Integrated Sexual Health & HIV Needs Assessment

West Sussex County Council

Public Health and Social Research Unit

Contents

List of Tables

List of Figures

Executive Summary

> The World Health Organisation (WHO) define **sexual health** [1] as "... a state of physical, mental and social wellbeing in relation to sexuality. It 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".
>
> NHS England describe HIV as "a virus that infects and destroys cells responsible for combating infections, leaving the body susceptible to diseases it would normally be able to fight. Without treatment, the immune system can be compromised and rare infections or cancers develop. When these are particularly serious, the person is said to have AIDS (Acquired Immune Deficiency Syndrome)."

Good sexual health is an intrinsic part of good overall physical, mental and emotional health. Most adults in West Sussex are sexually active. Sexual health is an important public health matter. Poor sexual health can, significantly, add to the burden of disease in the local population with diagnosed, and undiagnosed, sexually transmitted infections (STIs).

We know that while everyone who is sexually active risks exposure to a STI, there are some groups at a higher risk, these are:

- men who have sex with men;
- younger adults;
- people from black and minority ethnic groups;
- people in prisons and immigration removal centres (IRCs).

There is also an association between STIs and deprivation.

Sexual health should not be isolated from other issues. Decisions sexually active people make cannot be separated from other aspects of their health and wider wellbeing,

especially their mental and emotional wellbeing. This means that effective links and pathways between services are important. This includes services tackling substance misuse, mental health and those that support vulnerable young people and adults, including young people in care and people with learning disabilities.

This needs assessment examines sexual health needs of the West Sussex population and the current population-level sexual health outcomes.

Sexual health services are commissioned locally to meet the needs of the population and the responsibility for services lies with three separate parts of the health and wider wellbeing system:

- Local authorities;
- Clinical commissioning groups (CCGs);
- NHS England.

There remains a complex picture in terms of the responsibility, planning and delivery of sexual health services. While this needs assessment focusses on parts of the system which fall to the local authority and NHS England, it is recognised that needs cut across organisational boundaries. Outcomes in one area can have lifelong implications, for example early detection and treatment of STIs can reduce infertility and ectopic pregnancies.

Local authorities commission:

- Contraception in the form of implants and intra-uterine devices, along with all prescribing costs, but excluding contraception provided as an additional service under GP contract.
- Sexually transmitted infection (STI) testing and treatment, chlamydia screening as part of the National Chlamydia Screening Programme (NCSP), and HIV testing.
- Sexual health aspects of psychosexual counselling.
- Any sexual health specialist services, including young people's sexual health and teenage pregnancy services, outreach, HIV prevention and sexual health promotion services in schools, colleges and pharmacies.

Clinical commissioning groups (CCGs) commission:

- Most abortion services.
- Vasectomy.
- Aspects of psychosexual counselling unrelated to sexual health.
- Gynaecology (including the use of contraception for non-contraceptive purposes).

NHS England commissions:

- Contraception provided as an additional service under the GP contract.
- HIV treatment and care (includes the drug costs of post-exposure prophylaxis after sexual exposure).
- Promotion of opportunistic testing and treatment for STIs and patient requested testing by GPs.
- Sexual health elements of prison health services.

- Sexual assault referral services (SARCs).
- Cervical screening.
- Specialist foetal medicine services.

Although some current gaps/issues are also identified, a key task for a needs assessment is to articulate what changes might be needed in the future, for example in terms of population growth or technological opportunities; and to clearly identify the nature and scale of some groups at higher risk of poorer outcomes.

Finally, we recognise that detailed health needs assessments can be seen as documents which focus on what is not working, rather than what is. It should be recognised that in relation to sexual health in West Sussex, there is a great deal of good news and some of the population-level outcomes are amongst the best in the country.

A previous in-depth needs assessment was undertaken in 2014. This was shortly after the transition of some of the public health system to local authorities. This was a detailed needs assessment and included interviews with almost 40 key informants, engagement with service users and had 89 recommendations. As part of this refreshed needs assessment we have not repeated an extensive engagement exercise. We have reviewed the 2014 recommendations and undertaken more recent interviews with local informants to focus on specific issues and areas of change (such as online testing).

Recommendations

1. **A sexual health strategy group should be established (led by WSCC Public Health) to:**
   (a) increase the communication between services across the county, including services for vulnerable groups, and communication with partner and third sector organisations and service users and service user groups.
   (b) identify emerging issues and risks across the system.
   (c) actively engage with wider stakeholders on the issues of sexual health.
2. **Expand performance indicators and monitoring relating to service user experience and views.** Currently data sharing is good between the commissioned provider and local authority. Data are used to monitor performance and identify demand fluctuation and trends. This should also include service user views and experiences. Where surveys are undertaken by the provider, content could be shared and discussed with commissioners on an annual basis.
3. **Recommendations relating to young people**
   - Increase detection for chlamydia to meet recommended Public Health England target
   - Ensure that clinic hours continue to meet the needs of young people.
   - Maintain outreach efforts that promote and normalise the service so that young people in need of treatment and advice know where to access

this.
- Monitor the effectiveness of the pilot fast-track pathway for Children Looked After.

4. **Outreach to higher risk groups and links to other services**
   (a) There are increasing pressures on the local health and care system, including to budgets and workforce; but it is important that higher risk groups, including outreach to those groups, are prioritised, and barriers to service access addressed.
   (b) Treatment pathways should be developed (where absent) and reviewed annually between services including those for higher risk and vulnerable groups, such as children leaving care, adults with learning disabilities, and people known to substance misuse services.
   (c) Of note there is a considerable overlap between people most at risk of poor sexual health and harmful drug and alcohol activity. The opportunities for closer, and joint, working, needs to be developed and prioritised by the relevant local authority commissioners. Some co-commissioning of services should be considered.
5. **Recommendations relating to HIV**
   - Advocate for the use of PReP[a] which is a cost-effective means of protecting against the acquisition and the onward transmission of HIV.
   - Maintain testing coverage to increase the chance of timely diagnosis and to remind those presenting at clinics that HIV remains a key issue in their sexual health.
   - Sustain efforts to ensure early diagnoses and treatment and sustained access to treatment and services that promote good health and wellbeing and work to ensure the viral load remains low or undetectable.
   - Continue to pursue late diagnoses with the same urgency, treating all cases as a critical incident.
   - Follow the UNAIDS 90:90:90 strategy implemented in England by PHE. This focusses on achieving the 90:90:90 target[b], which has implications for both minimising onward transmission and maximising quality of life for people living with HIV.
   - Ensure support for outreach work on HIV, especially for harder to find cases such as ethnic minorities and cases of heterosexual transmission.

[a] PReP (pre-exposure prophylaxis) is a drug taken in advance of sexual exposure to prevent HIV infection.

[b] The UN 90:90:90 target asserts that of all people living with HIV: 90% should know they have it; 90% of those should be receiving the necessary treatment, and that of those 90% should be virally suppressed. Viral suppression means that HIV cannot be transmitted.

Emerging Issues

- The needs assessment has identified a number of emerging issues which should be considered in the commissioning and planning of services, not exclusively sexual health services.
    1. **Increased use of online information and home testing.** While this will act to increase choice and access for some people, this is not true for some high risk and vulnerable groups, including people with learning disabilities or people subject to sexual exploitation and abuse. A Health Equity Audit (HEA) should be undertaken to examine the overall access and take up sexual health services and specifically who is and isn't using online services.
    2. **People living in older age with HIV.** Plan for people living longer with HIV, including the possibility of co-morbidities and long-term conditions. HIV itself is considered to be a long-term condition. This also has implications for adult social care and support. Consideration needs to be given to whether a separate pathway for older people living with HIV is needed and how it would sit alongside the pathway for older people generally.
    3. **Emergence of new STIs and Antimicrobial resistance.**
        - There is some concern about the possible emergence of antibiotic-resistant Gonorrhoea, or so-called "Super Gonorrhoea".
        - Mycoplasma Genitalium (MGen) is an emerging sexually transmitted infection which is of concern due to the high proportion of cases in which it is resistant to antibiotics. In the calendar year 2018, 27 people in West Sussex were investigated for an MGen infection. Mycoplasma Genitalium is a new challenge for integrated sexual health services.
- **Gaps in knowledge.** Information relating to some groups at a local level is limited, further consideration is needed in relation to trans people, sex workers, young offenders and gypsy and travellers.
- **High Risk Populations in HMP Ford and Immigration Removal Centres.** This needs assessment has not included services for people in HMP Ford and immigration removal centres (IRCs) at Gatwick airport (Brooke House and Tilsey House). These facilities have high risk populations. The responsibility and planning of services for these populations transferred to NHS England Health and Justice in 2013. Separate health needs assessments were undertaken prior to 2013 and may need to be updated.

Demographics, Population Characteristics and Higher Risk Groups

Demographics and Population Change

- West Sussex is a large county comprised of a coastal strip with a series of medium size coastal towns, small to medium size towns in relatively rural areas and large town centres. Services need to serve and be accessible to different communities including both urban and rural areas across a large geographic area.
- In 2017 the population was over 850,000. In the next five years, using population projections produced by the Office for National Statistics (ONS), a 4% increase

in population is projected overall, with a lower increase (1.5%) projected of 15-24 year olds.

- In relation to reproductive health, in 2017 there were 141,700 women aged 15-44 years, this was 2,300 lower than the number in 2012. Using current projections a small increase is projected in the next 5 years (of approximately 1,000), **service demand generated by demographic growth alone is therefore likely to be modest.**

People at Higher Risk of Poor Sexual Health Outcomes

- In meeting the needs of the population it is important that we understand and identify groups and areas within the county where the risk of poorer sexual health outcomes is greater. This includes young people, men who have sex with men and people from some ethnic minority groups.
    1. **Young people.** Although West Sussex, overall, has an older population compared with England, **there are areas with larger populations of younger adults (16-24 year olds).** In Crawley 9.4% of the population are aged 16-24 years (approximately 10,500 people) and in Chichester 9.8% are in this age group (approximately 11,800). The University of Chichester has sites based in Chichester and Bognor.
       Some young people are at additional risk, this includes children in or leaving local authority care and young people in the criminal justice system. In West Sussex in 2018 there were 704 children in care[1], 69 of which were unaccompanied asylum seekers.
    2. **Men who have sex with men.** Using national research it is estimated that **1.5% of men define themselves as gay, and a further 1.0% as bisexual.** This would equate to approximately 5,000 men who define themselves as gay and 3,400 as bisexual in West Sussex.
    3. **Black and Ethnic Minority (BAME) Groups.** Public Health England (PHE) identify specific issues relating to black Caribbean and black African communities. For black African communities PHE state that there should be a priority to increase HIV testing and for black Caribbean communities a priority to reduce sexual risk behaviours and increase condom use. Robust data relating to ethnic minorities are relatively poor, but in 2011 these communities were relatively small in West Sussex, with 3,400 adults (16+ years) of a black African background and 1,200 of a black Caribbean background; the majority reside in Crawley.

Deprivation

- **There is a strong and consistent association between deprivation and a number of outcomes, including teenage pregnancy and STIs.** This may relate to both behavioural risk, such as being more likely to have unprotected sex and an increased level of substance misuse, but may also be due to issues relating to service access, including access to sexual health services and emergency contraception.

[1] As at March 31st 2018.

- Although West Sussex is a relatively wealthy county it has areas of considerable deprivation, for example **neighbourhoods in Littlehampton and Bognor are within the most 10% deprived areas in England.** Service access, take-up and outcomes for people from deprived areas and lower socio-economic groups should be monitored to promote equity.

People who have substance misuse problems

- People who misuse alcohol and drugs are more likely to:
  - initiate sexual activity at an earlier age
  - have more sexual partners
  - use condoms less consistently
  - have more sexually transmitted infections
- **In relation to young people, use of drugs and alcohol is associated with riskier sexual behaviour.** Young people with substance problems are more likely to engage in risky sexual behaviours during adolescence and continue risky sexual behaviours to the extent that substance problems persist. Risk reduction education is a crucial component of substance abuse treatment for young people.

People who are homeless or in insecure housing

- People who have more chaotic lifestyles or insecure housing can have difficulties accessing services and/or sustaining treatment. Homelessness is also associated with higher rates of alcohol and drug misuse, as well as overall poorer physical and mental health.

People with a Learning Disability

- The sexuality of people with disabilities is often ignored, neglected or stigmatised by society. People with learning disabilities can be more vulnerable to sexual abuse. There are approximately 4,500 people on GP learning disability registers in West Sussex.

Trans people

There is limited information locally relating to the sexual health needs of people whose gender identify differs from that assigned at birth[2]. A population-level health needs assessment relating to trans people in Brighton and Hove was published in 2015 (the first in the UK). In relation to sexual health needs, one issue raised was the need for inclusive language when describing anatomy. Some respondents to a local survey praised the approach taken by sexual health services at the University of Brighton, for example in the labelling of testing kits, *“The University of Brighton has addressed this issue by re-labelling these kits ’If you have a penis’ and ’If you have a vagina’. I think this should be the case everywhere.” (community survey respondent)*.

[2]The term trans was used in the Brighton and Hove Trans Needs Assessment (2015), where the steering group for that needs assessment defined trans as *"an umbrella term to describe people whose gender identity differs from their assigned sex at birth".*

Sexual attitudes and behaviour

Sexual attitudes and behaviour change over time. Understanding change is important in the planning and delivery of services. In the absence of local data relating to sexual attitudes and behaviour information from the National Surveys of Sexual Attitudes and Lifestyles (NATSAL) is summarised below[3].

- **Behaviour change has been greatest amongst women.** In the 16-44 years age group, the average number of partners for women over a lifetime has increased from 3.7 in 1990/91 to 7.7 in 2010/12. For men during the same period the number increased from 8.6 to 11.7, so the gap between men and women has fallen.
- **People start having sex at an earlier age and continue having sex into their 70s.**
- **The frequency with which people have sex has declined.**
- **Same–sex relationships have become more accepted.** People have become less tolerant of married people having sex outside of marriage
- **Risky behaviours remain the key driver of STIs.**
- The 2010-2012 survey included questions on unplanned pregnancies and found that **1 in 6 pregnancies were unplanned, and 1 in 60 women experience an unplanned pregnancy in a year.**
- **1 in 6 people feel that their own health has impacted their sex life,** but of these people less than 25% will seek help. Where help is sought (from a health professional) it is usually from a GP.
- **1 in 10 women and 1 in 70 men report that they have experienced non-volitional sex** (sex against their will). Of these people, less than half tell anyone else about their experience and of these only 13% of women and 8% of men go to the police.

In relation to 16-24 year olds, the survey conducted in 2010 to 2012 found that 31% of men and 30% of women reported having heterosexual sex before the age of 16.

	Men	Women
Age at first heterosexual intercourse	16	16
Heterosexual intercourse before 16 years	30.90%	29.20%
Average number of sexual partners	6.5	5.2
At least one new partner in last year	46.00%	38.30%
Genital contact without intercourse past year	71.30%	72.60%
Occasions of sex in the last four weeks	5.1	5.8
Anal sex in the past year	18.50%	17%

Table 1 – *Sexual activity of young people aged 16-24, Great Britain, 2012*

[3]The summary adapts information published by UCL.

Population level outcomes: sexually transmited infections

References are made throughout this summary of how West Sussex compares with similar local authorities, comparable in relation to demographic and socio-economic characteristics. West Sussex is grouped with 15 other local authorities and these are used to benchmark outcomes and performance indicators.

Overall number and rate of STIs

- **In 2017 there were a total of 4,497 new STI diagnoses (all STIs),** a rate of 531 per 100,000 population. This was the lowest rate of new diagnoses in the last 5 years, and below the national rate of 743 per 100,000 but similar to other comparable local authorities.
- Of the new diagnoses this **included 1,998 cases of Chlamydia, 766 of genital warts, 473 of genital Herpes, 412 of Gonorrhea and 75 of Syphilis.** Rates of new STI diagnoses for Chlamydia, Gonorrhoea, Syphilis, Herpes and Warts are consistently below the England rate, however for Gonorrhoea, Herpes, and Syphilis diagnosis rates are among the highest of similar authorities.
- **In terms of trends over time, rates of new diagnoses of Chlamydia, Gonorrhoea, and Syphilis have been increasing in West Sussex for the past ten years,** at a similar rate of increase to the England rate.
- **Overall testing rates** are important as the level of diagnoses is strongly associated with the level of testing within a local community. The testing rate in 2017 was 14,592 per 100,000, this remains significantly lower than the England rate of 16,739 / 100,000. Although the testing rate in West Sussex is 3rd highest amongst similar authorities, **the testing rate has declined in the last 3 years and is significantly lower than the England rate.**

HIV

- In recent years **the proportion of late HIV diagnoses** (i.e. where the CD4 cell count[a] is less than 350 per mm^3) has remained fairly stable at approximately 42%, this is similar to England (41%) and means that 54 people in West Sussex were diagnosed late between 2015 – 2017.

[a] CD4 count is used as a measure the strength of the immune system. A person with a lower CD4 count, which occurs in HIV infection, is at risk of opportunistic infections and illness.

Individual STIs

Chlamydia

- **Among young people the Chlamydia detection rate has been falling in West Sussex**, this is in line with statistical neighbours and England. The Public Health Outcomes Framework recommends that local areas should aim to

achieve a chlamydia detection rate among 15 to 24 year olds of at least 2,300 per 100,000 population, in 2017 the rate in West Sussex overall was 1,414 / 100,000 compared with the England rate of 1,882 / 100,000. West Sussex has the 6th lowest amongst comparable authorities and rates have fallen in recent years for men and women.

- Within the county the detection rate is highest in Adur and Crawley (although below 2,300 at 1,966 and 1,903 respectively) and lowest in Horsham (1,102 /100,000) and Mid Sussex (841 / 100,000). The detection rate in Mid Sussex is the third lowest for a lower tier authority in the country.
- There was a dramatic change in the chlamydia detection rate in Worthing, from a rate of 5,439 per 100,000 in 2016 to 1,541 in 2017. Such a dramatic change may indicate a data problem or correction and should be verified / monitored.
- In Crawley, the number of chlamydia diagnoses per 100,000 population is higher than that for England overall: 382.8 diagnoses per 100,000 population compared to the England rate of 361.3 per 100,000.
- After increases in the rate of diagnoses of chlamydia from 2008 to 2012/13 rates have fallen back in recent years, in overall diagnostic rates and in the rate for the over 25s.

Syphilis

- The rate of syphilis diagnoses per 100,000 population in 2017 was 8.9 per 100,000 (75 diagnoses), compared with a national rate of 12.5 / 100,000. **The diagnosis rate per 100,000 has increased over the last 5 years, locally and nationally.** Although well below the national rate, West Sussex has the second highest rate compared with similar local authorities.
- In Crawley, the rate of syphilis diagnoses per 100,000 population in 2017 was 23.3 per 100,000 (diagnoses), compared with a national rate of 12.5 / 100,000.

Gonorrhoea

- The rate of gonorrhoea diagnoses per 100,000 population in 2017 was 48.6 per 100,000 (412 diagnoses), compared with a national rate of 78.8 / 100,000. **The diagnosis rate per 100,000 has increased over the last 5 years, locally and nationally.** Although well below the national rate, West Sussex has the highest rate compared with similar local authorities.
- In Crawley, the rate of gonorrhoea diagnoses per 100,000 population in 2017 was 113 per 100,000 (diagnoses), compared with a national rate of 78.8 / 100,000.

Genital Herpes

- The rate of first episode genital herpes diagnoses per 100,000 population was 55.9, this was similar to the England rate of 56.7. The West Sussex rate in 2017 was the third highest amongst comparable authorities.

Genital Warts

- The rate of first episode genital warts diagnoses per 100,000 population in 2017 was 90.4 (766 diagnoses). This was below the England rate of 103.9 / 100,000 and was the 7th lowest amongst comparable authorities.

Mycoplasma Genitalium

- Mycoplasma Genitalium (MGen) is an emerging sexually transmitted infection which is of concern due to the high proportion of cases that are resistant to antibiotic treatment. In the calendar year 2018, 27 people in West Sussex were investigated for an MGen infection. Mycoplasma Genitalium is a new challenge for integrated sexual health services.

HIV

- **In 2017 there were 827 people living with a positive HIV diagnosis in West Sussex.** This represents a rate of 1.79 per 1,000 population aged 15-59 years (England rate of 2.32).
- **HIV coverage in West Sussex has been higher than the England average since 2014 and is higher than most of its statistically similar neighbours.**[4] In 2017 the coverage rate was 77%. Testing coverage of men who have sex with men is particularly high at 93.9%, in 2017 this was the fifth highest rate in England.
- **In recent years the proportion of late HIV diagnoses (i.e. where the CD4 cell count is less than 350) has remained fairly stable** at approximately 42%, this is similar to England (41%) and means that 54 people in West Sussex were diagnosed late between 2015 – 2017.
- Although West Sussex ranks 5th amongst its comparable neighbours, clearly any late diagnosis reduces the effectiveness of treatment for the individuals concerned. Across the county, there are more late diagnoses than the England average in Adur, Worthing, and Horsham.
- Across the county almost all people living with HIV are on ART[5] (ranging from 96% in Mid Sussex to 100% in Arun, compared to the England average of 98%). Of these people, most are virally suppressed and are therefore unable to pass on HIV, even if they are having unprotected sex.

Population level outcomes: reproductive health and teenage pregnancy

Overall Fertility Rate

- **In 2017 the fertility rate was 62 live births per 1,000 women aged 15 to 44 (England 63 per 1,000).** There were 8,795 live births. The fertility rate in West Sussex is the 4th highest of comparable authorities. It has remained fairly stable over the last 5 years, with births remaining under 9,000.

Teenage Pregnancy

- **Teenage pregnancy in West Sussex has continued to fall, in 2016 there were 162 conceptions, compared with 408 in 2008.** The rate of 12.2 per 1,000 15-17 year olds is amongst the lowest of comparable local authorities. 48% of teenage conceptions ended in abortion in West Sussex, a slightly lower percentage than England (52%). Although these are small numbers, it

[4] This is noted as an area of considerable improvement since the 2014 Needs Assessment.
[5] ART = Antiretroviral therapy

is important to note that teenage pregnancy remains higher in more deprived neighbourhoods. These are in Littlehampton, Bognor, Worthing and west Crawley.

- **The number and rate of conceptions to girls under the age of 16 years has also fallen.** In 2016 there were 25 conceptions, compared with 54 in 2011. Again this indicator compares well with similar authorities and England overall.

Abortion

- **In 2017 the rate of abortions per 1,000 female population aged 15-44 in West Sussex was 14.0, in line with comparable authorities** and below the England rate (17.2/1,000). The percentage of abortions undertaken under 10 weeks in West Sussex is, at 73.4%, significantly lower than England (76.6%) and 6th lowest amongst comparable authorities, and it has fallen in the last 2-3 years.
- Of the abortions to women aged under 25 years, **24% (188 abortions) were repeat abortions** i.e. abortions to women who had had previous abortions. This was lower than the percentage in 2016 (29%) and is "middling" in terms of comparable local authorities.

Long Acting Reversible Contraception

- **The use of long acting reversible contraception in West Sussex is relatively high** (66.2 per 1,000 female population aged 15-44 years) compared with similar authorities and England (47.4/1,000). 2017 saw an improvement in this measure from 2016.

Pelvic Inflammatory Disease (PID)

- The hospital admission rate for pelvic inflammatory disease (PID) admissions was unusually high in 2016/17. There were 462 admissions in 2016/17, over 100 more than in 2015/16. The higher number of admissions in 2016/17 meant that the rate per 100,000 at 326.1 was significantly higher than the England rate (242.4/100,000) and was the second highest amongst comparable authorities. Admissions should be monitored to evaluate whether admissions fall back to previous levels, PHE note that PID should be monitored alongside chlamydia screening coverage.

Comparitive performance

There are many indicators relating to sexual health and HIV. This means it can be difficult to summarise how local performance and outcomes compares overall to other areas.

In 2017 PHE developed its first Public Health Dashboard. This brought together information on a number of key public health issues[6] including sexual and reproduction health. The purpose of the dashboard is to inform local decision-makers, including elected members, on how the local delivery of services compares with all local authorities and with local authorities considered the most similar.

For each subject there is a combined overall ranking made up of a number of indicators. In 2018 for sexual and reproductive health, West Sussex was ranked 1st amongst comparable authorities (1st of 16).

	West Sussex Value	West Sussex Trend	Ranking amongst similar LAs	National Ranking
			Out of 16	Out of 152
Overall Summary Ranking	1st	No trend data	1st	25th (top quartile)
Chlamydia detection, rate per 100,000, aged 15-24 years (2017)	1,414 per 100,000		11th (best Gloucestershire)	126th (Bottom quartile)
HIV testing coverage, total (%) (2017)	77.1%		4th (best Devon)	22nd (Top quartile)
Total prescribed LARC (excluding injections) rate per 1,000, aged 15-44 (2016)	64.4 per 1,000		5th (best Gloucestershire)	14th (Top quartile)
Under 18s conception rate (2016)	12.2 per 1,000		3rd (best Oxfordshire)	25th (Top quartile)
STI testing rate (exc chlamydia aged <25) rate per 100,000 (2017)	14,592 per 100,000		3rd (best East Sussex)	63rd (2nd quartile)

Figure 1 – *West Sussex indicator values and ranking on PHE dashboard. Source: PHE Fingertips.*

[6]The dashboard includes services that fall within the local authority **mandated** functions and public health grant conditions. The dashboard ranks authorities in terms of best start in life, childhood obesity, alcohol and drug treatment, NHS health checks and sexual health services and tobacco control.

Current Public Health Commissioned Services

West Sussex County Council commissions an integrated sexual health service (ISHS) from Western Sussex Hospitals NHS Trust. Integration of services allows for people accessing services to have as many as possible of their sexual health needs met at a single visit. This reduces loss to follow up and also allows the service to make use of the synergies between need for treatment and contraception.

Services

The integrated service offers the following, though some services are not available at all sites:

- 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
- Contraception procedures – by appointment
- Intrauterine contraception
- Psychosexual counselling – by appointment

Locations

The sevice operates **hubs** out of Crawley, Worthing and Chichester.

At additional sites there are smaller clinics that are sometimes nurse-led. Symptomatic patients are advised to attend a hub, but many services are available at these sites.

- Bognor Regis (two clinics)
- Chichester College Brinsbury
- Crawley FindItOut
- East Grinstead
- Horsham
- Horsham FindItOut
- Lancing
- Littlehampton

Access by Walk-in and Appointment

- Services at hubs are open in the evenings most days and on Saturday mornings. This expands access to when people are most likely to need it. In 2010, a previous target of providing access to sexual health services within 48 hours was suspended. While this means that there is currently no national target for waiting times in sexual health services, services naturally aim to keep these as short as possible.
- Appointments can also be booked with the service, usually for particular services such as psychosexual counselling. Appointments also form an important part of work with other services, particularly for young people.

Location	Days available
Bognor Regis	Monday, Wednesday
Chichester	Monday, Tuesday, Thursday to Saturday
Chichester College Brinsbury	Wednesday afternoons, term time, college students
Crawley	Monday to Saturday
Crawley FindItOut	Tuesday afternoons, young people aged 13-25
East Grinstead	Tuesday
Horsham	Monday and Wednesday
Horsham FindItOut	Thursday afternoons, young people aged 13-25
Lancing	Wednesday
Littlehampton	Thursday
Worthing	Monday to Saturday

Table 2 – *Clinics where walk-in and wait services are available, together with available days.*

Location	Days available
Bognor Regis	Monday
Chichester	Monday, Wednesday to Friday
Crawley	Monday to Friday
East Grinstead	Tuesday morning and evening
Horsham	Wednesday and Thursday
Lancing	Tuesday
Worthing	Monday to Friday

Table 3 – *Clinics where booked appointments are available, together with available days.*

Psychosexual services

The integrated service offers **psychosexual therapy for a range of sexual issues** such as:

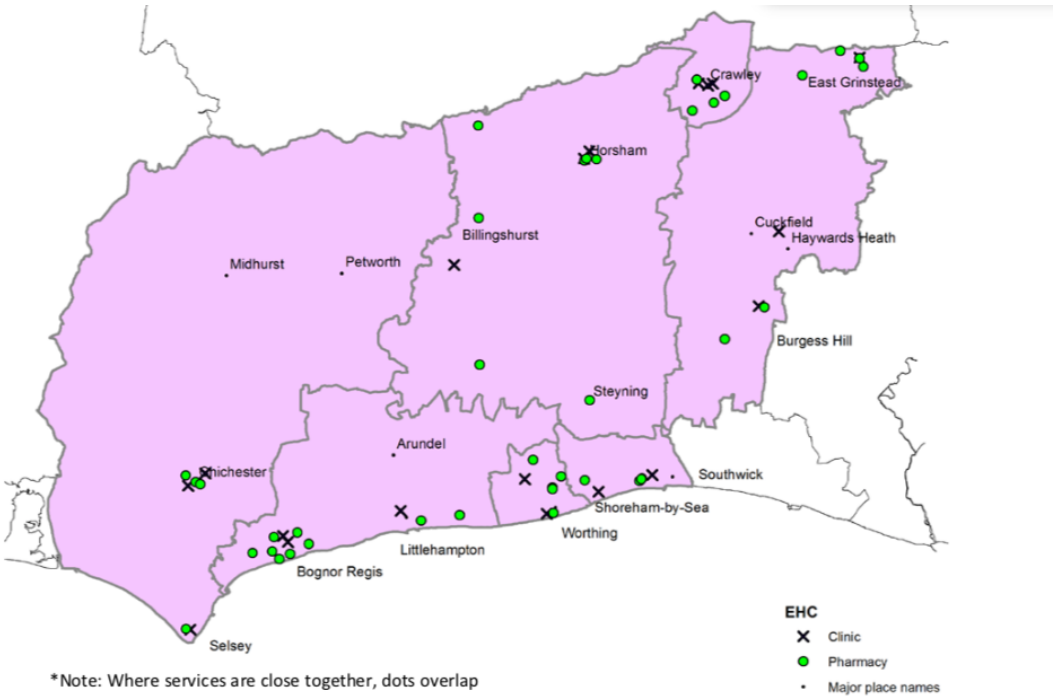
- Difficulties with erection, ejaculation, orgasm, desire;
- Sexual trauma or pain;
- Sexual function relating to ill health and disability;

Psychosexual therapy is offered by appointment at clinics in Worthing, Crawley and Chichester. Referrals are encouraged from health professionals such as GPs, other doctors, nurses, and health advisors. Appointment times vary and therapy is time-limited.

The service **does not** provide counselling for the following:

- Acute rape victims;
- Problems of gender identity/dysphoria;
- Situations where the sexual problem is part of a major psychiatric disorder;
- Relationship problems not related to sexual disorder;
- Sexual practices which would be the subject of action under the criminal justice system.

Figure 2 – Pharmacies in West Sussex where Emergency hormonal contraception can be accessed.



Contraception

The integrated service offers fitting of contraceptive devices and provides other means of contraception such as oral contraceptive and condoms.

Emergency hormonal contraception (EHC) will prevent around 95% of pregnancies if taken up to five days after having unprotected sex. It is available from the integrated service, as well from pharmacies throughout West Sussex. 38 community pharmacies in West Sussex currently participate in the EHC scheme and these are spread throughout the county. Community pharmacies participating in the scheme include: 7 pharmacies in Crawley, including within 3 teenage pregnancy "hotspot" wards; 7 pharmacies in Bognor, which also contains 3 teenage pregnancy "hotspot" wards; 5 pharmacies in Worthing, which contains 2 teenage pregnancy "hotspot" wards.

Termination of Pregnancy

Women seeking termination of pregnancy can be referred to a provider by either their GP or a doctor from the integrated sexual health service. Termination of pregnancy services in West Sussex are commissioned by the CCG and provided to all three West Sussex CCGs by the British Pregnancy Advisory Service (BPAS). The service is located in Brighton (Tuesdays to Saturdays) with a satellite in Bognor (Tuesdays).

Vasectomy and Sterilisation

Vasectomy services are provided by West Sussex urology and are commissioned by the CCGs. Sterilisation for women is also commissioned by CCGs, though no services

are currently provided.

Outreach

The integrated sexual health service conducts outreach efforts to engage more young people and vulnerable groups to access the service, for example:

- **Allsorts LGBT**
- **Brighton and Hove Albion FC** work with the under 18s and under 23s. With under 18s emphasis is on Fraser competency: understanding what being sexually active means and what the consequences are. With under 23s the emphasis is on signposting the service and normalising the idea of getting tested, using contraception etc.
- **Young parent groups** - emphasis on contraception and sexual health - either with people who have recently become pregnant or have recently had a child
- **Work with school nurses and also a team of looked-after children's nurses** – including working with children placed out of county in West Sussex.
- **C-card scheme**
- **University and colleges**
- **People who are homeless** - the integrated service works with homelessness groups to provide sexual health outreach

Online testing for asymptomatic infections (for home testing and return)

- A scheme has recently been introduced and is being piloted by the West Sussex service where the patient accesses the website and answers some questions about their recent sexual history. According to the responses given, the patient is referred to the central booking line to make an appointment, or given the option of having a self-testing kit sent to their address. This kit is then returned to the service and evaluated as samples collected in person would be.
- There is also a service run by Preventex for HIV testing.
- Online information and home-testing kits increases the choice and the convenience for people accessing sexual health services. For some people this may also be considered discreet and therefore more acceptable. This may act to increase levels of testing. But for some groups, including people at higher risk of poor sexual health they will not be suitable; such as people with a learning disability or people subject to sexual abuse and/or exploitation.

Local service Key Performance Indicators (KPIs)

In addition to surveillance of population level outcomes, services commissioned by West Sussex County Council have locally defined performance indicators embedded in the existing contract. Information is provided by the provider to contract officers on a regular basis (some data are provided on a monthly basis to support forecasting demand and spend). Data are used to monitor the contract and also facilitate demand

forecasting. Indicators relate both to activity but also include system development and quality.

Service KPIs include:

- People who are offered a HIV test as part of an STI screen
- People who are turned away
- People accepted for psychosexual counselling and are seen within 18 weeks (Referral from within ISHS, terminations of pregnancy (ToP) and from GPs and primary care.
- Number of organisations participating in the condom distribution and C Card schemes.
- 15 Steps Challenge
- Friends and Family Test (FFT) and Comments Cards as a test of Service User satisfaction
- Percentage of individuals accessing services who have a sexual history and STI/HIV risk assessment undertaken (new or rebook attendances)
- Number of people accessing contraception services only who are offered a chlamydia test in the 15-24 age group
- Number of contacts per index patient who have attended a health care site for testing and epidemiological treatment within 30 days of the first partner notification discussion
- Number of people that make a formal complaint about the service (by letter or email)
- Number of people accessing outreach services
- Percentage of new men who have sex with men who accept Hepatitis B vaccination
- Number of primary care healthcare professionals trained and in what capacity, i.e. DFSRH, insert and remove LARCs
- Total people under 18 and number of escalations due to concerns identified

Overall Activity Levels and First Time Attendance

Overall attendances at sexual health venues have increased from 24,300 to 28,900 between 2013 and 2017 and the proportion of people receiving a sexual health screen on first attendance has increased from 68% to 79% over the same time period.

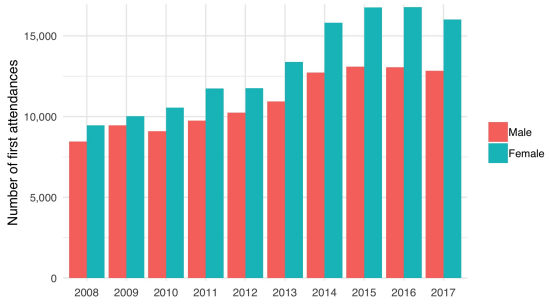
Year	First time attendances	Number of attendances with sexual health screen	% receiving sexual health screen
2013	24,300	16,500	68
2014	28,500	20,700	72
2015	29,900	22,000	74
2016	29,800	22,400	75
2017	28,900	22,700	79

Table 4 – *First time attendances at sexual health venues by West Sussex residents, 2013-17.*

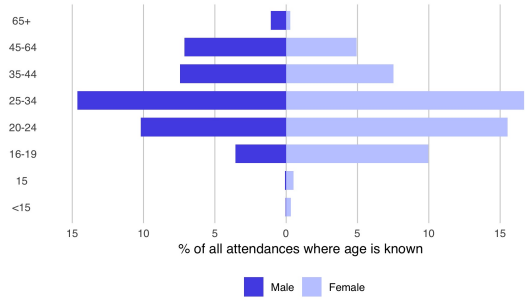
First attendance by background characteristics

Age and Gender

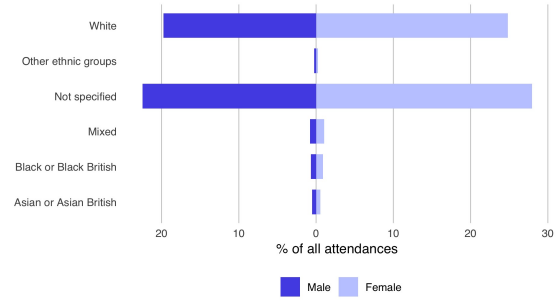
- The number of men and women attending a sexual health service has gradually increased since 2008 (Figure 3, graph 3a below).
- The largest proportion attending the service are aged between 25 and 34 years (graph 3b). A greater proportion of women attending are from the youngest age groups, while male attendances skew toward the older age groups.
- In relation to attendance by ethnic background in 2017 (graph 3c) data for over 40% of first time attendances was not specified, this makes evaluating the equity of access to the service difficult.
- Graph 3d shows the proportion of attendances by stated sexual orientation, where this information is specified. The largest proportion of attendances (53%) were by heterosexual women, while 31% of all attendances were by heterosexual men. Lesbian women appear to be under-represented in terms of attendance. Compared to ethnicity, far fewer attendances include people of unknown or unstated sexual orientation.



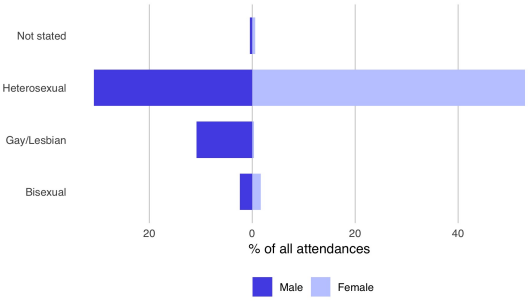
(a) *First attendances by gender, 2008-2017.*



(b) *By age and gender, 2017.*



(c) *By ethnic background and gender, 2017.*



(d) *By sexual orientation and gender, 2017.*

Figure 3 – *First attendances at Sexual Health Services in West Sussex. Source: PHE HIV/STI portal.*

Addressing the needs of higher risk groups and links with other services

There are some groups who are at a higher risk of poor sexual health. For this needs assessment we have not engaged directly with those groups or service users. National research and evidence provides some insight into specific needs and how they can be best met, but, in addition, a number of key informants (KIs) were identified to provide a West Sussex view. There are also a number of local reports, such as a Homelessness Needs Audit and health needs assessment of looked after children which have been used to inform this needs assessment.

Copies of all previous needs assessments are available on the JSNA website.

Key informants were contacted to provide insight into the needs of some groups at higher risk of poorer sexual health, notably people known to substance misuse services, people with a learning disability and children looked after. KIs were asked about specific needs, existing services and ideas for changes/improvements *(what's working well? what isn't? and how could things be better?).*

Common themes

- Some **higher risk groups have existing mechanisms to check on their health and wellbeing,** these provide a good opportunity to address sexual health needs, but while these mechanisms are considered well utilised for some groups, they are a missed opportunity for others, for example:
  - **All looked-after children have health assessments within 20 working days of coming into council care,** for children over 5 years old these are refreshed every 12 months. It was considered that sexual health issues were raised and included in assessments.
  - About 50% of adults with a **learning disability** (on a GP LD register) have a health check, this includes sections on relationships and sexual health. Besides the need to increase the percentage of people having an annual health check, the use of these to raise and address sexual health needs was considered limited and a missed opportunity.
- **The importance of good and timely information.** For all groups the importance of information and guidance was noted. Tailored information was available (for example easy read versions) but needed to be promoted and displayed by staff. In terms of clarity of service information for staff, there was praise for the clarity and accessibility of information.
- **Some people require considerable support to access and use universal services.** A common theme identified by all KIs was the level of support required to help some people engage with a service. For example an adult with a learning disability may feel uncomfortable in a waiting area, or a young person with a substance misuse service may be less likely to attend an appointment. There was praise for the existing service in terms of the response and ease of booking appointments and supporting clients from other services.

Some **specific issues** were raised for different groups:

People with a Learning Disability

- Sexual and relationship education is often limited for people with a learning disability. There could be opportunities for education sessions by staff from sexual health services in settings such as colleges or day centres.
- The needs of people with a learning disability should be considered in the move to a greater use of kit/online testing.
- Many people, including families and health professionals, simply fail to acknowledge sexual health needs of adults with learning disabilities, or recognise that many are sexually active. This acts as a barrier to having sexual health needs met and is a barrier to access to services or programmes such as cervical screening. This also can act as a barrier to identifying sexual abuse.

People who are homeless

In 2016, West Sussex County Council conducted a Homelessness Needs Audit using a survey developed by Homeless Link survey to engage with people, including those living on the street.

The survey contained questions about health, including sexual health. The questions that asked about sexual health included:

- Have you had a sexual health check in the past 12 months?
- Do you know where to access free contraception?
- Do you know where to access advice about sexual health?

Of those who answered, 24.8% reported having had a sexual health check during that time. This was lower than the national average of 35%.

Differences between gender and age within West Sussex were also present with a significant difference between males (20.5%) and females (38.8%) having had sexual health checks within the last 12 months. Similar differences are observed across England.

In relation to advice 86% reported they knew where to find advice about their sexual health. The majority stated they would contact a GP or nurse, or attend a sexual health clinic. 82% percent also stated they knew where to access free contraception.

The report noted that *"While these results are broadly positive, more engagement is required to determine the level of sexual risk homeless people encounter, and whether more work needs to be done with respect to outreach for this population".*

People with a substance misuse problem

West Sussex County Council Drug and Alcohol Treatment services are provided by Change Grow Live (CGL). The service supports adults and young people to understand the risks their drug or alcohol use pose to their health and wellbeing, and supports them to reduce or stop use safely. Drug and alcohol treatment services are split into services for people under 25 years and for people over 25. The U25 service is registered for C-card condom distribution and chlamydia testing scheme.

A number of issues were raised in relation to substance misuse and sexual health (and between services treating substance misuse and sexual health services):

- **There is no set pathway between services.** Access and use tends to be on an ad hoc basis and dependent on the person working with the client, and the relationship built up between services. There are some very good relationships but there is concern that these could be subject to change as circumstances or staff change.
- **Every area across the county is a little bit different and people work differently too**, this means that existing pathways and contacts are variable from one area to another. There is some direct contact e.g. sometimes young people will be booked into sexual health services with an appointment to avoid waiting in the clinic, but usually only under 18s.
- **For older people accessing the service, sexual health needs tend to be revealed at the assessment stage**, so in unpacking problems with drugs and/or alcohol, it might be necessary to also refer them into sexual health services for their wellbeing.
- **Issues around drugs and alcohol mean that some clients face additional risks and concerns** including where someone has turned to sex work or is being sexually exploited (e.g. engaged in sex for additional supply of misused substance). There may also be cases of child sexual exploitation or general criminal exploitation.
- **The range of people seen in substance misuse services means that there are also cases where people accessing the service are sexually inexperienced** and don't know the precautions they have to take. Therefore health promotion is necessary by either training staff members of the substance misuse service or the integrated sexual health service for these kinds of cases.
- **In some cases it's difficult to talk about pregnancy**, the conversations could be had earlier – i.e. whether client wishes to avoid pregnancy, or whether they are actually trying to conceive.

People with a substance misuse problem, cont.
KIs thought that overall there is a need to consider how services work together to achieve better results across the health and public health system, in relation to substance misuse services and sexual health service there may be a number of opportunities for joint working:

- The substance misuse service being supported to have HIV testing capability within the service
- Connections to online service run by the ISHS.
- Greater links and referrals between services, i.e. getting people from substance misuse service into the ISHS and vice versa, the KI could not recall a referral into substance misuse from the ISHS
- It was noted that a project working with women who have had one or more children taken into cause (the PAUSE project) had developed strong referral pathways and links with ISHS but if there were similar pathways for providing LARC to some people accessing the substance misuse service it might be possible to prevent pregnancies before children are taken in to care and avoid any removals. As such, substance misuse services should be viewed as part of the bigger preventative picture and work should be undertaken to get existing systems to work more effectively together.

Vulnerable Young People
Children at risk of Sexual Exploitation (CSE)

- All young people under the age of 18 years who access the integrated sexual health service are assessed against the 'Spotting the Signs' pro forma. The total number of service users under the age of 18 years are reported on, as are the number where concerns are identified and escalated.

Children Looked After

- Generally CLA will access service as any other young people would, though there is a trial under way about a fast-track pathway into the ISHS for CLA. At the moment the trial is based on postcode and is being evaluated. The situation is slightly different for unaccompanied asylum seeker children (UASC). All UASC are sent on the national Safer in the UK programme and receive closer health follow-ups from nurses.
- All children looked after (CLA) have health assessments within 20 working days of coming into council care, these are refreshed every 12 months for children over the age of 5. These assessments will discuss sexual health.
- CLA nurses carry C-cards and testing kits.
- Staff consider that the existing pathways are good, with no access barriers.There's been some feedback that termination of pregnancy services are difficult to access by public transport but attendance at those services are confidential, so no evidence/reason that this affects CLA adversely in particular.
- CLA are also likely to access school nurse services – but this would also be confidential, as would the texting service ChatHealth.

1. Introduction

The West Sussex Joint Strategic Needs Assessment [2] is an on-going process that examines the health and wellbeing needs of the local population.

As part of that process, this needs assessment investigates the sexual health needs of young people and adults in West Sussex. This assessment focusses on children and adults (people aged 16 years or over[1]), and includes all sexual health commisioning responsibilities in West Sussex. However, some aspects will require additional needs assessments. The report examines not just contraception and sexual health, but also considers what promotes and supports good sexual health.

Having good sexual health is an important aspect of overall physical and emotional health and wellbeing. It is central to the development of some of the most important relationships in our lives. Sexually active people can be negatively affected by their sexual health decisions and may need to take precautions or access sexual health services to maintain a positive and healthy sexual life.

1.1 The Aims of this needs assessment

This needs assessment reviews the sexual health needs of the county's population, and makes recommendations to support the commissioning of services to meet those needs.

The information presented aims to answer the following basic questions:

- What are the characteristics of the population of West Sussex?

[1] The age thresholds that define a person as an adult can change between services. Where appropriate this will be noted.

- What are the risk factors and protective factors affecting the sexual health of the population?
- What are the sexual health conditions and needs requiring commissioned services? Who accesses them and how many?
- What services are currently provided to meet those needs?
- How well are current services meeting those needs? What gaps and/or barriers, if any, need to be addressed?

The needs assessment incorporates data from a wide variety of sources and includes evidence collated from an extensive consultation process with service users, local organisations and professionals.

1.2 Objectives

- To gather information in order to provide an overview and increased understanding of current sexual health provision in West Sussex.
- To better understand the demand for and use of sexual health provision in West Sussex.
- To create an overview of the sexual health needs of West Sussex based on current information.
- To use the overview of needs to assess whether or not resources have been appropriately directed.
- To make recommendations with regard to service provision, location, capacity, expected performance, cost and effectiveness.
- To make recommendations regarding the spatial allocation of resources between and within different groups and geographical areas with respect to identified need.

1.3 Methodology and Content

This needs asessment uses the mixture of approaces described in Figure 1.1.

Throughout, the needs assessment collates background data on the characteristics of the local population and the prevalence of disease (epidemiological approach). It also compares local provision and outcomes using a comparative approach.

The remainder of the needs assessment involves the views of local stakeholders, commissioners, those using services, and the wider population. Chapter 6 considers a wide range of possible groups of people with specific needs with respect to sexual health. The chapter aims to explain the sources of need within these groups and how services currently address that need. Where appropriate, suggestions are made for further addressing this need.

HIV treatment is commissioned by NHS England and therefore chapter 7 specifically addresses HIV. Maintaining high levels of HIV testing coverage and early diagnosis are of paramount importance. There is also a discussion of HIV stigma and the UNAIDS 90:90:90 target that underpins Public Health England's HIV treatment objectives.

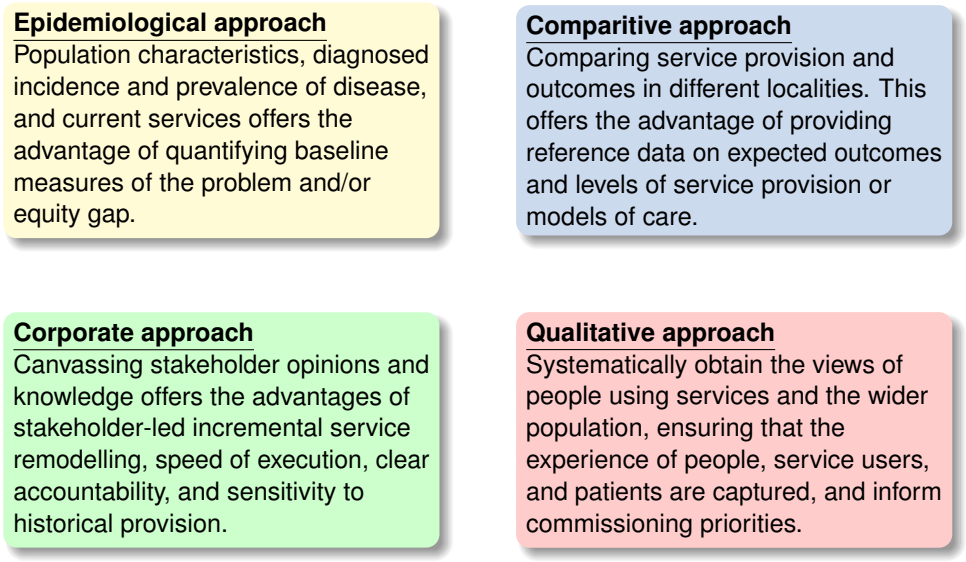


Figure 1.1 – *Approaches undertaken in mixed methods needs assessments.*

Technology presents many opportunities to improve health outcomes and reduce need. This is also the case for sexual health. While services are provided at convenient hours and work hard to reduce the stigma associated with attending sexual health clinics, many attendences could be reduced to providing testing kits for asymptomatic infections that could be ordered online. However, for symptomatic cases, younger people, and for people who may be engaged in risk taking behaviour, it is paramount that these people continue to be able to see a consultant face-to-face. Chapter 8 investigates the possibility of moving some elements of an integrated sexual health service to an online model. Needs identified in previous chapters are also examined in the light of how an online service might affect them.

1.4 Previous Sexual Health Needs Assessment

A sexual health needs assessment was conducted for West Sussex in 2014 [3] as sexual health commisioning responsibilities were transferred to the local authority. This needs assessment provides an update now that the integrated service has been in operation for five years, with a view to better understanding the many interactions of sexual health with other services in and around West Sussex.

2. Policy Context

2.1 Sexual Health Commissioning in England

In April 2013, following publication of the Healthy Lives, Healthy People white paper [4] and changes introduced in the Health & Social Care Act 2012 [5], local authorities took on a new public health role. This included provision of integrated sexual health services and long acting reversible contraception.

The arrangements for the commissioning of sexual health services are summarised below [6].

Local authorities commission the following services:

- Contraception in the form of implants and intra-uterine devices, along with all prescribing costs, but excluding contraception provided as an additional service under the GP contract;
- Sexually transmitted infection (STI) testing and treatment, Chlamydia screening as part of the National Chlamydia Screening Programme (NCSP), and HIV testing;
- Sexual health aspects of psychosexual counselling;
- Any sexual health specialist services, including young people's sexual health and teenage pregnancy services, outreach, HIV prevention and sexual health promotion services in schools, colleges and pharmacies.

Clinical Commissioning Groups (CCGs) commission:[1]

- Most abortion services;
- Vasectomy;

[1] There are three CCGs in West Sussex: Coastal West Sussex, Horsham and Mid Sussex, and Crawley.

- Aspects of psychosexual counselling unrelated to sexual health;
- Gynaecology[2].

NHS England commissions:

- Contraception provided as an additional service under the GP contract;
- HIV treatment and care;[3]
- Promotion of opportunistic testing and treatment for STIs, and patient-requested testing by GPs;
- Sexual health elements of prison health services;
- Sexual Assault Referral Centres (SARCs);
- Cervical screening;
- Specialist foetal medicine services.

For this needs assessment, the focus is on the above mentioned services that West Sussex provides. However, any consideration of these services also requires some grounding in the wider sexual health economy in which they operate.

2.2 Public Health Outcomes Framework

To accompany the transfer of public health responsibilities to local authorities, the Department of Health published the Public Health Outcomes Framework [7]. This sets out the desired outcomes for public health and how they are to be achieved by local authorities. These outcomes focus on length and quality of life as well as reducing health inequalities.

The main themes of the Public Health Outcomes Framework are:

- Improving the wider determinants of health
- Health promotion
- Health protection
- Healthcare public health and preventing premature mortality

The importance of improving sexual health is acknowledged in the Public Health Outcomes Framework with the inclusion of three sexual health indicators:

Indicator	PHOF Theme
Under-18 conceptions	Improving the wider determinants of health
Chlamydia diagnoses in 15-24 year-olds	Health promotion
People presenting with HIV at a late stage of infection	Health protection

Table 2.1 – *Key sexual health indicators and corresponding themes in the Public Health Outcomes Framework.*

[2]This includes the use of contraception for non-contraceptive purposes.
[3]This includes drug costs for post-exposure prophylaxis (PEP) after sexual exposure

2.3 A Framework for Sexual Health Improvement in England

Following publication of the Public Health Outcomes Framework, the Department of Health published "A Framework for Sexual Health Improvement in England" [8]. This report lays out four key objectives and ten ambitions for sexual health services in England.

2.3.1 Key objectives

1. Improve the sexual health of the whole population
2. Reduce inequalities and improve sexual health outcomes
3. Build an open and honest culture where everyone is able to make informed and responsible choices about relationships and sex
4. Recognise that sexual ill health can affect all parts of society, often when it is least expected.

These objectives are also the central guiding principles of this needs assessment.

2.3.2 Ambitions

1. **Build knowledge and resilience among young people:**
   - all children and young people receive good-quality sex and relationship education at home, at school and in the community;
   - all children and young people know how to ask for help, and are able to access confidential advice and support about wellbeing, relationships and sexual health;
   - all children and young people understand consent, sexual consent and issues around abusive relationships;
   - young people have the confidence and emotional resilience to understand the benefits of loving, healthy relationships and delaying sex.
2. **Improve sexual health outcomes for young adults:**
   - all young people are able to make informed and responsible decisions, understand issues around consent, see the benefits of stable relationships, and are aware of the risks of unprotected sex;
   - prevention is prioritised;
   - all young people have rapid and easy access to appropriate sexual and reproductive health services;
   - all young people's sexual health needs – whatever their sexuality – are comprehensively met.
3. **All adults have access to high quality services and information:**
   - individuals understand the range of choices of contraception and where to access them;
   - individuals with children know where to access information and guidance on how to talk to their children about relationships and sex;
   - individuals with additional needs are identified and supported;
   - individuals and communities have information and support to access testing to increase earlier diagnosis and prevent the transmission of HIV and STIs.

4. **People remain healthy as they age:**
    - people of all ages understand the risks they face and how to protect themselves;
    - older people with diagnosed HIV can access any additional health and social care services they need;
    - people with other physical health problems that affect their sexual health can get the support they need for sexual health problems.
5. **Prioritise prevention:**
    - build a sexual health culture that prioritises prevention and supports behaviour change;
    - ensure that people are motivated to practise safer sex, including using contraception and condoms;
    - increased availability and uptake of testing to reduce transmission;
    - increase awareness of sexual health among local healthcare professionals and relevant non-health practitioners, particularly those working with vulnerable groups.
6. **Reduce rates of sexually transmitted infections (STIs) among people of all ages:**
    - individuals understand the different STIs and associated potential consequences;
    - individuals understand how to reduce the risk of transmission;
    - individuals understand where to get access to prompt, confidential STI testing and provision allows for prompt access to appropriate, high-quality services, including the notification of partners;
    - individuals attending for STI testing are also offered testing for HIV.
7. **Reduce onward transmission of and avoidable deaths from HIV:**
    - individuals understand what HIV is and how to reduce the risk of transmission;
    - individuals understand how HIV is prevented;
    - individuals understand where to get prompt access to confidential HIV testing;
    - individuals diagnosed with HIV receive prompt referral into care, and high-quality care services are maintained;
    - individuals diagnosed with HIV receive early diagnosis and treatment of STIs.
8. **Reduce unwanted pregnancies among all women of fertile age:**
    - increase knowledge and awareness of all methods of contraception among all groups in the local population;
    - increase access to all methods of contraception, including long- acting reversible contraception (LARC) methods and emergency hormonal contraception, for women of all ages and their partners.
9. **Improve termination of Pregnancy Counselling:**
    - all women requesting an abortion should be offered the opportunity to discuss their options and choices with a trained counsellor.
10. **Continue to reduce the rate of under-16 and under-18 conceptions:**
    - all young people receive appropriate information and education to enable

them to make informed decisions;
- all young people have access to the full range of contraceptive methods and where to access them.

2.4 Integrated Sexual Health Services: National Service Specification

Public Health England provides a national service specification [9] for integrated sexual health services to help local authorities commission effective, high-quality, integrated sexual health care.

It covers:

- the rationale for commissioning effective and easy to access services
- the objectives of service provision
- key outcomes to consider
- a description of what should be offered at various levels of service
- professional and other quality standards covering sexual health
- a description of the need to work in partnership with other services such as termination of pregnancy, general practice, and mental health services.

The specification is offered as a tool to help local authorities and their providers. It can be adapted to fit local needs.

The integrated model of sexual health services aims to provide easy access to services through open access 'one stop shops'. These sites provide a single location where the majority of sexual health and contraceptive needs can be met at, usually by one health professional. Ideally such services should have extended opening hours and be in accessible locations.

The aims of the integrated sexual health service are to improve sexual health by:

- Promoting sexual health, including information and advice that reduces the stigma associated with STIs, HIV and unwanted pregnancy
- Providing rapid and easy access to services for the prevention, detection and management (treatment and partner notification) of STIs to reduce prevalence and transmission
- Facilitating rapid and easy access to the full range of contraceptive services (including LARC) for all age groups
- Preventing unwanted pregnancy including unwanted pregnancy among teenagers
- Providing rapid access to services to diagnose, counsel and manage unwanted pregnancy (including rapid access to NHS funded abortion services for those who choose this option)
- Supporting women and couples to plan pregnancy
- Reducing late diagnoses of HIV
- Improving the sexual health of people living with HIV
- Continuously improving services through development, innovation, and consultation with service users and the local population
- Developing a sexual health economy that provides a comprehensive service with clear referral pathways between providers, enabling effective planning through clinical leadership and clinical networks

- Providing accredited training to doctors, nurses and other practitioners working in both the Service, NHS and local authority commissioned services.

Objectives include:

- Providing sexual health information and advice in order to develop increased knowledge, especially in high-need communities
- Ensuring that services are acceptable and accessible to people disproportionately affected by unwanted pregnancy and sexual ill health based on up to date sexual health needs assessment
- Providing opportunities for people to manage their own sexual health either independently or with support
- Rapid and easy access to services for the prevention, detection and management (treatment and partner notification) of sexually transmitted infections to reduce prevalence and transmission
- Provision of chlamydia screening as part of the National Chlamydia Screening Programme (NCSP)
- Access for all age groups to a complete range and choice of contraception including long acting methods, emergency contraception, condoms and support to reduce the risk of unwanted pregnancy
- Access to free pregnancy tests and appropriate onward referral to abortion services or maternity care
- Promoting access and reduce waiting times to abortion services and maternity care through the provision of information on client self-referral (where available)
- Increasing the uptake of HIV testing and rapid referral to HIV care services following diagnosis with timely initiation of treatment when clinically indicated[4]
- Engaging local prevention groups and non-governmental organisations to facilitate collaboration with service development and health promotion
- Developing the sexual health workforce through delivery of the full range of FSRH and BASHH accredited postgraduate training including specialist training programmes
- Delivering undergraduate training when linked to a university that trains health care professionals
- Coordinate and support the delivery of sexual health care across a locality through expert clinical advice, clinical governance and clinical networks[5]
- Maintenance of undergraduate and postgraduate medical and nurse training if service provision is taken over by another provider
- Supporting evidence-based practice in sexual health (this should include participation in audit and service evaluations and may include research)
- Promoting service and key sexual health messages to the local population, via

[4]HIV Standards suggest that people who have a new diagnosis of HIV should be informed of their CD4 count and have the opportunity to discuss management, antiretroviral therapy and opportunistic infection prophylaxis within 2 weeks of this initial assessment (i.e. within 1 month)

[5]This should include providing specialist expert advice to other service providers and organisations; training of nursing and medical sexual health experts; delivering multidisciplinary postgraduate training, including to primary and secondary care; and may include delivering undergraduate training and postgraduate training including placements for medical and nursing students and training and education for specialty medical trainees which should be in line with the latest GMC curriculum.

the use of innovative and appropriate media and marketing techniques tailored to specific audiences.

2.5 West Sussex Health and Wellbeing Board

The West Sussex Health and Wellbeing Board (HWB) is a strategic board providing systems leadership for health and wellbeing in West Sussex. The HWB brings together elected members, senior leaders from the NHS, Local Authorities, Voluntary Sector and other partners to work together to:

- improve the health and wellbeing of the residents of West Sussex
- reduce the health inequalities gap by improving the health and wellbeing of the poorest
- promote joined up working to ensure better quality of services for all

The Board includes representation from key organisations in West Sussex with major responsibilities for commissioning and delivering health, social care and public health services, as well as those responsible for services that impact on the wider determinants of health, such as housing, transport and education. It sets the direction of travel for health and wellbeing services across the county.

The HWB directs its work along three themes: **starting well, working well, and ageing well.** Sexual health appears within all these themes. This ranges from

- stressing the importance from a prevention perspective of informative and non-judgemental sex and relationships education for young people **(starting well)**
- making the case for the productivity and social cost savings of a reliable long-acting reversible contraception (LARC) and other forms of family planning **(working well)**
- maintaining focus on the diagnosis and treatment of as many cases of STIs as possible, regardless of stigma **(working well)**
- planning in detail for mitigating sexual risk later on in the life course **(ageing well)**
- ensuring a culture of safeguarding that protects and acts for and on behalf of the most vulnerable within the county **(all themes)**.

A key aim of this needs assessment is to provide the West Sussex Health and Wellbeing Board with the information needed to best fulfil its aims with regard to the sexual health of the population of West Sussex.

3. West Sussex Demography

3.1 Population characteristics

West Sussex is a large county in the southeast of England. It comprises a coastal strip with a series of medium size coastal towns (Shoreham, Worthing, Littlehampton, Bognor), small to medium size towns in relatively rural areas (Petworth, Midhurst, Storrington, Burgess Hill, Arundel) and large town centres (Chichester, Crawley, Horsham, Haywards Heath). This needs assessment covers a geographical area containing seven Local Authorities (Figure 3.1) and three Clinical Commissioning Groups (Figure 3.2).

3.1.1 Age and gender

According to ONS 2017 mid-year estimates [11], there are approximately 852,400 people resident in West Sussex, 504,500 aged 16-64 and 192,900 aged 65 years or over.

Table 3.1 shows how the population of West Sussex is distributed over the districts and boroughs. The majority of the population is concentrated in Arun and Mid Sussex, while Worthing and Crawley have higher population density. The gender ratio is approximately the same across districts, except for Crawley. Crawley also has a younger population, as can be seen in Table 3.2.

Table 3.3 shows 2017 mid-year estimates for population of West Sussex and the districts and boroughs. The table also includes estimates for births, deaths, and the net amount of internal and international migration.

Figure 3.3 shows how the population of West Sussex is distributed by age and gender, and how it compares to both England and the remainder of the South East region. The

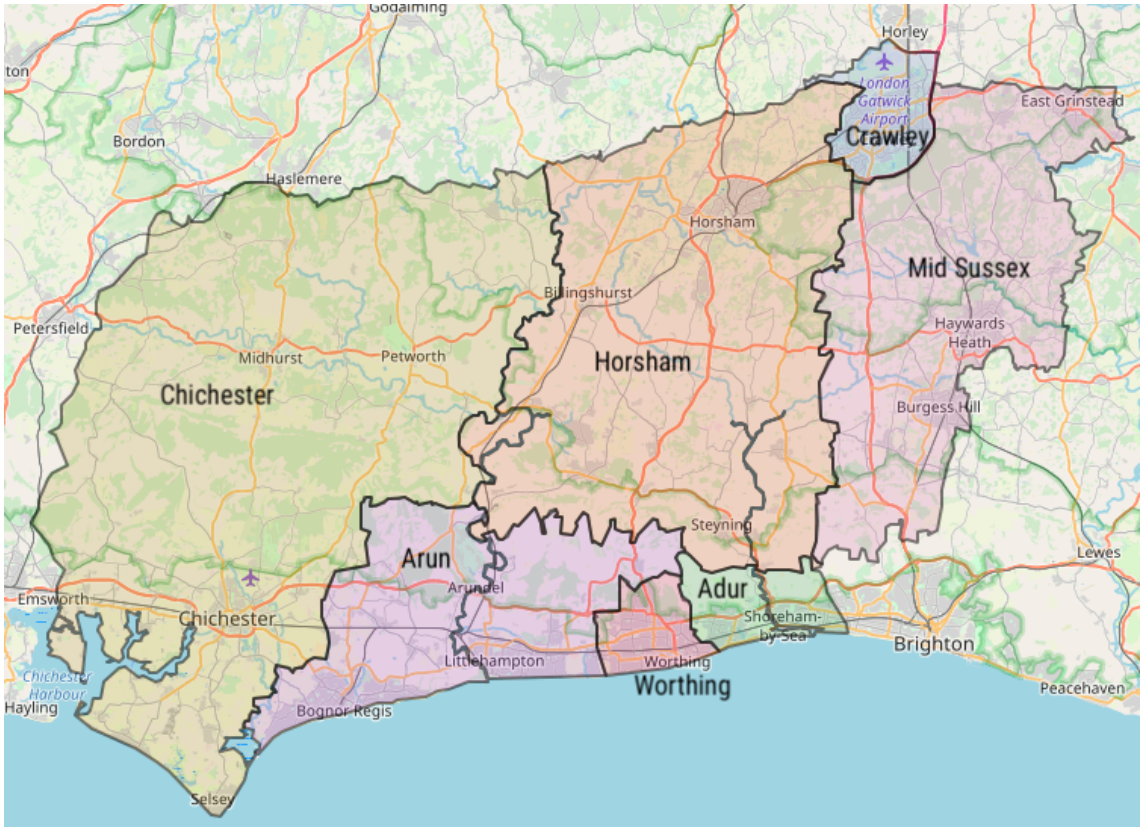


Figure 3.1 – *The districts and boroughs of West Sussex. Source: OpenStreetMap [10].*

largest population group is women aged 50-54 years. Compared to the South East and England as a whole, there are fewer people in each of the young age groups from 10-14 through to 40-44.

Area	Men	Women	All
Adur	31,000	32,700	63,700
Arun	76,200	82,400	158,700
Chichester	58,000	62,200	120,200
Crawley	56,000	55,700	111,700
Horsham	68,200	72,000	140,100
Mid Sussex	72,300	76,000	148,300
Worthing	53,000	56,700	109,600
West Sussex	414,600	437,700	852,400

Table 3.1 – *Mid-year population estimates by district and sex, June 2017. Source: ONS.*

3.1.2 Trends in Population

Figure 3.4 shows the population of West Sussex at five year intervals between 1995 and 2015. The figure includes estimates for the population aged 15 and under, and the working age population (defined as those aged 16 to 64 years). Over 65s comprise

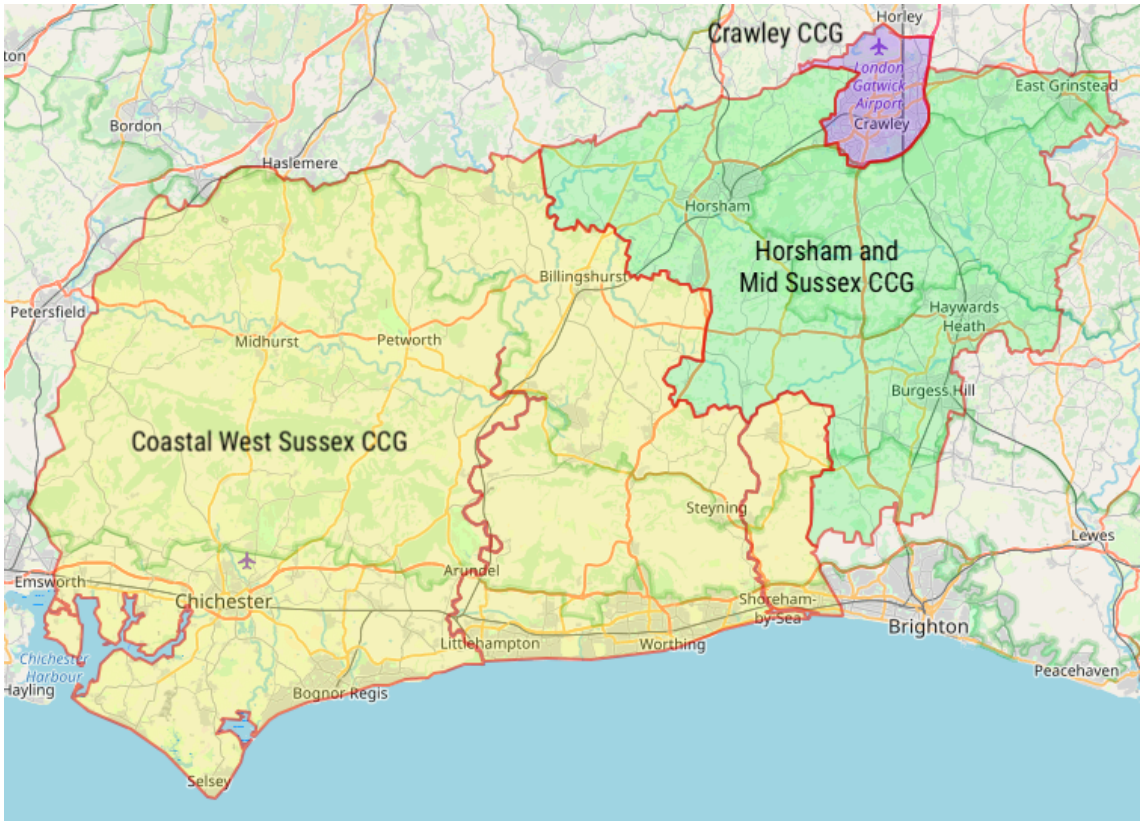


Figure 3.2 – *Clinical Commissioning Groups in West Sussex. Source: OpenStreetMap [10].*

	Age group				
Area	**0-15**	**16-64**	**65 & over**	**18 - 24**	**All ages**
Adur	11,600	37,200	14,900	4,100	63,700
Arun	25,400	87,900	45,400	10,300	158,700
Chichester	19,800	68,400	32,000	9,500	120,200
Crawley	24,400	72,400	14,900	8,000	111,700
Horsham	25,400	83,500	31,300	8,700	140,100
Mid Sussex	29,100	89,300	30,000	9,000	148,300
Worthing	19,400	65,800	24,500	7,100	109,600
West Sussex	155,000	504,500	192,900	56,500	852,400

Table 3.2 – *2017 Mid-year population estimates by district and age. Source: ONS.*

the fastest growing population group in West Sussex. The age dependency ratio, the ratio of working age adults to the remainder of the population, has been falling in West Sussex for many years.

The Office of National Statistics provides population projections for local authority geographies. Current projections for West Sussex estimate an overall population increase of 10% over the next ten years, with higher percentage increases in 65-84 years olds and 85+ year olds. Based on these projections, additional demand for

Local Authority	Mid-year Population 2016	Births	Deaths	Net Internal Migration	Net International Migration	Other	Mid-year Population 2017
Adur	63,621	672	722	84	76	-10	63,721
Arun	157,287	1,478	2,165	1,763	252	42	158,657
Chichester	119,125	1,004	1,503	1,249	298	19	120,192
Crawley	111,546	1,584	787	-1,215	534	2	111,664
Horsham	138,523	1,320	1,312	1,391	223	-3	140,142
Mid Sussex	147,540	1,547	1,438	398	296	2	148,345
Worthing	109,246	1,096	1,447	608	124	5	109,632
West Sussex	846,888	8,701	9,374	4,278	1,803	57	852,353

Table 3.3 – *2017 mid-year population estimates with components of change. Source: ONS.*

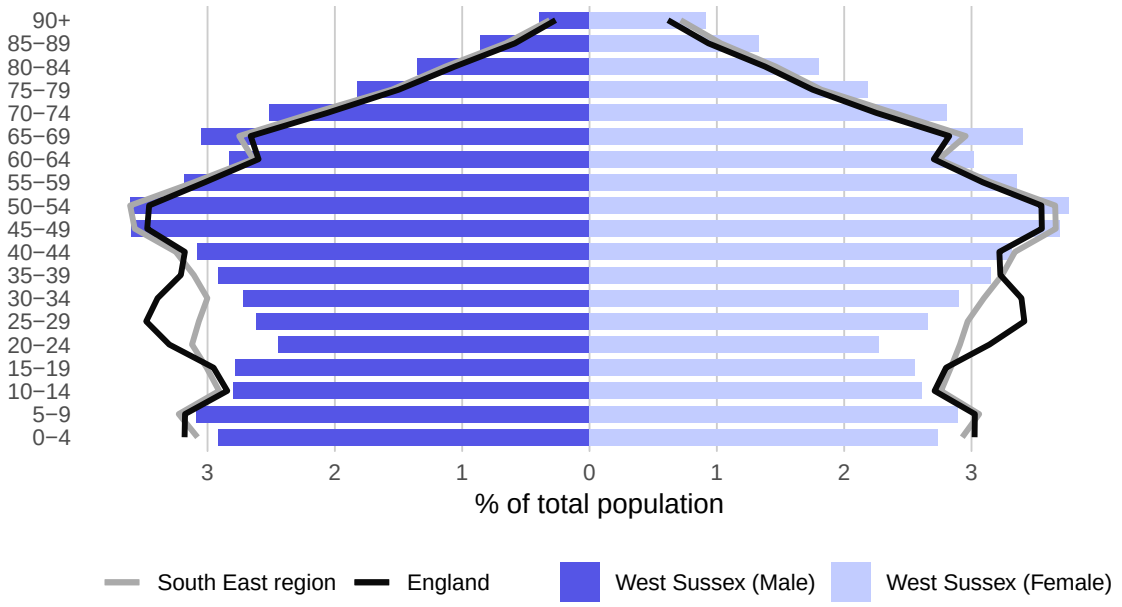


Figure 3.3 – *Population pyramid for West Sussex. Source: ONS.*

sexual health services based on demographic pressures will be modest.

Figure 3.5 shows population projections for the population of West Sussex towards 2040. Projections for three age groups important to planning sexual health services are shown: children, young people, and the working age population. Population projections are based on particular assumptions and therefore may not anticipate the effect on birth rates and migration flows of phenomena such as Brexit or sustained climate change.

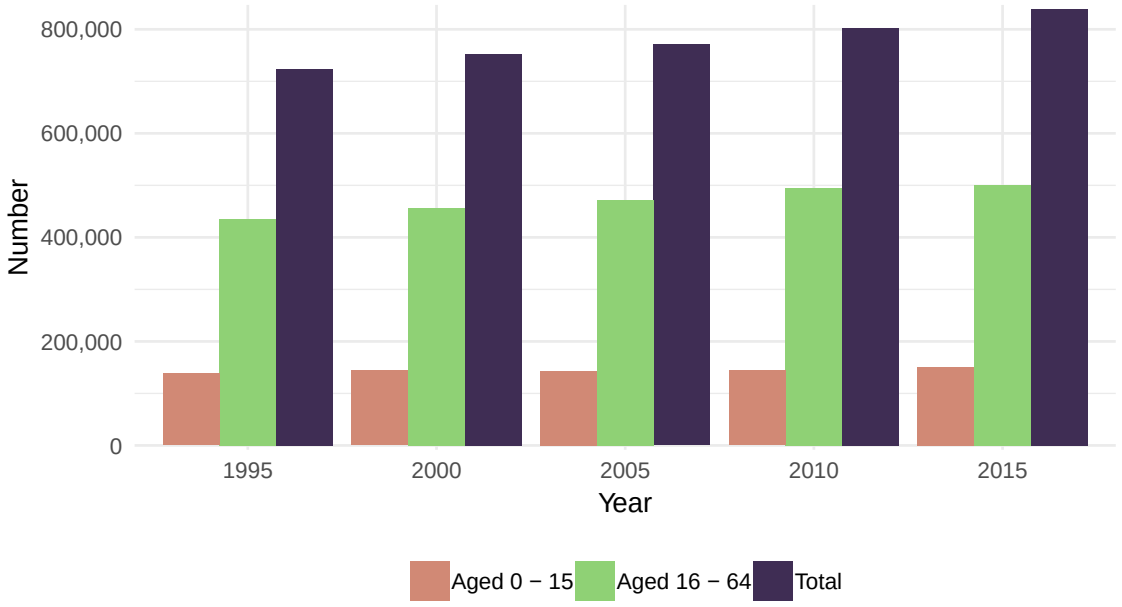


Figure 3.4 – *Total population of West Sussex at five year intervals between 1995 and 2015, with the number of 0-15 year olds and 16-64 year olds. Source: ONS.*

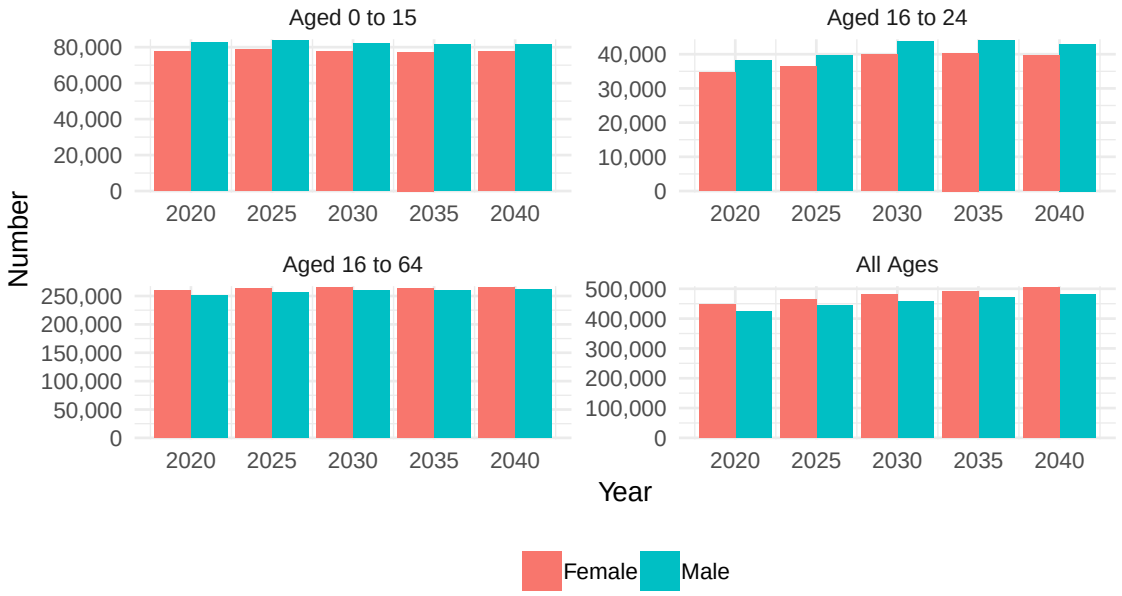


Figure 3.5 – *Population projections for various age groups in West Sussex at five year intervals between 2020 and 2040. Source: ONS.*

3.1.3 Sexual orientation

No regular household survey collects robust information on sexual orientation and estimates vary considerably. Figures from national surveys should be considered carefully alongside their sampling criteria and the confidence intervals given. It is also unlikely that small-scale locally-conducted surveys are generalisable to populations

in other areas. The National Survey of Sexual Attitudes and Lifestyles (NATSAL) is a nationally conducted survey that asks people about their sexual attitudes and lifestyles [12].

Where necessary this needs assessment uses results from NATSAL-3 concerning self-reported sexual orientation, as in Table 3.4. However, rates using denominators derived from NATSAL-3 should be regarded as indicative only because age group is not given in conjunction with sexual orientation in the available data sources. The rates presented may be overestimates for young lesbian, gay, and bisexual people, and underestimates for older lesbian, gay, and bisexual people.

	Self-defined sexual identity (all ages)			
Sex	**Heterosexual**	**Gay/Lesbian**	**Bisexual**	**Other**
Male	97.1%	1.5%	1.0%	0.3%
Female	97.3%	1.0%	1.4%	0.3%

Table 3.4 – *Percentage of NATSAL-3 respondents across all age groups identifying as heterosexual, gay, bisexual, or other.*

3.1.4 Deprivation

The Indices of Deprivation are produced every 3-4 years and published by the DCLG. The indices rank each small area of England and Wales in terms of deprivation and the findings are incorporated into many Government allocation formulae. The latest indices were published in 2015.

West Sussex is a less deprived county according to the IMD 2015. However, county level data masks considerable differences within areas. There are neighbourhoods that rate among the 10% most deprived in England. In 2015 West Sussex ranked 130th out of 152 upper-tier authorities on the Indices of Deprivation; in 2010 West Sussex ranked 130th. Because deprivation is a relative measure, the change in ranking for West Sussex may not be significant. In relation to neighbouring authorities, West Sussex is relatively less deprived than East Sussex (ranked 99th) and Brighton and Hove (ranked 76th), and more deprived than Hampshire (ranked 141st) and Surrey (ranked 150th).

Deprived areas tend to have higher rates of teenage pregnancy [13], higher admission rates to hospital and higher numbers of families encountering social services. The correlation between under 18 conceptions as measured by the Public Health outcomes framework indicator 2.04 can be seen in Figure 3.6. While many rates of STI diagnosis are correlated with deprivation, some sexual health outcomes are uncorrelated to deprivation, like late diagnoses of HIV, as can be seen in Figure 3.7.

- The map in Figure 3.8 shades small areas according to their relative deprivation ranking.
- The most deprived areas are shaded dark red, and the least deprived shaded dark blue.
- The darkest red shading represents areas within the most deprived 10% in England.

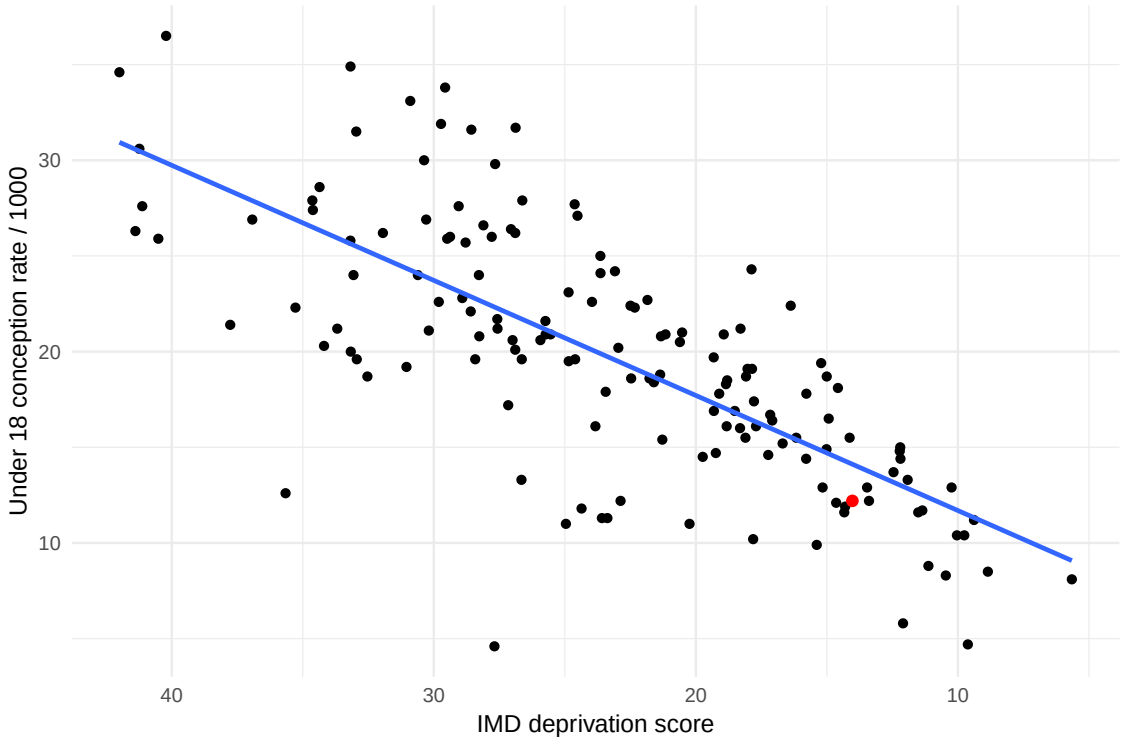


Figure 3.6 – *Teenage conceptions in England, 2016. The number of conceptions to mothers aged 18 or below, plotted against IMD deprivation score for local authorities in England. In each subfigure West Sussex is plotted in red. Source: PHE Fingertips.*

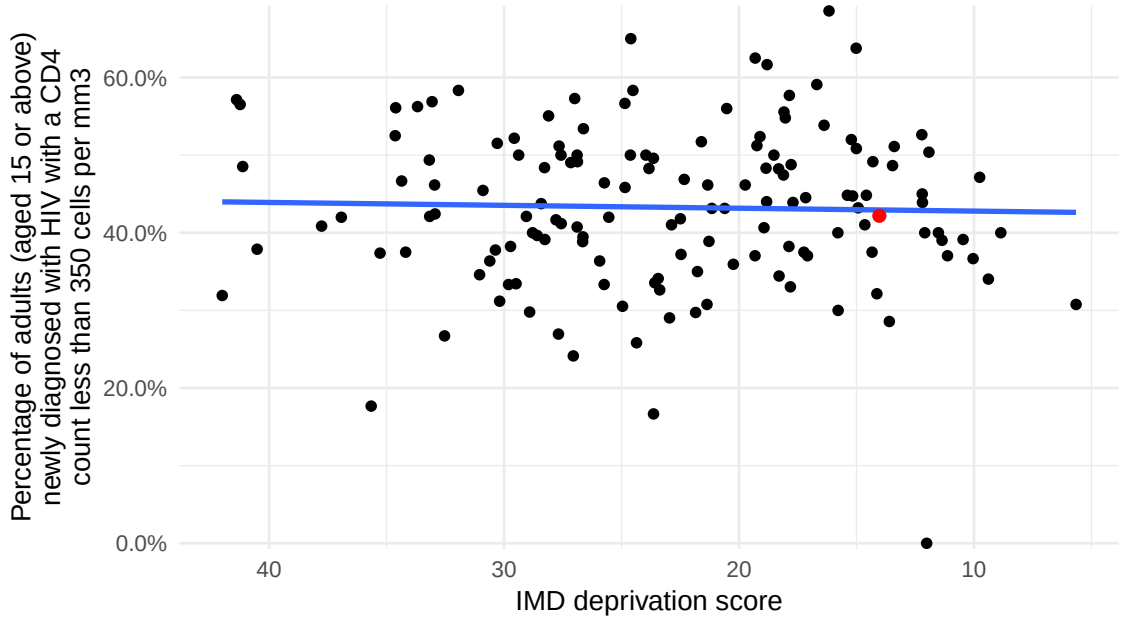


Figure 3.7 – *New HIV diagnoses in England, 2016. The figure shows the number of new diagnoses of HIV for English local authorities, plotted against IMD deprivation score. West Sussex is plotted in red. Source: PHE Fingertips.*

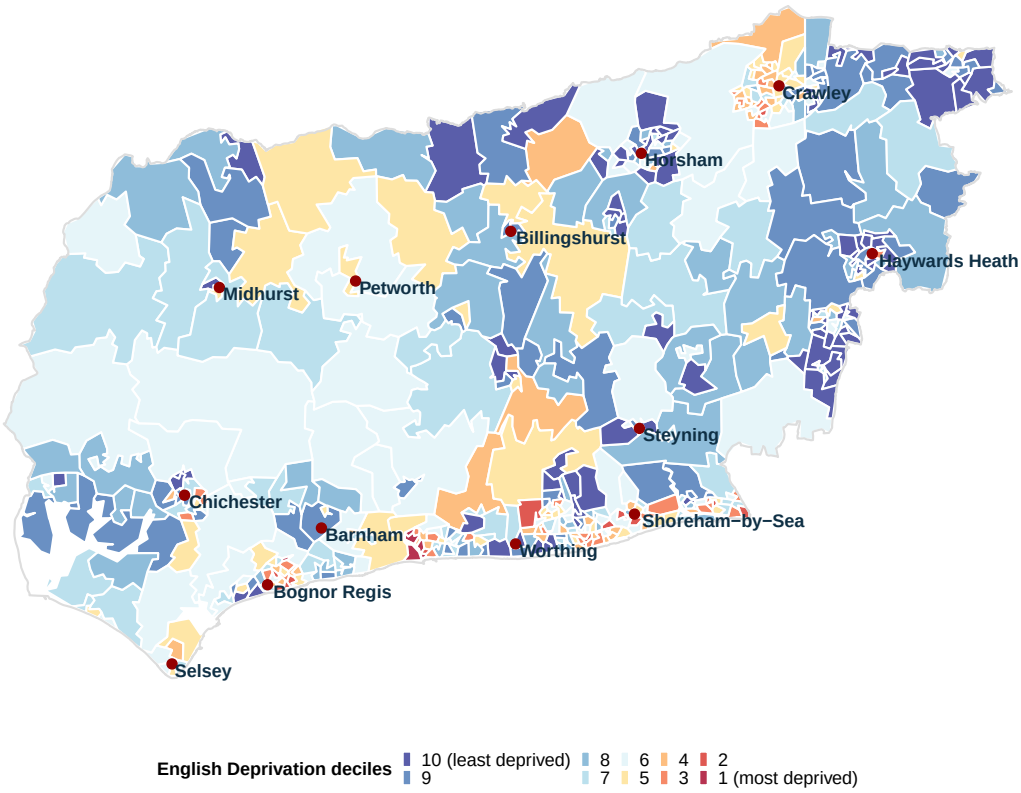


Figure 3.8 – *Map of West Sussex showing 2015 indices of multiple deprivation by small areas. Source: DCLG.*

In relation to Lower Super Output Areas the following were in the most 10% (darkest red shading in Figure 3.8) and 20% deprived (light red) of all LSOAs in England:

LSOA	IMD 2015 Score	EDD	LSOA	IMD 2015 Score	EDD
Arun 004A	49.075	1	Adur 008A	39.348	2
Arun 004B	46.681	1	Arun 016C	38.625	2
Arun 011C	45.536	1	Worthing 006E	38.366	2
Arun 014A	45.137	1	Worthing 009A	37.764	2
Arun 017D	44.101	2	Arun 017B	37.309	2
Worthing 010A	43.799	2	Adur 004B	36.270	2
Arun 011D	43.287	2	Adur 004D	35.208	2
Worthing 011D	42.994	2	Arun 017E	34.292	2
Crawley 013D	41.018	2	Adur 006C	33.917	2

Table 3.5 – *LSOAs in the two most deprived English deprivation deciles (EDDs), IMD 2015. Source: DCLG*

3.1.5 Housing and Homelessness

The relationship between housing and wider health outcomes is complex. Young people most at risk of being in poor housing will be those with existing, and sometimes multiple health problems; but for some young people health problems can be triggered by housing problem. For example, it is estimated that 20% of young people start drug use after they become homeless. This is in part due to greater exposure to drugs. There is also a strong association between drug use and sexual risk taking.

At the extreme end, homelessness is associated with very poor health outcomes

- Mental health problems, increased risk of self-neglect/self-harming, and suicide
- Increased exposure to infections
- Limited ability to adopt healthy lifestyle in relation to diet or exercise
- Without a permanent address, limited access to primary care
- Young adults, and notably young men are also more likely to live in Houses in Multiple Occupation (HMOs), and more likely to suffer injury and twice as likely to die in fires than those living in “single dwelling”
- Increased risk of exchanging sex for money and/or shelter.

In the case of sexual health, the fact that the current service can be accessed anonymously and without a prior appointment means that some of the barriers to accessing services are removed. However, away from the hubs in Worthing, Crawley, and Chichester it is harder to access services because ’spoke’ clinics can have shorter hours, be open on fewer days, and have a smaller range of services. Chaotic lifestyles can also create difficulties in accessing services. In West Sussex, the integrated service works with homelessness groups to provide sexual health outreach.

Figure 3.9 shows the number of households in West Sussex accepted as homeless or in priority need from Q1 of 2010 to Q1 of 2018.

3.1.6 Ethnicity

The highest population rates of STI diagnoses are among people of black ethnicity, especially those of black Caribbean ethnicity. This sexual health inequality is likely the consequence of a complex interplay of cultural, socio-economic and behavioural factors [14].

While people from some BME groups have been identified as having higher diagnosis rates of sexually transmitted infections (for example in England in 2016 the diagnosis rate for Gonnorrhoea in black or black British people is greater than 4 times that for white people [15]); the picture in relation to specific BME groups can be more complex.

However, among Asian minority groups there are less attendance and fewer diagnoses. This could indicate an area of unmet need if Asian people are not accessing services for cultural reasons.

The relationship between ethnicity and access to sexual health services is complex, as it is mediated by deprivation. People from BME groups are more likely to live in poverty, have lower educational attainment and have higher rates of unemployment.

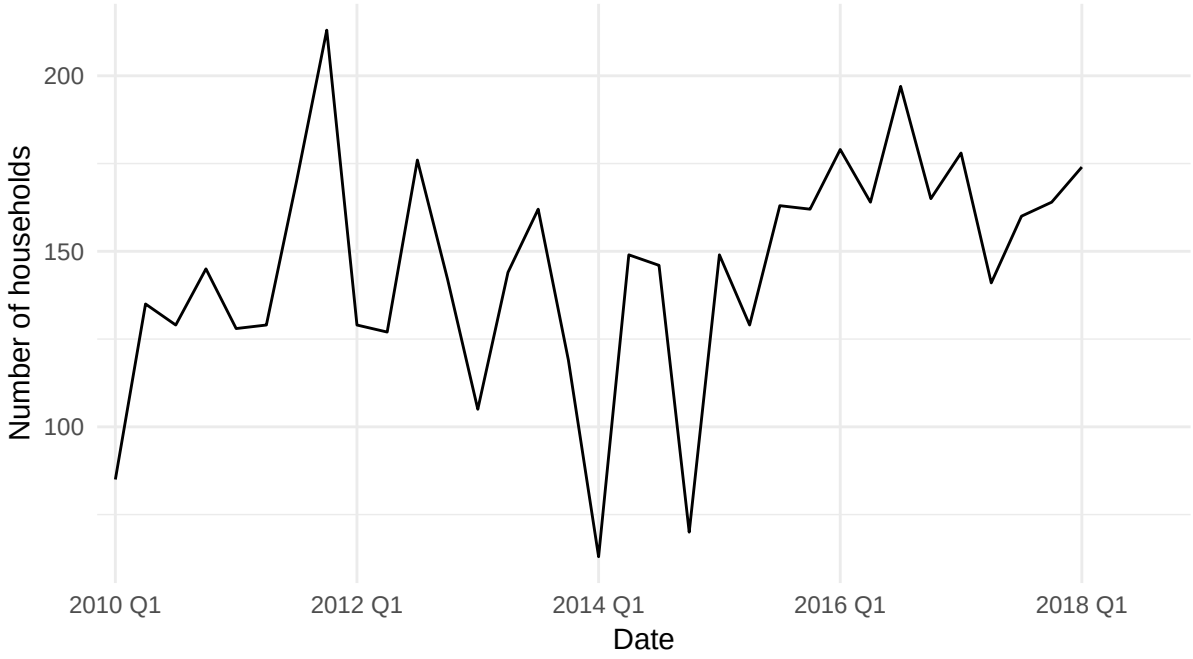


Figure 3.9 – *Households accepted as homeless or in priority need, West Sussex Q1 of 2010 to Q1 of 2018. Source: DCLG.*

Figure 3.10 shows that West Sussex is becoming more ethnically diverse. Data from the 2011 census show that 11% of the population is from an ethnic minority, compared with 6.5% in 2001. Of the black and ethnic minority (BME) groups, "white other" accounts for 4% of the West Sussex population.

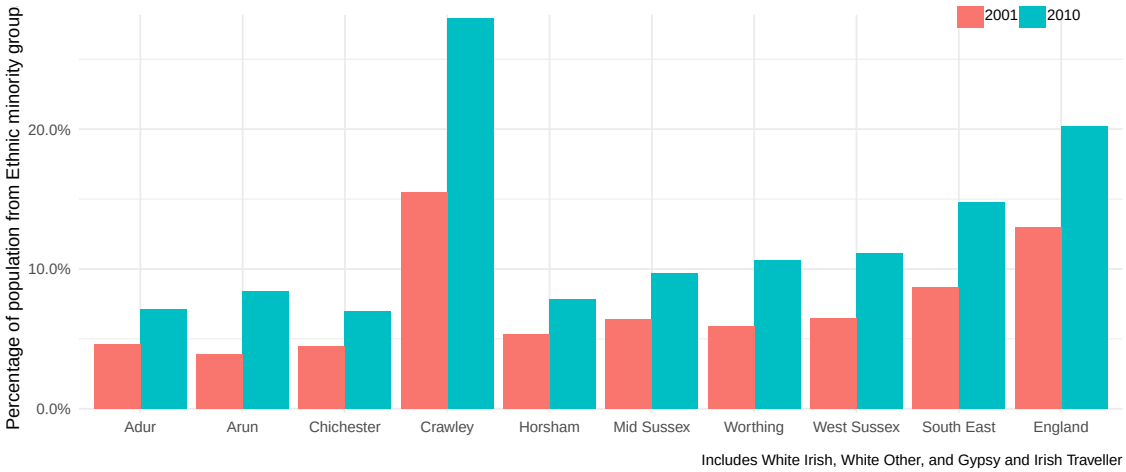


Figure 3.10 – *Percentage of population from ethnic minority groups in West Sussex and its districts and boroughs. Proportion includes White Irish, White Other, and Gypsy and Irish Traveller. Source: Census, 2001 and 2011.*

Figure 3.10 also shows the difference between local authority areas in West Sussex, and the change over time. In Crawley almost 28% of the population has an ethnic minority background, compared with 7% in Chichester. The growing ethnic diversity of

the county should be considered by commissioners when planning services.

Ethnicity	Male	Female
Asian or Asian British	3.6%	3.5%
Black or Black British	0.9%	0.9%
Mixed	1.6%	1.5%
Other	0.4%	0.3%
White	93.6%	93.9%

Table 3.6 – *Percentage of West Sussex population by ethnicity. Source: Census, 2011.*

3.2 Local authorities that are statistically similar to West Sussex

The Chartered Institute of Public Finance and Accountancy (CIPFA) has calculated the local authorities that are neighbours of one another in a statistical sense. Each local authority in England is measured on a variety of economic and social indicators and the CIPFA neighbours of a local authority are the fifteen local authorities that are the shortest distance from it with respect to these different dimensions.

Name	IMD 2015 Rank	Population aged 16-64	Total Population
Essex	112	982,193	1,468,177
Gloucestershire	124	419,419	628,139
Warwickshire	120	378,564	564,562
Worcestershire	110	386,830	588,370
Hampshire	141	908,331	1,370,728
East Sussex	99	347,345	552,259
Devon	105	502,290	787,171
Suffolk	101	490,844	756,978
Staffordshire	116	581,824	870,825
Oxfordshire	144	472,737	682,444
Kent	104	1,040,757	1,554,636
North Yorkshire	125	393,875	611,633
Somerset	98	354,271	555,195
Northamptonshire	106	508,411	741,209
Cambridgeshire	133	446,335	648,237
West Sussex	130	554,525	852,353

Table 3.7 – *CIPFA neighbours of West Sussex with ID rank of average rank, working age population (16 to 64 years) and total population. Deprivation data are from ID 2015, [16] Population data are ONS 2017 mid-year estimates, [11].*

3.3 National Data and Surveys

Data on sexual attitudes and lifestyle are not routinely collected at a local level (or are not openly distributed for privacy reasons). Therefore information about sexual experience and practice must be inferred from national surveys and datasets. The NATSAL-3 survey [12] has already been cited in reference to sexual orientation.

The first National Survey of Sexual Attitudes and Lifestyles (NATSAL-1) took place in 1990-91. It provided urgently needed population-based data to inform the prevention and prediction of HIV transmission. A second survey (NATSAL-2) in 1999-2001 extended the investigative focus to wider aspects of sexual and reproductive health. Data from these surveys have been widely used to inform sexual and reproductive health policy in Britain. These two surveys were retrospectively matched to the 1991 and 2001 censii.

The third installment of the survey (NATSAL-3) took place in 2012 [12]. Table 3.8 shows summary results on sexual experience and lifestyle for 16 to 24 year olds.

	Men	Women
Age at first heterosexual intercourse	16	16
Heterosexual intercourse before 16 years	30.90%	29.20%
Average number of sexual partners	6.5	5.2
At least one new partner in last year	46.00%	38.30%
Genital contact without intercourse past year	71.30%	72.60%
Occasions of sex in the last four weeks	5.1	5.8
Anal sex in the past year	18.50%	17%

Table 3.8 – *Sexual activity of young people aged 16-24, Great Britain, 2012*

Some summary results from NATSAL-3

- **Behaviour change has been greatest amongst women.** In the 16-44 years age group, the average number of partners for women over a lifetime has increased from 3.7 in 1990/91 to 7.7 in 2010/12. For men during the same period the number increased from 8.6 to 11.7, so the gap between men and women has fallen.
- **People start having sex at an earlier age and continue having sex into their 70s.**
- **The frequency with which people have sex has declined.**
- **Same–sex relationships have become more accepted.** People have become less tolerant of married people having sex outside of marriage
- **Risky behaviours remain the key driver of STIs.**
- The 2010-2012 survey included questions on unplanned pregnancies and found that **1 in 6 pregnancies were unplanned, and 1 in 60 women experience an unplanned pregnancy in a year.**
- **1 in 6 people feel that their own health has impacted their sex life,** but of these people less than 25% will seek help. Where help is sought (from a

health professional) it is usually from a GP.

- **1 in 10 women and 1 in 70 men report that they have experienced non-volitional sex** (sex against their will). Of these people less than half tell anyone else about their experience and of these only 13% of women and 8% of men go to the police.
- In relation to 16-24 year olds the survey conducted in 2010 to 2012 found that **31% of men and 30% of women reported having heterosexual sex before the age of 16.**

4. Sexual Health Services in West Sussex

4.1 The Integrated Sexual Health Service

West Sussex County Council commissions an integrated sexual health service from Western Sussex Hospitals Trust. Integration of services is crucial as it allows for people accessing services to have as many as possible of their sexual health needs met at a single visit. This reduces loss to follow up and also allows the service to make use of the synergies between need for treatment and contraception.

The integrated service offers the following, though some services are not available at all sites:

- 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
- Contraception procedures – by appointment
- Intrauterine contraception
- Psychosexual counselling – by appointment

The sevice operates hubs out of the following sites:

- Chichester
- Worthing
- Crawley

At additional sites there are smaller clinics that are sometimes nurse-led. Symptomatic patients are advised to attend a hub, but many services are available at these sites.

- Bognor Regis (two clinics)
- Chichester College Brinsbury
- Crawley FindItOut
- East Grinstead
- Horsham
- Horsham FindItOut
- Lancing
- Littlehampton

Table 4.1 shows where walk-in clinics are available throughout the county:[1]

Location	Days available
Bognor Regis	Monday, Wednesday
Chichester	Monday, Tuesday, Thursday to Saturday
Chichester College Brinsbury	Wednesday afternoons, term time, college students
Crawley	Monday to Saturday
Crawley FindItOut	Tuesday afternoons, young people aged 13-25
East Grinstead	Tuesday
Horsham	Monday and Wednesday
Horsham FindItOut	Thursday afternoons, young people aged 13-25
Lancing	Wednesday
Littlehampton	Thursday
Worthing	Monday to Saturday

Table 4.1 – *Clinics where walk-in and wait services are available, together with available days.*

Services at hubs are open in the evenings most days and on Saturday mornings. This expands access for when people are most likely to need them. Waiting times remain an issue but are no worse than in other areas. There is currently no target nationally for waiting times in sexual health services, though services naturally aim to keep these as short as possible.

Appointments can also be booked with the service, usually for particular services such as psychosexual counselling. Table 4.2 shows clinics where appointments are available[2]. Appointments also form an important part of work with other services, particularly for young people.

4.2 Psychosexual services

The service offers psychosexual therapy for a range of sexual issues such as:

- Difficulties with erection, ejaculation, orgasm, desire;
- Sexual trauma or pain;
- Sexual function relating to ill health and disability;

[1] This information is correct as of January 2019.
[2] This information is correct as of January 2019.

Location	Days available
Bognor Regis	Monday
Chichester	Monday, Wednesday to Friday
Crawley	Monday to Friday
East Grinstead	Tuesday morning and evening
Horsham	Wednesday and Thursday
Lancing	Tuesday
Worthing	Monday to Friday

Table 4.2 – *Clinics where booked appointments are available, together with available days.*

Psychosexual therapy is offered by appointment at clinics in Worthing, Crawley and Chichester. Referrals are encouraged from health professionals such as GPs, other doctors, nurses, and health advisors. Appointment times vary and therapy is time-limited.

The service does not provide counselling for the following:

- Acute rape victims;
- Problems of gender identity/dysphoria;
- Situations where the sexual problem is part of a major psychiatric disorder;
- Relationship problems not related to sexual disorder;
- Sexual practices which would be the subject of action under the criminal justice system.

4.3 Contraceptive services

The integrated service provides the following contraceptive services:

- Condoms
- Diaphragms and caps
- Emergency Contraception information
- Implant
- Injection
- Intrauterine options
- Natural family planning
- Patch
- The pill
- Vaginal ring

GPs also provide contraceptive services that are paid for by West Sussex County Council but these are out of scope of this needs assessment.

4.4 Emergency hormonal contraception

Emergency hormonal contraception will prevent around 95% of pregnancies if taken up to five days after having unprotected sex. It is available from the integrated service,

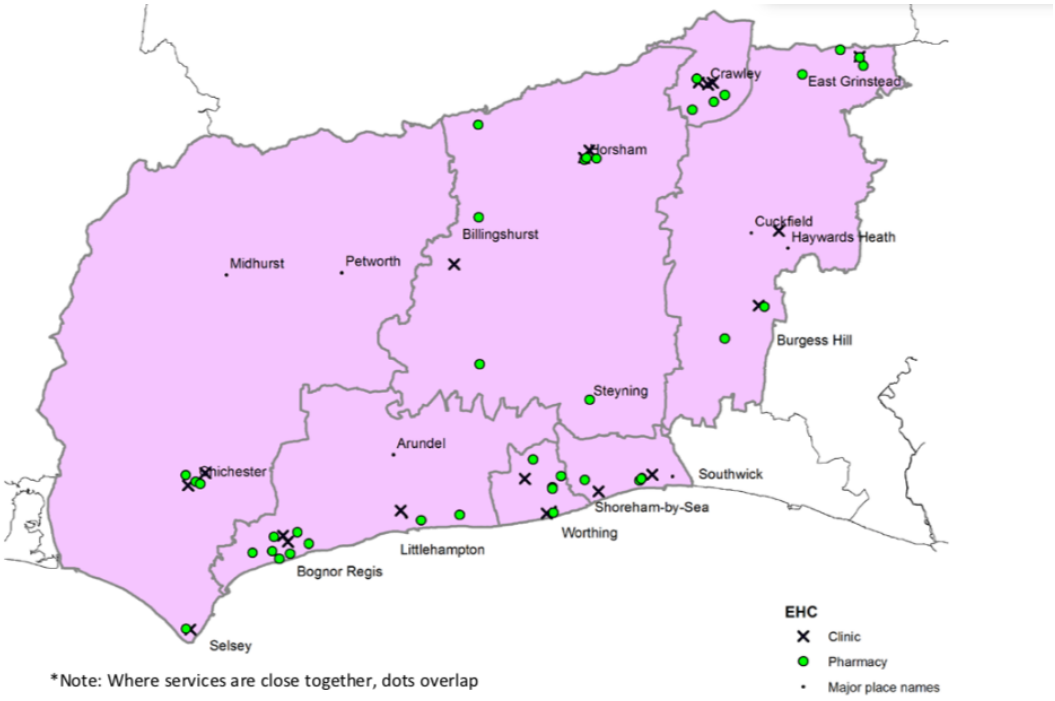


Figure 4.1 – *Map showing locations of pharmacies in West Sussex where Emergency hormonal contraception can be accessed. Source: West Sussex Pharmaceutical Needs Assessment 2018.*

as well from several pharmacies throughout West Sussex, as shown in Figure 4.1.

4.5 Termination of Pregnancy

Women seeking termination of pregnancy can be referred to a provider by either their GP or a doctor from the integrated sexual health service.

Termination of pregnancy services in West Sussex are commissioned by the CCG and provided to all three West Sussex CCGs by the British Pregnancy Advisory Service (BPAS). The service is located in Brighton (Tuesdays to Saturdays) with a satellite in Bognor (Tuesdays).

4.6 Sterilisation

Vasectomy services are provided by a GP with a special interest (GPSI) and are commissioned by the CCGs. Sterilisation for women is also commissioned by CCGs, though no services are currently provided.

4.7 Services for young people

As shown in Table 4.1 there are two FindItOut centres in Horsham and Crawley that offer walk-in and wait one afternoon each week. These clinics are for young people

aged 13-25. There is also a clinic in term time at Chichester College Brinsbury, which is only for students of the college.

4.8 Outreach

The integrated service has two outreach healthcare assistants who organise chlamydia and gonorrhoea testing of young people and perform outreach in youth groups such as the Allsorts LGBT, Brighton and Hove Albion FC youth teams, IPEH, Chichester University, further education colleges and schools. Outreach work includes practical matters such as condom demonstrations and health promotion, but also explaining what to expect from the service and how to access it. Normalisation of service use is for increasing access.

Staffing has been an issue for the outreach healthcare assistants. Work is often seasonal, focussed around calendar events such as Freshers' Week and sexual health week in September. There are also two outreach nurses, covering patches in the north and south of the county.

5. Outcomes in West Sussex

At a glance:

- The under 16 conception rate in West Sussex is consistently below the England rate, and is below the majority of its statistically similar neighbours.
- The under 18 conception rate in West Sussex is consistently below the England rate, and is below the majority of its statistically similar neighbours.
- Rates of new STI diagnoses for Chlamydia, Gonorrhoea, Syphilis, Herpes and Warts are consistently below the England rate, though for Gonorrhoea, Herpes, and Syphilis diagnosis rates are among the highest of its statistically similar neighbours.
- Rates of new diagnoses of Chlamydia, Gonorrhoea, and Syphilis have been increasing in West Sussex for the past ten years, at a similar rate of increase to the England rate.
- Among young people the Chlamydia detection rate has been falling in West Sussex, this is in line with statistically neighbours and England.
- HIV coverage in West Sussex has been higher than the England average since 2014 and is higher than most of its statistically similar neighbours.
- The proportion of late HIV diagnoses (i.e. where the CD4 cell count is less than 350 per mm^3) have decreased and are now similar to the England average.
- Uptake of long-acting reversible contraception in West Sussex is higher than in its statistically similar neighbours and the England rate.
- Termination of pregnancy rates are highest in Crawley CCG and Coastal West Sussex CCG, particularly in the 20-24 age group. Rates in Crawley are also higher than the England and Wales rate for almost every age group.

5.1 Teenage conceptions

Teenagers have the highest rate of unplanned pregnancy with disproportionately poor outcomes.

- Over 50% of under-18 conceptions end in abortion and inequalities remain between and within local authorities.
- Babies born to mothers under 20 years have a 24% higher rate of stillbirth than average, 56% higher rate of infant mortality and 30% higher rate of low birth weight.
- Children born to teenage mothers have a 63% higher risk of living in poverty.
- Mothers under 20 years have a 30% higher risk of poor mental health 2 years after giving birth. This affects their own wellbeing, and their ability to form a secure attachment with their baby.
- Teenage mothers are more likely than other young people to not be in education, employment or training; and by the age of 30 years, are 22% more likely to be living in poverty than mothers giving birth aged 24 years or over.
- Young fathers are twice as likely to be unemployed aged 30 years, even after taking account of deprivation.
- Recent analysis of the Next Steps data shows that some of these poor outcomes are also experienced by young parents up to the age of 25 years.

Since the introduction of the Teenage Pregnancy Strategy in 1999, England has achieved a 59.7% reduction in the under-18 conception rate between 1998 and 2016. The rate of 18.8/1,000 is currently at the lowest level since 1969, with the greatest reductions in the most deprived areas, and a doubling in the proportion of young mothers in education, training or employment.

In West Sussex the under-18 conception rate has been consistently below the England rate and that of its CIPFA neighbours. The West Sussex rate has fallen alongside the England rate as can be seen in Figure 5.1

However, despite the significant progress England's teenage birth rate remains higher than comparable Western countries, and inequalities in the under-18 conception rate persist between and within local areas.

Maintaining the downward trend is a priority in the Department of Health Framework for Sexual Health Improvement in England [8] and key to PHE priorities, including reducing health inequalities, ensuring every child gets the best start in life and improving sexual and reproductive health.

- High quality, comprehensive relationships and sex education (RSE) that improves use of contraception has a strong impact on teenage pregnancy rates.
- RSE also has wider safeguarding and health benefits.
- Contraceptive services need to be accessible and youth friendly to encourage early uptake of advice.

An open and honest culture around sex and relationships is also associated with lower teenage pregnancy rates. Countries with more open approaches to young people's sexual health, as assessed by better RSE, more parental communication and more accessible contraceptive services, have lower conception rates.

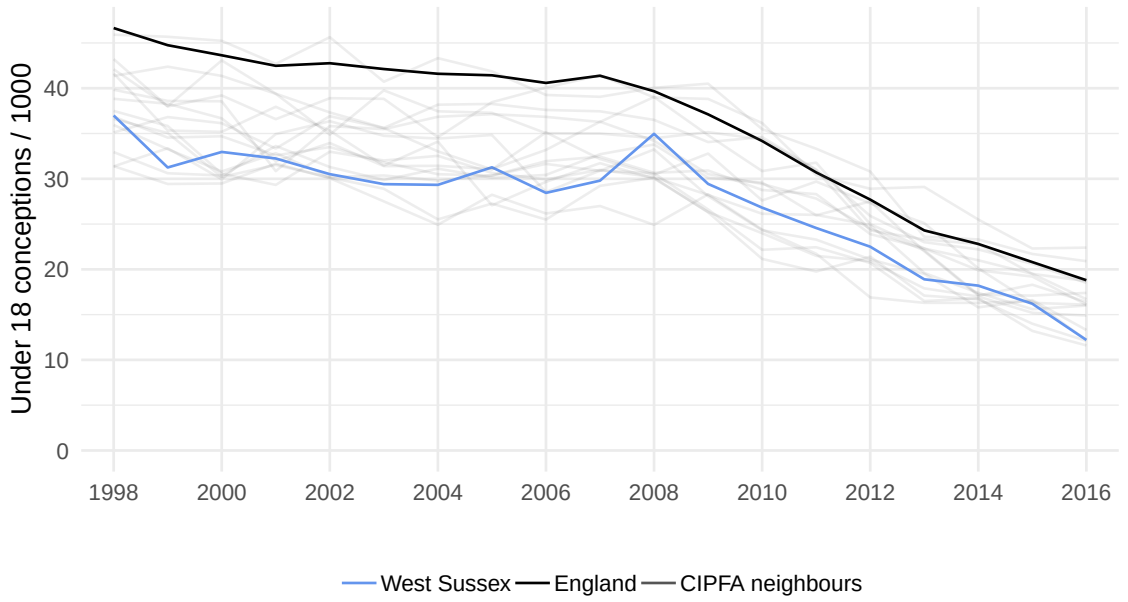


Figure 5.1 – *Under-18 conception rate in England, West Sussex, and its CIPFA neighbours. Source: PHE/Fingertips.*

Some young people will be at greater risk of early pregnancy and require more intensive RSE and contraceptive support, combined with programmes to build resilience and aspiration providing the means and the motivation to prevent early pregnancy. Reaching young people most in need involves looking at area and individual level associated risk factors.

Table 5.1 shows the conception rate for women aged under 18 years in the districts and boroughs of West Sussex, along with the county-wide and national rate. Rates in Crawley are higher than the England average, a consequence of the younger population and the number of neighbourhoods in the more deprived deciles. Rates in Adur and Worthing are slightly lower than the England average and are considerably higher than the county average.

Area	Rate (95% CI)
Adur	17.0 (9.7-27.6)
Arun	12.2 (7.9-17.8)
Chichester	10.8 (6.4-17.1)
Crawley	23.5 (17.0-31.7)
Horsham	5.8 (3.3-9.6)
Mid Sussex	6.1 (3.4-10.1)
Worthing	17.5 (11.7-25.2)
West Sussex	12.2 (10.4-14.3)
England	18.8 (18.5-19.1)

Table 5.1 – *Under 18 conception rates for districts and boroughs of West Sussex, West Sussex and England, 2016. Source: PHE Fingertips.*

5.2 Attendances

Data on attendances are taken from the Genitourinary Medicine Clinic Activity Dataset (GUMCAD). Reports are based upon quarterly submissions of GUMCADv2 data from sexual health services. Data from Enhanced GPs are not currently included. Reports include local authority of residence (upper and lower tier, based on LSOA of residence), service type (GUM / non-GUM), the service attended, and the date of attendance.

Data on attendance include sexual health screens with and without an HIV antibody test at a first attendance. Data are presented by:

- Gender and age group
- Gender and sexual orientation
- Country of birth
- Gender, sexual orientation and ethnic group

The number of West Sussex residents attending sexual health services for the first time has gradually increased between 2008 and 2017, though attendances of men have levelled out since 2014. (Figure 5.2).

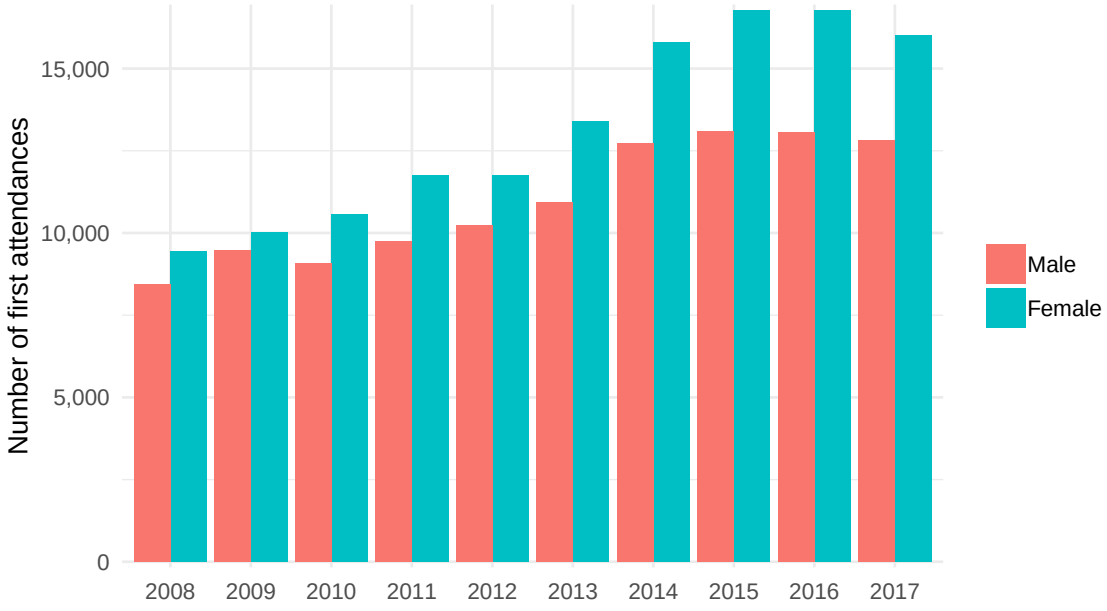


Figure 5.2 – *Number of first attendances at sexual health services in West Sussex by gender, 2008 to 2017. Source: PHE HIV/STI portal.*

In West Sussex in 2017 the largest proportion of attendances were among those aged between 25 and 34 for both men and women (Figure 5.3). A greater proportion of women attending are from the youngest age groups, while male attendances skew toward the older age groups.

Figure 5.4 shows the number of first attendances at sexual services in West Sussex by ethnic group in 2017. To highlight the incompleteness of this data, the figure retains number of attendances where no ethnicity was specified. In both men and women, the largest proportion of attendances were those where no ethnicity was specified. Among

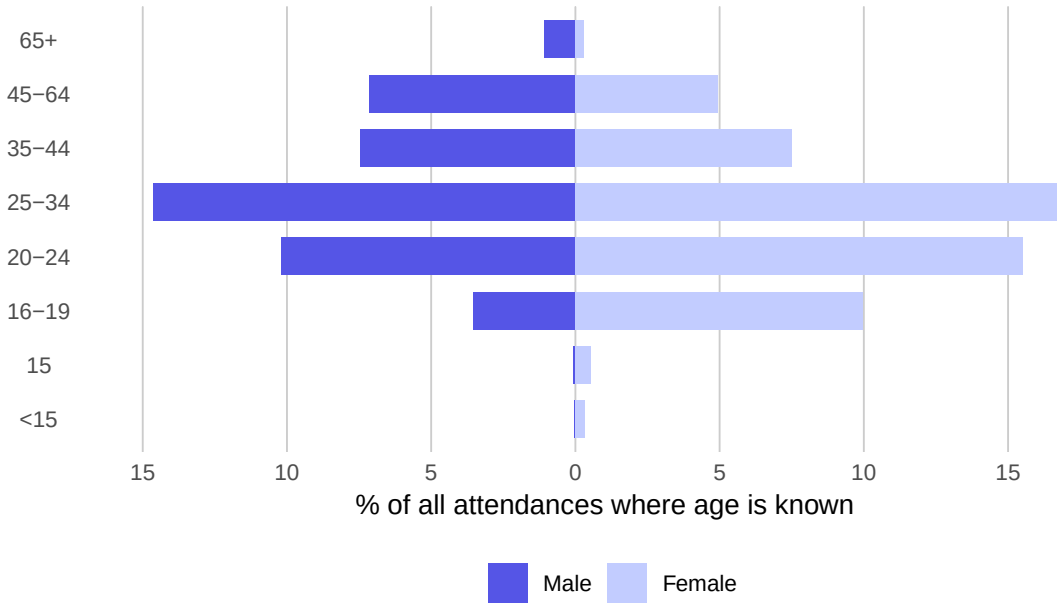


Figure 5.3 – *Proportion of first attendances at sexual health services in West Sussex by age and gender, where both of these have been recorded. Source: PHE HIV/STI portal.*

attendances where ethnicity information was specified around 40% of attendances were by white men and approximately 45% of attendances were by white women.

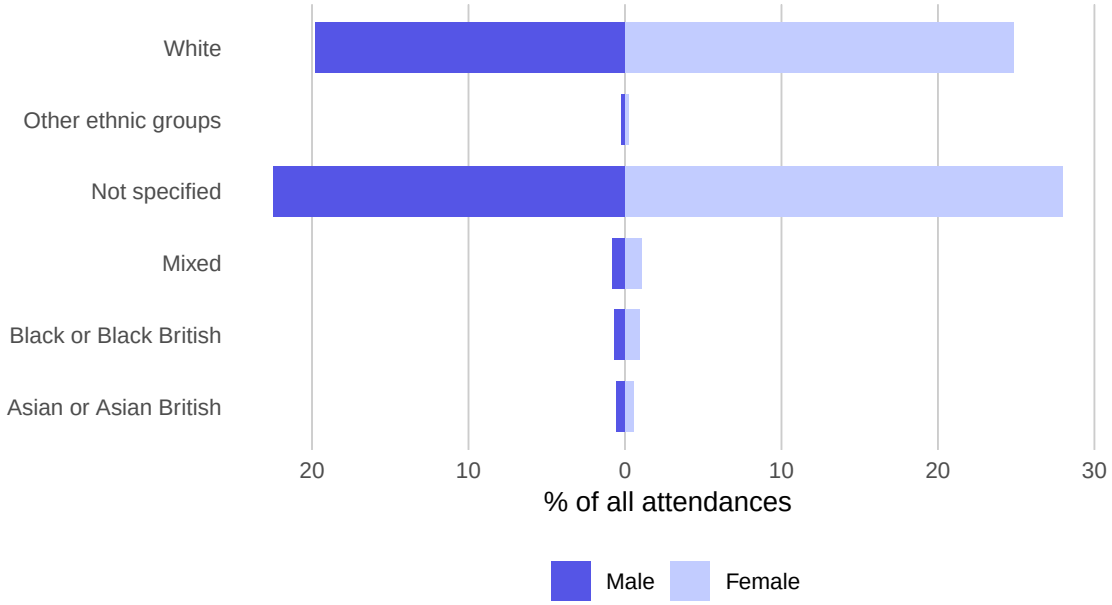


Figure 5.4 – *Proportion of first attendances at sexual health services in West Sussex by gender and ethnicity. Attendances where ethnicity is not specified have been retained. Source: PHE HIV/STI portal.*

When attendances are considered by reported sexual risk group (Figure 5.5), the

largest proportion of attendances (53%) were by heterosexual women, while 31% of all attendances were by heterosexual men. Lesbian women appear to be under-represented in terms of attendance. Compared to ethnicity, fewer attendances include people of unknown or unstated sexual orientation.

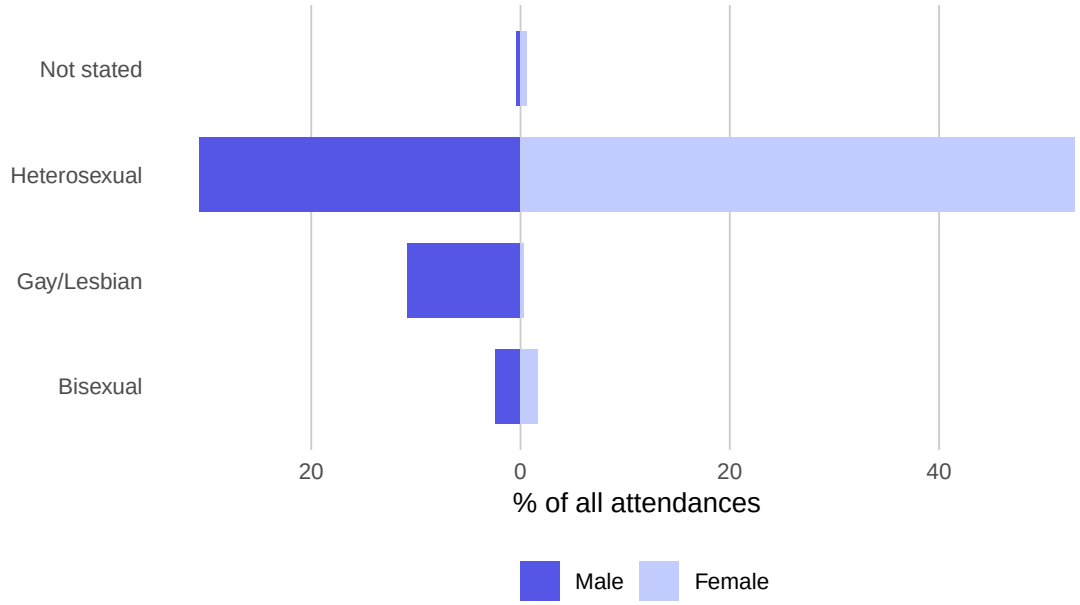


Figure 5.5 – *Proportion of first attendances at sexual health services in West Sussex by gender and sexual orientation. Attendances where orientation is not stated have been retained. Source: PHE HIV/STI portal.*

The GUMCAD dataset also includes information on the number of sexual health screens performed at first attendance. A sexual health screen is defined as a combination of tests for two or more of the following: Chlamydia, Gonorrhoea, Syphilis, and HIV. Sexual health screens taken at follow-up are not included in these figures.

Figure 5.6 shows the proportion of first attendances in West Sussex where a sexual health screen was taken for the years 2008 to 2017 broken down by age and sexual orientation. While this proportion has been relatively stable, there has been a large increase in the proportion of gay and bisexual men who are offered a sexual health screen at first attendance over the time period. However, higher proportions of heterosexual men were offered screens at first attendance compared to gay and bisexual men.

The British Association for Sexual Health and HIV (BASHH) guidelines for the sexual health care of men who have sex with men [17] recommend that there should be 80% uptake of a screening offer on first attendance by men who have sex with men. Note that this information does not say what proportion of men who have sex with men accept an offer of a sexual health screen. However in 2017, 71% of gay men and 68% of bisexual men were offered a sexual health screen on first attendance. For the uptake rate to meet the BASHH guidance, around 88% of gay men and 85% of bisexual men would need to be offered screens to achieve the observed rates. For comparison, PHE

estimates that across England 86.1% of men who have sex with men are offered an HIV screen when attending a sexual health service.

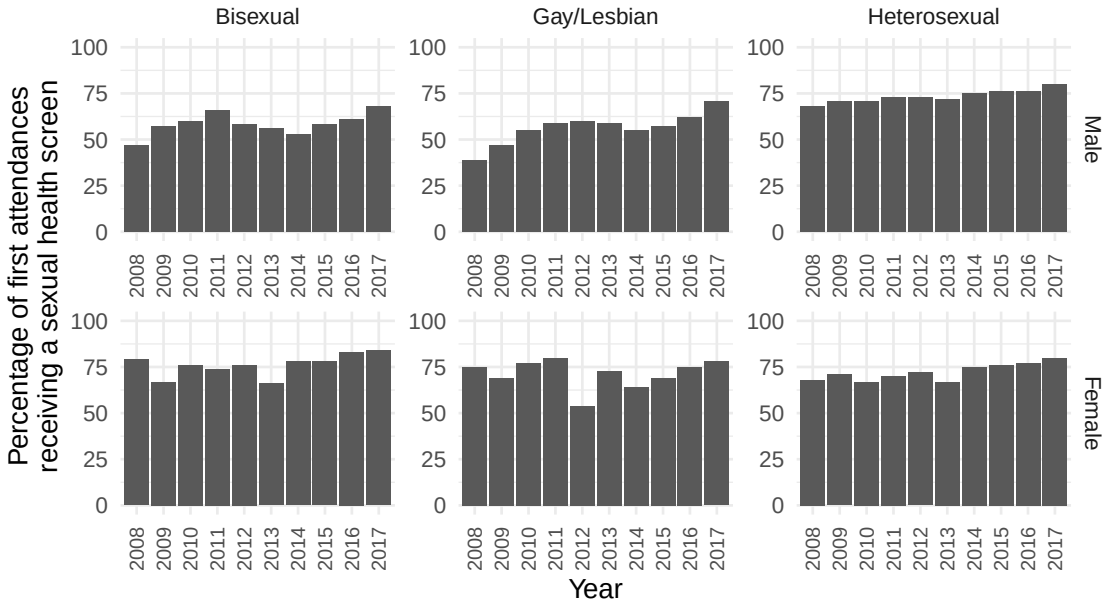


Figure 5.6 – *Proportion of first attendances at sexual health services in West Sussex receiving a sexual health screen, by gender and sexual orientation. Attendances where orientation is not stated have not been retained. Source: PHE HIV/STI portal.*

5.3 STIs

5.3.1 Chlamydia

Chlamydia is a bacterial sexually transmitted infection. While it is mostly asymptomatic, it can lead to severe complications later, particularly in women. These include ectopic pregnancy, pelvic inflammatory disease (PID) and tubal factor infertility. Long term sequelae in men include epidydimitis, which can also cause infertility. Chlamydia is treated with antibiotics.

In the GUMCAD data Chlamydia figures (and data totals for newly diagnosed STIs) include data from 'non-GUM' community services which are sourced from NCSP and from CTAD for all age groups. Unless specified, the results in this section present all chamydia diagnoses irrespective of source.

The burden of Chlamydia mainly falls on young people and men who have sex with men. Around half of all diagnoses in West Sussex are of those aged under 25 (Figure 5.7). In those aged over 25, the majority of diagnoses are among men. When diagnoses are considered by gender and orientation (where stated), around one in eight diagnoses are made in gay and bisexual men (Figure 5.8).

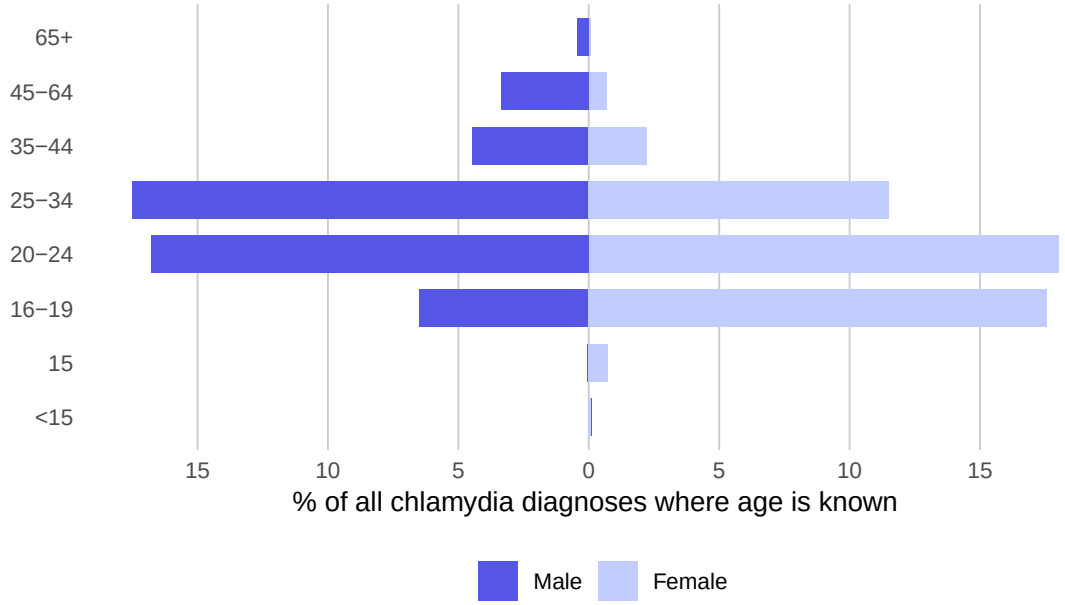


Figure 5.7 – *Proportion of Chlamydia diagnoses at sexual health services in West Sussex, by gender and age group. Attendances where age was not stated have not been included. Note that these may include people who receive multiple diagnoses of Chlamydia. Calendar year 2017. Source: PHE HIV/STI portal.*

In 2017 the chlamydia diagnosis rate in West Sussex was 235.9 per 100,000 population, lower than the England rate of 361.3 per 100,000. The rates of the statistically similar neighbours of West Sussex ranged from 204.7 per 100,000 to 348.7 per 100,000.

Of all West Sussex chlamydia diagnoses in 2017 where ethnicity was specified, around 2.6% were in men of mixed ethnicity and 2.2% were in women of mixed ethnicity

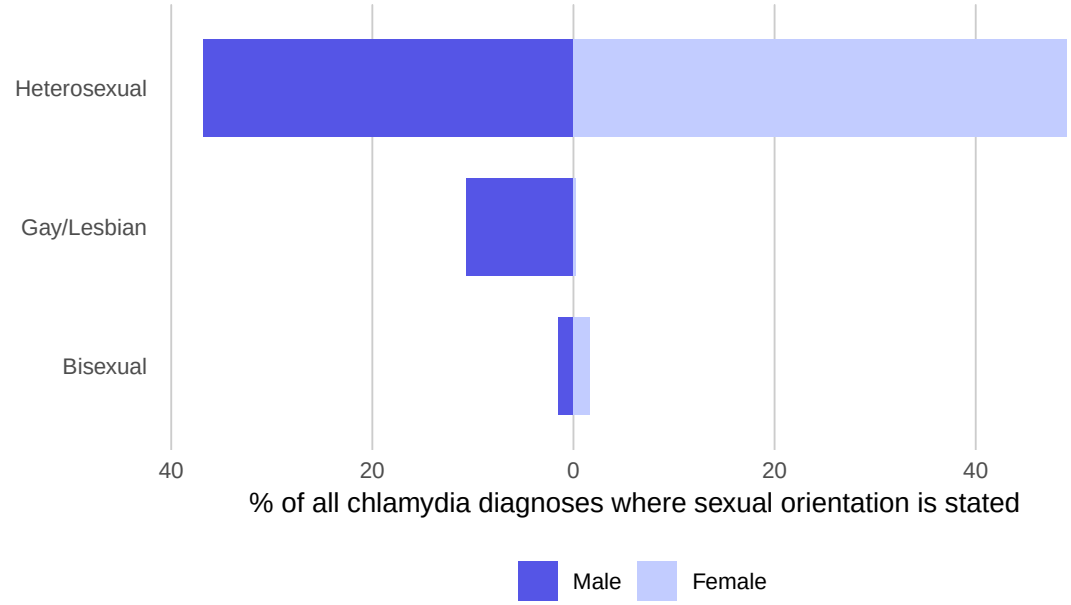


Figure 5.8 – *Proportion of Chlamydia diagnoses at sexual health services in West Sussex, by sexual orientation and age group. Note that these may include people who receive multiple diagnoses of Chlamydia. Calendar year 2017. Source: PHE HIV/STI portal.*

(Figure 5.9). In the 2011 census, around 1.5% of the West Sussex population was specified as being of mixed ethnicity. Around 1.8% of Chlamydia diagnoses were in men of Black or Black British ethnicity, compared to 0.9% of the overall population in 2011 Census.

There is some variation in Chlamydia diagnosis rates across the districts and boroughs of West Sussex. In Crawley, the chlamydia diagnosis rate was 382.8 per 100,000, higher than the England rate. Additionally, in 2017 the Chlamydia diagnosis rate in Adur was 301.8 per 100,000 and in Worthing it was 271.9 per 100,000. Reasons for these higher rates are likely to be the greater number of sexually active younger people in these areas and proximity to other areas with high rates of Chlamydia diagnoses, such as London and Brighton.

Chlamydia detection rate (PHOF indicator)

The detection rate is the rate of chlamydia diagnoses in the target population for screening (those aged 15 to 24 years). Diagnoses found outside of this age range are referred to as the diagnostic rate. This is to help distinguish between those infections that are found through proactive screening services and those which are found through clinical care. The detection rate is an indicator on the PHOF.

In West Sussex, the chlamydia detection rate in West Sussex has been falling since 2014, with a particularly sharp fall between 2016 and 2017 (from 1898.8 to 1414.4 per 100,000 in 15-24 year olds). However the detection rate has also fallen in England over the same period. West Sussex is among the poorest performing of its CIPFA neighbours at present, with many of the CIPFA neighbours of West Sussex increasing

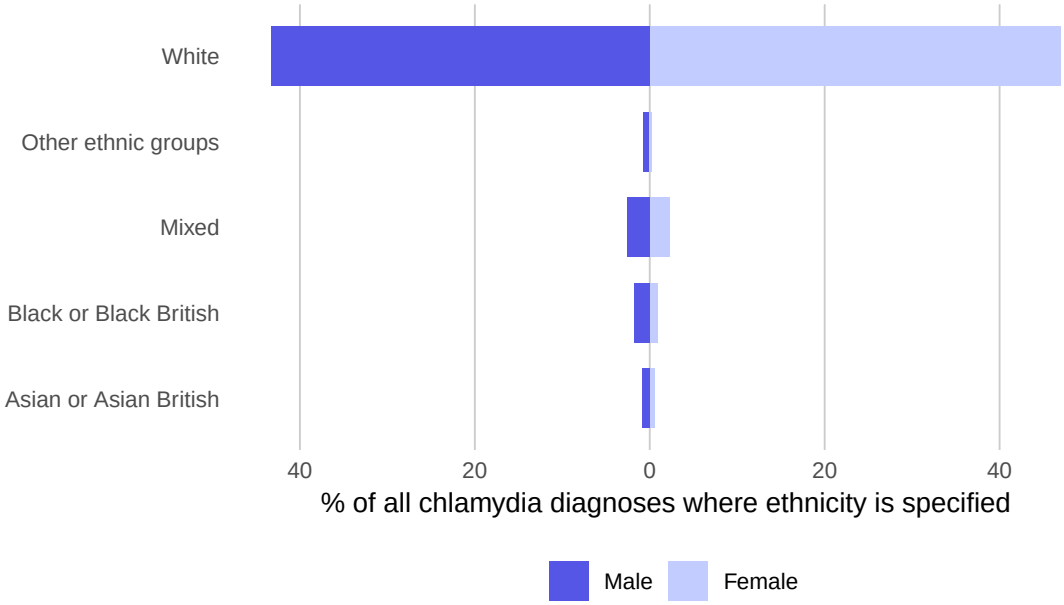


Figure 5.9 – *Proportion of Chlamydia diagnoses at sexual health services in West Sussex, by ethnicity and age group. Note that these may include people who receive multiple diagnoses of Chlamydia. Calendar year 2017. Source: PHE HIV/STI portal.*

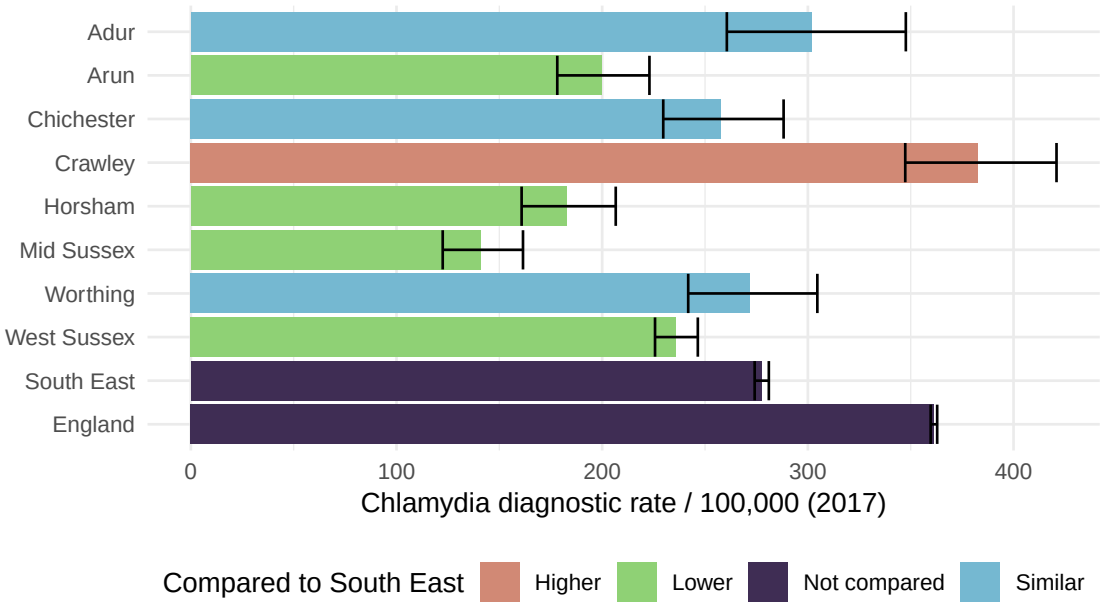


Figure 5.10 – *Chlamydia diagnosis rate in districts and boroughs of West Sussex. Source: PHE HIV/STI portal.*

their detection rates. Figure 5.11 shows that West Sussex is now 11th out of the 16 local authorities.

Because the chlamydia detection rate directly affects young people, it is further discussed among the other needs of young people in section 6.1 (page 95).

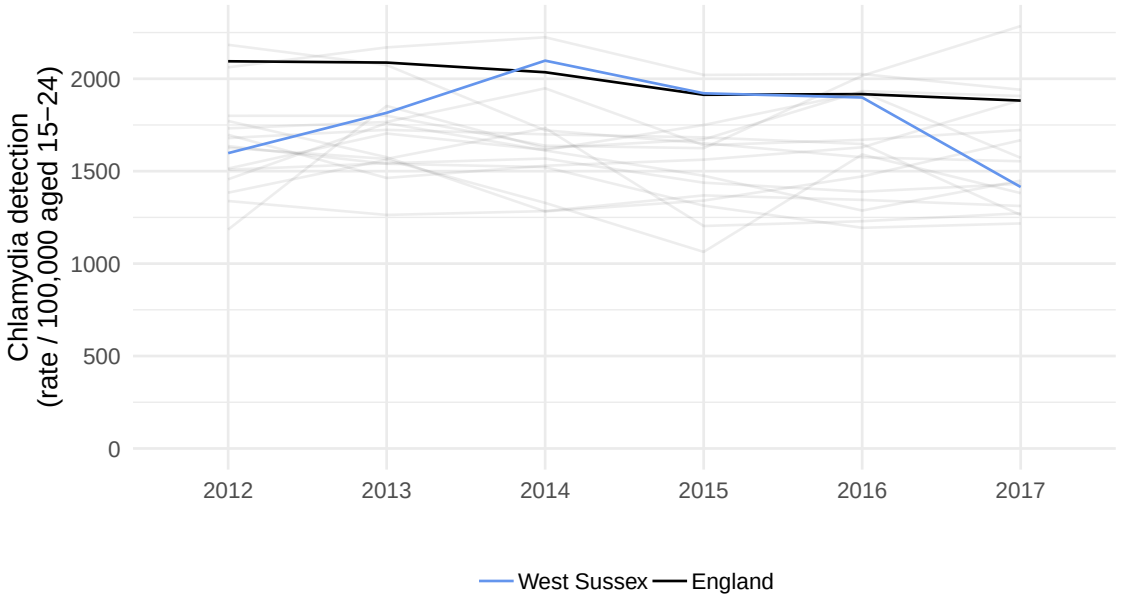


Figure 5.11 – *Chlamydia detection rate in West Sussex (blue), England (black) and its CIPFA neighbours (grey), 2012-2017. Source: PHE Fingertips, PHOF indicator 3.04.*

5.3.2 Gonorrhoea

Gonorrhoea is a bacterial sexually transmitted infection that is often asymptomatic, though it can produce symptoms, particularly in men. Untreated, it can have long-term health consequences including infertility.

Gonnorhoea is treated with antibiotics though yhere is some concern about the possible emergence of antiobiotic-resistant Gonorrhoea, or so-called "Super Gonorrhoea".

The burden of Gonorrhoea mainly falls on the young, and among men who have sex with men. Around 70% of all diagnoses in West Sussex are in men, which is likely due to men being more likely to experience symptoms. Around 35% of diagnoses are in those aged under 25 (Figure 5.12). In those aged over 25, the majority of diagnoses are among men. When diagnoses are considered by gender and orientation (where stated), around half of all diagnoses are made in gay and bisexual men (Figure 5.13).

In 2017 rates of Gonorrhoea diagnoses in West Sussex were, at 48.6 per 100,000 population, lower than the England rate of 78.8 per 100,000. The rates of the statistically similar neighbours of West Sussex ranged from a minimum of 29 per 100,000 to a maximum of 62 per 100,000.

Of all West Sussex Gonorrhoea diagnoses in 2017 where ethnicity was specified, around 3.2% were in men of mixed ethnicity and 1.2% were in women of mixed ethnicity (Figure 5.14). In the 2011 census, around 1.5% of the West Sussex population was specified as being of mixed ethnicity. Around 3.9% of Gonorrhoea diagnoses were in men of Black or Black British ethnicity. Black and Black British men comprised 0.9% of the overall West Sussex population in 2011 Census.

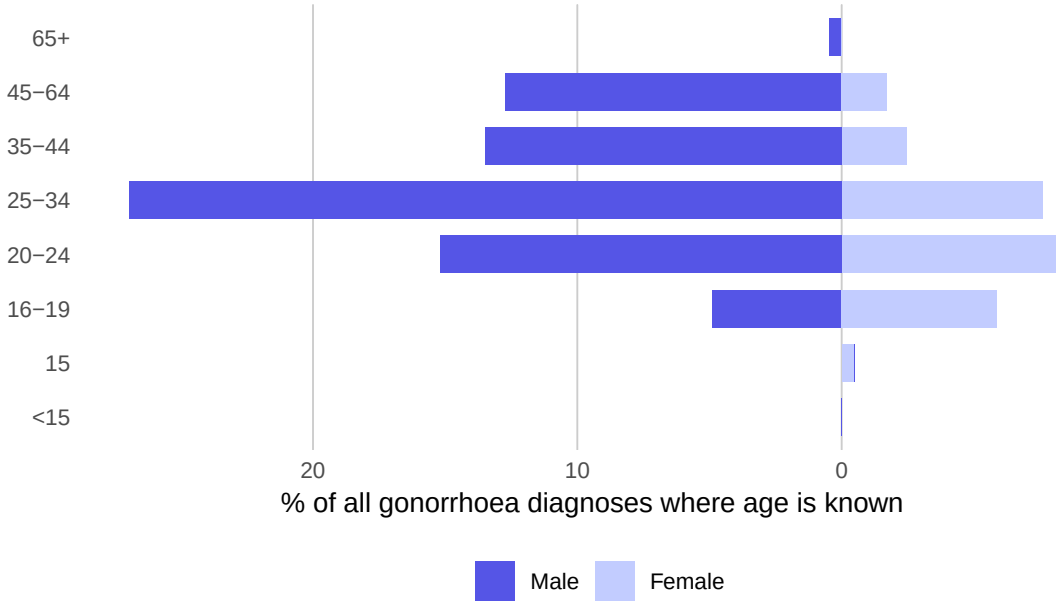


Figure 5.12 – *Proportion of Gonorrhoea diagnoses at sexual health services in West Sussex, by gender and age group. Attendances where age was not stated have not been included. Note that these may include people who receive multiple diagnoses of Gonorrhoea. Calendar year 2017. Source: PHE HIV/STI portal.*

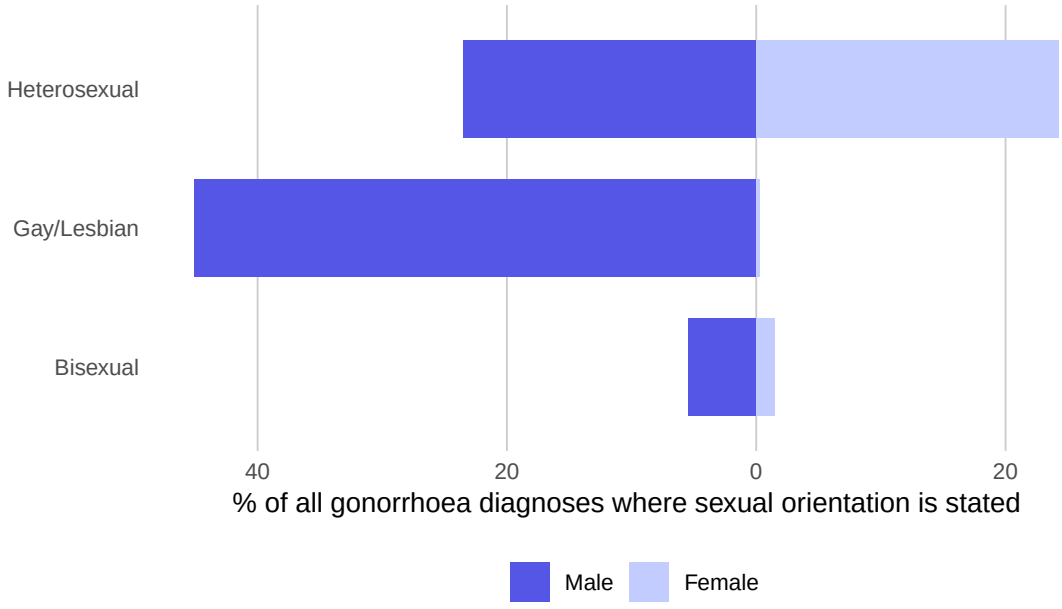


Figure 5.13 – *Proportion of Gonorrhoea diagnoses at sexual health services in West Sussex, by sexual orientation and age group. Note that these may include people who receive multiple diagnoses of Gonorrhoea. Calendar year 2017. Source: PHE HIV/STI portal.*

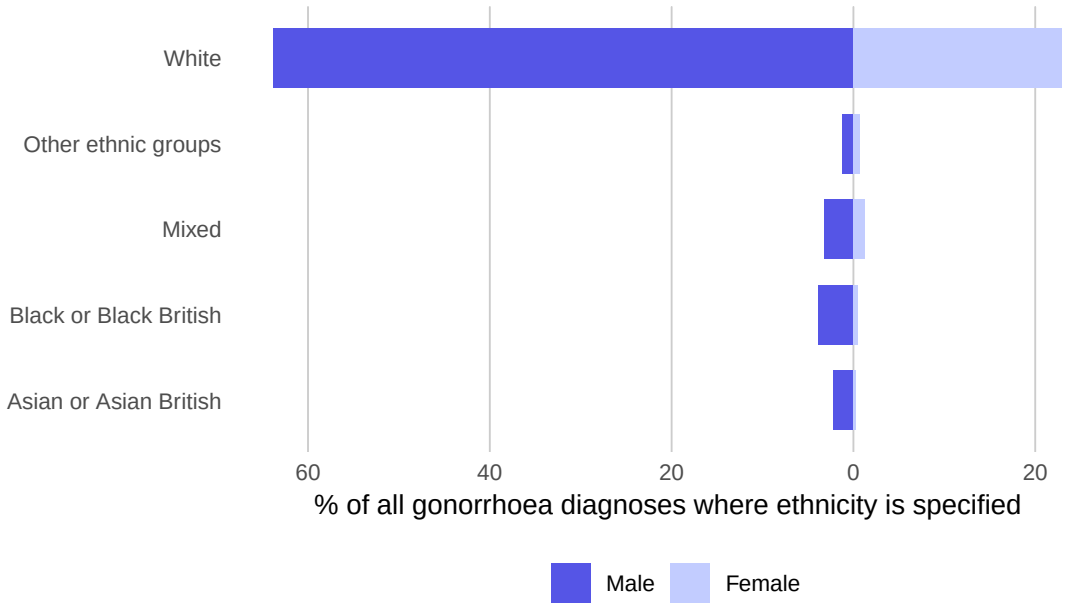


Figure 5.14 – *Proportion of Gonorrhoea diagnoses at sexual health services in West Sussex, by ethnicity and age group. Note that these may include people who receive multiple diagnoses of Gonorrhoea. Calendar year 2017. Source: PHE HIV/STI portal.*

Compared to 2016, every district and borough of West Sussex saw their rate of Gonnorhoea diagnoses increase. In Crawley, Gonorrhoea was diagnosed at a rate of 113.0 per 100,000, which is much higher than the England rate.

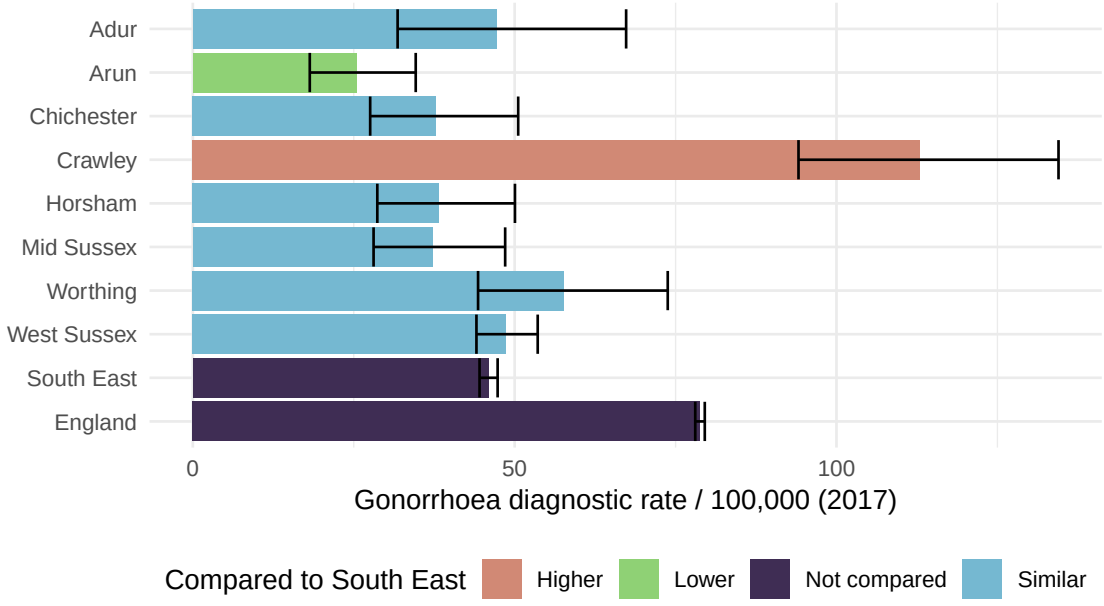


Figure 5.15 – *Gonnorhoea diagnosis rate in districts and boroughs of West Sussex. Source: PHE HIV/STI portal.*

5.3.3 Syphilis

Syphilis is a bacterial infection that can be spread through sexual contact, including oral sex and is treated with antibiotics. Left untreated it can, over time, have potentially serious health implications.

The burden of Syphilis mainly falls on men who have sex with men. Around 84% of all diagnoses in West Sussex are in men who have sex with men and around 85% of diagnoses are in those aged over 25 (Figures 5.17 and 5.16).

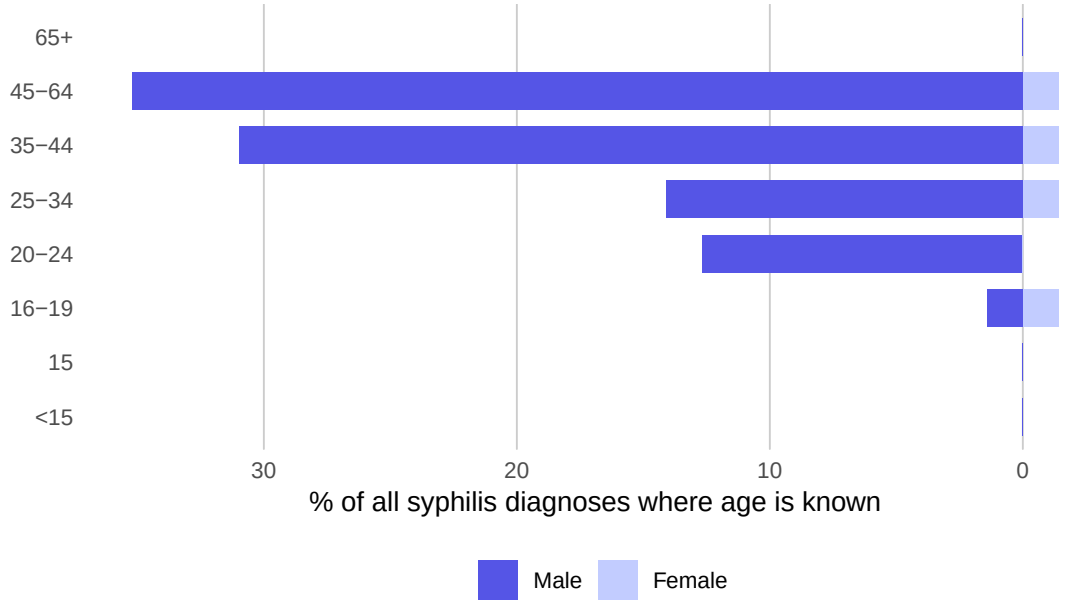


Figure 5.16 – *Proportion of Syphilis diagnoses at sexual health services in West Sussex, by gender and age group. Attendances where age was not stated have not been included. Calendar year 2017. Source: PHE HIV/STI portal.*

In 2017 rates of Syphilis diagnoses in West Sussex were, at 8.9 per 100,000 population, lower than the England rate of 12.5 per 100,000. The rates of the statistically similar neighbours of West Sussex ranged from a minimum of 3.4 per 100,000 to a maximum of 9.4 per 100,000.

In 2017, of all Syphilis diagnoses in West Sussex where ethnicity was specified, 2.7% were among Black and Black British men, and 2.7% were of men where ethnicity was specified as mixed or other. For 93% of all Syphilis diagnoses, the ethnicity specified was white.

There is variation in Syphilis diagnosis rates across the districts and boroughs of West Sussex. In Crawley, Syphilis was diagnosed at a rate of 23.3 per 100,000, which is almost double the England rate (12.5 per 100,000). Rates of Syphilis diagnoses in Horsham, Mid Sussex, and Worthing are also fairly high at 8.7, 8.1 and 9.2 per 100,000 respectively. Crawley is ranked 23rd out of 326 local authorities for Syphilis rates.

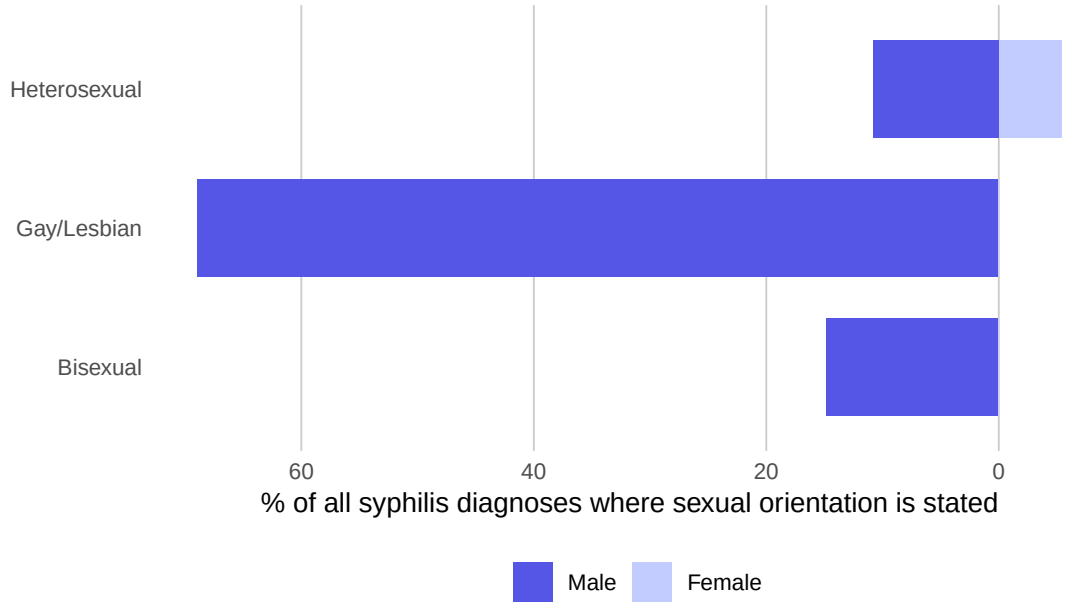


Figure 5.17 – *Proportion of Syphilis diagnoses at sexual health services in West Sussex, by sexual orientation and age group. Calendar year 2017. Source: PHE HIV/STI portal.*

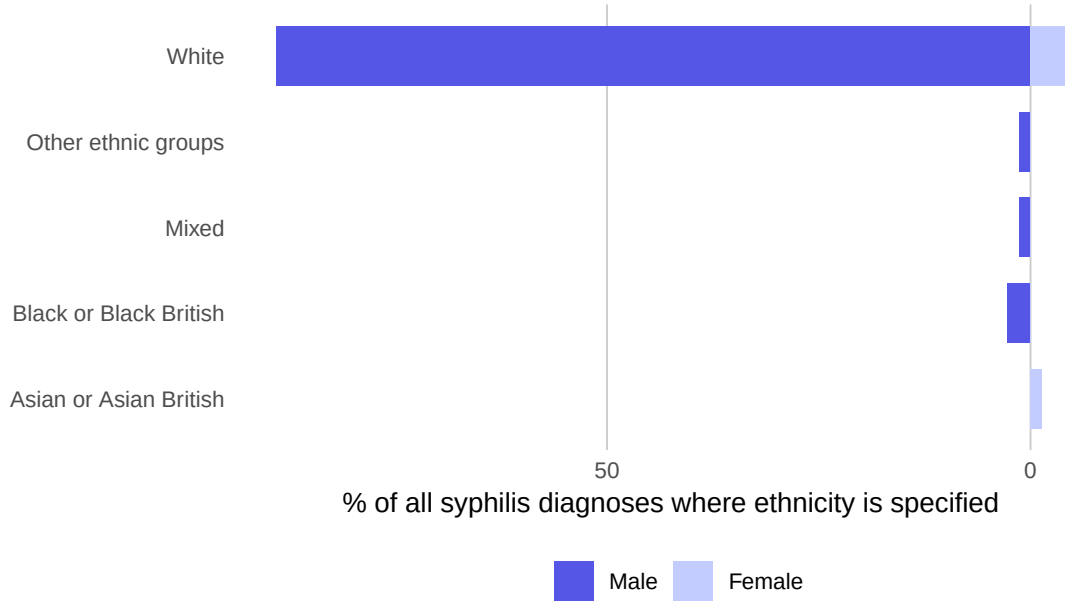


Figure 5.18 – *Proportion of Syphilis diagnoses at sexual health services in West Sussex, by ethnicity and age group. Calendar year 2017. Source: PHE HIV/STI portal.*

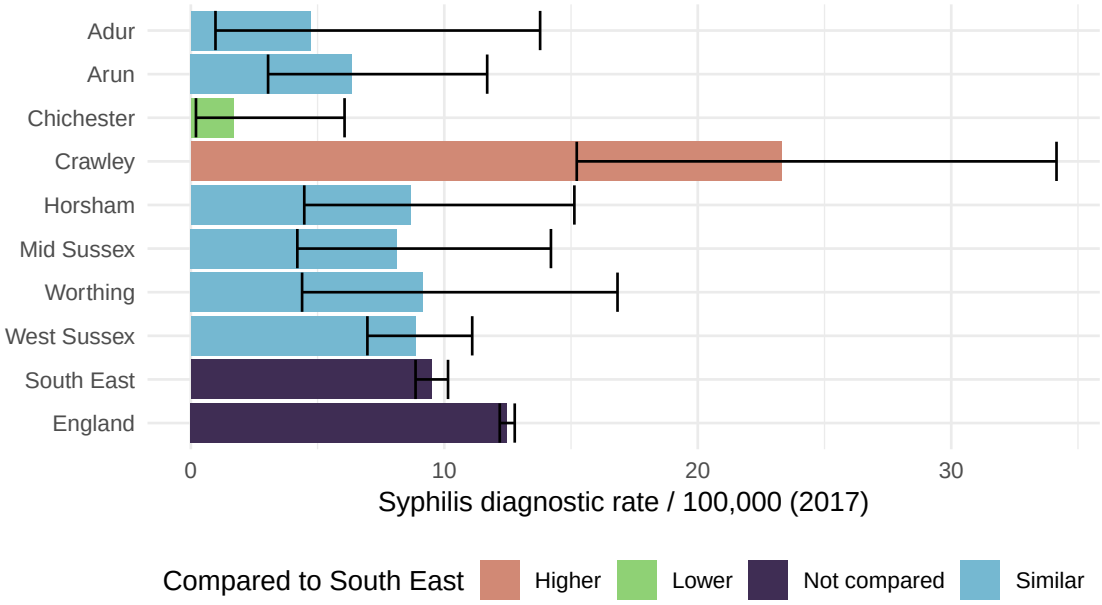


Figure 5.19 – *Syphilis diagnosis rate in districts and boroughs of West Sussex. Source: PHE HIV/STI portal.*

5.3.4 Herpes

Genital herpes is an infection by the herpes simplex virus (HSV) of the genitals. Most people either have no or mild symptoms and thus do not know they are infected. When symptoms do occur, they typically include small blisters that break open to form painful ulcers.

The greater proportion of genital herpes diagnoses are in people aged 25 and over, around 57%. Almost two thirds of diagnoses occur in heterosexual women and the majority of genital herpes diagnoses are in white women, with small a proportion of diagnoses in women from other ethnic backgrounds. In 2017 rates of Herpes diagnoses in West Sussex were, at 55.9 per 100,000 population, lower than the England rate of 56.7 per 100,000. The rates of the statistically similar neighbours of West Sussex ranged from a minimum of 29.4 per 100,000 to a maximum of 62.3 per 100,000.

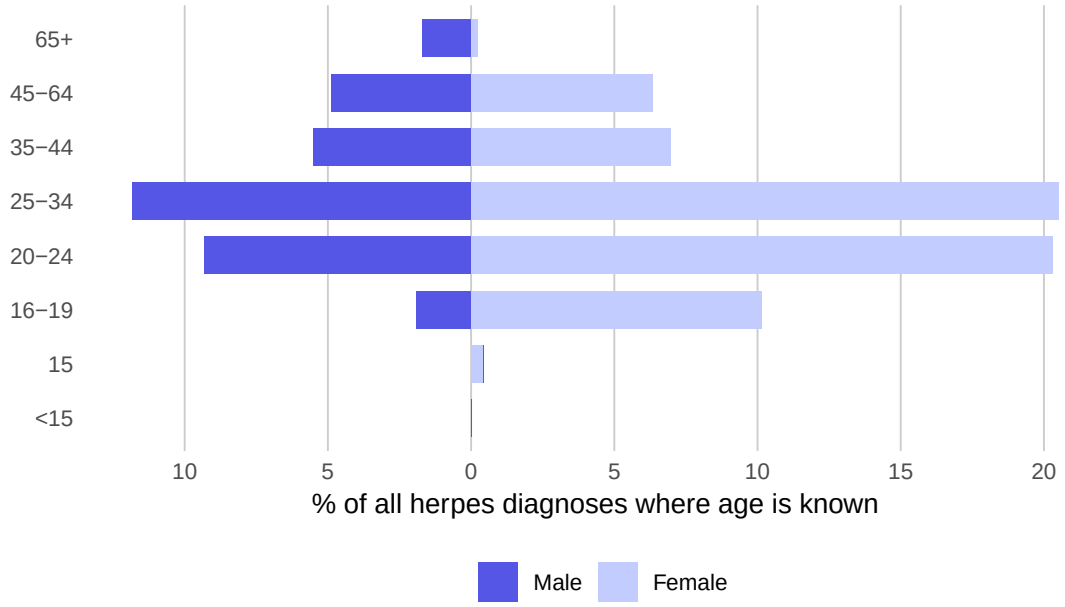


Figure 5.20 – *Proportion of Herpes diagnoses at sexual health services in West Sussex, by gender and age group. Attendances where age was not stated have not been included. Calendar year 2017. Source: PHE HIV/STI portal.*

Rates of genital herpes vary across the districts and boroughs of West Sussex. Rates are highest in Crawley (78.9 per 100,000) and in Worthing (65.9 per 100,000) and are higher than the England average. Rates are also high in Arun at 52.8 per 100,000, which is the only district or borough of West Sussex with a higher rate of herpes diagnoses in 2017 compared to 2016.

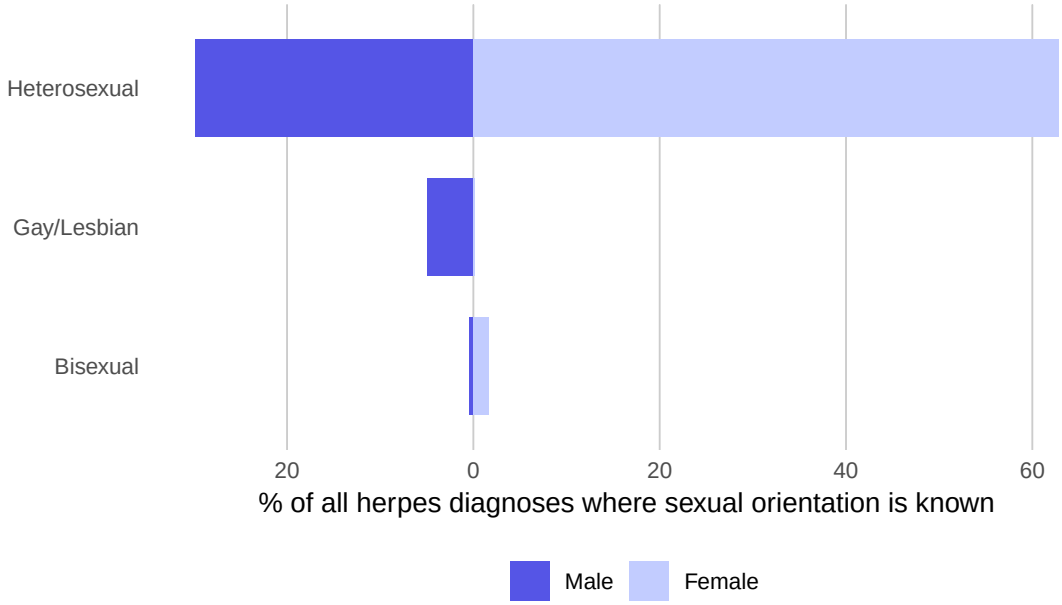


Figure 5.21 – *Proportion of Herpes diagnoses at sexual health services in West Sussex, by gender and sexual orientation. Attendances where sexual orientation was not stated have not been included. Calendar year 2017. Source: PHE HIV/STI portal.*

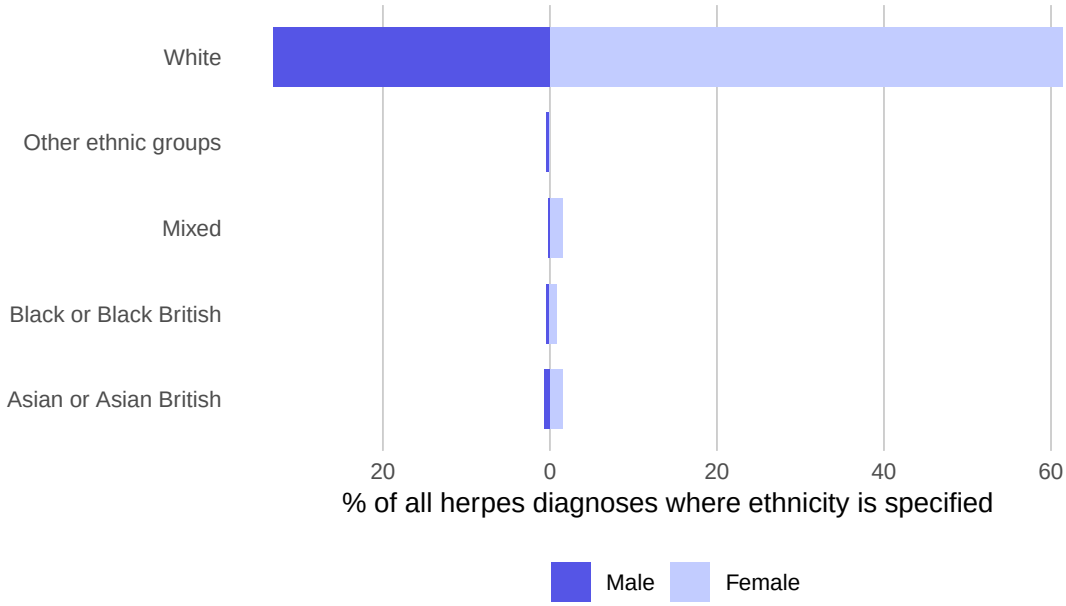


Figure 5.22 – *Proportion of Herpes diagnoses at sexual health services in West Sussex, by gender and ethnicity. Attendances where ethnicity was not specified have not been included. Calendar year 2017. Source: PHE HIV/STI portal.*

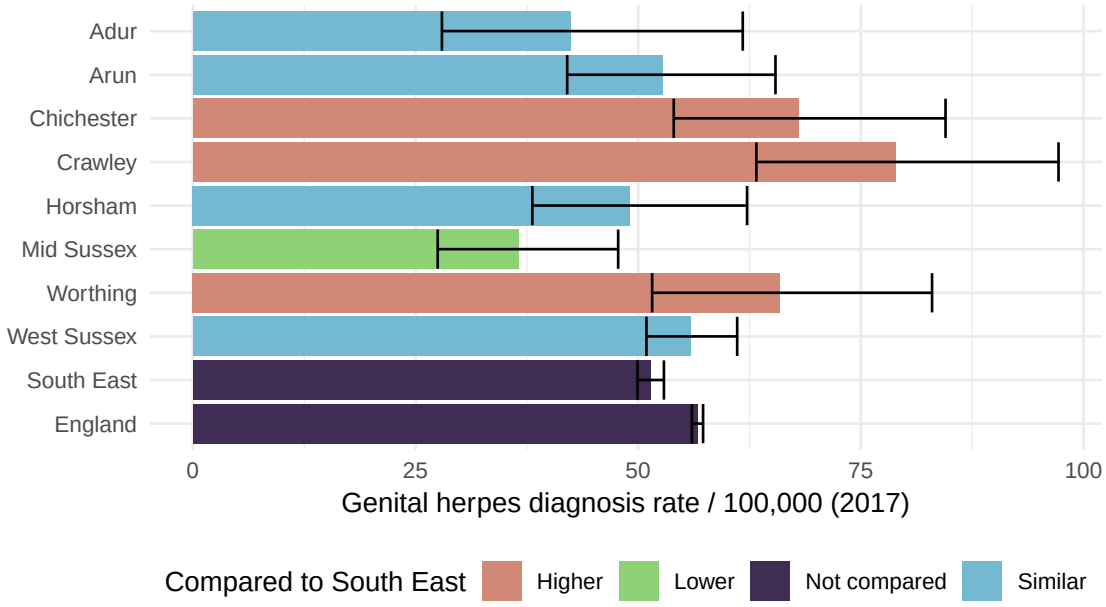


Figure 5.23 – *Genital herpes diagnosis rate in districts and boroughs of West Sussex. Source: PHE HIV/STI portal.*

5.3.5 Genital warts

Genital warts are a sexually transmitted infection caused by certain types of human papillomavirus (HPV). Usually they cause few symptoms, but can occasionally be painful.

Since 2008, HPV vaccination has been provided as part of a national vaccination programme for girls aged 12 to 13. While the types of HPV that cause warts are not the same as those that cause cancers, the cohort effects of the vaccine can be seen in rates of Warts diagnoses since the introduction of the vaccine.

First diagnoses of genital warts are common in young people who are more likely to be sexually active, though the added protection of the vaccine has led to fewer warts diagnoses in the younger age groups. Figure 5.24 shows that in 2017 around 23.7% of first diagnoses of genital warts were made in women aged under 25 and 24.4% in men under 25. 92% of first diagnoses of genital warts were made in heterosexual men and women. 6% of first diagnoses of genital warts were made in men who have sex with men.

In 2017 rates of genital warts diagnoses in West Sussex were, at 90.4 per 100,000 population, lower than the England rate of 103.9 per 100,000. The rates of the statistically similar neighbours of West Sussex ranged from a minimum of 66.0 per 100,000 to a maximum of 106.8 per 100,000.

Figure 5.26 shows the proportion of warts diagnoses where the ethnicity of the attendee is specified. In 2017, 95% of all warts diagnoses were among white people.

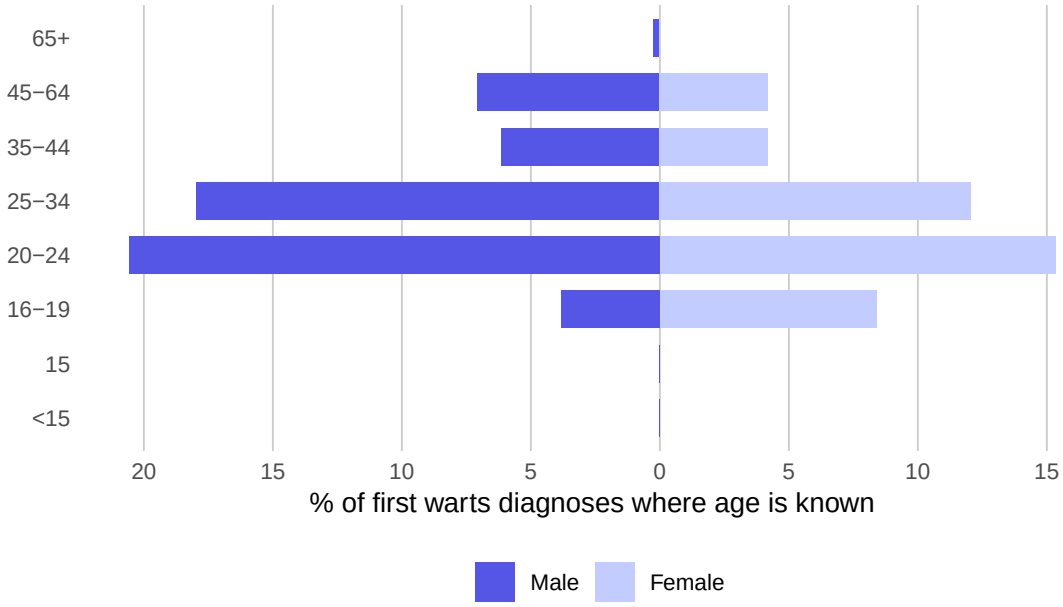


Figure 5.24 – *Proportion of first genital warts diagnoses at sexual health services in West Sussex, by gender and age group. Attendances where age was not stated have not been included. Calendar year 2017. Source: PHE HIV/STI portal.*

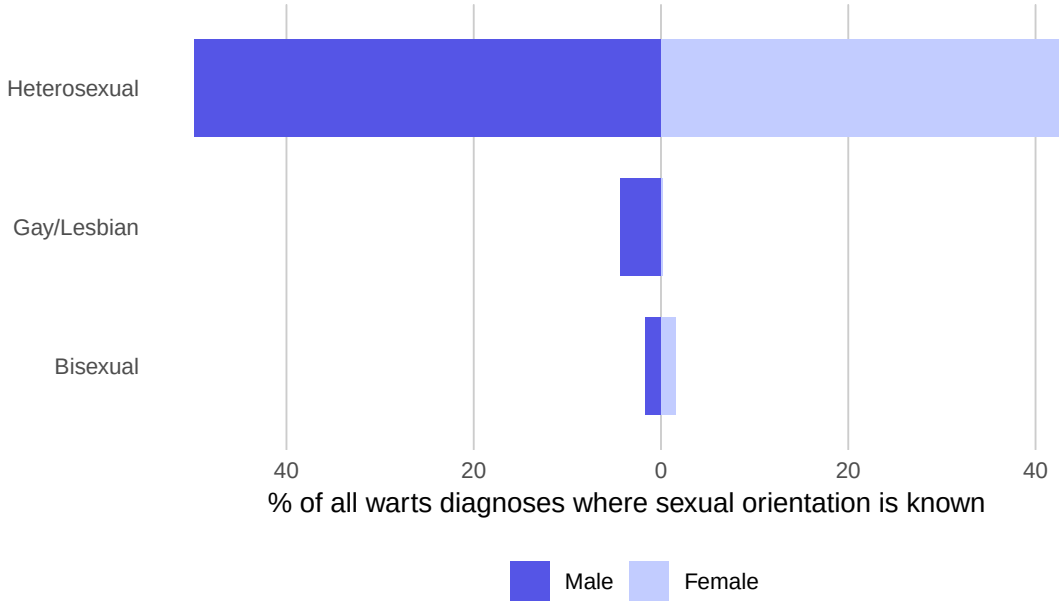


Figure 5.25 – *Proportion of first genital warts diagnoses at sexual health services in West Sussex, by gender and sexual orientation. Attendances where sexual orientation was not stated have not been included. Calendar year 2017. Source: PHE HIV/STI portal.*

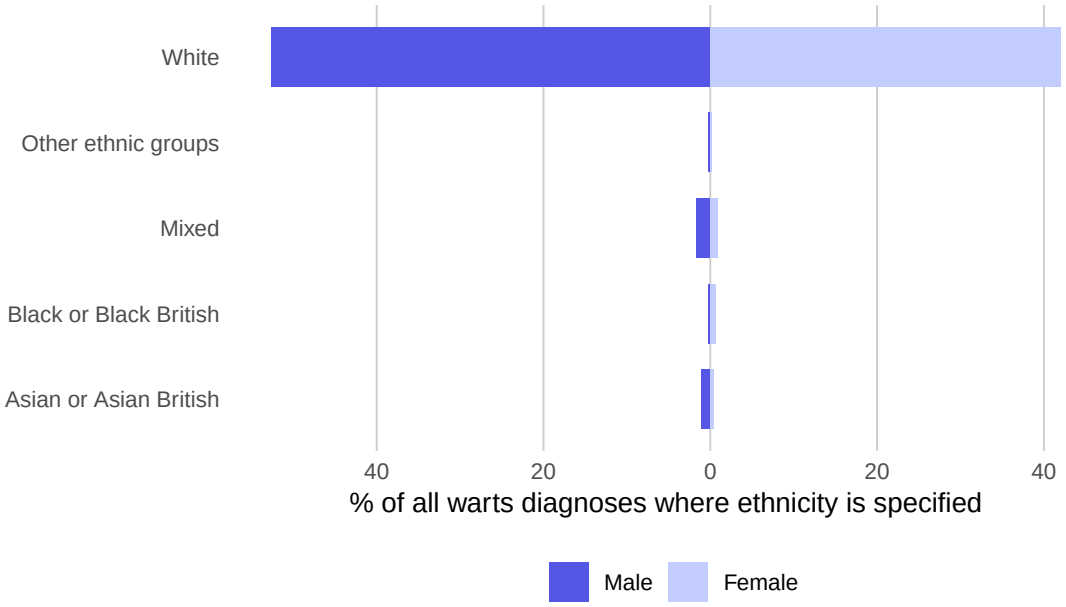


Figure 5.26 – *Proportion of first genital warts diagnoses at sexual health services in West Sussex, by gender and sexual orientation. Attendances where sexual orientation was not stated have not been included. Calendar year 2017. Source: PHE HIV/STI portal.*

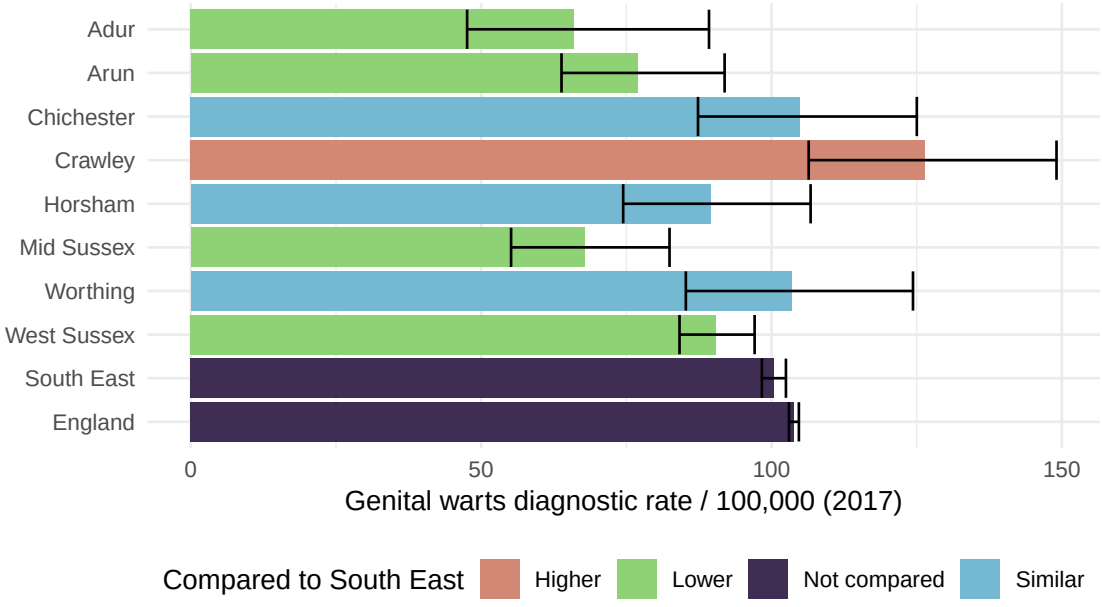


Figure 5.27 – *Genital warts diagnosis rate in districts and boroughs of West Sussex. Source: PHE HIV/STI portal.*

5.3.6 Other STI Diagnoses

The GUMCAD data also collates rates of new and 'other' STI diagnoses, the latter includes recurrent episodes of herpes and warts, as well as subsequent presentations for HIV following a diagnosis. In West Sussex the rate of new STI diagnoses has been falling, though it is among the highest of West Sussex's statistically similar neighbours. Neverthless, the West Sussex rate is still considerably lower than the England rate and this is true for both men and women as can be seen in Figure 5.28.

The rate of other STI diagnoses in West Sussex are among the highest of its statistically similar neighbours for both men and women. In 2017, the West Sussex rate was similar to the England rate, though the rate between 2011 and 2016 for men was higher than the England rate. In women, the West Sussex rate was similar to the England rate between 2008 and 2017. This suggests that the number of recurrent STIs in West Sussex may be high, particularly for men.

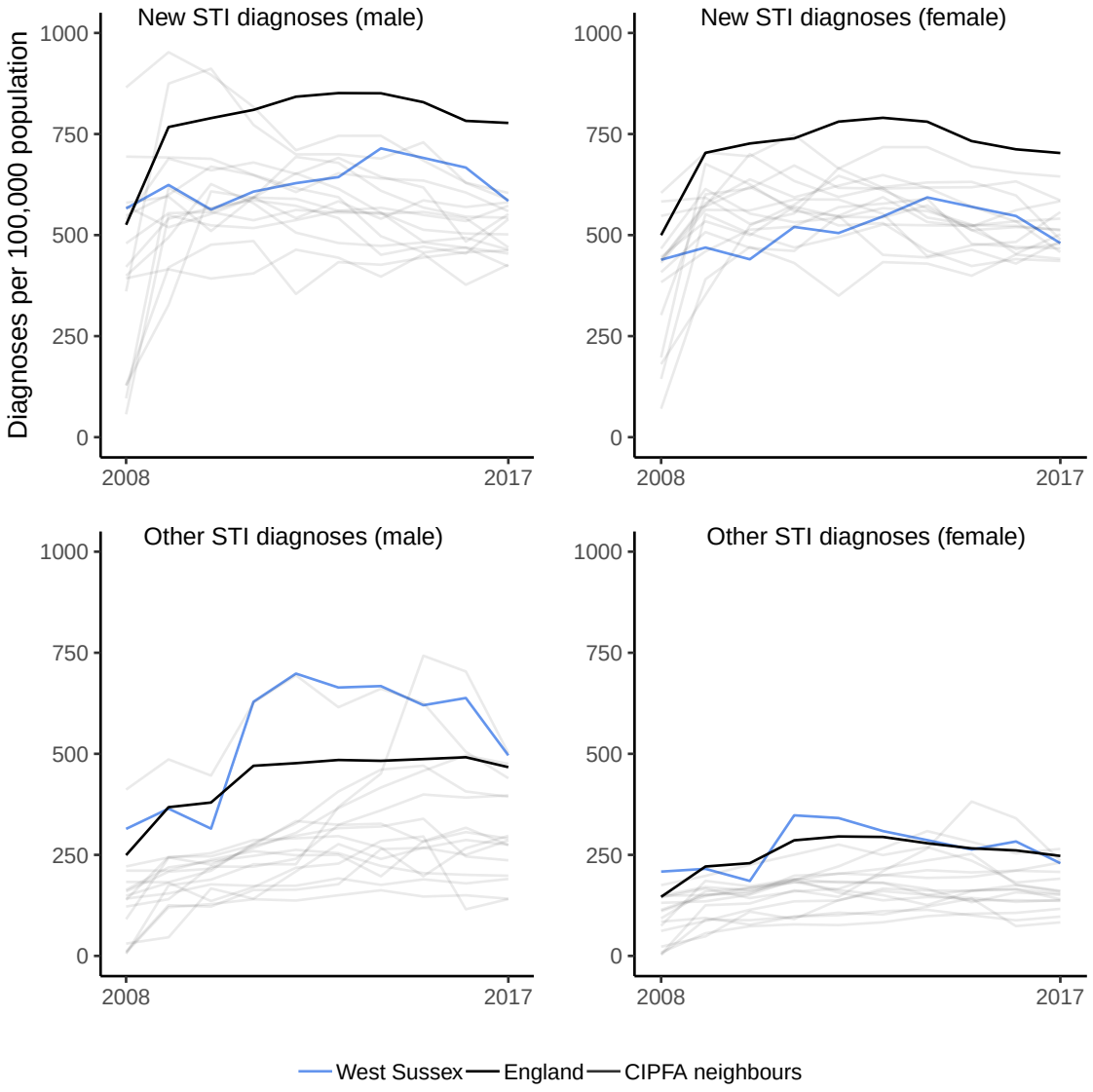


Figure 5.28 – *New and other STI diagnoses per 100,000 population, 2008 to 2017. West Sussex is shown in blue and England in black, with grey lines indicating rates in the CIPFA neighbours of West Sussex. See main text for definitions of new and other diagnoses. Source: PHE HIV/STI portal, accessed October 2018. Rates are calculated using ONS population estimates based on the 2011 census.*

5.4 HIV

The PHE sexual health profiles [7] record the following indicators relating to HIV:

- Coverage of HIV testing measured in specialist sexual health services.
- Rate of new HIV diagnosis per 100,000 population among people aged 15 or over.
- Percentage of adults (aged 15 or above) newly diagnosed with HIV with a CD4 count less than 350 cells per mm^3 (late diagnosis).
- Prevalence of diagnosed HIV infection per 1,000 among persons aged 15 to 59 years.

5.4.1 Coverage

In 2017 coverage of HIV testing in specialist sexual health services in West Sussex was 77.1% of the eligible population, this has increased from 61.4% in 2009. West Sussex coverage is higher than the England average, which in 2017 was 65.7%. Since 2009 coverage rates in England have been rising, with West Sussex seeing slightly faster increases in coverage. Figure 5.29 shows how coverage for West Sussex, England and the statistically similar neighbours of West Sussex has changed since 2009.

See also notes made on page 68 regarding the proportion of new attendances at sexual health services where a full sexual health screen is given.

5.4.2 Rates of new diagnosis

Across the South East there were 405 new diagnoses of HIV in 2017, accounting for 10% of all new diagnoses in England. The rate of new diagnoses of HIV in West Sussex in 2017 was 5.4 per 100,000 population aged 15 or over. The rate in the South East was 5.6 per 100,000 and in England it was 8.7 per 100,000. The rate of new diagnoses of HIV in West Sussex is among the highest of its statistically similar neighbours, as can be seen in Figure 5.30.

In the South East, 51% of new diagnoses were acquired by men who have sex with men. This is compared to 53% in 2016 and 40% in 2008. Of the new diagnoses in men who have sex with men, 84% were white and 59% were UK born.

Sex between men and women is the second most frequent infection route with 44% of new HIV diagnoses. There were 24% fewer new diagnoses across this transmission route in 2017 compared to the previous year. Among heterosexually transmitted cases, 44% of new infections were in African-born persons, compared to 67% in 2008. 40% of heterosexually transmitted new diagnoses of HIV in 2017 were of people born in the UK.

In the South East, 3% of new HIV diagnoses were acquired through injecting drug use.

The highest proportion of new HIV diagnoses in men was in the 25 to 34 years age group. The highest proportion of new HIV diagnoses in women was in the 35 to 54 years age group.

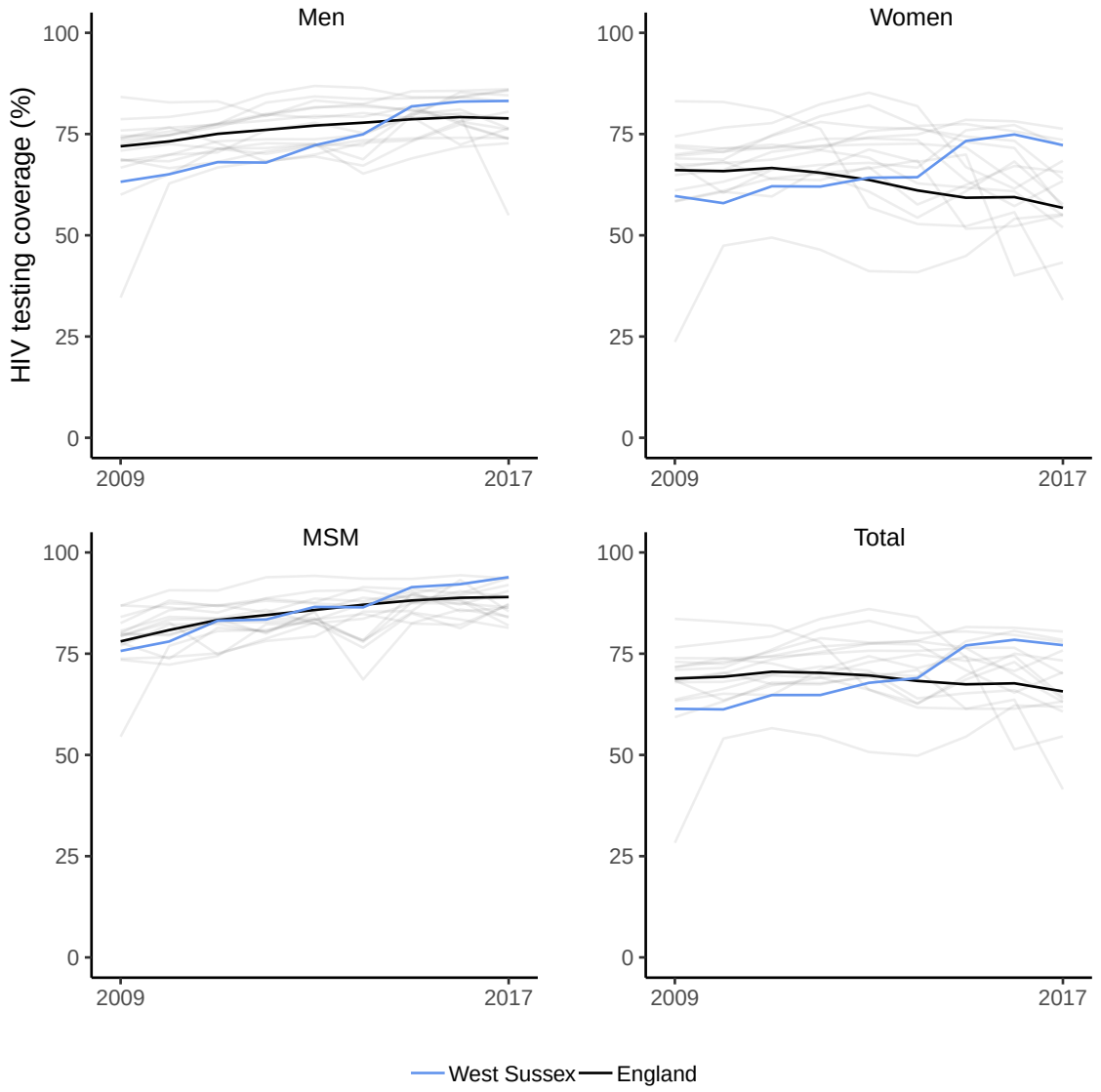


Figure 5.29 – *HIV testing coverage for West Sussex, England and the statistically similar neighbours of West Sussex, 2009 to 2017. Source: PHE Fingertips.*

5.4.3 Late diagnosis

It is crucial that people with newly acquired HIV begin treatment immediately. Having a CD4 cell count below 350 cells per mm^3 at diagnosis increases tenfold mortality within a year of diagnosis. A person receiving diagnosis of HIV with a CD4 cell count below 350 cells per mm^3 is regarded to be a late diagnosis. PHE has actively sought to reduce the proportion of late diagnoses of HIV. In West Sussex, any late diagnosis is treated as a critical incident in order to identify any missed opportunities to make an earlier diagnosis.

Because of small numbers, the percentage of late HIV diagnoses are calculated across three year periods. In 2015-2017, 42.2% of new diagnoses of HIV in West Sussex occurred late similar to the England percentage of 41.1%. Figure 5.31 shows that since 2009-11, the percentage of late HIV diagnoses in West Sussex has been similar

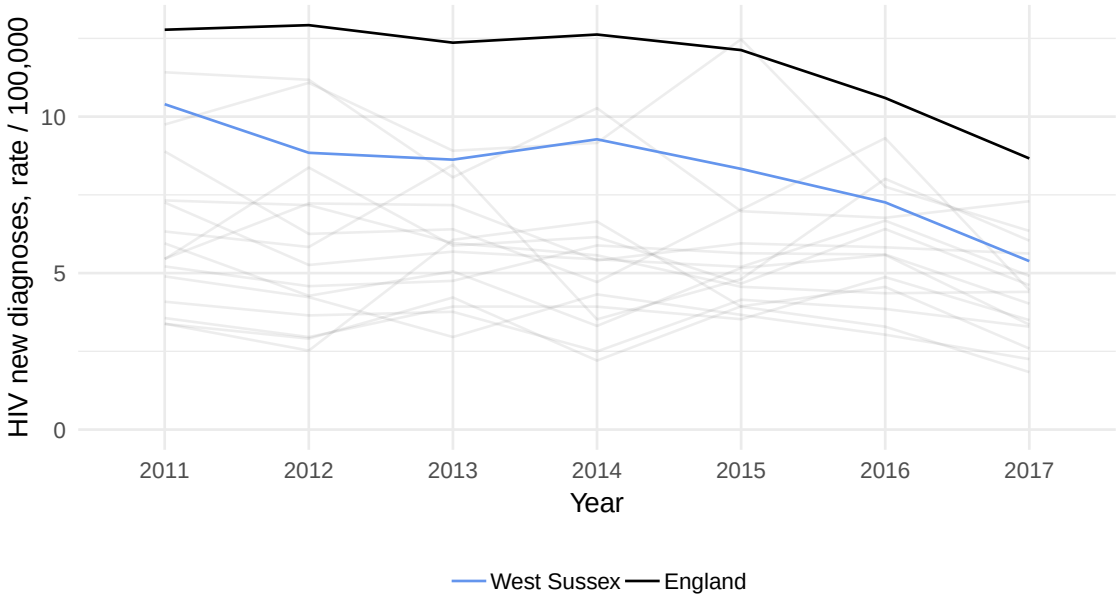


Figure 5.30 – *Rate of new HIV diagnoses in West Sussex and its statistically similar neighbours. The England rate is also given for comparison. Source: PHE Fingertips.*

to that in England and lower than the majority of its CIPFA neighbours.

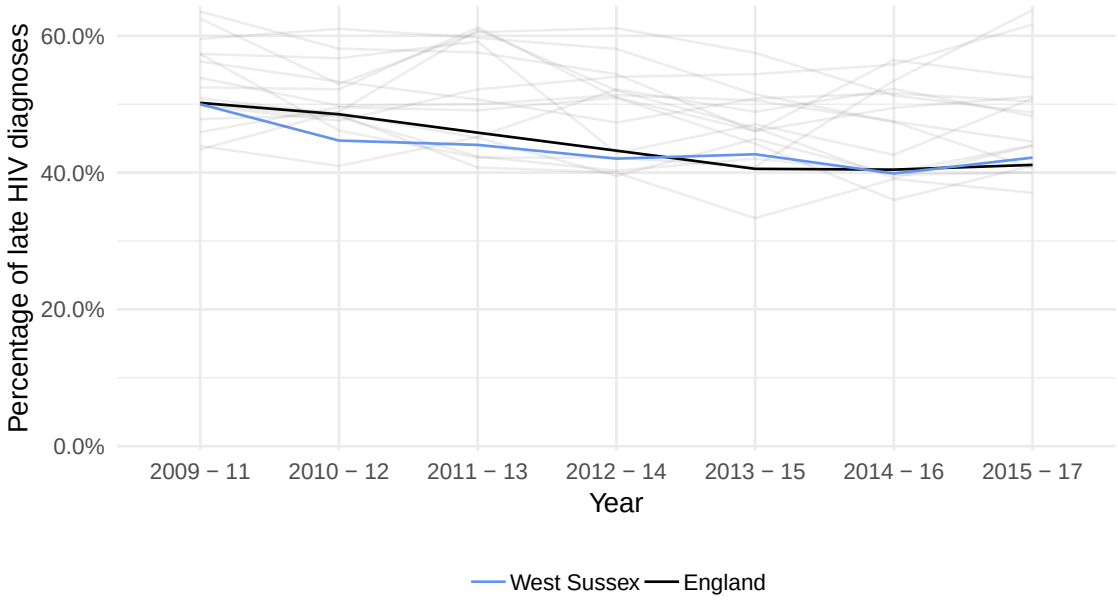


Figure 5.31 – *Percentage of new HIV diagnoses made late, with a CD4 cell count below 350 per mm^3, 2009-11 to 2015-17. Grey lines are the CIPFA neighbours of West Sussex. Source: PHE Fingertips.*

In the South East, diagnosis of heterosexuals is most likely to occur late (57% of males, 55% of females). In MSM, 34% of new diagnoses are late diagnoses. By ethnic group,

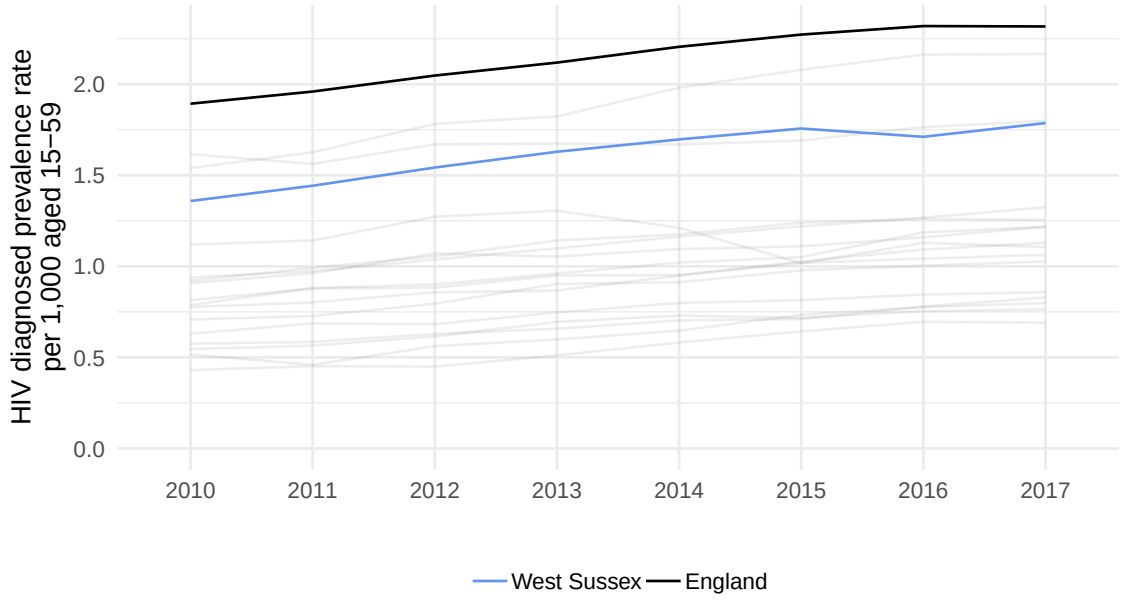


Figure 5.32 – Diagnosed HIV prevalence per 1,000 population aged 15-59 in England, West Sussex and its CIPFA neighbours, 2010 to 2017. Source: PHE Fingertips.

black Africans are more likely to be diagnosed late than whites (62% of new diagnoses are late, compared to 38%).

Factors affecting late diagnosis are likely to be stigma attached to knowledge of HIV status, lack of information about the condition and poor access to services.

5.4.4 Estimated Prevalence

An area is considered to have a high prevalence of HIV if the rate exceeds 5 per 1,000 population aged 15 to 59 years. No areas in West Sussex had a high prevalence of HIV in 2017. PHE recommends that expanded HIV testing be introduced in areas where prevalence exceeds 2 per 1,000 population. Rates in Crawley (3.3), Adur (2.2) and Worthing (2.4) all exceed this threshold. In Crawley, around 62% of MSOAs exceed the threshold in 2017, while in Adur 25% did and in Worthing prevelence exceeded 2 per 1,000 in 23% of areas.

The prevalence of diagnosed HIV in West Sussex (1.8 per 1000 population aged 15 to 59 years) was significantly lower than that of England (2.3 per 1000 population aged 15 to 59 years). Prevalence in West Sussex was among the highest of its CIPFA neighbours and has been rising since 2010 at a similar rate to England, as can be seen in Figure 5.32.

5.5 Contraception

5.5.1 Long-acting reversible contraception

The PHE sexual health profiles include five LARC related indicators:

- Total prescribed LARC (excluding injections) rate per 1,000
- GP prescribed LARC (excluding injections) rate per 1,000
- SRH service prescribed LARC (excluding injections) rate per 1,000
- Under 25s choosing LARC (excluding injections) at SRH services (%)
- Over 25s choosing LARC (excluding injections) at SRH services (%)

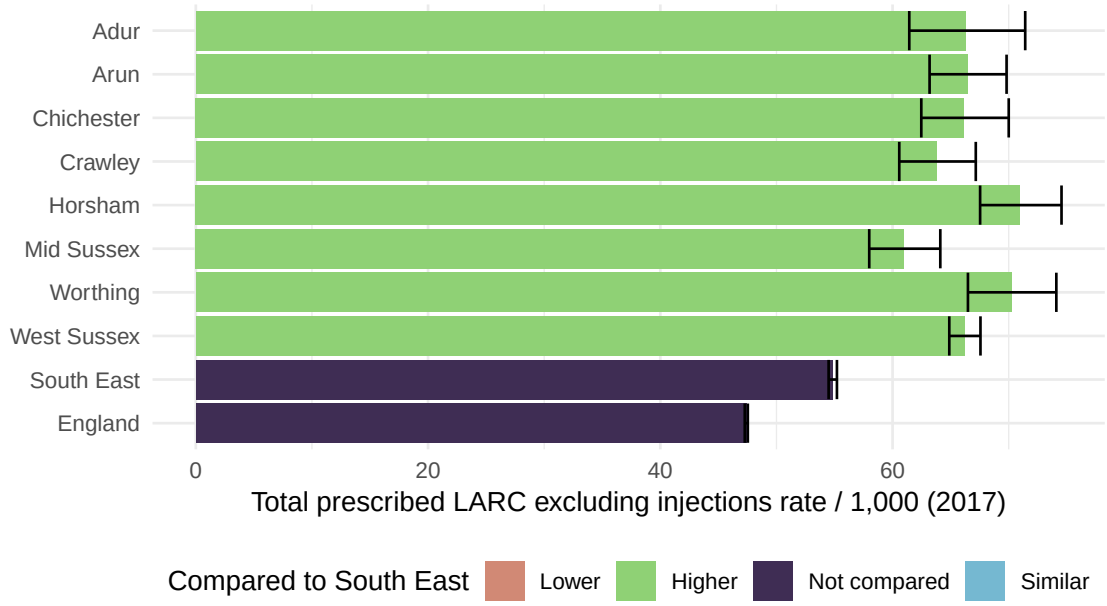


Figure 5.33 – *Total prescribed LARC (excluding injections) rate per 1,000 in 2017. Source: PHE Fingertips.*

In 2017, the total rate of prescribed LARC was 66 per 1,000 women aged 16-44 in West Sussex (Figure 5.33). This higher than the South East region and England as a whole. Every district and borough of West Sussex has a higher rate of LARC prescription than England and the South East.

The majority of LARC was prescribed by GPs (approximately 50 per 1,000, Figure 5.34) and the remainder was prescribed in SRH settings (approximately 16 per 1,000, Figure 5.35). The GP prescription rate in West Sussex is higher than England and the South East in every district and borough. Rates of LARC prescribing in SRH venues is higher than England and the South East in Chichester and Worthing, similar to regional rates in Arun and Crawley, whilst in Adur, Horsham and Mid Sussex the rates are lower than the region as a whole. The county as a whole prescribes LARC in SRH settings at a lower rate than the South East region as a whole.

At SRH services in West Sussex in 2017, around 18% of under 25s chose LARC as their method of contraception (Figure 5.36), this is lower than in England and the South East (approximately 23%). The proportion in Adur, Chichester, Crawley, and Mid

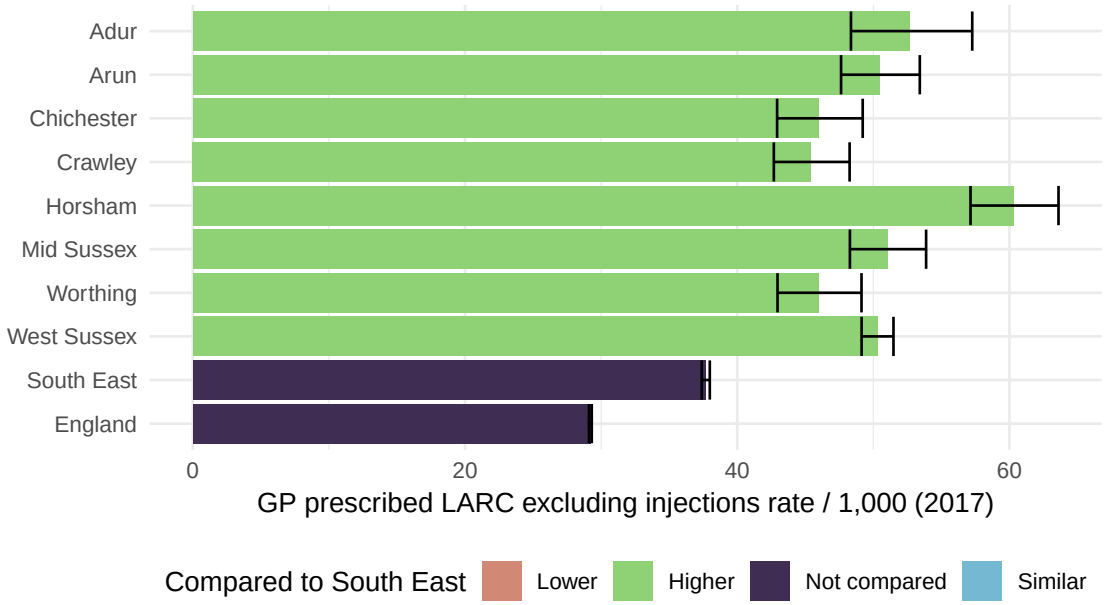


Figure 5.34 – *GP prescribed LARC (excluding injections) rate per 1,000 in 2017. Source: PHE Fingertips.*

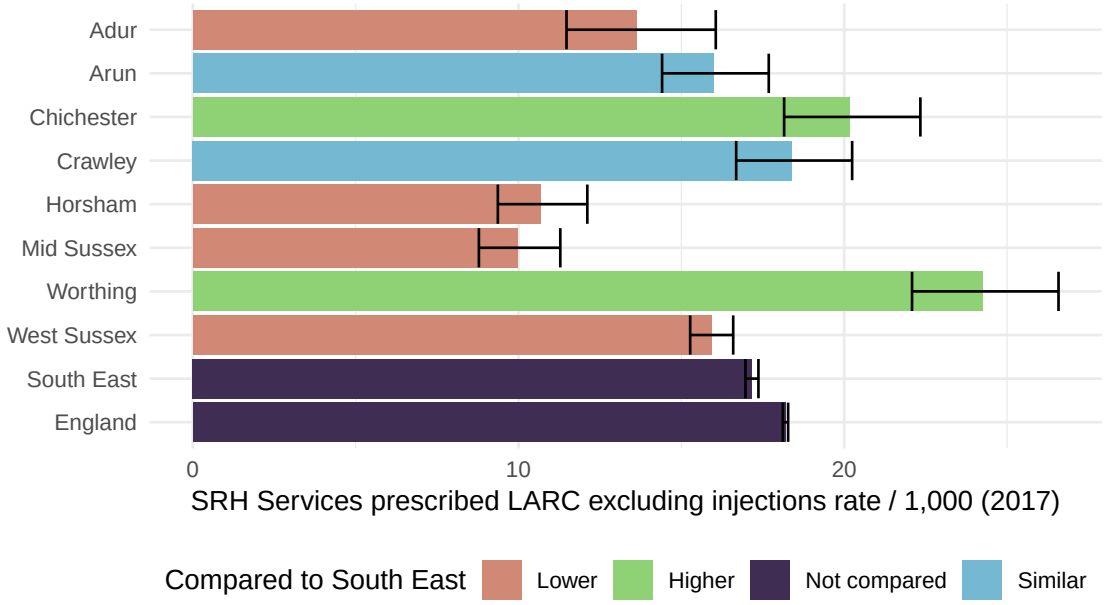


Figure 5.35 – *SRH prescribed LARC (excluding injections) rate per 1,000 in 2017. Source: PHE Fingertips.*

Sussex is similar to the South East. More engagement may be needed with under 25s in other districts and boroughs.

At SRH services in West Sussex in 2017, around 27% of over 25s chose LARC as their method of contraception (Figure 5.37), this is lower than in England and the South East (approximately 38%). The percentage is lower across all districts and boroughs, suggesting that SRH services may need to more across the county to understand why

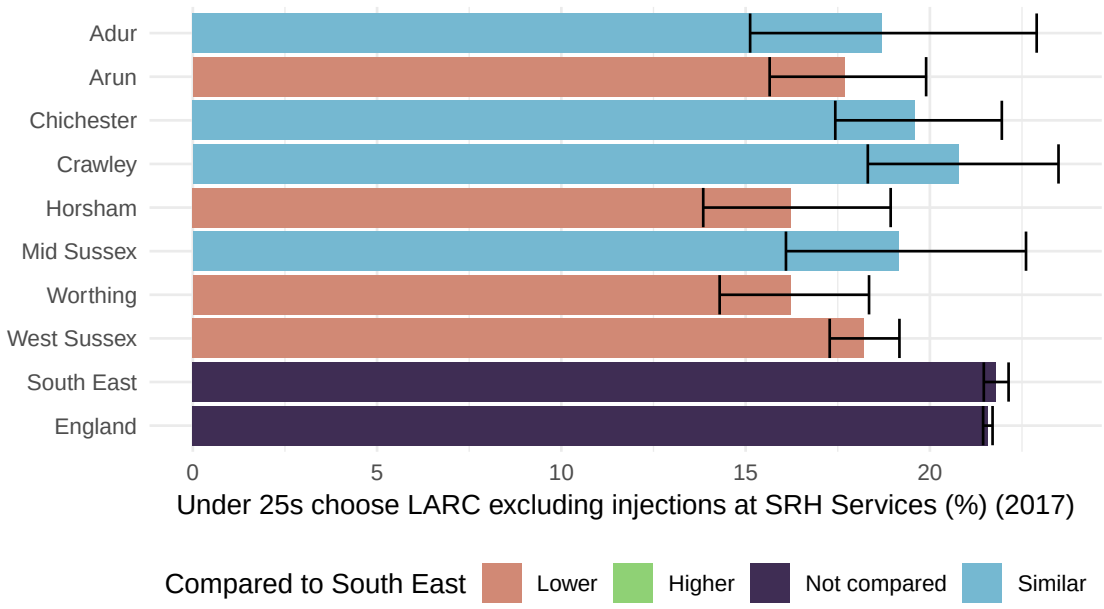


Figure 5.36 – *Percentage of under 25s choosing LARC at SRH services (excluding injections) in 2017. Source: PHE Fingertips.*

over 25s are not choosing LARC as a long-term form of contraception.

5.5.2 Other forms of contraception

The PHE sexual and reproductive health profiles also include the percentage of women at SRH services choosing injections (Figure 5.38), hormonal short-acting contraceptives (Figure 5.39), and user-dependent methods for their contraceptive needs (Figure 5.40). The proportion of women choosing injections at SRH services is lower than the South East and England, except in Crawley (where it is higher) and in Adur and Mid Sussex (where it is similar). The most popular choices for contraception at SRH services are hormonal short-acting contraceptives and user-dependent methods.

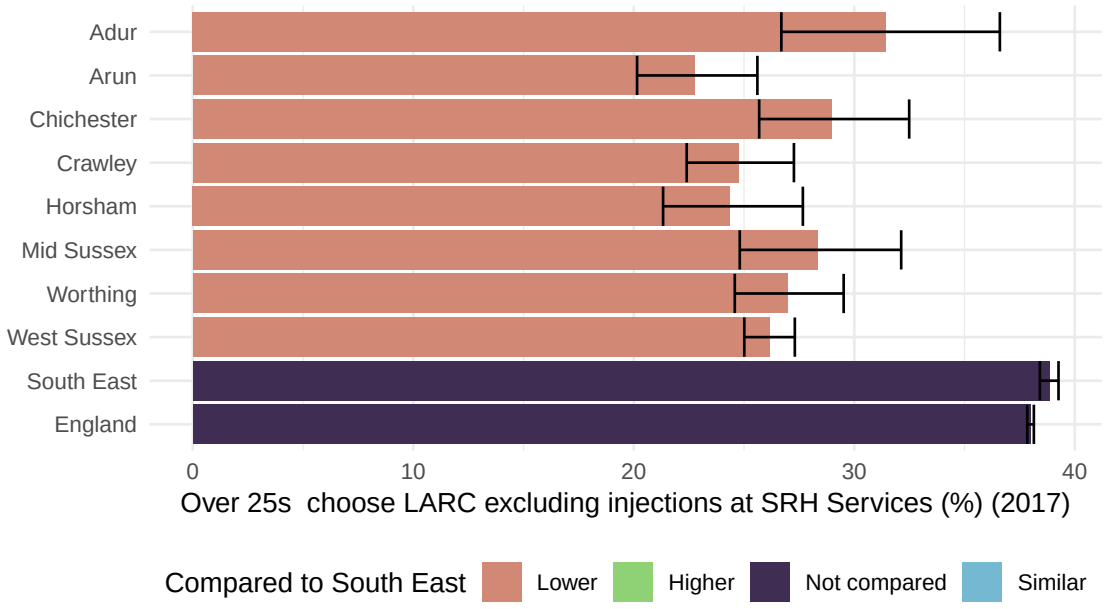


Figure 5.37 – *Percentage of over 25s choosing LARC at SRH services (excluding injections) in 2017. Source: PHE Fingertips.*

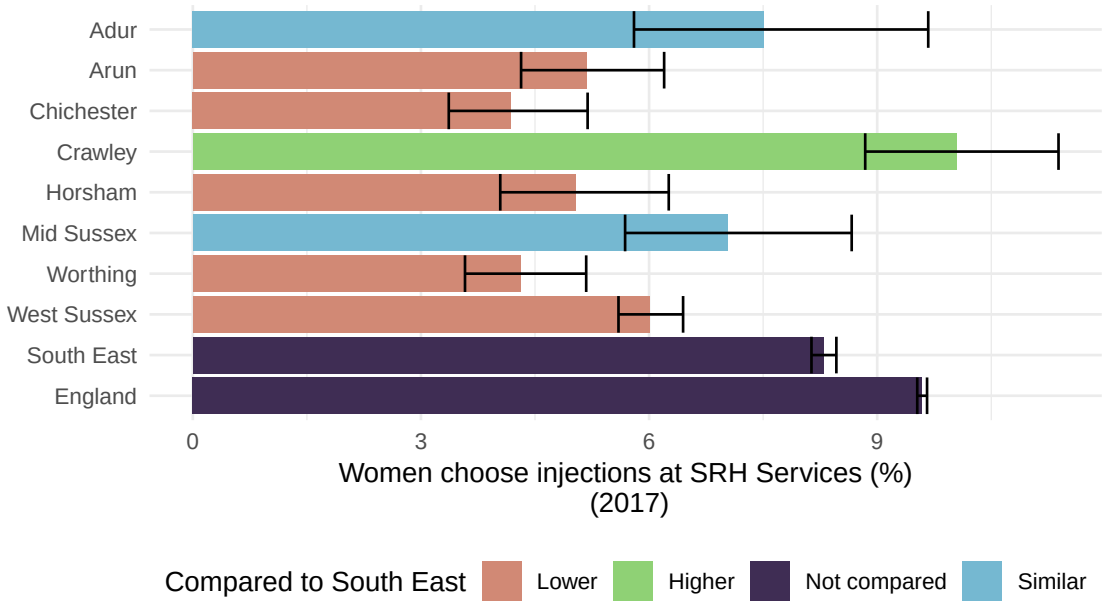


Figure 5.38 – *Percentage of women choosing injections at West Sussex SRH services in 2017. Source: PHE Fingertips.*

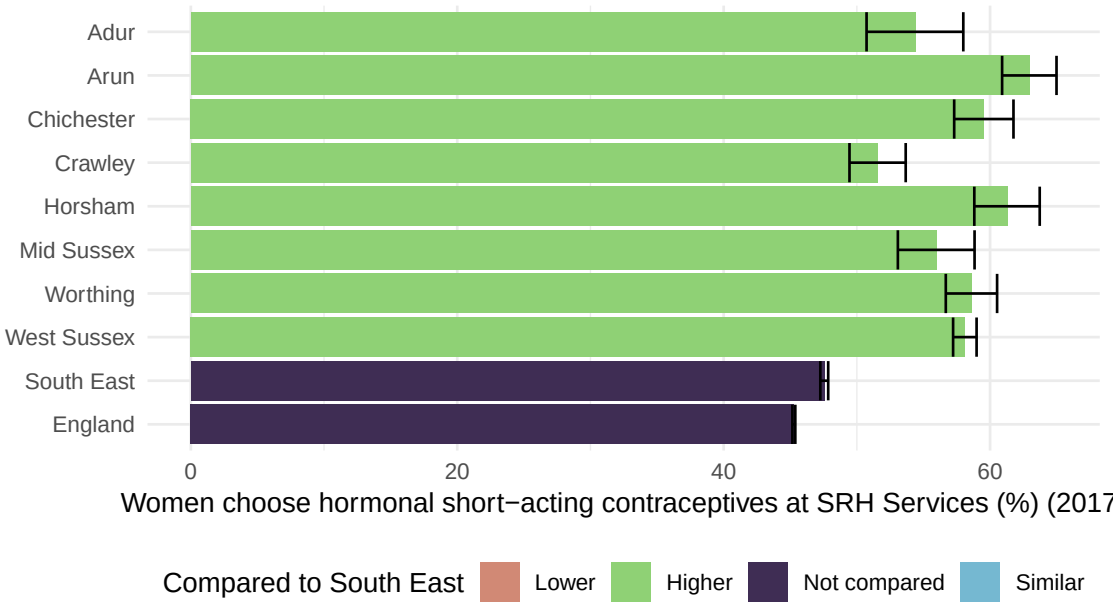


Figure 5.39 – *Percentage of women choosing hormonal short-acting contraceptives at West Sussex SRH services in 2017. Source: PHE Fingertips.*

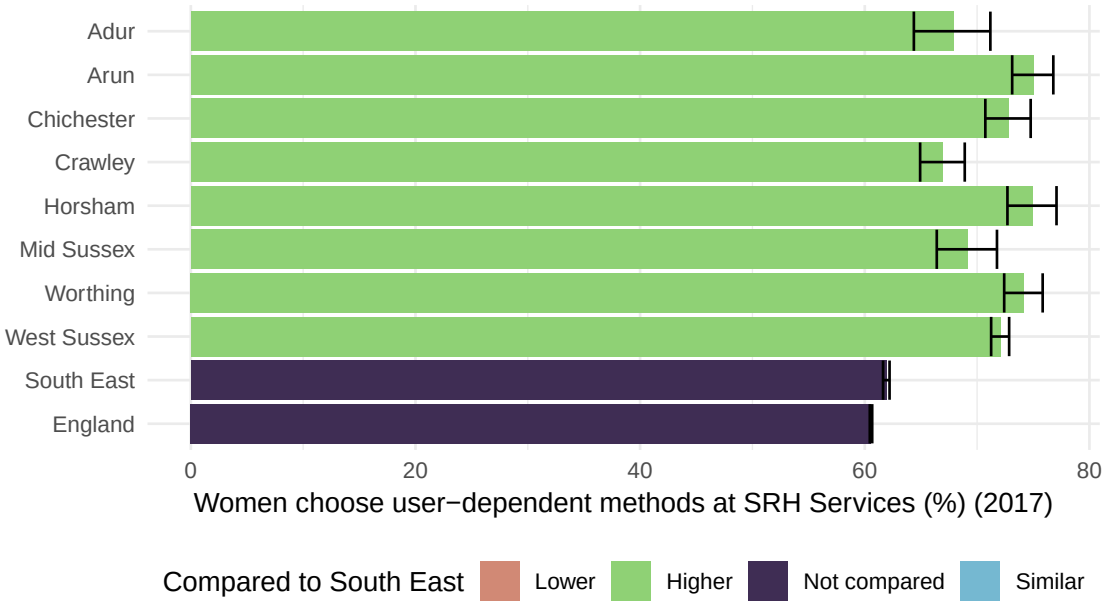


Figure 5.40 – *Percentage of women choosing user-dependent contraceptive methods at West Sussex SRH services in 2017. Source: PHE Fingertips.*

5.6 Termination of pregnancy

Termination of pregnancy rates are highest in Crawley CCG and Coastal West Sussex CCG, particularly in the 20-24 age group. Rates in Crawley are also higher than the England and Wales rate for almost every age group.

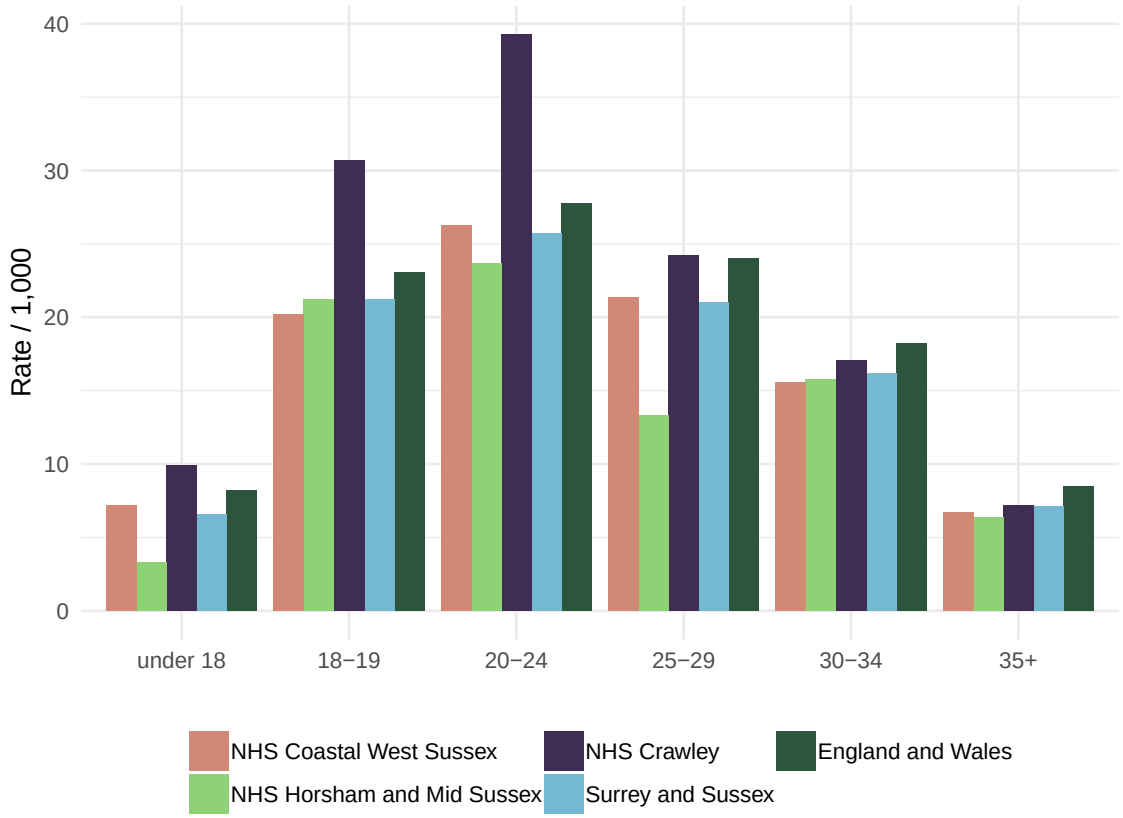


Figure 5.41 – Rate of abortions by age group in West Sussex CCGs, 2017. Source: PHE Fingertips.

6. Need arising in the population

The needs assessment process must also consider those groups within the population who may have more urgent need than the general population.

The impact of STIs remains greatest in young heterosexuals aged 15 to 24 years, black ethnic minorities and MSM. Public Health England (PHE) is conducting and managing a number of initiatives to address this inequality.

However there are also a number of other groups in the population who may have hidden needs or difficulties in accessing services. This chapter also considers the likely need in these groups based on available data and current services that are available.

6.1 Young People

6.1.1 Background

The high rates of STIs among young people are likely to be due to greater rates of partner change [12] (See also Table 3.8, page 55). Statutory, high-quality relationship and sex education at all secondary schools will equip young people with the information and skills to improve their sexual health.

PHE recently launched a health promotion campaign to promote condom use and positive sexual relationships among 16 to 24 year olds [18]. The vast majority of areas in England have condom schemes which distribute condoms to young people (mostly under 20 years of age) through a variety of outlets with an estimated coverage of 6% in under 20 year olds. West Sussex has a C-card scheme that offers 13-20 year olds free condoms, confidential advice and a Chlamydia testing kit from venues across West Sussex.

There has been a long term decline in the chlamydia detection rate among 15 to 24 year olds and notable variations by geographic area, often reflecting rates of testing. Given the large drops in testing nationally and the high positivity of women within sexual and reproductive health services it is likely that some infected women are going undiagnosed.

PHE recommends that local authorities with detection rates below the PHOF recommended indicator of 2,300 per 100,000 population (such as West Sussex, see page 70) should consider means to promote chlamydia screening to most effectively detect and control chlamydia infections. Ways to address this could include:

- embedding chlamydia screening for 15 to 24 year olds into a variety of non-specialist SHSs and community-based settings;
- focusing on venues serving populations with the highest need based on positivity;
- emphasise the need for repeat screening annually and on change of sexual partner;
- emphasise the need for re-testing after a positive diagnosis within three months of initial diagnosis;
- ensure treatment and partner notification standards are met.

To help local areas improve their chlamydia detection rate in 15 to 24 year olds, PHE developed the chlamydia care pathway (CCP) to outline comprehensive case management for an episode of chlamydia testing, diagnosis and treatment [19]. CCP support is delivered through facilitated workshops, the aim of which is to create action plans for how services might be improved or resources redistributed to most effectively identify infected individuals.

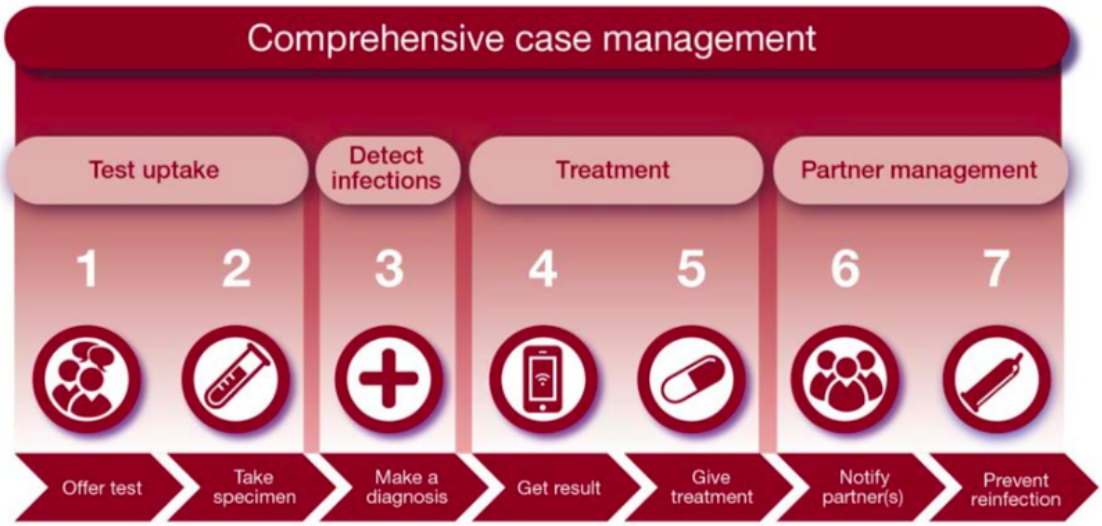


Figure 6.1 – *The Chlamydia care management pathway, introduced by PHE in 2016 to improve chlamydia detection rates. Source: PHE, [19].*

Gonorrhoea diagnoses are high among young people (Figure 5.12, page 73) and increasing. This is worrying due to the ongoing circulation of gonorrhoea strains that are resistant to the standard antibiotic treatment of azithromycin and the emergence of strains that are resistant to further forms of antibiotic treatment.

6.1.2 Outcomes

Although West Sussex overall has an older population compared with England, there are areas with larger populations of younger adults (16-24 year olds). In Crawley 9.4% of the population is aged 16-24 years (approximately 10,500 people) and in Chichester 9.8% are in this age group (approximately 11,800). The University of Chichester has sites based in Chichester and Bognor.

Figure 5.3 (page 66) shows the proportion of first attendances in West Sussex by age group. Around 14% of attendances are among people under 20 and 40% are among under 25.

Young people experience more diagnoses of chlamydia and gonorrhoea than over 25s (Figure 5.7, page 69). The chlamydia detection rate in young people in West Sussex was 1,418 per 100,000 in 2017. While there are fewer diagnoses of many STIs in young people, the rates at which they occur are higher. For example, in West Sussex in 2017:

- the rate of chlamydia diagnosis in young men was approximately 3 times that of older men
- the rate of chlamydia diagnosis in young women was approximately 7.5 times higher than that of older women
- the rate of gonorrhoea diagnosis in young women is approximately 4 times higher than that of older women

Both under-16 and under-18 conception rates in West Sussex have been falling year on year (Figure 5.1, page 64), however this depends on maintaining and improving access to contraception and health promotion messages.

The percentage of young people choosing LARC in SRH services in West Sussex is below that of the South East (Figure 5.36, 91), with Horsham and Worthing having the lowest percentages. However, LARC prescription rates at GPs are higher than the England rate so it may be that more young people are getting LARC from their GP (rates for prescription of LARC at GPs are not given by age).

Abortion rates are highest in the youngest age groups, particularly in Crawley CCG where abortion rates are significantly higher than the England and Wales rate for both the 18-19 and 20-24 age groups (Figure 5.41, page 94).

6.1.3 Services

The integrated service runs clinics for students of Chichester college at its Binsbury campus and at the FindItOut centres in Crawley and Horsham.

All young people under the age of 18 years who access the integrated sexual health service are assessed against the spotting the signs pro forma. The total number of service users who are under the age of 18 years are reported on, as are the number where concerns are identified and escalated.

School nursing services act as tier 1 services for children at schools. School nurses will mostly signpost in to the integrated service, placing the emphasis on helping children to know where they can get help with their sexual health needs.

The Chathealth service [20] provides an SMS contact for school children in West Sussex, offering a connection to a school nurse for discussing problems with health and emotional wellbeing. Sexual health and worries about relationships and pregnancy are included within this services. All episodes are considered closed and stay closed once an episode is finished. Confidentiality is maintained unless queries raise safeguarding concerns. The availability of the service relies on schools advertising it.

There are approximately 260 schools in West Sussex. The school nursing service is currently depleted and there are not enough school nurses to allocate one to every school at present. Many primary schools have withdrawn the "puberty talk". In some schools, nurses are still delivering sex education but in many schools it has to be a teacher, usually the person required to be the lead for sexual health. The forthcoming introduction of mandatory relationship and sex education will likely stretch these resources further.

6.1.4 Outreach

The integrated sexual health service conducts several outreach efforts in an attempt to engage more young people with the service. These include:

- **Allsorts LGBT** The outreach service works with 16-24 year olds at Horsham and Chichester Allsorts venues, talking about sexual health services. Focus is on describing how to access the service and what to expect there.
- **Brighton and Hove Albion FC** The club's academy is based in Shoreham. The outreach team work with the under 18s and under 23s. With under 18s, emphasis is on Fraser competency: understanding what being sexually active means and what the consequences are. Under 23s outreach aims to signpost services and normalise the idea of getting tested and using contraception.
- **Young parent groups** in Chichester and Bognor. The emphasis is on contraception and sexual health either with people who have just started pregnancy or have recently had a child.
- Work with **school nurses** and also a team of looked-after children's nurses. In particular they have worked with a team based in Brighton who work with children placed out of county in West Sussex. This involves getting teens signed up to C-card scheme where appropriate and providing information about the service.
- **The C-card scheme** is available for young people aged 13-21, who can join the scheme to get free condoms, confidential advice and a Chlamydia testing kit from venues across West Sussex.[1]
- **University and college outreach** also signposts toward the service and aims to inform young people when they should get tested.
- **The national chlamydia and gonorrhoea screening programme** (NCSP) provides kit-based testing for chlamydia and gonorrhoea remotely. The service also supply kits to organisations that will hold them for use on request e.g. universities and colleges.

[1] Free condoms are available to Over 21s from all clinics.

6.1.5 Recommendations

- Increase detection for chlamydia to meet recommended PHE target
- Ensure that clinic hours continue to meet the needs of young people
- Improve experience around contraception booking and delivery
- Maintain outreach efforts that promote and normalise the service so that young people in need of treatment and advice know where to access this
- Work with schools to ensure that forthcoming mandatory relationships and sex education forms a substantive part of prevention relating to the sexual health of young people

6.2 Men who have sex with men

6.2.1 Background

Men who have sex with men (MSM) continue to experience high rates of STIs and remain a priority for targeted STI prevention and health promotion work. HIV Prevention England have been contracted to deliver, on behalf of PHE, a range of activities which include promoting condom use and awareness of STIs, which are particularly aimed at MSM.

Gonorrhoea diagnoses are high among MSM (Figure 5.13, page 73), and are increasing. This is worrying due to the ongoing circulation of gonorrhoea strains that are resistant to the standard antibiotic treatment of azithromycin and the emergence of strains that are resistant to further forms of antibiotic treatment.

There is a long term trend of increasing syphilis diagnoses among MSM. There is evidence that condomless sex associated with HIV sero-adaptive behaviours (which include selecting partners perceived to be of the same HIV sero-status), is leading to increased STI transmission. PHE will publish an action plan, with recommendations for PHE and partner organisations, to address the continued increase in syphilis diagnoses in England.

Nationally, the diagnosis rate of acute bacterial STIs in HIV-positive MSM is around four times that of MSM who were HIV-negative or of unknown HIV status. This suggests that rapid STI transmission is occurring in dense sexual networks of HIV-positive MSM. Sero-adaptive behaviour increases the risk of infection with STIs, hepatitis B and C, and sexually transmissible enteric infections like *Shigella*. For those who are HIV negative, sero-adaptive behaviour increases the risk of HIV seroconversion as national figures indicate that 13% of MSM who are infected with HIV are unaware of their infection [21].

The continued reduction in genital warts diagnoses is associated with the high coverage of HPV vaccination in adolescent girls through the national HPV vaccination programme. While young heterosexual men stand to benefit from female-only HPV vaccination through herd protection, this is not necessarily the case for MSM. As a result, a targeted HPV vaccination pilot programme for MSM ran from June 2016 to the end of March 2018 in 42 specialist SHSs and HIV clinics across England (including in West Sussex). The experience of this pilot supported the decision to proceed to a phased national

rollout of targeted HPV vaccination for MSM attending specialist SHSs and HIV clinics, in 2018. While a national impact on genital warts in this population is not expected to be seen for some time, HPV vaccination of MSM will provide direct protection against HPV infection with the aim of reducing the incidence of genital warts and HPV-related cancers.

6.2.2 Outcomes

Rates of STIs in MSM populations are crude estimates because there are no precise estimates of the size of the population. However, when calculating denominators using NATSAL-3 estimates (Table 3.8, page 55) it is clear that rates of STIs in men who have sex with men are higher than in the remainder of the population.

- In 2017 the diagnosis rate of chlamydia in men who have sex with men was approximately 14 times that of heterosexual men, 11 times that of heterosexual women and 7 times that of women who have sex with women.
- In 2017 the diagnosis rate of gonorrhoea in men who have sex with men was approximately 84 times that of heterosexual men, 86 times that of heterosexual women and 29 times that of women who have sex with women.
- In 2017 the diagnosis rate of syphilis in men who have sex with men was approximately 300 times that of heterosexual men.
- In 2017 the diagnosis rate of first episode herpes in men who have sex with men was approximately 7 times that of heterosexual men, 3 times that of heterosexual women and 3 times that of women who have sex with women.
- In 2017 the diagnosis rate of first episode genital warts in men who have sex with men was approximately 5 times that of heterosexual men, 6 times that of heterosexual women and 4 times that of women who have sex with women.

The rate of new HIV diagnoses in West Sussex in 2017 was 5.4 per 100,000 population aged 15 or over, which is similar to the South East region (5.6) and lower than the England rate (8.7). Between 2015 and 2017 the proportion of new HIV diagnoses considered to be late were 42.2%. The proportion of late diagnoses has been steadily falling since 2009-2011 and is now among the lowest of West Sussex's statistically similar neighbours. However, the proportion has increased slightly on the 2014-2016 period and there is a need to maintain uptake of HIV screening, particularly among identified risk groups such as MSM.

HIV testing kits are available to West Sussex residents who meet risk criteria from the `https://www.test.hiv` website. This aims to increase the number of people, particularly men who have sex with men, who get tested for HIV. Remote testing by kit may help some people who find it difficult to attend clinics to nonetheless get tested.

There is an ongoing national PreP impact trial which offers pre-exposure prophylaxis to people at risk of acquiring HIV. So far there have been around 9,000 participants enrolled at 140 clinics across England, including in West Sussex. The trial has had a higher than expected uptake among MSM.

6.2.3 Outreach

- Each year on World AIDS day (1st December), the integrated service promotes the importance of knowing HIV status and getting tested for HIV.
- Terrence Higgins Trust performs outreach in Brighton and would be interested in offering outreach services to MSM in West Sussex, particularly in Worthing and Crawley.
- The integrated service is represented at pride events across the county.
- The integrated service is part of the Sussex HIV network.

6.2.4 Recommendations

- Increase outreach
- Examine whether facilitating access to PreP beyond the Impact trial is financially viable
- Expand engagement with local MSM population beyond Pride and World AIDS day
- More health promotion in line with PHE programmes
- Maintain integration of HIV treatment and care

6.3 Black and Minority Ethnic Populations

6.3.1 Background

The high rate of STI diagnoses among black ethnic communities is most likely the consequence of a complex interplay of cultural, economic and behavioural factors. Data from a national probability sample indicate that men of black Caribbean or any other black backgrounds are most likely to report higher numbers of recent sexual partners and concurrent partnerships; this, coupled with assortative sexual mixing patterns, may be maintaining high levels of bacterial STIs in these communities [22]. HIV Prevention England also delivers, on behalf of PHE, prevention activity targeted at black ethnic communities.

6.3.2 Population background

Figure 3.10 (page 53) shows the difference between local authority areas in West Sussex, and the change over time. In Crawley almost 28% of the population has an ethnic minority background, compared with 7% in Chichester.

6.3.3 Outcomes

Ethnicity is poorly recorded in the GUMCAD data set. Around 45% of all diagnoses in 2017 have no attributable ethnicity data given. Hence the following observations should be taken as indicative:

- The rate of chlamydia diagnoses in women of mixed ethnicity is around three times that of white women.

- The rate of chlamydia diagnoses in men of Black or Black British ethnicity is approximately four times that of white men. A similar disparity exists in diagnoses of men of mixed ethnicity and other ethnicity.
- The rate of gonorrhoea diagnoses in women of mixed ethnicity is around 3 times that of white women.
- The rate of gonorrhoea diagnoses in women of other ethnicity is approximately 10 times that of white women.
- The rate of gonorrhoea diagnoses in men of Black or Black British ethnicity is around 6 times that of white men. A similar disparity exists in diagnoses of men of other ethnicity (5 times).
- The rate of first herpes diagnoses of men of other ethnicity is approximately 3 times that of white men.

In the South East in 2017, around 18% of HIV new diagnoses were in Black Africans and around 1% were of Black Caribbean. Among heterosexual transmissions of HIV, approximately 44% of new infections were in African-born persons (compared to 67% in 2008).

Black Africans are more likely to be diagnosed with HIV late than white people (62% compared to 38%).

6.3.4 Recommendations

The 2016 West Sussex Black and Minority Ethnic Communities needs assessment [23] highlighted that sexual health and screening services did not robustly record data and that this may be a reflection of the desire to not be identified by some in the community. It appears that this continues to be an issue.

The same needs assessment also found anecdotal evidence to suggest that some women may be unwilling to engage with screening programmes due to the manner in which results are often posted to the individual's home, where the husband/father will often be solely responsible for reading mail. While the integrated service is anonymous at point of use, it may be the case that reassurance about how results are communicated needs to form an integral part of outreach work. This may also be a barrier to the adoption of online testing in these communities.

6.4 Substance misuse services

People who misuse alcohol and drugs are more likely to:

- initiate sexual activity at an earlier age
- have more sexual partners
- use condoms less consistently
- be at risk of sexually transmitted infections

In young people, use of drugs and alcohol is associated with riskier sexual behaviour. Young people with substance problems are more likely to engage in risky sexual behaviors during adolescence and to continue risky sexual behaviors to the extent

that substance problems persist. Risk reduction education is a crucial component of substance abuse treatment for young people.

West Sussex County Council Drug and Alcohol Treatment services are provided by Change Grow Live (CGL). The service supports adults and young people to understand the risks their drug or alcohol use pose to their health and wellbeing, and supports them to reduce or stop use safely. Drug and alcohol treatment services are split into services for people under 25 years and for people over 25. The U25 service is registered for C-card condom distribution and chlamydia testing scheme.

A number of issues were raised in relation to substance misuse and sexual health (and between services treating substance misuse and sexual health services):

- There is no set pathway between services. Access and use tends to be on an ad hoc basis and dependent on the person working with the client and the relationship built up between services. There are some very good relationships but there is concern that these could be subject to change as circumstances or staff change.
- Every area across the county is a little bit different and people work differently too, so existing pathways and contacts are variable from one area to another. There is some direct contact so sometimes young people will be booked into sexual health services with an appointment to avoid waiting in the clinic, usually U18 only.
- For older people accessing the service, sexual health needs tend to be revealed at the assessment stage, so in unpacking problems with drugs and/or alcohol, it might be necessary to refer into sexual health services for the wellbeing of the person.
- Issues around drugs and alcohol mean that some clients face additional risks and concerns including where someone has turned to sex work or is being sexually exploited (e.g. engaged in sex for additional supply of misused substance). There may also be cases of Child Sexual Exploitation or general criminal exploitation.
- Although the range of people seen in substance misuse services mean that there are also cases where people accessing the service are sexually inexperienced and don't know the precautions they have to take etc, so health promotion role is necessary (either training of staff members of the substance misuse service but also in the integrated sexual health service itself for these kinds of cases).
- In some cases it's difficult to talk about pregnancy, the conversations could be had earlier – i.e. whether client wishes to avoid pregnancy, or whether they are actually trying to conceive.

Key informants thought that overall there is a need to consider how services work together to achieve better results across the health and public health system, in relation to substance misuse services and sexual health service there may be a number of opportunities for joint working:

- The substance misuse service being supported to have HIV testing capability within the service
- Connections to online service run by the integrated service.

- Greater links and referrals between services, i.e. getting people from substance misuse service into the integrated service and vice versa, the KI could not recall a referral into substance misuse from the integrated service
- It was noted that a project working with women who have had one or more children taken into care (the PAUSE project) had developed strong referral pathways and links with integrated service. If there were similar pathways for providing LARC to some people accessing the substance misuse service to support prevention of pregnancies before children are taken in to care – e.g. avoid any removals. As such, substance misuse services should be viewed as part of the wider preventative picture and work should be undertaken to get existing systems to work more effectively together.

6.5 Looked After Children

Generally CLA will access services as other young people would, though there is a trial under way about a fast-track pathway into the ISHS for CLA. At the moment the trial is based on postcode and is being evaluated. The situation is slightly different for unaccompanied asylum seeker children (UASC). All UASC are sent on the national Safer in the UK programme and receive closer health follow-ups from nurses.

All children looked after (CLA) have health assessments within 20 working days of coming into council care, these are refreshed every 12 months for children over the age of 5. These assessments will discuss sexual health.

CLA nurses carry C-cards and testing kits.

Staff consider that the existing pathways are good, with no access barriers.There's been some feedback that termination of pregnancy services are difficult to access by public transport but attendance at those services are confidential, so there is no evidence stating that this affects CLA adversely in particular.

CLA are also likely to access school nurse services – but this would also be confidential, as would the texting service ChatHealth.

6.6 Homeless People

In 2016, West Sussex County Council conducted a Homelessness Needs Audit[2] using the Homeless Link survey [24] to engage with people living on the street and in sheltered accommodation. The survey contained questions about health, and sexual health in particular.

The questions that asked about sexual health included:

- Have you had a sexual health check in the past 12 months?
- Do you know where to access free contraception?
- Do you know where to access advice about sexual health?

[2]At time of writing the Homelessness Needs Audit is unpublished. Findings mentioned here are provisional.

However, there were no direct questions about whether they are currently sexually active, what type of sexual activity they may have engaged in, and whether there were any high risk sexual behaviours or safe sex i.e. condom use.

The survey asked whether participants had received a sexual health check in the preceding 12 months. Of those who answered, 24.8% reported having had a sexual health check during that time. This was lower than the national percentage of 35%. Differences between gender and age within West Sussex were also present with a significant difference between males (20.5%) and females (38.8%) having had sexual health checks within the last 12 months. Similar differences are observed across England.

Respondents were asked two further questions about access to sexual health advice: 86% reported they knew where to find advice with their sexual health. The majority stated they would contact a GP or nurse, or attend a sexual health clinic. 82% percent also stated they knew where to access free contraception.

While these results are broadly positive, more engagement is required to determine the level of sexual risk homeless people encounter, and whether more work needs to be done with respect to outreach for this population.

6.7 People Living With HIV

Positive Voices 2017 [25] is a survey of people living with HIV and receiving care in England and Wales. Participants were randomly sampled from the national HIV surveillance database and recruited from 73 HIV clinics. A total of 4,422 people responded (51% response rate). There were 432 responses from the South East region, approximately 10% of all survey responses.

Participants from the South East included 58% gay/bisexual men and 42% heterosexuals. 4% were “newly diagnosed” in the previous two years (2015-2017), and 16% have been diagnosed for more than 20 years (1996 and earlier). Participants from the South East included slightly more gay/bisexual men and a higher proportion of people aged over 55.

Respondents in the South East valued being able to attend the HIV clinic of their choice and that their clinic refer them to a range of health and support services when required. Respondents rated the service from their clinic on a scale of 0 to 10 and the average rating for the South East was 9.3. Of those who rated their clinic, 63% said their level of satisfaction had remained the same for the last two years, 30% said that their satisfaction had increased and 7% said their satisfaction had decreased.

The needs of people with HIV are diverse. The extent to which these needs are assessed, planned for, and met directly impacts on the overall health of the patient. A needs assessment of respondents attending HIV services in the South East found significant unmet need around peer support, disclosure support and support for managing long term conditions.

Respondents indicated unmet needs in every form of social and welfare services, with greatest need indicated in respect of relationship advice, loneliness and isolation, and childcare services.

Overall, the self-reported health of respondents within the South East was high; 73% rating their health as good or very good. The overall score for quality of life of people with HIV nationally was 0.60, compared to 0.86 in the general population of England. The overall score from respondents in the South East was 0.61. Anxiety and depression were the most challenging areas affecting patients, with half reporting some problems.

The top three chronic physical conditions reported by respondents from the South East were:

1. High cholesterol
2. High blood pressure
3. Asthma and arthritis

Good mental health remains an important factor in ensuring a good quality of life for people living with HIV. 39% of respondents from the South East had a diagnosis of depression, compared to 19% in the general population. 29% of respondents from the South East had a diagnosis of anxiety, compared to 15% in the general population.

Levels of drug use among people living with HIV in the South East is similar (28% of respondents) compared to national figures (21% of all respondents). The proportion of respondents (21%) who are current smokers was the same as in the national sample. Binge drinking was more common in South East respondents (37%) compared to the overall population of people living with HIV, and fewer respondents were non-drinkers (20%) compared to the overall population (25%).

There continues to be a fear of stigma and discrimination that prevents disclosure of HIV status. Around 10% of respondents from the South East reported that they have never told anyone about their HIV status outside a healthcare setting. 16% reported that they were worried about being discriminated against in a healthcare setting in the past year and 11% said they had avoided seeking healthcare when they had needed it in the past year. However, only 3% said they had actually been refused healthcare or delayed a treatment or medical procedure in the past year.

People living with HIV in the South East feel supported by HIV support services. 62% of respondents who had ever used HIV support services said that they had been very important for their health and wellbeing. However, almost a third of respondents said that it had become more difficult to access these services in the last two years.

The number of people living with HIV over the age of 50 is growing. They will be more vulnerable to cancers and age-related illnesses so health care must evolve to ensure their needs are met. New antiretroviral drugs continue to be developed which are more efficient and better tolerated. Health services will continue to address the issue of HIV stigma and improve the quality of life for people with HIV.

6.8 People With Learning Disabilities

The sexuality of people with disabilities is often ignored, neglected or stigmatised by society. People with disabilities have the right to sexual health and wellbeing and should be acknowledged as sexual beings. All practicable steps should be taken to help a person make a decision, which includes decisions about sexuality.

Ongoing relevant and practical sex and relationships education (SRE) for people with disabilities is crucial to their sexual and emotional development.

People with disabilities can be more vulnerable to sexual abuse and require protection in these circumstances. A 2015 report [26] found that young people with learning disabilities are vulnerable to child sexual exploitation due to factors that include 'over-protection, social isolation and society refusing to view them as sexual beings'. The research also found that significant numbers of children with learning disabilities are not being adequately protected due to a lack of specialist services and a failure to implement existing national and local policies.

Safeguarding processes acknowledge and take account of the needs of people with learning disabilities. The integrated service in West Sussex has an industry-leading safeguarding capability and provides training on the issue locally and regionally. As commissioner of the integrated service, West Sussex should use its role to ensure that other services working with people with learning disabilities across the health and social care system receive appropriate safeguarding training.

Staff working with and caring for people with disabilities should:

- respect the confidentiality and privacy of the individual's sexual expression as far as possible
- take a holistic view of sexuality to encompass sensuality and intimacy
- the focus should be on the needs of the individual rather than on the disability

The training and support needs of people working with and caring for people with disabilities must be addressed. There is a need for clear policies and guidance for professionals working with people with disabilities in the field of sexual health and relationships. Sexual health professionals and services should meet the practical, emotional and physiological needs of people with disabilities. Individuals should be provided with support to empower them to make informed choices about their sexual health, and services must be fully accessible to people with disabilities.

People with disabilities should be fully consulted in the development of sexual health services. More engagement with people with learning disabilities in West Sussex and their carers is needed.

7. HIV

7.1 Introduction

Human Immunodeficiency Virus (HIV) is now a largely treatable condition. If treated appropriately, a person with HIV can experience almost the same life expectancy as someone without the condition [27]. However early diagnosis increases the likelihood of these improved outcomes, with the added benefit of potentially preventing onward transmission. To this end, the UNAIDS organisation has established the 90:90:90 target [28] and this has been adopted by PHE as the cornerstone of its HIV strategy [29]. The 90:90:90 target asserts that of all people living with HIV:

- 90% should know that they have it
- 90% of those should be receiving the necessary treatment
- and that of those, 90% should be virally suppressed.

7.2 Services in West Sussex

7.2.1 Prevention, screening and diagnosis

The integrated service offers testing for HIV and other STIs, either through a walk-up service or as booked appointments. A website contains information about clinic times and access to a central booking number.

HIV testing is also available in the form of an online kit (see page 118). This is a blood-based test and results are available with a quick turnaround.

7.2.2 Treatment and care

NHS England commissions HIV treatment and care services in West Sussex. Provision of HIV treatment and care is paid for point of use, not where the patient lives. Thus this needs assessment considers only services that are accessed within West Sussex, principally at the hubs of the integrated service.

7.2.3 Community HIV Specialist Service

The Community HIV Specialist Service [30] is for adults living with HIV. It offers specialist HIV and MH nursing including home visits and health checks, as well as information, access and referrals to support workers. It also works with other professionals such as specialist HIV pharmacy, psychology, psychiatry, and dietician services, and with other agencies including voluntary bodies. There is also a Service User Group.

The service has three units covering the West Sussex and Brighton & Hove areas:

- Brighton and Hove Team (based at The School Clinic, Brighton)
- North Team (based at Crawley Hospital)
- South Team (based at Zachary Merton Hospital, Rustington)

Generally patients are referred to the service via GPs, specialist HIV clinics, or by other medical or social care professionals. The service also accepts direct self-referrals from patients, except where a mental health issue is involved.

Terence Higgins Trust run Positive Self-Management Programmes (PSMP) based in Worthing. The course lasts for 6 weeks and is for anyone living with HIV. The aim is to provide support mechanisms, a chance to meet others and develop self-confidence to help people feel more in control.

Some of the course topics include:

- Decisions: Taking HIV medication
- Working with your Healthcare Team
- Relaxation techniques and exercise
- Healthy eating
- Managing Fatigue/Tiredness
- Sex, Intimacy and disclosure
- Planning for the future

This service is commissioned by Coastal West Sussex CCG.

7.3 Data for West Sussex, the South East and England

The PHE sexual health profiles [7] record the following indicators relating to HIV:

- Coverage of HIV testing measured in specialist sexual health services.
- Rate of new HIV diagnosis per 100,000 population among people aged 15 or over.
- Percentage of adults (aged 15 or above) newly diagnosed with HIV with a CD4 count less than 350 cells per mm^3 (late diagnosis).
- Prevalence of diagnosed HIV infection per 1,000 among persons aged 15 to 59 years.

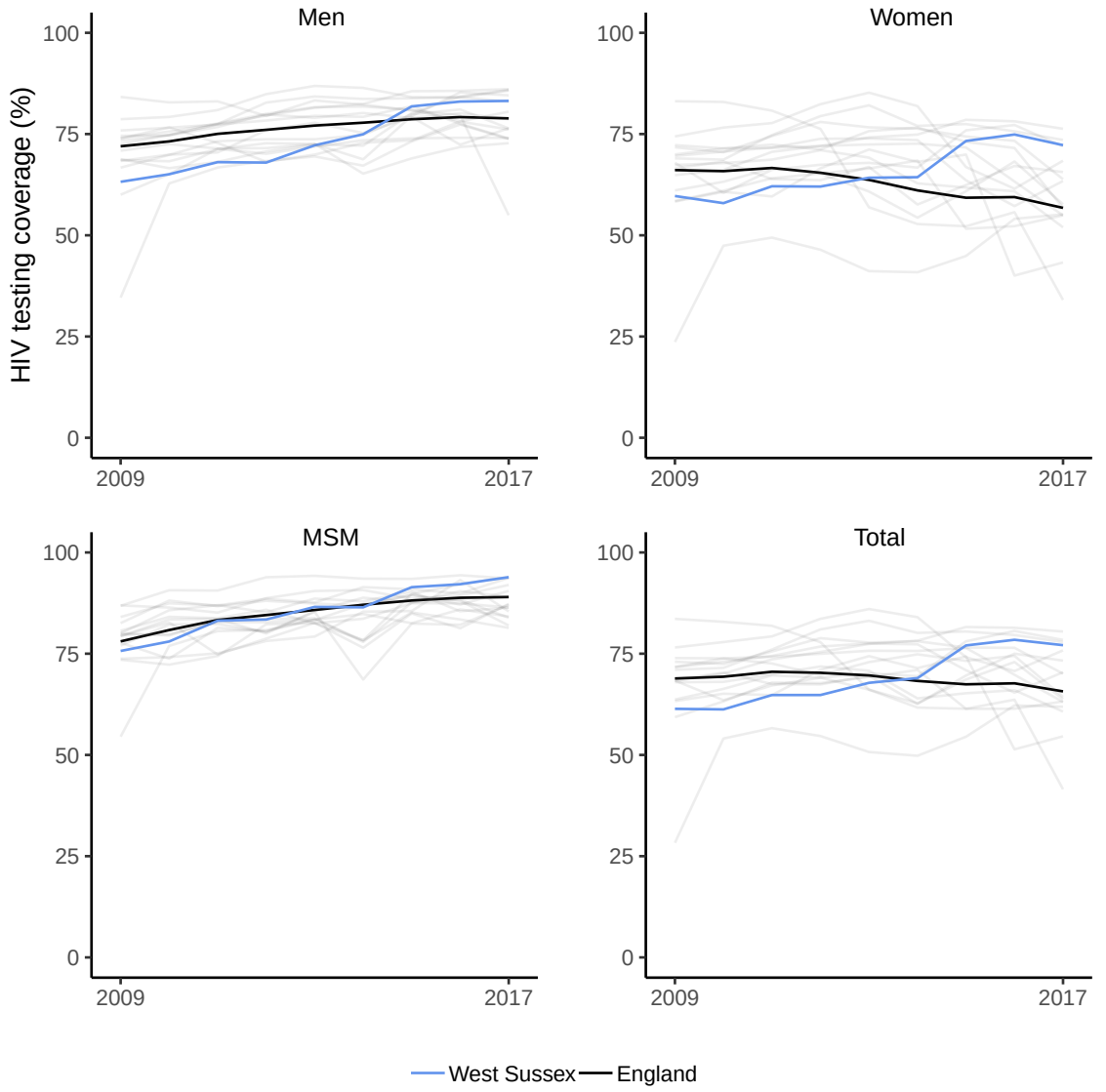


Figure 7.1 – *HIV testing coverage for West Sussex, England and the statistically similar neighbours of West Sussex, 2009 to 2017. Source: PHE Fingertips.*

7.3.1 Coverage

In 2017 coverage of HIV testing in specialist sexual health services in West Sussex was 77.1% of the eligible population. This has increased from 61.4% in 2009 and has increased over this period. West Sussex coverage is higher than the England average, which in 2017 was 65.7%. Since 2009 coverage rates in England have been rising, with West Sussex seeing slightly faster increases in coverage. Figure 7.1 shows how coverage for West Sussex, England and the statistically similar neighbours of West Sussex has changed since 2009.

See also notes made on page 68 regarding the proportion of new attendances at sexual health services where a full sexual health screen is given.

7.3.2 Rates of new diagnosis

Across the South East there were 405 new diagnoses of HIV in 2017, accounting for 10% of all new diagnoses in England [31]. The rate of new diagnoses of HIV in West Sussex in 2017 was 5.4 per 100,000 population aged 15 or over. The rate in the South East was 5.6 per 100,000 and in England it was 8.7 per 100,000.

In the South East, 51% of new diagnoses were acquired by men who have sex with men. This is compared to 53% in 2016 and 40% in 2008. Of the new diagnoses in men who have sex with men, 84% were white and 59% were UK born.

Sex between men and women is the second most frequent infection route with 44% of new HIV diagnoses. There were 24% fewer new diagnoses across this transmission route in 2017 compared to the previous year. Among heterosexually transmitted cases, 44% of new infections were in African-born persons, compared to 67% in 2008. 40% of heterosexually transmitted new diagnoses of HIV in 2017 were of people born in the UK.

In the South East, 3% of new HIV diagnoses were acquired through injecting drug use.

The highest proportion of new HIV diagnoses were in men aged 25 to 34 years old and in women aged 45 to 54 years old.

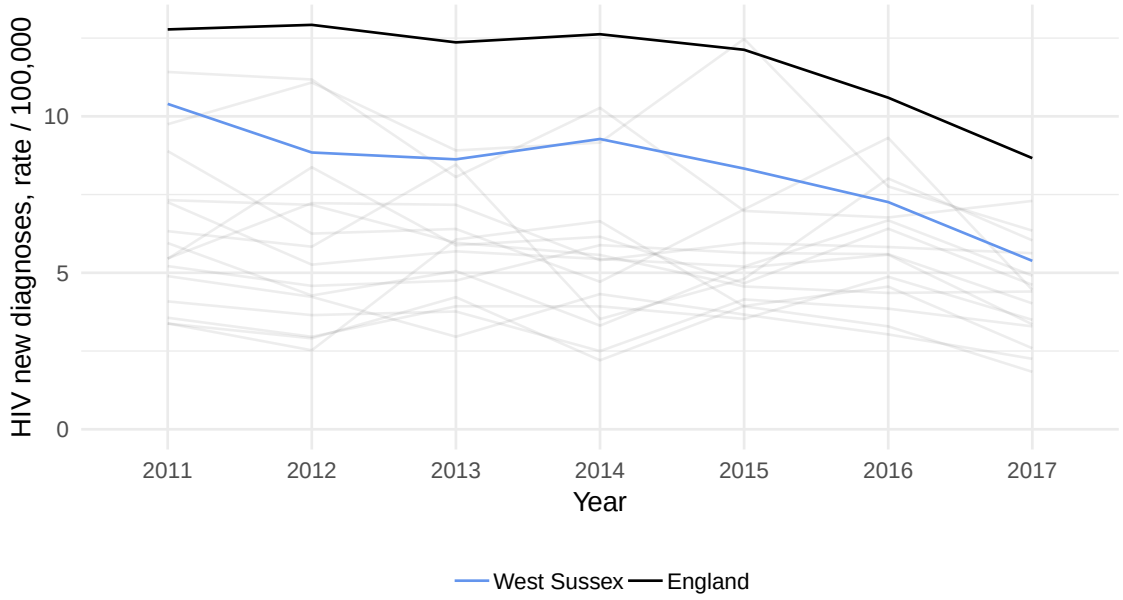


Figure 7.2 – *Rate of new HIV diagnoses in West Sussex and its statistically similar neighbours. The England rate is also given for comparison. Source: PHE Fingertips.*

7.3.3 Late diagnosis

It is crucial that people with newly acquired HIV begin treatment immediately. Having a CD4 cell count below 350 cells per mm^3 at diagnosis increases tenfold mortality within a year of diagnosis. A person receiving diagnosis of HIV with a CD4 cell count

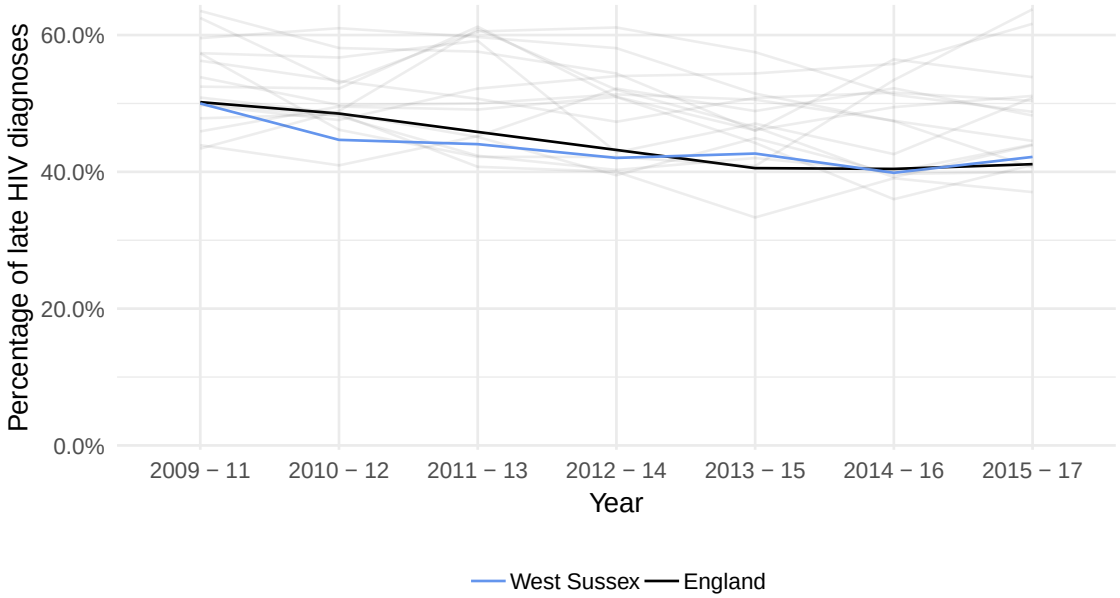


Figure 7.3 – *Percentage of new HIV diagnoses made late, with a CD4 cell count below 350 per mm3, 2009-11 to 2015-17. Grey lines are the CIPFA neighbours of West Sussex. Source: PHE Fingertips.*

below 350 cells per mm^3 is regarded to be a late diagnosis. PHE has actively sought to reduce the proportion of late diagnoses of HIV. In West Sussex, any late diagnosis is treated as a critical incident in order to identify any missed opportunities to make an earlier diagnosis.

Because of small numbers, the percentage of late HIV diagnoses are calculated across three year periods. In 2015-2017, 42.2% of new diagnoses of HIV in West Sussex occurred late similar to the England percentage of 41.1%. Figure 7.3 shows that since 2009-11, the percentage of late HIV diagnoses in West Sussex has been similar to that in England and lower than the majority of its CIPFA neighbours.

In the South East, diagnosis of heterosexuals is most likely to occur late (57% of males, 55% of females). In MSM, 34% of new diagnoses are late diagnoses. By ethnic group, black Africans are more likely to be diagnosed late than whites (62% compared to 38%).

Factors affecting late diagnosis are likely to include stigma attached to knowledge of HIV status, lack of information about the condition, and poor access to services.

7.3.4 Prevalence

An area is considered to have a high prevalence of HIV if the rate exceeds 5 per 1,000 population aged 15 to 59 years. No areas in West Sussex had a high prevalence of HIV in 2017. PHE recommends that expanded HIV testing be introduced in areas where prevalence exceeds 2 per 1,000 population. Rates in Crawley (3.3), Adur (2.2) and Worthing (2.4) all exceed this threshold. In Crawley, around 62% of MSOAs exceed

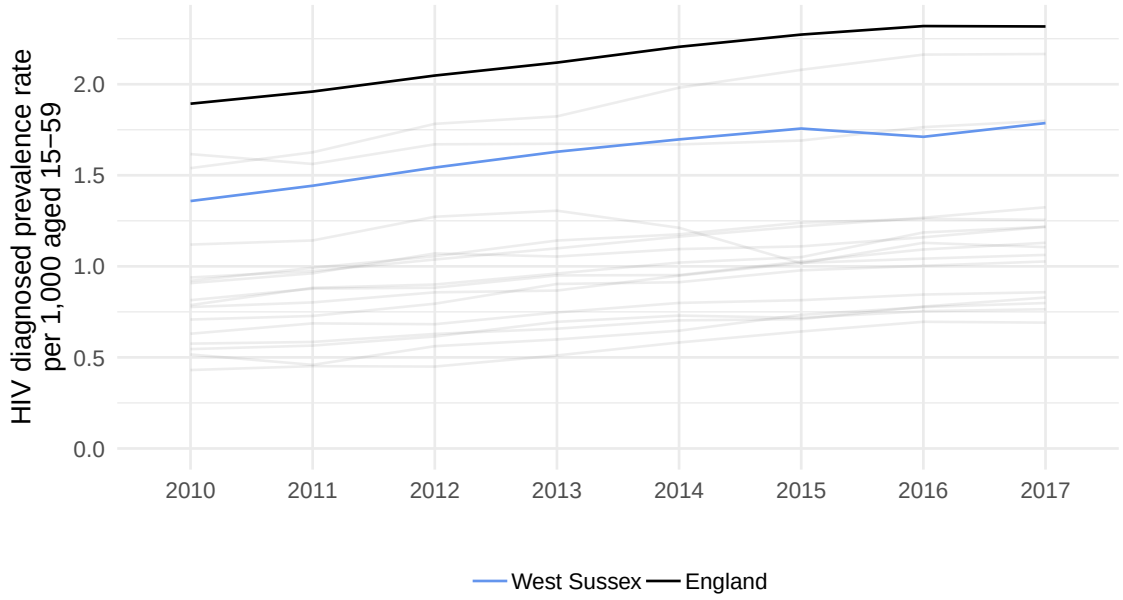


Figure 7.4 – Diagnosed HIV prevalence per 1,000 population aged 15-59 in England, West Sussex and its CIPFA neighbours, 2010 to 2017. Source: PHE Fingertips.

the threshold in 2017, while in Adur 25% did and in Worthing prevelence exceeded 2 per 1,000 in 23% of areas.

The prevalence of diagnosed HIV in West Sussex (1.8 per 1000 population aged 15 to 59 years) was significantly lower than that of England (2.3 per 1000 population aged 15 to 59 years). Prevalence in West Sussex was among the highest of its CIPFA neighbours and has been rising since 2010 at a similar rate to England, as can be seen in Figure 7.4.

7.4 Risk groups

The groups considered to be most at risk of HIV infection are men who have sex with men, black African men and women, and injecting drug users.

Gay, bisexual and other men who have sex with men comprised just over half of new HIV diagnoses in South East England in 2017, though this proportion has fallen from 67% in 2008. Less than half of MSM testing for HIV had at least one HIV test at the same service during the previous year (2017) so opportunities for testing are being missed.

Black Africans continue to constitute the greater proportion of heterosexual men and women in the UK accessing HIV care. A large percentage of Black Africans receive late diagnoses of HIV, which has a huge impact on the efficacy of treatment. In the South of England in the years between 2014 and 2016, around 68% of heterosexual Black African men newly diagnosed with HIV were diagnosed late. For Black African heterosexual women, 52% of new HIV diagnoses were late. This compares to 55% in heterosexual white men and and 42% in heterosexual white women.

While around 3% of new infections of HIV are in injecting drug users makes this mode of transmission comparitively rare, it is nonetheless as much an avoidable form of transmission as sexual routes. This needs assessment has already considered the potential synergies between the integrated sexual health service and substance misuse services (see page 102) and staff of substance misuse services should be made aware of HIV testing services available from the integrated service. Around two thirds of injecting drug users in England who accessed a clinical service in the previous year had not been tested for HIV.

7.4.1 People living with undiagnosed HIV

In England, outside of London, it is estimated that 9% (CI (credible interval): 6% to 15%) of people living with HIV are not diagnosed. This is approximately 5,800 (3,800 - 10,100) undiagnosed people. According to current trends for new diagnoses, around 3,000 of these people may be men who have sex with men while approximately 2,300 people will have acquired HIV through heterosexual transmission. The groups with the highest proportions of undiagnosed HIV are thought to be injecting drug users (around 10%, CI: 5% to 19%), men who have sex with men (11%, CI: 5% to 22%) and heterosexual men (excluding black Africans) (10%, CI: 6% to 25%).

7.5 Prevention

7.5.1 Condom use

Rates of condomless sex with casual partners has been increasing since the early 2000s. Around half of sexually active young people said they have had sex without condoms with a new partner.

Condoms remain the best prevention against most forms of sexually transmitted infection.

Condomless sex is also an issue for people with HIV who are virally supressed or people who are sero-sorting (having sex with people who have the same HIV status). Whilst the risk of HIV transmission can be minimised by these factors, transmission of other sexually transmitted infections remains possible.

Correct and consistent condom use should be promoted. Engagement is needed to address the underlying factors that lead to risk-taking behaviour, especially in MSM. These include low self-esteem, participation in Chemsex and sero-adaptive behaviour.

7.5.2 PreP

HIV Pre Exposure Prophylaxis (HIV–PrEP) is the use of antiretroviral agents by people who do not have HIV prior to a potential exposure to HIV to prevent acquisition of infection. Studies have shown that consistent use of HIV-PrEP can be an effective prevention intervention. HIV–PrEP has the potential, within a combination prevention approach, to have a significant role in the control of HIV transmission. The first

phase of implementation is a 3-year clinical trial launched in October 2017 with the aim of recruiting 13,000 participants in England. As of October 2018, almost 9,000 participants had been recruited.

In terms of current recruitment to the trial, there has been higher than estimated uptake among men who have sex with men and lower uptake in other high risk groups. This may be due to increased awareness of PrEP among MSM compared to other groups. Prior to the launch of the trial, a website called `iwantPrEPnow.co.uk` was set up by volunteers who felt that PrEP was a powerful tool for helping to stop the spread of HIV. The aim of the site was for anyone to be able to access PrEP and be able to confidently make their own choice about their sexual health and HIV protection. In November 2017, iwantPrEPnow became part of Terrence Higgins Trust and its work is equally funded by Terrence Higgins Trust and Elton John AIDS Foundation [32].

PHE will produce estimates of future demand for PrEP at local authority level. There could be a significant impact on level 3 services, so commissioners should take these figures into account when planning services.

7.5.3 Testing

Testing is a pivotal form of prevention as it leads to diagnosis and promotes partner notification. 4.3% of partners of people diagnosed with HIV in England in 2017 also tested positive for HIV.

As part of concerted efforts to ensure people at risk of HIV are aware of their status, there is an online testing service for HIV (see page 118).

7.6 Issues

7.6.1 Mental Health

Good mental health remains an important factor in ensuring a good quality of life for people living with HIV. 39% of respondents from the South East had a diagnosis of depression, compared to 19% in the general population. 29% of respondents from the South East had a diagnosis of anxiety, compared to 15% in the general population.

7.6.2 Stigma

Efforts need to be strengthened to reduce stigma and barriers to treatment.

There continues to be a fear of stigma and discrimination that prevents disclosure of HIV status. Around 10% of respondents from the South East Positive Voices survey [25] reported that they have never told anyone about their HIV status outside a healthcare setting. 16% reported that they were worried about being discriminated against in a healthcare setting in the past year and 11% said they had avoided seeking healthcare when they had needed it in the past year. However, only 3% said they had actually been refused healthcare or delayed a treatment or medical procedure in the past year.

7.6.3 Co-infection and other STIs

As rates of other STIs including gonorrhoea, syphilis, lymphogranuloma venereum, hepatitis C and Shigella have been shown to be higher in MSM who are HIV positive, it is important that MSM living with HIV are specifically made aware of the risks of these infections and how to prevent them.

Respondents to the Positive Voices identified unmet needs with regard to advice about their sex lives, so it may be that important messaging is not being delivered.

7.6.4 Long term conditions

HIV is considered a disability under the Equality Act 2010. The population of people diagnosed with HIV is diversifying and growing older. In 2017, 44% of people living with diagnosed HIV in the South East of England were aged between 35 and 49 years and 42% were aged 50+. The Positive Voices survey identified a number of additional long term conditions commonly experienced by people living with diagnosed HIV. These include high cholesterol, high blood pressure, asthma and arthritis.

Commissioners of HIV care should also consider the interactions that an older population living with HIV may have with other elements of the health and social care system.

7.7 Recommendations

For West Sussex, the best way to counter against the possibility of unmet need with respect to HIV is to:

- Maintain testing coverage to increase the chance of timely diagnosis and to remind those presenting at clinics that HIV remains a key issue in their sexual health.
- Advocate for the use of PrEP which is a cost-effective means of protecting against the acquisition and the onward transmission of HIV.
- Follow the UNAIDS 90:90:90 strategy implemented in England by PHE. This focusses on achieving the 90:90:90 target, which has implications for both minimising onward transmisison and maximising quality of life for people living with HIV.
- Plan for people living longer with HIV, including the possibility of co-morbidities and long-term conditions. HIV itself is considered to be a long-term condition. This also has implications for adult social care and support. Consideration needs to be given to whether a separate pathway for older people living with HIV is needed and how it would sit alongside the pathway for older people generally.
- Continue to pursue late diagnoses with the same urgency, treating all cases as a critical incident.
- Ensure support for outreach work on HIV, especially for harder to find cases such as in ethnic minorities and cases of heterosexual transmisison.

8. Online Services

8.1 Introduction

Technological innovations provide great opportunities for improving sexual health outcomes. As of 2018 89% of people in the UK aged 18 to 75 own a smartphone, tablet or another mobile internet-connected device [33], rising to 96% in 18-24 year olds. This means there are opportunities to get people engaged with sexual health services almost at the immediate point of need. If done correctly these interactions can follow the guiding principles of an integrated sexual health, acting as a one stop shop that is anonymous and discreet. However, there are also precautions that need to be taken with regard to safeguarding of minors and ensuring that people with emotional needs get the opportunity to discuss their sexual health needs in a face to face setting.

This chapter discusses the options available for addressing the sexual health needs of West Sussex residents with technological innovations. The possibilities extend beyond mere channel shift, and many of the options could be used cost effecitively to extend and enhance current services in both prevention and treatment. However, such services must be designed to be equitable, to safeguard the young, and capture opportunities for health promotion and partner notification.

To this end, the West Sussex integrated sexual health service already has a capable, secure and functional website that provides information about sexual health, clinic opening times, and a central booking phone number. The site works well on mobile devices, though the Google site test [34] (run in January 2019) recommends that the loading time of the site could be reduced by 50% and that this could increase retention of visitors.

Links to sexual health resources on the county council website refer to the integrated sexual health service website. This is to ensure a single source of up-to-date information without duplicating effort to maintain it.

8.2 Potential form of online services

Online services for sexual health could take many forms, including:

- **Kit-based testing** in which a person requests a kit online that is sent to their address. The person collects samples for asymptomatic infections and returns them to the lab for testing. The kinds of tests that are sent are dependent on a brief survey of recent sexual activity. In some cases, the person may be invited to attend in-person.
- **Online booking** in which a person can request an appointment at a sexual health clinic from the website.
- **Remote consultations**, using services such as Skype, allow for symptoms to be discussed in a confidential setting where the patient may be more comfortable and at a convenient time. However, this still requires the use of physician time and diagnosis of symptomatic infections may be better suited to health care venues.
- **Online buddying**, which again uses web-based chat services, can be used in psycho-sexual settings or to help facilitate behavioural change.

Kit-based testing is the most common form of online testing already used in a number of local authorities across England. The patient accesses the website, takes a short survey and according to the outcomes of the survey is either offered an appointment or given the option of having a self-testing kit sent to their address. This kit is then returned to the service and evaluated in the same way that samples collected in person would be. Most forms of "online testing" operate in this way.

Example: HIV online testing

A service supplying kits for HIV testing that can be requested online already exists in West Sussex. It has been operated by Preventex since October 2015 and can be accessed at `https://www.test.hiv`. Approximately 850 kits were ordered between August 2018 and December 2019, and around 4,250 since the inception of the service. Its aim is to provide a quick turnaround HIV testing process for men who have sex with men, so that they can be aware of their status and to avoid the health consequences of late diagnosis (see also section 7.3.3).

Preventx has partnered with Yorkshire MESMAC to deliver the service nationally. Yorkshire MESMAC is one of the oldest and largest sexual health organisations in the country with a keen focus on HIV testing and offers advisory and referral services to its patients. Users of the service who receive a reactive result (indicating that HIV antigens or antibodies were present) will need to attend a local clinical service for a confirmatory test and any follow up care and treatment.

MESMAC contacts the Integrated Sexual Health Service directly before contacting the patient. It's at this point that MESMAC introduce themselves to the local services, and explain that we are about to call one of their local residents with a reactive HIV test result. No patient details are passed to the local service at this point. MESMAC's role is as a conduit and connector between the patient and the clinic so the purpose of the call is twofold - firstly, to give advance notice to the clinic that we

> are going to be making a referral, secondly to gather enough information to ensure that the referral is effective and easy for the patient. MESMAC will also contact the local HIV support agency to see if there is anything they can offer e.g. buddying into the clinical service. This will be guided by the local clinic, who may have a good relationship with other local services.
>
> No information about the patient is shared without their expressed permission.

Kit-based online testing programmes can vary widely. Possible sources of variation in this approach include:

- The kits sent out (which brand, for which infections, instructional and promotional material)
- The method for returning the kit
- The method for following up unreturned kits
- The alternatives offered in place of a kit or absence of usable swabs from the kit
- The survey used to determine whether someone should receive a kit or be offered an in-person appointment

These sources of variation will impact on whether kit based testing improves outcomes and provides an equitable service.

Based on several studies of this kind of online testing, users tend to be young, white, heterosexual women. There are higher rates of online testing among MSM and BME in London compared to outside London.

Return rates are critical, studies show a range of 48-76%. Return rates were highest among women, MSM, people with an asymptomatic infection, in less deprived areas and for kits provided to the patient's home rather than in a clinical setting. In some pilots it was not possible to ascertain differences in return rates for specific audiences, usually because of small sample sizes.

There are sometimes issues wth sample rejection rates. Users of kits sometimes find it difficult to supply viable samples. In one pilot in Hampshire, around 1 in 6 blood samples were ineligible [35].

Online testing is generally acceptable to users, though many pilots do not include a comparator arm of patients who access the service as usual. For asymptomatic individuals, the proportion of online tests testing positive was found to be comparable to GU clinic rates. Many studies did not send kits to symptomatic people, but in studies where symptomatic people were considered, test positivity was higher than in comparable clinic populations.

Treatment outcomes vary from service to service. Generally the time to test was shorter for people accessing services online but many studies found no differences in the time taken to receive treatment. Further evaluations of online services need to examine the barriers to delivery of treatment to those testing positive. Health promotion messaging and partner notification are also crucial for preventing onward transmission.

8.3 Opportunities of online testing

By expanding access to testing for asymptomatic infections, there is the chance to increase testing and treatment of infections such as chlamydia and gonorrhoea. The convenience of online testing could lead to greater frequency of testing without the need to add extra clinical resources beyond laboratory capacity.

The service could expand to become more equitable in this situation, particularly if cultural barriers to access are preventing some groups from attending in person. Online services will need to be able to communicate in a direct and discreet fashion for this to be successful.

Emphasis needs to be placed on quick delivery of treatment in the event of a positive test. If online testing can reduce the time it takes for a positive diagnosis to be reached, then robust processes must be in place for delivery of treatment. Moreover, delays in the return of samples need to minimised. This necessitates the need for clear instructions and health promotion material that will convince the service user to return the kit upon receipt.

Successful treatment depends upon robust partner notification, particularly if the patient is at risk of re-infection by a partner or engaging in high risk behaviour. If partner notification is to be a major issue, then there will also need to be alternative mechanisms to get high risk individuals into clinics where appropriate contact tracing can be performed.

By freeing up resources that are normally used for testing of asymptomatic infections, capacity for complex and symptomatic cases can be made available. This could take the form of offering appointments, particularly for high risk individuals accessing the online testing that the service believes would achieve better outcomes from an in-person consultation. This could create capacity for outreach into the vulnerable populations identified elsewhere in this needs assessment.

If online testing causes the cases seen in clinic to become more complex, this may necessitate staff changing their skill mix and provide opportunities for training and new learning.

Allowing people to test for asymptomatic infections by kit based testing could convince people (particularly young people) to get tested as regularly as PHE recommends, providing opportunities to increase chlamydia detection rates and deliver regular health promotion messages. Such testing could also synergise with delivery of repeat LARC implants or other forms of contraception, an important group of service users who may not be using condoms to prevent against STIs.

8.4 Risks of online testing

Along with the opportunities presented by online testing, there are a number of challenges and risks.

Many service users value the anonymous and confidential nature of the current services and may have privacy concerns about divulging contact details online. Recently

introduced GDPR regulations mean that online testing must be carried out in a secure fashion with respect to users privacy or risk large fines. This exposes the council and its providers to some risk.

Moreover, should the provision of online testing reduce the capacity of the service to provide an anonymous walk-up service, this may create inequities of service for people who rely on its anonymity. There is a trade-off involved as many people value and use the current level of service provision.

Further issues of potential inequity arises in how the algorithm decides who receives a kit and who is asked to attend the clinic in person. If a person accessing the service does not feel at risk, they may not respond to a request to attend the clinic where they would have been willing to return a kit. All such messaging needs to be persuasive and take into account the needs of the person accessing the service.

The kits need to be returned in order for diagnoses to be made. This means understanding the audience for kits and making sure that the promotional messaging and branding inspires users to return their samples in a timely fashion. Instructions for providing samples need to be clear and understood by people who may not use English as their first language.

There are issues of compliance. The kits must be returned in a usable state as otherwise this will lead to follow up messages about the kit (if not returned) or the additional expense of sending further kits. Moreover, unusable returns will lead to worse outcomes if diagnosis is delayed particularly if the waiting time causes stress for the individual.

There are considerable safeguarding concerns about online testing. All people who access the service in person who are under the age of 18 are templated against spotting the signs criteria. While gateway surveys to online testing can provide similar templating opportunities, these can be easily provided with fake responses. All material aimed at discerning the risk status of a person accessing the service should make clear that it is possible to attend anonymously and that there are confidential services available for the disclosure of abuse and exploitation.

If there is indeed to be a channel shift toward more online testing for asymptomatic infections, careful consideration will need to be given to how people receive health promotion messages about their sexual and reproductive health. Clearly online materials will need to adopt a tone that resonates with anyone who might access the service. Again, this requires an understanding of the different groups of users who might access an online service and how to ensure that websites and apps are able to differentiate between them. These are issues of technology and marketing that may prove beyond the knowledge or financial pressures of service providers.

8.5 West Sussex Kit-based testing pilot

In November 2018 the West Sussex integrated sexual health service began a pilot of online testing running alongside the existing Chlamydia and Gonorrhoea Screening Programme (see page 98). The service allows people to order a self-testing kit to be

delivered directly to them to carry out in the comfort of their own home. People should receive kits within 2-3 days of ordering. People ordering kits online need a valid UK mobile number as their results are sent to them by text.

The kit tests people for Chlamydia, Gonorrhoea, HIV and Syphilis. Chlamydia and Gonorrhoea are tested for by urine sample (men) or vaginal swab (women). HIV and Syphilis are tested for using a finger-prick blood test. The website provides instructional videos for how to perform the self-tests.

People accessing the pilot are required to complete a short health questionnaire; this ensures they are guided to their appropriate service option. If the questionnaire recommends self-testing is available to someone, they can order it online and it will be delivered directly to their requested address within 2-5 days.

The website will advise people who have symptoms and people who are in risk groups to seek an in-person appointment. In this situation they are provided with the telephone number of the central booking line.

8.6 Recommendations

- Engage with potential service users to discover what aspects of an online integrated sexual health service would be beneficial to them in terms of outcomes and their engagement with the service.
- Continue to monitor the benefits and challenges of online testing in sexual health.
- Evaluate the results of the online pilot conducted by the integrated sexual health service.

Bibliography

Reports

[1] World Health Organisation. *Defining sexual health: Report of a technical consultation on sexual health 28–31 January 2002, Geneva*. World Health Organisation, 2006 (cited on page 11).

[3] Nudge Associates. *Sexual Health Needs Assessment*. West Sussex County Council, 2014 (cited on page 36).

[4] HM Government. *Healthy Lives, Healthy People*. HM Government, 2010 (cited on page 37).

[5] *Health and Social Care Act*. 2012 (cited on page 37).

[6] Public Health England. *Making it work: A guide to whole system commissioning for sexual health, reproductive health and HIV*. Public Health England, Mar. 2015 (cited on page 37).

[8] Department of Health. *A Framework for Sexual Health Improvement in England*. Department of Health, Mar. 2013 (cited on pages 39, 63).

[9] Public Health England and Department of Health and Social Care. *Integrated Sexual Health Services: A suggested national service specification.* Public Health England, Aug. 2018 (cited on page 41).

[13] NICE. *Sexually transmitted infections and under-18 conceptions: prevention*. NICE, Feb. 2007 (cited on page 49).

[15] Public Health England. *Sexually Transmitted Infections and Chlamydia Screening in England, 2016*. Public Health England, June 2017 (cited on page 52).

[19] Public Health England. *National Chlamydia Screening Programme (NCSP) Chlamydia Care Pathway*. Public Health England, May 2016 (cited on page 96).

[21] Public Health England. *Towards elimination of HIV transmission, AIDS and HIV-related deaths in the UK*. Nov. 2017 (cited on page 99).

[23] R. Whitehead and R. Jevons. *Black and Minority Ethnic Communities in West Sussex, 2016: Health and Social Care Needs Assessment*. Public Health and Social Research Unit, West Sussex County Council, 2016 (cited on page 102).

[24] Homeless Link. *Homeless Health Needs Audit*. Homeless Link, 2014 (cited on page 104).

[25] Public Health England. *Positive Voices the national survey of people living with HIV National Report*. Public Health England, 2017 (cited on pages 105, 115).

[26] A. Franklin, P. Raws, and E Smeaton. *Unprotected, overprotected: meeting the needs of young people with learning disabilities who experience, or are at risk of, sexual exploitation*. Barnardo's, The Children's Society, British Institute of Learning Disabilities (BILD), Paradigm Research and Coventry University, 2015 (cited on page 107).

[28] Joint United Nations Programme on HIV/AIDS (UNAIDS). *90-90-90: An ambitious treatment target to help end the AIDS epidemic*. Joint United Nations Programme on HIV/AIDS (UNAIDS)., 2014 (cited on page 108).

[29] Public Health England. *HIV in the UK: 2016 report*. Public Health England, Dec. 2016 (cited on page 108).

[31] J. Forde and P. Crook. *Annual epidemiological spotlight on HIV in the South East: 2017 Data*. Public Health England, Jan. 2019 (cited on page 111).

Articles

[12] C. H. Mercer et al. "Changes in sexual attitudes and lifestyles in Britain through the life course and over time: findings from the National Surveys of Sexual Attitudes and Lifestyles (Natsal)". In: *The Lancet* 382 (Nov. 2013), pages 1781–94 (cited on pages 49, 55, 95).

[14] K.A. Fenton et al. "Ethnic variations in sexual behaviour in Great Britain and risk of sexually transmitted infections: a probability survey." In: *The Lancet* 365.9466 (2005), pages 1246–55 (cited on page 52).

[17] D. Clutterbuck et al. "2016 United Kingdom national guideline on the sexual health care of men who have sex with men". In: *International Journal of STD & AIDS* 0.0 (Nov. 2017), pages 1–46 (cited on page 67).

[22] S. Wayal et al. "Examining ethnic variations in sexual behaviours and sexual health markers: evidence from a British national probability sample survey." In: *The Lancet Public Health* 2 (2017), e458–72 (cited on page 101).

[27] H. Samji et al. "Closing the Gap: Increases in Life Expectancy among Treated HIV-Positive Individuals in the United States and Canada." In: *PLOS One* 8.12 (2013) (cited on page 108).

[35] S. Williams et al. “Acceptability, uptake and impact of online home-sampling for STIs in Hampshire, UK: a service evaluation”. In: *Sexually Transmitted Infections* 93.Suppl 1 (2017), A1–A103 (cited on page 119).

Websites

[2] *West Sussex Joint Strategic Needs Assessment (JSNA)*. URL: http://jsna.westsussex.gov.uk (cited on page 34).

[7] *Public Health Outcomes Framework*. URL: https://fingertips.phe.org.uk/profile/public-health-outcomes-framework (cited on pages 38, 85, 109).

[10] *OpenStreetMap is built by a community of mappers that contribute and maintain data about roads, trails, cafés, railway stations, and much more, all over the world.* URL: https://www.openstreetmap.org/ (cited on pages 45, 46).

[11] ONS. *Mid-year Population Estimates, West Sussex, 2017*. June 2018. URL: http://nomisweb.co.uk (cited on pages 44, 54).

[16] *English indices of deprivation 2015*. Sept. 2015. URL: https://www.gov.uk/government/statistics/english-indices-of-deprivation-2015 (cited on page 54).

[18] *What's it like to have an STI?* URL: https://www.nhs.uk/protect-against-stis-use-a-condom/home (cited on page 95).

[20] *ChatHealth - school nursing text service*. URL: https://www.southernhealth.nhs.uk/services/childrens-services/school-nursing/chathealth/ (cited on page 98).

[30] *HIV - Community HIV Specialist Service*. URL: https://www.sussexcommunity.nhs.uk/services/servicedetails.htm?directoryID=16310 (cited on page 109).

[32] *About Us - I Want PrEP Now*. URL: https://www.iwantprepnow.co.uk/about-us/ (cited on page 115).

[33] *Global Mobile Consumer Survey 2018: The UK Cut*. URL: https://www.deloitte.co.uk/mobileuk/ (cited on page 117).

[34] *Google Site Test*. URL: https://testmysite.withgoogle.com/intl/en-gb (cited on page 117).