



10.43 All respondents were asked specifically whether they themselves would follow local sexual and reproductive health services if they were on social media (such as Facebook and Twitter), and 84.1% of respondents said that they would not.

Important aspects of sexual and reproductive health services

10.44 Finally respondents were then asked what they thought are the three most important things to people who use sexual and reproductive health services. In total 372 respondents commented on this question, and Appendix B Table 4 below gives a summary of the responses, coded to different themes. As the table shows, the most commonly mentioned aspects were 'Location and accessibility' (30.8% of comments), 'Privacy/confidentiality' (28.1% of comments), 'Helpful/respectful staff' (14.9%), 'Information and promotion' (7.2%), 'Staff skills and training' (6.1%) and 'Range of services' (5.6%).

Appendix B Table 4: Most important aspects of sexual and reproductive health services

Most important thing	Count	Percentage
Location and accessibility	221	30.8%
Privacy/confidentiality	202	28.1%
Helpful/respectful staff	107	14.9%
Information and promotion	52	7.2%
Staff skills and training	44	6.1%
Range of services	40	5.6%
Free service	23	3.2%
Appointment services/options	15	2.1%
Reliable, safe, trusted	14	1.9%

Appendix C: Key Informants Engaged by this Sexual Health Needs Assessment

Role	Name	Organisation
Director of Public Health, Commissioner for Health and Social Care	Judith Wright	WSCC
Public Health Consultant/	Dr Peter Hayward	WSCC
Sexual Health Commissioner	Paul Woodcock	WSCC
Cabinet Member	Cllr Christine Field	WSCC
Health and Well-being Board Chair	Cllr Louise Goldsmith	WSCC
Director of Community Commissioning	Sue Hawker	WSCC
Chief Operating Officer & Director of Service Operations	Diane Ashby	WSCC
Director of Finance and Assurance	Richard Hornby	WSCC
Director of Strategic Development	Derek Irvine	WSCC
Director of Adult Services	Amanda Rogers	WSCC
Director of Children's Services	Stuart Gallimore	WSCC
Strategic Commissioning Manager	Graham Olway	WSCC
Acute Supply Manager	Nicky Bentley	NHS E
Service Specialist – National service specifications	Fiona Mackison	NHS E
Pharmacy Lead		
Lead for Adult Social Care/Services	Sharon Gogan	WSCC
Lead for Children's/Young People's Social Care/Services	Annie MacIver	
Commissioning Manager for Drug and Alcohol Team	Philippa Gibson	WSCC
Prevention & Well-being Commissioner	Sally Tabbner	WSCC
Data/Research Lead	Jacqueline Clay	WSCC
CCG Chair-Coastal West Sussex	Dr Katie Armstrong	CCG-CWS
GP Willow Green Surgery, FFSRH, Clinical Lead for Gynaecology and Unscheduled Care CWS CCG, Fertility LES GP	Dr Sarah Pledger	CCG-CWS
GP Partner Maywood Healthcare, Clinical Lead for Gynaecology and Unscheduled Care CWS CCG, Fertility LES GP	Dr Vicky Beattie	CCG-CWS
Clinical Lead for Gynaecology and Unscheduled Care CWS CCG	Claire Holloway	CCG-CWS
CCG Chair-Horsham and Mid Sussex	Dr Minesh Patel	CCG-H&MS

CCG Accountable Officer-H&MS	Sue Braysher	CCG-H&MS
CCG Chief Clinical Officer for Crawley CCG	Dr Amit Bhargava	CCG-Crawley
LMC Chair	Dr Jeremy Luke	LMC
Other GPs with Sexual Health Interests	Dr Amelia Bolgar	Pulborough
Practice Nurses	TBC	
Practice Managers	TBC	
Lead Consultant in GUM/HIV-Chichester	Dr Emma Rutland	WSHT
Lead Consultant in GUM/HIV-Crawley	Dr Noshi Narouz	WSHT
Lead Consultant in GUM/HIV-Worthing	Dr Judith Zhou	WSHT
Lead Consultants in Reproductive Health	Dr Val Godfree	WSHT
Matron / Cilinical Manager	Nicki Amas	WSHT
Matron	Helen McCutcheon	WSHT
Group Manager Women's Services	Tunde Adewopo	WSHT
Director of Clinical Services	Jeannie Baumann	WSHT
Outreach Manager / Chlamydia Screening	Richard Williams	WSHT
Team Leader	Sandra Hollands	WSHT
Team Leader	Shirley Chapman	WSHT
Team Leader	Kay Bennett	WSHT
Head of Commissioning	Fiona Cantrell	WSHT
Head of Communications	Jonathon Keeble	WSHT
Commercial Director	Mike Jennings	WSHT
Head of Operational Planning and Performance	Giles Frost	WSHT
Business Support Manager, Sexual Health	Jo Lutman	WSHT
Retiring Sexual Health Consultant	Dr Andrew Nayagam	WSHT
Abortion Provider Leads	Rosemary Cutmore	bpas
Contract manager Abortion Services	Jane Williams	NHS South-CSU
Relevant Voluntary Sector Leads	Mark Tweed	THT South
Teenage Pregnancy Lead-Youth Service	Karon Chamberlain	WSCC
Service Manager-Youth service	Graham Vagg	WSCC
SARC Lead for West Sussex	Trish Harrison	WSCC
Public Health Lead-Area Team	Fiona Harris	Surrey and Sussex Area Team
Area Team-Prison lead	Nicky Croft	Surrey and Sussex Area Team

Clinical Service Manager - HIV		
Community HIV Specialist Team	Anna Bamford	Sussex Community Trust
GP	Dr Lucy Cox	Saxonbrook Medical, Crawley
Lead / Designated Nurse LAC	Karen Hughes	Westhampnett Centre, Chichester
Head of Children's Commissioning	Alison Nutall	LAT

Appendix D: Community Groups and Organisations contacted via Facebook/Twitter

Name	Area	Category	Type
Action for Deafness	All	Sensory disability	Hearing impairment
Action in Rural Sussex	All	Rural communities	Support – rural communities
Addaction	Worthing	Alcohol and drugs	Support – addiction
Voluntary Action Arun & Chichester (VAAC)	Arun & Chichester	Community projects and services	Umbrella organisation
Arun & Chichester Community Cohesion Group	Chichester	Community projects and services	Umbrella organisation
AGE UK E.G. & District	East Grinstead	Older people	Support – older people
Age UK Horsham	Horsham	Older people	Support – older people
Age UK Horsham - additional contact		Older people	Support – older people
Age UK West Sussex	All	Older people	Support – older people
Better Together Polish Association	Crawley	BME	Support – Polish
Blueprint 22	Worthing	Young people	Community project
BME Community Services	All	Long term condition	Support – HIV

Capital Project Trust	Bognor Regis	Mental Health	Support – Mental Health
Crohn's and Colitis UK Brighton & West Sussex Group	All	Long term condition	Support – Crohns and Colitis
Connecting Communities	Chichester	BME	Polish translation
	Chichester	BME	Lithuanian translation
	Chichester	BME	Russian translation
Crawley Portuguese Association	Crawley	BME	Support – Portuguese
Diabetes UK West Sussex Downs	All	Long term condition	Support – Diabetes
Filipino British Association Of East Grinstead	East Grinstead	BME	Support – Filipino
Headway in West Sussex	All	Long term condition	Support – Acquired brain injury
Home-Start Crawley, Horsham & Mid-Sussex	Crawley	Young people	Support – Parents
Home-Start Worthing & Adur	Worthing	Young people	Support – Parents
ICIS: information for life	All	Community projects and services	Information provider
Impact Initiatives	All	Community projects and services	Umbrella organisation
Gatwick Detainees Welfare Group	All	Criminal justice and detention	Suppoer – Detainees
Mencap Mid Sussex	All	Learning disability	Support – Learning disability
Mencap	Worthing	Learning disability	Support – Learning disability
Worthing Mencap - new contact details	Worthing	Learning disability	Support – Learning disability
Mind - Coastal West Sussex	All	Mental health	Support – Mental Health
myhiv	All	Long term condition	Support – HIV
Oasis pregnancy crisis centre	Crawley and Horsham	Reproductive health	Service – Pregnancy advice
Options pregnancy crisis centre	Chichester	Reproductive health	Service – Pregnancy advice
The Older Voice	All	Older people	Support – Older people (computers)
Rainbow Families	All	LGBTI	Support – LGBT parents

Relate - Brighton, Hove, Worthing & Districts	Worthing	Relationships	Counselling
Relate - Relate North & South West Sussex	Crawley & Horsham	Relationships	Counselling
Scope - Worthing & District	Worthing	Physical disability	Support – Cerebal palsy and similar
Soldiers' and Sailors' Families Association (SSAFA)	All	Armed Forces	Soldiers and sailors and partners
St. Peters House Project	All	Long term condition	Support – HIV
Sussex Beacon	All	Long term condition	Support – HIV
Sussex Deaf Association	All	Sensory disability	Hearing impairment
Sussex Oakleaf Housing Association	All	Mental health	Housing
Sussex Pathways	All	Criminal justice and detention	Support – Offenders
Terrence Higgins Trust	All	Long term condition	Support – HIV
Worthing Indian Group	Worthing	BME	Support – Indian
Worthing Society for the Blind	Worthing	Sensory disability	Support – Visual impairment
Your space	All	Young people	Support – Online info
Brighton & Hove Albion FC			
Mumsnet West Sussex			

Appendix E: Revised National Service Guide: A Resource for Developing Sexual Assault Referral Centres (DH 2009)

10.45 SARCs should provide equitable access to an individually tailored service based on comprehensive need assessments, choice of action at every stage of care, immediate clinical and non-clinical care and support, forensic examination and referral to appropriate services. Some SARCs continue to provide ongoing support to victims who attend follow-up services or enter criminal justice processes. To avoid a postcode lottery for victims of sexual violence and abuse, SARCs are expected to work towards attaining the minimum elements of a SARC set out below to ensure consistency in the service provision for victims across the country.

10.46 **Twenty-four hour access**, including arrangements for self-referrals, to crisis support, first aid, safeguarding, specialist clinical and forensic care in a secure unit.

10.47 Appropriately trained **crisis workers** to provide immediate support to the victim and significant others where relevant, throughout the examination process.

10.48 **Choice of gender of physician** wherever possible.

10.49 Access to **forensic physicians** and other practitioners who are appropriately qualified, trained and supported and who are experienced in sexual offences examinations for adults and children.

10.50 **Dedicated, forensically approved premises** and a facility with decontamination protocols following each examination to ensure high-quality forensic integrity and a robust chain of evidence.

10.51 The medical consultation includes a **risk assessment** of harm/self harm, together with an assessment of vulnerability and sexual health; **immediate access** to emergency contraception, post exposure prophylaxis (PEP) or other acute, mental health or sexual health services and follow-up as needed.

10.52 Access to support, advocacy and follow-up provided through an **independent sexual violence adviser (ISVA)** service, including support throughout the criminal justice process, should the victim choose that route.

10.53 Well **co-ordinated interagency arrangements** are in place, involving local third sector service organisations supporting victims and survivors, and are reviewed regularly to support the SARC in delivering to agreed care pathways and standards of care.

10.54 The **SARC has a core team** to provide 24/7 cover for services, which meets NHS standards of clinical governance and the European Working Time Directive.

10.55 A **minimum dataset** and **appropriate data collection procedures** in each SARC.

Appendix F: Key Informant Survey

Introduction

West Sussex County Council (WSCC) has commissioned independent consultants Nudge Associates Limited to undertake a comprehensive sexual and reproductive health needs assessment (cSRHNA).

As part of this they would like your views on sexual and reproductive health services in West Sussex.

Sexual and reproductive health services include testing, diagnosis and treatment for sexually transmitted infections (STIs) including HIV, advice and provision of contraception (including emergency contraception), abortion services, treatment for sexual difficulties such as erection problems and fertility treatments.

Services may be from specialist sexual health clinics, family doctors, hospitals or pharmacies.

Your views will help West Sussex County Council ensure sexual and reproductive health services meet the needs of people like you in West Sussex in the future.

The survey should take you no more than 5 minutes to complete.

The survey is confidential - you will not be identified by the answers you give us.

Please note the closing date for this survey is 5pm on Friday 9th May.

If you are completing a paper copy of the survey, and wish to return it via Freepost, the address is:

Freepost RTHX-BHSJ-YXJY
Nudge Associates Limited
19 Pioneer House
46 Britannia Street
London
WC1X 9JH

Many thanks for your time.

Part 1: Awareness of sexual and reproductive health services

1. If you needed to use sexual and reproductive health services in West Sussex would you know where to go?

- ◯ Yes
- ◯ No

2. If you needed emergency contraception would you know where to go?

- ◯ Yes
- ◯ No

Specialist services for sexual infection screening (including HIV) and advice and provision of contraception (including emergency contraception) are currently provided in Bognor Regis, Burgess Hill, Chichester, Crawley, East Grinstead, Haywards Heath, Horsham, Lancing, Littlehampton, Pulborough, Shoreham and Worthing.

3. Do you know where any of these services are?

- ◯ Yes
- ◯ No

4. Can you reach any of these places by public transport?

- ◯ Yes
- ◯ No

5. How long would it take you to travel to the closest one from your home or normal place of work (whichever is best for you)?

- ◯ Up to 30 minutes
- ◯ Between 30 minutes and 1 hour
- ◯ Between 1 and 2 hours
- ◯ More than 2 hours

Part 2: Experiences of sexual and reproductive health services

6. Have you ever used any sexual and reproductive health services anywhere?

- ◯ Yes
- ◯ No

7. Have you used any sexual and reproductive health services in West Sussex within the last 12 months?

- ◯ Yes
- ◯ No

8. How many times in the last 12 months?

9. Was this in...(select all that apply)?

- [ ] Bognor Regis
- [ ] Burgess Hill
- [ ] Chichester
- [ ] Crawley
- [ ] East Grinstead
- [ ] Haywards Heath
- [ ] Horsham
- [ ] Lancing
- [ ] Littlehampton
- [ ] Pulborough
- [ ] Shoreham
- [ ] Worthing
- [ ] Other (please say what)

10. How would you rate the service(s) you used on each of the following (On a scale of 1-5, where 1 = very poor and 5 = excellent):

	1	2	3	4	5
The location	○	○	○	○	○
The opening times	○	○	○	○	○
The quality of the service	○	○	○	○	○
The confidentiality of the service	○	○	○	○	○

11. Is there anything that could have been improved about the service(s)?

12. Thinking about these services, to what extent do you agree with the following statement:

"I would recommend the sexual and reproductive health service to a friend or family member"

- ◯ Strongly agree
- ◯ Agree
- ◯ Neither agree or disagree
- ◯ Disagree
- ◯ Strongly disagree

Part 3: Views on future services

13. If your GP (your local doctor) offered a full range of sexual and reproductive health services would you prefer to attend services with your GP?

- ◯ Yes
- ◯ No

Please say why...

14. Where do you think information on local sexual and reproductive health services should be located (please choose your top five)?

- ☐ GP surgeries
- ☐ School/Colleges/Universities
- ☐ Pharmacies
- ☐ Council Website
- ☐ NHS Direct
- ☐ Local hospital website
- ☐ Community health services (NHS services provided outside a hospital)
- ☐ Local community organisations
- ☐ Job Centre Plus
- ☐ Local library (e.g. on notice boards)
- ☐ In bus and train stations
- ☐ In local bars and clubs
- ☐ In sports centres
- ☐ In other community locations
- ☐ Through social media (such as Facebook and Twitter)

Anywhere else (please say where)...

15. If you included social media (such as Facebook and Twitter) in your answer to the question above, please say why and how you think it should be used?

16. Would you follow local sexual and reproductive health services if they were on social media (such as Facebook and Twitter)?

- ◯ Yes
- ◯ No

17. What do you think are the three most important things to people who use sexual and reproductive health services?

Part 4: Some details about you

18. What is the first part of your postcode (e.g. AL6) – this will be used to help us map need by local areas. It will not be used to identify you personally in any way.

19. How would you define your gender?:

- ◯ Female
- ◯ Intersex
- ◯ Male
- ◯ Transsexual
- ◯ Transgender
- ◯ Prefer not to say

Other (please specify)

20. How would you describe your sexuality?

- ◯ Bisexual – I am sexually attracted to both men and women
- ◯ Gay man – I am sexually attracted to men
- ◯ Gay woman/lesbian - I am sexually attracted to women
- ◯ Heterosexual/straight - I am mainly sexually attracted to people of the opposite sex
- ◯ Prefer not to say

Other (please specify)

21. How old are you?

- ◯ Under 15
- ◯ 15-19
- ◯ 20-24
- ◯ 25-34
- ◯ 35-44
- ◯ 45-64
- ◯ 65-70
- ◯ Over 70

22. What is your ethnic group?

- ◯ Asian / Asian British - Bangladeshi
- ◯ Asian / Asian British - Indian
- ◯ Asian / Asian British - Pakistani
- ◯ Asian / Asian British - Any other Asian background (please write in)
- ◯ Black or Black British - African
- ◯ Black or Black British - Caribbean
- ◯ Black or Black British - Any other Black background (please write in)
- ◯ Chinese - Chinese
- ◯ Chinese - Any other (please write in)
- ◯ Mixed/Multiple ethnic groups - White and Asian
- ◯ Mixed/Multiple ethnic groups - White and Black African
- ◯ Mixed/Multiple ethnic groups - White and Black Caribbean
- ◯ Mixed/Multiple ethnic groups - Any other Mixed background (please write in)
- ◯ Other ethnic group (please write in)
- ◯ White - British
- ◯ White - Irish
- ◯ White - Any other White background (please write in)
- ◯ Not stated

If 'any other' please write in here:

23. Have you ever had an HIV test?

- ◯ Yes
- ◯ No

24. Have you had an HIV test in the last 12 months?

- ◯ Yes
- ◯ No

25. Have you ever had a chlamydia test?

- ◯ Yes
- ◯ No

26. Have you had a chlamydia test in the last 12 months?

- ◯ Yes
- ◯ No

Part 5: Sharing more

We would like some people to tell us more about their experiences and ideas about sexual and reproductive health services. This would be with other people who have taken part in the survey and members of our team.

27. Would you be interested in taking part in this?

- ◯ Yes
- ◯ No

28. Please provide your name, email and/or telephone number so we can contact you to arrange a suitable time...

Name:

Phone:

Email:

End of the survey

Thank you for completing the survey, your time is much appreciated!

Appendix G: Service User and Local Population Survey

Introduction

West Sussex County Council (WSCC) has commissioned independent consultants Nudge Associates Limited to undertake a comprehensive sexual and reproductive health needs assessment (cSRHNA).

Sexual and reproductive health services include testing, diagnosis and treatment for sexually transmitted infections (STIs) including HIV, advice and provision of contraception (including emergency contraception), abortion services, treatment for sexual difficulties such as erection problems and fertility treatments.

Services may be from specialist sexual health clinics, family doctors, hospitals or pharmacies.

The aim of the work is to produce a needs assessment to ensure existing services are meeting the population needs of West Sussex and to inform future sexual and reproductive health service development, commissioning and delivery.

If you would like, this survey can be confidential - you will not be identified by the answers you give us.

Please note the closing date for this survey is 5pm on Friday 9th May.

If you are completing a paper copy of the survey, and wish to return it via Freepost, the address is:

Freepost RTHX-BHSJ-YXJY
Nudge Associates Limited
19 Pioneer House
46 Britannia Street
London
WC1X 9JH

Many thanks for your time.

Part 1: Some details about you

*1. Organisation:

*2. Job Title:

*3. Summary of key responsibilities:

4. To what extent do you feel sexual and reproductive health is a priority in your role?

- ◯ No extent
- ◯ Some extent
- ◯ Significant extent
- ◯ Great extent

5. If you would like your response to be anonymous please tick here:

- ◯ Yes, make my response anonymous

Part 2: Views on current service delivery

6. To what extent do you think the current service model(s) in West Sussex is/are working well, with regard to:

	No extent	Some extent	Significant extent	Great extent
Equality of access to services	○	○	○	○
Promotion of sexual and reproductive health services	○	○	○	○
Promotion of services to vulnerable groups	○	○	○	○
Partnership working/local partnerships	○	○	○	○
Commissioning and procurement arrangements	○	○	○	○
Communication	○	○	○	○
Leadership	○	○	○	○
Pathways	○	○	○	○

7. To what extent do you think the current system is meeting the sexual and reproductive health needs of the following groups:

	No extent	Some extent	Significant extent	Great extent
Adolescents (Under 19)	○	○	○	○
Young people (20-25)	○	○	○	○
Black and Minority Ethnic (BME) groups	○	○	○	○
Male adolescents (Under 19)	○	○	○	○
Young men (20-25)	○	○	○	○
People living in areas of deprivation	○	○	○	○
Female adolescents (Under 19)	○	○	○	○
Young women (20-25)	○	○	○	○
Men who have sex with men (MSM)	○	○	○	○
Women who have sex with women (WSW)	○	○	○	○
Transgender, transexual and intersex individuals	○	○	○	○
Care leavers	○	○	○	○
Young offenders	○	○	○	○
Looked after children	○	○	○	○
Gypsies and travellers	○	○	○	○
People from vulnerable communities not listed above	○	○	○	○

8. What do you consider to be the three most successful aspects of the system as it currently operates?

9. What three aspects of the system would you most like to see change/improve?

10. Are there any particular gaps in sexual and reproductive health services?

11. Are there any particular barriers to accessing sexual and reproductive health services?

12. In your view what are the three most important things to people who use sexual and reproductive health services?

Part 3: Views on further improving service delivery

13. Are there any particular opportunities for prevention or building resilience that are not currently being taken?

14. Are there any particular staff training needs or other workforce issues?

15. To what extent do you think the Voluntary Community Organisation (VCO) sector should have a role in delivery of sexual and reproductive health services?

- ◯ No extent
- ◯ Some extent
- ◯ Significant extent
- ◯ Great extent

16. Are there any specific groups that you think need more outreach work/targeting? Please specify...

17. To what extent do you think that community assets (such as libraries, community centres, colleges, GP surgeries etc.) should be used to:

	No extent	Some extent	Significant extent	Great extent
Promote sexual and reproductive health services	◯	◯	◯	◯
Host sexual and reproductive health service delivery	◯	◯	◯	◯

18. Where do you think people should be able to find information about sexual and reproductive health services in future? Please choose your top five.

- [ ] GP surgeries
- [ ] School/Colleges/Universities
- [ ] Pharmacies
- [ ] Council Website
- [ ] NHS Direct
- [ ] Local hospital website
- [ ] Community health services (NHS services provided outside a hospital)
- [ ] Local community organisations
- [ ] Job Centre Plus
- [ ] Local library (e.g. on notice boards)
- [ ] In bus and train stations
- [ ] In local bars and clubs
- [ ] In sports centres
- [ ] In other community locations
- [ ] Through social media (such as Facebook and Twitter)
- [ ] Anywhere else (please say where)...

19. Finally do you have any other comments you would like to make?

End of survey

Thank you for completing the survey, your time is much appreciated!

Appendix H: Six-day Sexual Health Service Timetable

Sexual Health West Sussex: Service timetable

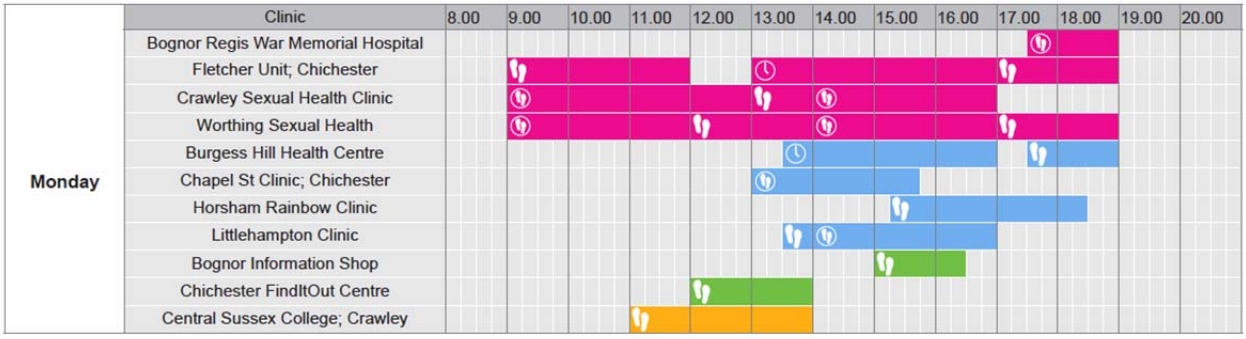
Sexual health and contraception: *Sexually transmitted infection screening and treatment, Chlamydia testing and treatment (available to all), HIV testing and treatment, Pregnancy testing, Termination/abortion referrals, Free condoms, Emergency contraception, General contraception ,Psychosexual counselling – by appointment*

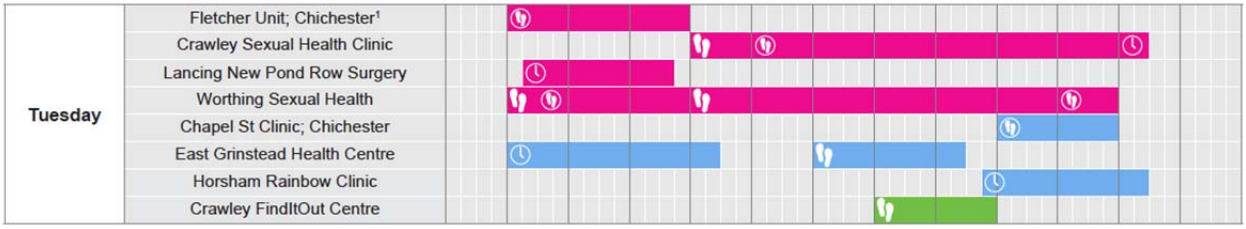
Contraception and sexual health: *Chlamydia testing and treatment (under 25s only), Bacterial vaginosis testing and treatment, Thrush testing and treatment, Sexual health advice, Pregnancy testing, Termination/abortion referrals, Free condoms, Emergency contraception, General contraception, Intrauterine contraception*

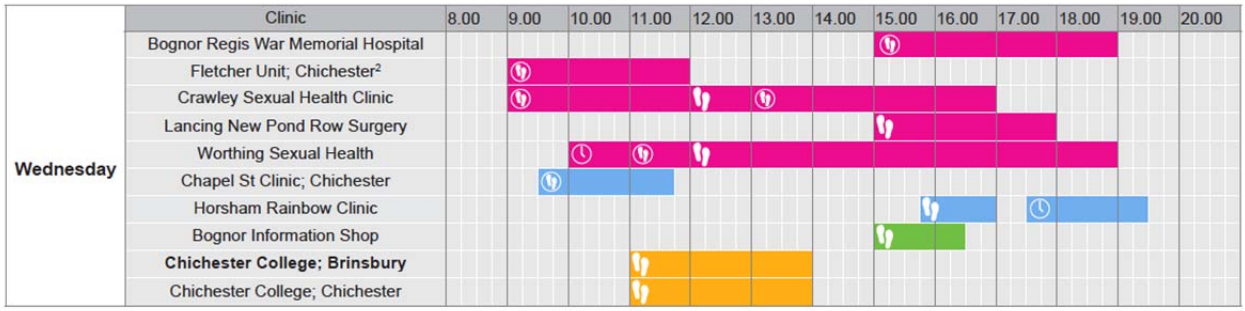
Sevices for under 25s: *Contraception and advice, Emergency hormonal contraception, Chlamydia testing (under 25s only), Sexual health advice, Pregnancy testing and ongoing referral, Free condoms*

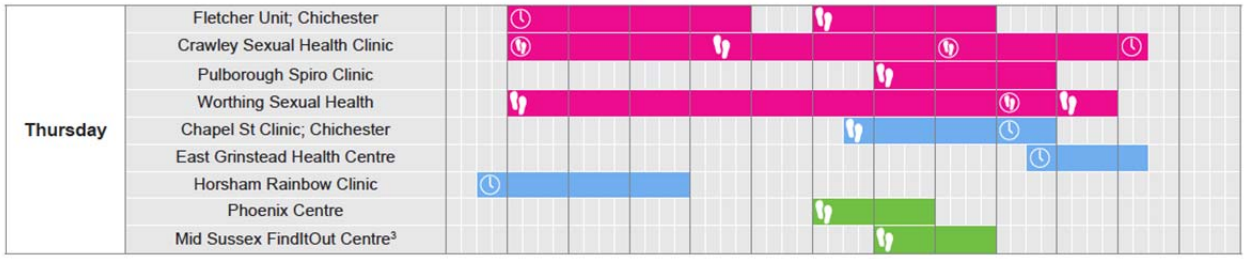
College based services (only available to college students, term time only): *Contraception and advice, Emergency hormonal contraception, Chlamydia testing, Sexual health advice, Pregnancy testing and ongoing referral Free condoms*

Appointment and walk-in | Walk-in | Appointment









	Clinic	8.00	9.00	10.00	11.00	12.00	13.00	14.00	15.00	16.00	17.00	18.00	19.00	20.00
Saturday	Fletcher Unit; Chichester													
	Crawley Sexual Health Clinic													
	Worthing Sexual Health[5]													

All information taken from www.sexualhealthwestsussex.nhs.uk/clinics/our-clinics correct as of 4th May 2014

1 Appointment times are for a specialist clinic
2 Clinic closes one hour earlier on the last Wednesday of each month
3 Every last Thursday of each month
4 1st and 3rd Friday of each month
5 Nurse-led service for contraception; STI screening without symptoms and follow-up treatments