Contents

1. EXECUTIVE SUMMARY ........................................................................................................... 8
2. INTRODUCTION ...................................................................................................................... 15
3. METHODOLOGY ..................................................................................................................... 15
4. EAST SUSSEX – LOCAL CONTEXT ...................................................................................... 16
5. SEXUALLY TRANSMITTED INFECTIONS .............................................................................. 20
   5.1 Sexually Transmitted Infection Testing in Genitourinary Medicine (GUM) Services .... 20
   5.2 STI Testing in Primary Care .............................................................................................. 21
   5.2.1 Testing for Acute STIs in Primary Care ...................................................................... 24
   5.2.2 Testing for HIV in Primary Care ................................................................................ 26
   5.3 Chlamydia Screening ........................................................................................................ 26
   5.3.1 Chlamydia Tests – Microbiology Data ....................................................................... 26
   5.3.2 National Chlamydia Screening Programme .............................................................. 29
6. PEOPLE LIVING WITH HIV .................................................................................................. 31
   6.1 People Living with Diagnosed HIV and Accessing Care ................................................ 31
   6.2 Ethnicity, Age and Deprivation of Individuals Seeking HIV-related Treatment .......... 32
   6.3 Routes of Transmission ..................................................................................................... 34
   6.4 Site of Treatment ............................................................................................................... 34
   6.5 Areas of High Prevalence ................................................................................................. 35
   6.6 HIV Late and New Diagnoses ......................................................................................... 35
7. CONTRACEPTION, CONCEPTION AND ABORTION .......................................................... 36
   7.1 Conceptions ....................................................................................................................... 36
   7.2 Abortions ........................................................................................................................... 39
   7.3 Under-18 Abortions: ......................................................................................................... 39
   7.4 Contraception Attendances by Health Setting and Type ................................................. 40
   7.5 Emergency Contraception: Total Market Review ............................................................ 44
8. PUBLIC AND PATIENT ENGAGEMENT .............................................................................. 47
   8.1 Mystery Shopping – Emergency Contraception ............................................................... 47
   8.1.1 Methodology ................................................................................................................ 47
   8.1.2 Results ........................................................................................................................... 49
   8.1.3 Discussion ..................................................................................................................... 53
   8.2 Young People’s Service Engagement ............................................................................ 54
   8.2.1 Introduction .................................................................................................................. 54
   8.2.2 Sex Education and Sources of Information ................................................................. 54
9. KEY STAKEHOLDER PERSPECTIVES

9.1 Thoughts about Service Changes since SHNA 2008 .................................................. 79
9.2 Barriers to Improving Sexual Health in East Sussex .................................................... 80
9.3 What Else Can Be Done to Improve Sexual Health across The County? ...................... 80
9.4 Vulnerable or In-need Groups ...................................................................................... 80
9.5 Prevention and Health Promotion .................................................................................. 81
9.6 Hub and Spoke: Service Pressure Points and Gaps ....................................................... 81
9.7 Commissioning: Specialist Services and the Role of Primary Care ............................. 82
9.8 LARC Uptake .................................................................................................................. 84
9.9 Sex and Relationship Education .................................................................................... 84
9.10 The Wish List ................................................................................................................ 85

10. SERVICE USER PATHWAYS AND TOUCHPOINTS ......................................................... 86
10.1 Web and Phone Entry Points ......................................................................................... 86
10.1.1 The Main East Sussex Sexual Health Website ......................................................... 87
10.1.2 The East Sussex Sexual Health Website for Those Aged Under 25 ....................... 89
10.1.3 The Circle Room Website ........................................................................................ 90
10.1.4 The Connexions 360 Website .................................................................................. 91
10.1.5 Other websites .......................................................................................................... 92
10.2 Phone ‘Touchpoints’ ..................................................................................................... 92
10.2.1 The ‘FREE 2 B ME’ App ......................................................................................... 93

11. CONCLUSIONS AND RECOMMENDATIONS ................................................................ 94
Abbreviations and Acronyms

BBV  Blood Borne Virus
BPAS  British Pregnancy Advisory Service
CD4  Cluster of Differentiation 4
CSHS  Community Sexual Health Service
CTAD  National Chlamydia Testing Data
EC  Emergency Contraception
EHC  Emergency Hormonal Contraception
ePACT  Prescribing Analysis and Cost Tabulation
ESDW  East Sussex Downs and Weald
ESHCT  East Sussex Hospital Care Trust
ESHT  East Sussex Healthcare NHS Trust
FGD  Focus Group Discussion
FNP  Family Nurse Partnership Programme
FPA  Family Planning Association
GP  General Practice/General Practitioner
GUM  Genitourinary Medicine
GUMCAD  Genitourinary Medicine Clinic Activity Dataset
H&R  Hastings and Rother
HCA  Health Care Assistant
Hep B/C  Hepatitis B/C
HIV  Human Immunodeficiency Virus
HPA  Health Protection Agency
IDU  Injecting Drug User
IMD  Index of Multiple Deprivation
IUICD  Intrauterine Contraceptive Device
IUD  Intrauterine Device
HSV  Herpes Simplex Virus
KC60  Former SHHAPT codes
KI  Key Informant
LA  Local Authority
LARC  Long-Acting Reversible Contraceptive
LGBT  Lesbian, Gay, Bisexual and Transgender
MS  Mystery Shopper
MSM  Men who have sex with men
NCDA  Newhaven Community Development Association
NCSP  National Chlamydia Screening Programme
NEET  Not in education, employment or training
NHS  National Health Service
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>NICE</td>
<td>National Institute for Health and Clinical Excellence</td>
</tr>
<tr>
<td>OUK</td>
<td>Options UK</td>
</tr>
<tr>
<td>PCT</td>
<td>Primary Care Trust</td>
</tr>
<tr>
<td>PEP</td>
<td>Post-exposure Prophylaxis</td>
</tr>
<tr>
<td>PGD</td>
<td>Patient Group Direction</td>
</tr>
<tr>
<td>PSHE</td>
<td>Personal, Social and Health Education</td>
</tr>
<tr>
<td>PLHIV</td>
<td>People Living with HIV</td>
</tr>
<tr>
<td>Q</td>
<td>Quarter</td>
</tr>
<tr>
<td>SHA</td>
<td>Strategic Health Authority</td>
</tr>
<tr>
<td>SHHAPT</td>
<td>Sexual Health and HIV Property Type codes</td>
</tr>
<tr>
<td>SHNA</td>
<td>Sexual Health Needs Assessment</td>
</tr>
<tr>
<td>SOPHID</td>
<td>Survey of Prevalent HIV Infections Diagnosed</td>
</tr>
<tr>
<td>SRH</td>
<td>Sexual and Reproductive Health</td>
</tr>
<tr>
<td>SRHAD</td>
<td>Sexual and Reproductive Health Activity Dataset</td>
</tr>
<tr>
<td>SRE</td>
<td>Sex and Relationship Education</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>TOP</td>
<td>Termination of Pregnancy</td>
</tr>
<tr>
<td>TP</td>
<td>Teenage Pregnancy</td>
</tr>
<tr>
<td>TYS</td>
<td>Targeted Youth Support</td>
</tr>
<tr>
<td>UAI</td>
<td>Unprotected Anal Intercourse</td>
</tr>
<tr>
<td>UK</td>
<td>United Kingdom</td>
</tr>
<tr>
<td>UPSI</td>
<td>Unprotected Sex Incident</td>
</tr>
</tbody>
</table>
Acknowledgements

Options UK would like to thank all those who provided information to us for their contribution to this needs assessment. We would firstly like to thank the Public Health Team, including Jo Bernhaut, Trudy Mills and Martina Pickin, who provided support throughout the project. We would also like to thank Clare Harmer, Bill O’Neill and others who facilitated our access to data included in this needs assessment. We are deeply grateful to the staff of sexual health services – Anthony Proom, Martin Jones, Fiona Cornford and Sorrel Tucker – who went above and beyond to facilitate service user engagement, and to provide crucial data for this needs assessment. We also gratefully acknowledge the support of Sarah Jaffey and Hastings Direct in setting up focus group discussions.

We would like to thank all of those who have contributed to this needs assessment, including all of those who took part in key stakeholder engagement, the young people who took part in interviews, focus groups and mystery shopping exercises, and all of the men and women who took part in focus groups.
1. EXECUTIVE SUMMARY

This report presents the findings of a Sexual Health Needs Assessment (SHNA) conducted by Options UK between December 2012 and June 2013 for East Sussex National Health Service (NHS) and County Council.

The overall objectives of the SHNA were to assess:

- service access and capacity to meet needs for emergency contraception amongst young people (under 25 years of age)
- how late diagnosis of HIV should be reduced in the East Sussex area
- the demand for, and young people’s views of, The Havens and Seaford young people’s services to inform future service developments
- the service use and needs of the over-25s: service access, unmet need and areas for future service development.

Four main methods were employed: an epidemiological and data review; service user engagement with key populations; a mystery shopper survey of pharmacies providing Emergency Hormonal Contraception (EHC); and a key stakeholder consultation. 107 people were engaged with through the course of the SHNA. Results of the SHNA are expected to inform future commissioning of sexual health and other services to meet government targets outlined in the “Public Health Outcomes Framework 2013-2014”, reduce health inequalities and address the Sexual and Reproductive Health (SRH) needs of the local population.

KEY FINDINGS

Sexually Transmitted Infections

Genitourinary Medicine (GUM) Services

- East Sussex has lower rates of Sexually Transmitted Infections (STIs) than England as a whole, and the South East Coast
- Hastings and Eastbourne have higher rates of all STIs than the England average, except for Gonorrhoea and Syphilis
- Chlamydia trachomatis is the most commonly diagnosed STI, and in some areas (notably Eastbourne and Hastings) surpassed the average for England as a whole
- The total number of all STIs diagnosed through sexual health clinics and the chlamydia screening programme has increased between 2009 and 2011, on average increasing by 4%
- Gonorrhoea has shown the greatest increase, of 20%, and chlamydia among the over-25-year-olds has risen by 10.6%
- The number of women diagnosed with acute STIs greatly outnumbers men (women accounted for 882 and men 526 of all diagnoses)
- Men and women in the 20-24 years age group were those most frequently diagnosed.

Non-GUM Setting – Primary Care

- Data from the microbiology laboratory at East Sussex Healthcare Trust (ESHT) were analysed to assess STI/Blood Borne Virus (BBV) testing in primary care
- These data include STI/BBV testing since 2008-2012 for 62 out of 82 General Practice (GP) surgeries, or 79% of the GP-registered population aged 15-59 years
STI/HIV testing in primary care has significantly increased over this time period, from 7,205 in 2008 to 16,975 in 2012, a 136% increase

Overall positivity rates have not improved significantly, however, ranging from 2 to 3% of all tests conducted

There were 19 HIV positives detected through primary care (2008-2012), reflecting a low overall positivity rate (0.5%), despite recent increases in testing volume

38% of all tests conducted were for Chlamydia trachomatis, with a positivity rate of 2.5%. This was followed by tests for gonorrhoea (at 15% of all tests), with a positivity rate of 0.4%

When disaggregating by age and sex, there are strong differences in tests conducted in primary care. Women account for the vast majority of tests: 83% of all tests conducted in primary care. Tests were most frequently conducted on women aged 20-34 years

Men appear to account for the highest burden of diagnoses but test less frequently than women

16 surgeries conducted 51% of all STI/BBV tests, suggesting that testing is concentrated in a few GP surgeries

By far the highest proportion of tests conducted was carried out by sexual health services (40%), followed by the chlamydia screening programme (29%), and GP surgeries (23%).

Chlamydia Screening Programme

The diagnosis rate is much higher in Eastbourne and Hastings than elsewhere in East Sussex, which could be indicative of good GUM access in these areas

The chlamydia diagnosis rate is well below the recommended threshold (>2,300 diagnoses per 100,000 population aged 15-24 years)

Given East Sussex’s status as a ‘low’ diagnosis area, expanded testing policies to include expanded testing through ‘core’ services should be considered, according to current guidance issued by the National Chlamydia Screening Programme (NCSP). In East Sussex, this would include primary care and pharmacies.

People Living with HIV

The Survey of Prevalent HIV Infections Diagnosed (SOPHID) reports that in 2011 there were 528 People Living with HIV (PLHIV) in East Sussex (354 living in East Sussex Downs and Weald (ESDW) and 174 living in Hastings and Rother (H&R)). This is a 25% increase since 2007 (421 diagnosed PLHIV)

Men tend to bear the burden of HIV, with over 75% of people diagnosed with HIV being male; this proportion has shown little change since 2007 (when 73% of those diagnosed with HIV were male). This may reflect the high numbers of PLHIV accessing care in the area who are Men who have Sex with Men (MSM)

If we extrapolate the current national reported rate of those who are HIV-positive but unaware of their infection to these data (at 24% of those who are HIV-positive), there are possibly up to a further 127 PLHIV in East Sussex (with a possible total of 655)

The population of diagnosed PLHIV has been ageing in East Sussex: those aged 45 years and above constituted 45% of all patients in 2007, but this increased to 54% in 2011

If a crude rate of increase is applied to this population, it is expected that there will be over 200 PLHIV aged 55 years and over in East Sussex by 2015
- HIV tends to be slightly more concentrated in areas of higher deprivation – 53% of PLHIV live in the two most deprived areas.
- The routes of transmission for HIV in East Sussex have remained proportionately unchanged since 2007 to 2011. In 2011, the most predominant route of transmission was sex between men (at 55%), followed by sex between men and women (39%).
- Most PLHIV (43%) are choosing to access their care within East Sussex, with most of those (28% of all patients) attending Avenue House in Eastbourne. A significant minority access their care in Brighton (16%). These proportions have remained relatively unchanged over the last 5 years.
- In 2010, three areas were above the threshold for areas of high prevalence of more than 2 per 1,000 population aged 15-59 years diagnosed with HIV: Eastbourne, Lewes and Hastings. In these areas, expanded HIV should be considered.
- Data for 2009-2011 show that in England, 50% of all new diagnoses are classified as ‘late’, as are 49.3% of all new diagnoses in East Sussex county council.

**Contraception, Conception and Abortion**

- The overall conception rate in East Sussex in 2011 was 76.9 per 1,000 women aged 15-44, slightly lower than in 2010. The conception rate is slightly lower than the overall rate for England (which is 80.4 per 1,000 women) and the rate for the South East (which is 78.1 per 1,000 women).
- There was a slight increase in under-18 conceptions in 2011 to 31.8/1,000 women from 31.3/1,000 women, despite an overall trend of decline since 2001.
- In 2011, the rate for under-18 conceptions was higher than both the England (30.7 per 1,000 women) and South East region (26.1 per 1,000 women) rates.
- In 2011, both H&R (20.6/1,000 per 1,000 resident women aged 15-44) and ESDW (18.3/1,000) had higher abortion rates than the England (17.6/1,000) or South East Coast Strategic Health Authority (SHA) (17.1/1,000) rates.
- The data show that in 2012, just over half (52%) of abortions were for women aged under 25, 43% were for women aged 25-39, and 5% were for women aged 40 years and over. These proportions have not changed substantially over the past four years.
- For the most recent year of available data (2012/13) 11,464 contraceptive consultations were carried out at specialist sexual health services, and for 31% of these, Long-acting Reversible Contraceptives (LARCs) were the main method of contraception provided. This is a rise of 288% from the figure reported in the 2008 SHNA, when only 4% of contraceptives dispensed were LARCs.
- The proportion of contraceptives prescribed in primary care which were LARCs was lower but significant, at 14% of all contraception consultations.
- Rates of LARC prescriptions in primary care have been increasing recently, and are now higher than those in the South East Coast and England as a whole.
- Access to condoms through the C-card distribution is good: during the six months Q1-2 2012/13, 26,281 condoms had been dispensed under the scheme – this is the equivalent of eight condoms per client.
- Data on Emergency Contraception (EC) shows that 68% were prescribed within primary care, 21% in specialist sexual health services, and 12% from pharmacies.
- Mapping EHC/EC dispensation against teenage pregnancy highlights that rates of dispensing are highest in urban centres, and that access in rural areas may be an issue.
PUBLIC AND PATIENT ENGAGEMENT

Mystery Shopping – Access to Emergency Contraception

- Mystery Shoppers (MSs) ranged in age from 13 to 20 years, with four aged under 16, and the majority aged 16 years of age
- The MS exercise found that access to pharmacies was rated highly, but that branding was often not visible – only 16% of visits reported that it was clearly displayed that EHC was available from outside the pharmacy
- Of the 24 visits conducted, only half (12 MS) were able to access EHC for free and to take it away from the pharmacy; five of these MSs were aged under 16 years
- Reasons for not being able to access EHC included being ‘too young’ (three) or being wrongly asked for payment (three)
- Most MSs felt that the staff treated them with dignity and respect, but younger mystery shoppers in a few instances experienced negativity
- Additional counselling on sexual health services/information appeared to need improvement, with most consultations not offering sufficient advice/services, such as providing condoms, advice on getting an STI screen or advice on further forms of contraception.

Young People’s Service Engagement

- Young people widely reported feeling more comfortable accessing SRH services through a GP with a special interest, rather than their own family GP
- Perceptions of limited service offer through ‘spoke’ clinics (such as Seaford) compared to hubs, are likely to account for lower use, along with low promotion of the services.

Men and women aged over 25 years

- Both men and women said that low access to information, as the result of limited sexual health education when they were young, was of concern among their peers
- Men and women self-identified as low or ad hoc users of sexual health care, though male respondents were more likely to identify as being routine ‘MOT-ers’ (STI testers)
- Women reported some difficulties in accessing STI/HIV testing through primary care, though in some cases stated that this was their preference. Men favoured SRH services for STI/HIV screens
- Men were principally concerned about avoiding pregnancy, and certain highly prevalent STIs, such as chlamydia. These concerns were often linked to alcohol-based socialising and consequent sexual risk-taking
- Walk-in SRH services were more likely to be used for long-acting contraception by women, owing to perceptions that they would offer a more medically competent and high-quality service
- Embarrassment about accessing SRH services was identified by some men and women as a barrier to care
- There was a clear reliance among both men and women on shorter-term forms of contraception, including much less reliable forms (such as withdrawal) owing to perceptions of side effects
- Both men and women wanted to see better promotion of SRH services available locally, with more encouragement for their peers to have routine STI tests
Among both men and women, there appears to be a greater demand for a fuller range of services to be offered, such as full STI/HIV screens.

**Men who have Sex with Men (MSM)**

- MSM in East Sussex appear to congregate in age-based social networks, with few to no gay venues offering immediately visible entry points for public health interventions. This is exacerbated by a reliance on web-based technologies.
- MSM in these interviews were concerned about unprotected sex among a core group of ‘risk-takers’ and low rates of testing for STIs/HIV among this group.
- MSM said that SRH knowledge and awareness in East Sussex, away from ‘gay hubs’ such as London and Brighton, tended to be low among their peers.
- Early engagement with SRH services and education was a strong influence on later testing behaviours, with younger men who had accessed Lesbian, Gay, Bisexual and Transgender (LGBT) youth groups and SRH education more likely to routinely attend STI/HIV screens.
- There were divergent views on the involvement of GPs in STI/HIV testing, but some men felt that they could play a vital role in encouraging routine testing among those who have never tested.
- Knowledge of the availability of Post-exposure Prophylaxis (PEP) was low, with many saying that they would not access it in a case of unprotected sex with a partner whose status was not known.
- MSM respondents wanted to see interventions to ‘normalise’ access to routine testing, targeting all population groups (not just gay men) but with greater visibility for MSM-specific messaging.
- MSM respondents strongly support interventions targeted at younger MSM, instilling ‘good habits’ at a younger age.
- Respondents were also very receptive to ‘MOT’ type messages, which encourage routine STI/HIV testing based on a period of time (e.g. every six months) and not based on risk-taking.

**People living with HIV**

- Several respondents identified issues to do with ‘living well with HIV’ as being of prime concern, including poverty, housing and mental health.
- Recent assessments for entitlements to benefits impacted several respondents, who consequently wanted to return to work as a result of poverty.
- Advocacy support for PLHIV facing severe poverty-related issues (such as threat of eviction) was highly valued, though this group may be a small number of the overall caseload.
- Most PLHIV were registered with their GP and had disclosed their HIV status with relatively few concerns.
- Respondents supported having more programmes where PLHIV talked about the realities of living with HIV as part of a comprehensive HIV prevention initiative.

**KEY STAKEHOLDER PERSPECTIVES**

- There was a strong consensus that SRH services and programmes had improved since the last SHNA in 2005.
Key stakeholders wanted to see better communication of the services offered, and were concerned that stigma over accessing services among young people could be acting as a barrier to care-seeking

‘Most-at-risk’ groups identified were the over-40s, where there were reported to be increases in STIs diagnosed (in line with national trends), and vulnerable younger people (at risk of sexual exploitation and not accessing services)

The development of ‘spoke’ services was said to have proceeded well; however, there were still concerns that there was an ongoing need to plug gaps in some rural areas (Rye, Heathfield, Lewes, Seaford)

A number of areas of development were highlighted, including: developing the role of non-clinical staff in better sexual health promotion, training, risk of budget cuts with service re-organisation, developing nurse-led services and the involvement of GPs in sexual health

The majority of respondents identified a potential crisis emerging due to the lack of Sex and Relationship Education (SRE) in schools, partly due to budget cuts and service pressures.

CONCLUSIONS AND RECOMMENDATIONS
In this section, recommended areas for action and discussion are highlighted, in response to identified gaps and needs.

Operational Recommendations: Services

- **Seaford**: consider piloting a re-launch of the service with earlier opening hours to catch the after-school slot (so 3.30pm). If possible, increase the service offer; carry out concerted promotion and a publicity campaign in local schools, GPs, with social media, etc. Work with local Targeted Youth Support (TYS) on this. Clarify the range of services available

- Work towards **You’re Welcome** charter across young people’s services and universal services to raise young people’s confidence in service access. This should include all pharmacies dispensing either the C-card scheme or emergency contraception

- Explore options for **increasing appointment slots (where needed)**, possibly starting with a few days/week

- Consider wider use of routine, text-based reminders to SRH service users to further encourage ‘MOT’ sexual health screens (particularly among ‘higher-risk’ groups, e.g. MSM)

- Maintain support for young LGBT groups to target appropriate sexual health advice and information and encourage good life-long sexual health habits

- Maintain support for one-to-one interventions to engage with MSM who have never tested for HIV

- All SRH services to raise awareness of the availability of PEP to most-at-risk populations, including MSM.

- **Data**: work with clinical leads in adjoining NHS areas to further analyse HIV data on late diagnosis to understand contributory factors (including migration from other services).

Communications and Promotion

- **Coordinated Publicity and Promotion Campaign** (to include schools, website etc.) promoting all the sexual health services offered by all partners (including GPs and pharmacies dispensing EC/C-card scheme). This should include urgently updating relevant websites so that they contain comprehensive and consistent information on services available and link to each other
• Ensure that young people are signposted towards high-quality services, and invest in mechanisms to maintain quality of care for young people
• Raise awareness of PEP and rapid access available through East Sussex’s SRH services, in particular targeting populations that are at higher risk, such as MSM.

Management, Monitoring and Evaluation
• Build in evaluation and continual service monitoring/research into any service changes and in a cyclical way (i.e. half-yearly reviews etc.)
• Ensure that service use data can be disaggregated by spoke/hub clinic, e.g. monitoring flow of service users and their age/sex profile, repeat visitors, to highlight variation in demand and allow a rapid response
• Ensure that services have the human resources available to be able rapidly to access, assimilate, and analyse service data (and share appropriately with wider partners)
• Payment by results – conduct a review of detailed service activity data (or a ‘shadowing’ exercise, if this is not possible) so as to recommend whether SRH services would benefit from a shift to tariff.

Human Resources
• Increase specialist staff capacity but ensure there is increase in doctor-level support – either through another staff doctor or through a partnership with neighbours to provide ‘virtual’ on-call support service for nurses
• Look at introducing training and skills enhancement for Health Care Assistants (HCAs) in delivering aspects of SRH services.

Coordination and Partnership
• Use the findings of this needs assessment to start a dialogue as to how ‘core services’ (SRH services, GPs and pharmacies) might coordinate service provision to provide joined-up services, and specifically to:
  - Ensure that all health settings promote ‘key’ messages around sexual health screening, local SRH services, and available resources in rural/remote areas (especially for young people)
  - Identify key stakeholders in each sector within East Sussex who can build capacities to meet local SRH needs: this SHNA has found that some GPs and pharmacies have consistently outperformed other health providers and are committed to providing good sexual health services
• Establish professional leads who can work on a ‘clinical champion’ model to encourage implementation of national guidance, and monitor performance and standards.
• Ensure new health improvement team/role builds upon previous good work and relationships and works in partnership and in a coordinated way. Ensure TYS and School nurses coordinate activities so they complement and support each other.
2. INTRODUCTION

This report presents the results of a Sexual Health Needs Assessment (SHNA), which analyses needs and gaps in sexual health services in East Sussex. The assessment was conducted by Options UK (OUK) between January and May 2013 for National Health Service (NHS) Sussex and East Sussex County Council.

The overall objectives of the SHNA were to assess:

- service access and capacity to meet needs for emergency contraception amongst young people (under 25 years of age)
- how late diagnosis of HIV should be reduced in the East Sussex area
- the demand for, and young people’s views of, The Havens and Seaford young people’s services to inform future service developments
- the service use and needs of the over-25s: service access, unmet need and areas for future service development.

Recommendations for addressing gaps and responding to challenges are made. Findings will help the local NHS and Local Authority to make informed strategic and operational decisions about future service delivery in order to improve sexual health services and reduce health inequalities.

3. METHODOLOGY

The SHNA employed a wide range of methods (which are detailed in the relevant sections), following the approach outlined in the SHNA ‘How To Guide’:

- Review of the local contexts and socio-demographic profile of East Sussex
- Analysis of routine and other service data, to review the ‘local picture’ in terms of Sexually Transmitted Infections (STIs), teenage conception rates, access to and use of contraception, HIV, and sexual health service data
- A comprehensive programme of public and patient engagement, including with: People Living with HIV (PLHIV); young people (16-24 years) sexual health service users; men and women aged 25-40 years, and Men who have Sex with Men (MSM)
- Corporate stakeholder engagement: qualitative in-depth interviews were conducted with Key Informants (KIs) with strategic or operational roles in commissioning, public health or service provision across East Sussex
- A ‘Mystery Shopper’ (MS) exercise to assess issues related to access to and service user experiences of young women seeking Emergency Hormonal Contraception (EHC) from pharmacies, and to assess findings against service standards

1 See www.apho.org.uk/resource/view.aspx?RID=74982 published by Design Options (now Options UK)
<table>
<thead>
<tr>
<th>Method</th>
<th>Description of Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>KI interviews</td>
<td>23 practitioners working in sexual health or related fields (Clinical (10), Non-sexual-health-related services (5), Non-clinical Sexual health (3), Senior Managers (3))</td>
</tr>
<tr>
<td>Public and Patient Engagement</td>
<td></td>
</tr>
<tr>
<td>Young people (14-18 years old)</td>
<td>12 small group discussions: 41 young people (26 male, 15 female)</td>
</tr>
<tr>
<td>PLHIV</td>
<td>2 Focus Group Discussions (FGDs): 10 people (6 men and 2 women, aged 23-52 years)</td>
</tr>
<tr>
<td>MSM</td>
<td>9 (6 in phone interviews and 3 in FGDs, aged 23-60 years)</td>
</tr>
<tr>
<td>MSs</td>
<td>24 young women aged 13-20 years</td>
</tr>
<tr>
<td>Total</td>
<td>107 people</td>
</tr>
</tbody>
</table>

### 4. EAST SUSSEX – LOCAL CONTEXT

**Demographics:** East Sussex is a varied county, with coastal towns, rural villages, some areas of high deprivation, and areas of outstanding natural beauty. In 2011, the population was just over half a million people. The county has the highest proportion of elderly residents of any county in England, with a quarter of residents over pensionable age (see Figure 1). The number of young people is projected to decline by 21% over the next fifteen years (from 86,791 aged 14-29 in 2011, to 68,561 in 2026)\(^2\). Black and minority ethnic groups form a lower than average percentage of the population in East Sussex compared with both regional and national averages, with the vast majority of the population (96%)\(^3\) identifying themselves as being of white ethnicity.

Figure 2 overleaf looks at deprivation across east Sussex. LSOAs are grouped by the Index of Multiple Deprivation national quintiles\(^4\). The most deprived areas of the county, as defined by the Indices of Multiple Deprivation\(^5\), are in the coastal towns of Hastings, St Leonards-on-Sea, Eastbourne, Bexhill-on-Sea and around Camber, Rye and Hailsham. The least deprived areas are in more rural, inland settings, which tend to attract a more affluent population.

---

\(^2\) [www.eastsussexinfigures.org.uk](http://www.eastsussexinfigures.org.uk), Population projections policy-based (interim), 2011-2026 – districts

\(^3\) East Sussex Local Economic Assessment. East Sussex County Council (June 2011)


\(^5\) East Sussex County Council, East Sussex Local Economic Assessment, 2011 [http://www.eastsussex.gov.uk/nr/rdonlyres/0d144b58-6e47-4b58-ae0e-cf7c84f88994/0/lea0103finalforcommentnfoptred2.pdf](http://www.eastsussex.gov.uk/nr/rdonlyres/0d144b58-6e47-4b58-ae0e-cf7c84f88994/0/lea0103finalforcommentnfoptred2.pdf)
Source: Office of National Statistics

Figure 2: Deprivation across east Sussex, by grouping LSOAs by the Index of Multiple Deprivation national quintiles
The unemployment rate in East Sussex is below the national average but higher than the regional rate. In September 2012, 3.1% of the population were claiming Job Seekers Allowance in East Sussex compared with a rate of 2.5% for the South East and 3.8% for Great Britain. Similarly, in 2011 the proportion of young people aged 16-18 who are classified as ‘NEET’ (not in education, employment or training) (5.9%) is lower than the national average (6.1%). Deprivation and child poverty in East Sussex are lower than the national average. However, in 2001, an estimated 16,000 children lived in poverty: there are still important inequalities within the population. In 2009-11, the differences in life expectancy between the least and the most deprived areas of East Sussex were found to be 8.2 years for men and 6.2 years for women.

Figure 3: Map of Services in East Sussex

Figure 3 shows the volume of young people registered with different GPs in East Sussex, and the location of sexual health services, including specialist services for young people. The aim of the map is to allow comparison between the distribution of young people, and the location of sexual health services.

---

In general, the map shows a good distribution of services according to the concentration of young people. One key informant practitioner had remarked that there is a gap in sexual health services around Heathfield, in the rural centre of the map. However, very few young people live in that area. Other exceptions are Forest Row, which has a notable population of young people. However, this is very close to East Grinstead in West Sussex, which has sexual health services. Robertsbridge, Wadhurst, Battle and Northiam also have between 500-1,000 young residents, but no immediately accessible sexual health services.
5. SEXUALLY TRANSMITTED INFECTIONS

5.1 Sexually Transmitted Infection Testing in Genitourinary Medicine (GUM) Services

A NOTE ON DATA: This section provides an overview of data on STI diagnoses from several different data sources. The Genitourinary Medicine Clinic Activity Dataset (GUMCAD) reports on diagnoses in Sexually Transmitted Infection (STI) clinics by NHS area of residence; data from 2009-2011 are presented in this report. STI/HIV testing in non-GUM settings is not available through GUMCAD (though will be in GUMCAD 2).

Data from the microbiology department of the East Sussex Healthcare Trust were analysed for further Section on ‘STI/HIV testing in Primary Care’ and ‘Chlamydia testing – an overview’. Laboratory data cannot be de-duplicated as this would require patient identification, and these data therefore include repeat and/or confirmatory tests. As a result, caution should be used in interpreting these data (see Section 5.2).

Table 2 shows the rate of acute STI diagnoses across the Local Authority (LA) areas of East Sussex and East Sussex top tier LA as a whole, and includes the rates for the South East Coast Strategic Health Authority (SHA) and England as a whole for comparison. Data are sourced from GUMCAD, so do not include diagnoses made in other clinical settings.

In general, East Sussex has lower rates of STIs than the South East Coast and England as a whole. However, there are some notable exceptions in Hastings and Eastbourne, which have higher rates the England average for all STIs, except for gonorrhoea and syphilis. Although East Sussex’s gonorrhoea rates are lower than the English average, there is substantial variation across the county, with the highest rates in Hastings and Eastbourne, and the lowest rates in Rother and Wealden, which are also the districts with the lowest rates of Chlamydia. Chlamydia trachomatis is the most commonly diagnosed STI, and in some areas (notably Eastbourne and Hastings) surpassed the average for England as a whole.

Table 2: Rates of acute STI diagnoses, per 100,000 population, in East Sussex LAs, South East SHA and England, 2011

<table>
<thead>
<tr>
<th>LA of residence</th>
<th>Chlamydia (by age group)</th>
<th>Gonorrhoea</th>
<th>Herpes</th>
<th>Syphilis</th>
<th>Warts</th>
<th>Acute STIs</th>
</tr>
</thead>
<tbody>
<tr>
<td>South East Coast</td>
<td>1,695.2</td>
<td>74.2</td>
<td>256.9</td>
<td>22.1</td>
<td>52.2</td>
<td>3.7</td>
</tr>
<tr>
<td>England</td>
<td>2,124.6</td>
<td>102.8</td>
<td>351.4</td>
<td>39.1</td>
<td>58.1</td>
<td>5.4</td>
</tr>
<tr>
<td>Eastbourne</td>
<td>2,467.4</td>
<td>86.2</td>
<td>370.2</td>
<td>17.5</td>
<td>58.8</td>
<td>1.0</td>
</tr>
<tr>
<td>Hastings</td>
<td>2,858.7</td>
<td>123.5</td>
<td>446.2</td>
<td>16.1</td>
<td>88.3</td>
<td>4.6</td>
</tr>
<tr>
<td>Lewes</td>
<td>1,802.8</td>
<td>47.5</td>
<td>220.6</td>
<td>10.3</td>
<td>35.9</td>
<td>0.0</td>
</tr>
<tr>
<td>Rother</td>
<td>2,068.6</td>
<td>30.9</td>
<td>212.7</td>
<td>2.2</td>
<td>35.6</td>
<td>0.0</td>
</tr>
<tr>
<td>Wealden</td>
<td>1,204.2</td>
<td>26.5</td>
<td>136.0</td>
<td>4.9</td>
<td>40.3</td>
<td>0.7</td>
</tr>
</tbody>
</table>

Shaded = higher than England rate, Unshaded = lower than England rate

Table 3: Numbers and percentage change in cases of acute STIs diagnosed, East Sussex 2009-2010

SOURCE: Published 31/05/2012, Health Protection Agency (HPA) Sexually Transmitted Infections annual data
Table 3 shows that the total number of all STIs diagnosed through sexual health clinics and the chlamydia screening programme has increased between 2009 and 2011. Gonorrhoea has shown the greatest increase, of 20%, and chlamydia among the over-25-year-olds has risen by 10.6%. The number of cases of Chlamydia diagnosed in 15-24-year-olds has remained relatively stable, with only a 2.1% increase, but has shown higher increase since 2008. The 2008 SHNA looked at KC60 data from Hastings and Rother Primary Care Trust (PCT) only, and not East Sussex Downs and Weald (ESDW). However, it does appear that levels of diagnosed Chlamydia have risen dramatically, as only 20 cases were reported in 1995, and 204 in 2006, and there was a steady rise in the number of cases detected between 1995 and 2006 in both sexes and particularly among younger people (aged <24 years). Rises in Chlamydia diagnoses may also be due to better case detection due to the advent of the national Chlamydia Screening Programme and the later introduction of more sensitive testing procedures (nucleic amplification testing).

Table 4: Number of Selected STI Diagnoses, Patients from East Sussex Downs and Weald PCT and Hastings and Rother PCT attending any clinic (2011)

<table>
<thead>
<tr>
<th>Gender</th>
<th>Age</th>
<th>Gonorrhoea</th>
<th>Chlamydia</th>
<th>Anogenital Herpes</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>≤15</td>
<td>0</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>&lt;5</td>
</tr>
<tr>
<td></td>
<td>16-19</td>
<td>&lt;5</td>
<td>73</td>
<td>9</td>
<td>85</td>
</tr>
<tr>
<td></td>
<td>20-24</td>
<td>15</td>
<td>178</td>
<td>16</td>
<td>210</td>
</tr>
<tr>
<td></td>
<td>25-34</td>
<td>8</td>
<td>99</td>
<td>29</td>
<td>138</td>
</tr>
<tr>
<td></td>
<td>35-44</td>
<td>&lt;5</td>
<td>25</td>
<td>19</td>
<td>50</td>
</tr>
<tr>
<td></td>
<td>45-64</td>
<td>5</td>
<td>12</td>
<td>16</td>
<td>33</td>
</tr>
<tr>
<td></td>
<td>65+</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>7</td>
</tr>
<tr>
<td>Total</td>
<td>37</td>
<td>392</td>
<td>92</td>
<td>521</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>≤15</td>
<td>0</td>
<td>&lt;5</td>
<td>0</td>
<td>&lt;5</td>
</tr>
<tr>
<td></td>
<td>15</td>
<td>0</td>
<td>&gt;5</td>
<td>&lt;5</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>16-19</td>
<td>5</td>
<td>171</td>
<td>43</td>
<td>219</td>
</tr>
<tr>
<td></td>
<td>20-24</td>
<td>8</td>
<td>165</td>
<td>49</td>
<td>223</td>
</tr>
<tr>
<td></td>
<td>25-34</td>
<td>&lt;5</td>
<td>65</td>
<td>39</td>
<td>106</td>
</tr>
<tr>
<td></td>
<td>35-44</td>
<td>0</td>
<td>10</td>
<td>19</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td>45-64</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>13</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>65+</td>
<td>0</td>
<td>0</td>
<td>&lt;5</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Total</td>
<td>17</td>
<td>429</td>
<td>166</td>
<td>612</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>54</td>
<td>821</td>
<td>258</td>
<td>1,133</td>
<td></td>
</tr>
</tbody>
</table>

5.2 STI Testing in Primary Care
**A NOTE ON DATA:**

ESHT microbiology laboratory data cover a substantial proportion, but not all, of the GP surgeries in East Sussex. 62 out of 82 of GP surgeries – or 79% of the GP-registered population in East Sussex aged 15-45 – use ESHT laboratories. It is likely that other GP surgeries use other laboratories in adjoining NHS areas. While these data therefore do not present the whole population, they offer an insight into most of East Sussex’s population. The numbers presented here are likely an underestimate of true testing rates and diagnoses.

These data show the positivity rate for all STIs/BBVs tested in GP from 2008-2012. Over this period of time, GPs conducted 55,374 tests, with an overall positivity rate of 2.6%.

Figure 4 shows that testing in primary care has been increasing since 2008. Data for Hepatitis B from 2011/12 are missing, and actual testing rates are thus very likely to be higher. STI/HIV testing in primary care has significantly increased over this time period, from 7,205 tests in 2008 to 16,975 in 2012, a 136% increase. However, overall positivity rates have not improved significantly.

**Figure 4: Volumes of STI/BBV tests conducted in GP with positivity rates by year of tests conducted, East Sussex NHS (2008-2012)**

The case detection rate varies widely, with 100% of Herpes Simplex Virus 2 (HSV-2) tests being positive\(^\text{12}\), and nineteen new cases of HIV diagnosed (0.48% positive). The very high rate of positive cases detected for HSV are likely due to the high numbers of carriers of HSV, and does not show active infection rates. The positivity rate for some of the acute STIs tend to be lower than those in Sexual and Reproductive Health (SRH) services, but nonetheless compare favourably. Thirty-eight

\(^{12}\) This likely indicative of the high number of carriers in the general population, and not of active infections.
per cent of all tests conducted were for Chlamydia trachomatis, with a positivity rate of 2.5%. This was followed by tests for gonorrhoea (15% of all tests), with a positivity rate of 0.4%.

Figure 5: STI/BBV tests conducted in GP with positives, East Sussex NHS (2008-2012)

When disaggregating by age and sex, there are strong differences in tests conducted in primary care. Figure 6 shows that women account for the vast majority of tests, accounting for 83% of all tests conducted in primary care. Most tests were conducted on women aged 20-34 years.

Figure 6: STI/BBV tests conducted in GP by sex and age, East Sussex NHS (2008-2012)

Table 5 shows that the proportion of positive cases detected was highest among men under 25 years, with 6.7% of all tests being positive, versus 4% in women, though overall testing volume in
men is very much lower. This suggests that primary care could do more to attract and target men for STI/HIV screens.

Table 5: Positives detected by sex and age, all STI/BBV tests conducted in general practice (2008-2012), East Sussex NHS

<table>
<thead>
<tr>
<th>Under-25s</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Negative</td>
<td>Positive</td>
</tr>
<tr>
<td>&lt;16</td>
<td>281</td>
<td>19 (6.3%)</td>
</tr>
<tr>
<td>16-19</td>
<td>351</td>
<td>21 (5.6%)</td>
</tr>
<tr>
<td>20-24</td>
<td>783</td>
<td>61 (7.2%)</td>
</tr>
<tr>
<td>25+</td>
<td>6,570</td>
<td>300 (4.5%)</td>
</tr>
<tr>
<td>Total</td>
<td>7,993</td>
<td>393 (4.7%)</td>
</tr>
</tbody>
</table>

5.2.1 Testing for Acute STIs in Primary Care

Figure 7: Number of tests for selected STIs in primary care with positives (2008-2012)

Figure 7 shows trends for the last five years of available data (2008-2012). Over this time period, there has been a rapid increase in testing for these STIs since baseline (2008): 185% increase in Chlamydia and syphilis, and 215% for gonorrhoea, possibly because of integration of further STI testing into chlamydia screening. Data for gonorrhoea are only available for the last two years, however. While overall numbers of cases detected have increased, the positivity rate has not kept up with the rate of increase in testing. In 2008, for instance, 3.2% of tests were positive, but in 2012, only 1.9% were. It is possible that better targeting of under-25 populations could increase detection rates.

Table 6 shows that, echoing the national picture, STIs positivity rates are highest among the population under 25. It also shows that again, men carry the highest burden of STI infection but test less frequently than women.
Table 6: Selected acute STI tests conducted with (numbers of positives) by sex and age (2012), East Sussex GP

<table>
<thead>
<tr>
<th></th>
<th>Men – numbers of tests (positive)</th>
<th>% Positive</th>
<th>Women – numbers of tests (positives)</th>
<th>% Positive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under-25s</td>
<td>157 (19)</td>
<td>10.8%</td>
<td>1,413 (55)</td>
<td>3.7%</td>
</tr>
<tr>
<td>25+</td>
<td>338 (13)</td>
<td>3.7%</td>
<td>4,136 (30)</td>
<td>0.7%</td>
</tr>
</tbody>
</table>

**Gonorrhoea 2012**

<table>
<thead>
<tr>
<th></th>
<th>Men – numbers of tests (positive)</th>
<th>% Positive</th>
<th>Women – numbers of tests (positives)</th>
<th>% Positive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under-25s</td>
<td>172 (5)</td>
<td>2.8%</td>
<td>1,462 (5)</td>
<td>0.3%</td>
</tr>
<tr>
<td>25+</td>
<td>344 (7)</td>
<td>2.0%</td>
<td>4,163 (6)</td>
<td>0.1%</td>
</tr>
</tbody>
</table>

**Syphilis 2012**

<table>
<thead>
<tr>
<th></th>
<th>Men – numbers of tests (positive)</th>
<th>% Positive</th>
<th>Women – numbers of tests (positives)</th>
<th>% Positive</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under-25s</td>
<td>516 (0)</td>
<td>1.7%</td>
<td>5,625 (0)</td>
<td>0%</td>
</tr>
<tr>
<td>25+</td>
<td>699 (12)</td>
<td></td>
<td>1,118 (7)</td>
<td>0.6%</td>
</tr>
</tbody>
</table>

**Engagement in STI testing among GPs across East Sussex**

While there have been impressive increases in the number of tests conducted in primary care, which need to be sustained, analysis of testing by primary care centre shows that these are highly clustered. Sixteen surgeries (see Table 7) conducted over 50% of the STI/HIV tests in 2012 with an average of 3.2% of the total conducted in each surgery. The further 83 surgeries each conducted an average of 0.6% of all STI/HIV tests. There was no apparent relationship between registered population and numbers of STI tests conducted, strongly suggesting that this results from GP interest and not from economies of scale. The average registered population (aged 15-59 years) for high-STI/BBV-testing surgeries was 3,574, compared to the East Sussex average of 3,869.

Table 7: Primary care surgeries in the upper two quartiles of testing conducted for STIs/HIV in 2012.

<table>
<thead>
<tr>
<th>Station Surgery</th>
<th>569</th>
<th>3.4</th>
<th>3,055</th>
<th>19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sidley road</td>
<td>697</td>
<td>4.1</td>
<td>8,259</td>
<td>8</td>
</tr>
<tr>
<td>Little Common Surgery</td>
<td>608</td>
<td>3.6</td>
<td>5,808</td>
<td>10</td>
</tr>
<tr>
<td>Roebuck House Surgery</td>
<td>565</td>
<td>3.3</td>
<td>7,456</td>
<td>8</td>
</tr>
<tr>
<td>Lighthouse Medical Practice</td>
<td>805</td>
<td>4.7</td>
<td>7,564</td>
<td>11</td>
</tr>
<tr>
<td>Seaside Medical Centre</td>
<td>730</td>
<td>4.3</td>
<td>7,158</td>
<td>10</td>
</tr>
<tr>
<td>Princes Park Health Centre</td>
<td>659</td>
<td>3.9</td>
<td>Not available</td>
<td>Not available</td>
</tr>
<tr>
<td>Seaford Health Centre</td>
<td>601</td>
<td>3.5</td>
<td>8,244</td>
<td>7</td>
</tr>
<tr>
<td>Downlands Medical Centre</td>
<td>520</td>
<td>3.1</td>
<td>4,784</td>
<td>11</td>
</tr>
<tr>
<td>Rye Medical Centre</td>
<td>412</td>
<td>2.4</td>
<td>3,528</td>
<td>12</td>
</tr>
<tr>
<td>Arlington Road Surgery</td>
<td>450</td>
<td>2.7</td>
<td>6,338</td>
<td>7</td>
</tr>
<tr>
<td>Warrior Square Surgery</td>
<td>265</td>
<td>1.6</td>
<td>4,718</td>
<td>6</td>
</tr>
<tr>
<td>Old School Surgery (Seaford)</td>
<td>631</td>
<td>3.7</td>
<td>4,790</td>
<td>13</td>
</tr>
<tr>
<td>Martin Oaks Surgery</td>
<td>247</td>
<td>1.5</td>
<td>4,114</td>
<td>6</td>
</tr>
<tr>
<td>The Meads Medical Centre</td>
<td>399</td>
<td>2.4</td>
<td>4,739</td>
<td>8</td>
</tr>
<tr>
<td>High Street Heathfield</td>
<td>434</td>
<td>2.6</td>
<td>6,620</td>
<td>7</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>8,592</td>
<td><strong>50.8%</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Analysis from 2008 shows that there has been relatively little change in these recent years: GPs who are interested in STI testing have continued to do so.

5.2.2 Testing for HIV in Primary Care

According to the microbiology data, there were a very low number of positives detected in primary care for HIV from 2008-2012 (nineteen cases in total), averaging 4 cases detected annually. Due to these low numbers, these have not been disaggregated. Figure 8 shows HIV testing disaggregated by age and gender. Testing rates are highest in the 25-plus population, with women testing more frequently than men. Overall there was a 0.48% positivity rate for HIV tests.

This strongly suggests that HIV testing policies need further careful consideration of how to apply national guidance on increasing the uptake of HIV testing within primary care (specifically, National Institute for Health and Clinical Excellence (NICE) guidance on increasing the uptake of HIV testing among MSM and Black African populations). It is likely that there is a low rate of mobility (or churn) through practices, and that routine (e.g. through new GP registrations) rather than opportunistic testing is less (cost-) effective.

5.3 Chlamydia Screening

5.3.1 Chlamydia Tests – Microbiology Data

This section presents data extracted from the microbiology data set, retrieved from the laboratory department located at the ESHT. As such, it presents data from Chlamydia trachomatis testing wherever this is offered (and not just through settings report to the chlamydia screening programme – see below Section 5.3.2). These data does not include testing in pharmacies.

Over the period from 2008 to 2012, there have been 91,280 tests conducted for Chlamydia trachomatis, though this figure cannot be de-duplicated and likely includes repeat/confirmatory tests.
Figure 9: Chlamydia tests conducted, with positives, negatives, and total number given (with positivity rate) (2008-2012) for East Sussex NHS area

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Tests</th>
<th>Negative</th>
<th>Positive</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008</td>
<td>30000</td>
<td>7469</td>
<td>27358</td>
<td>22954</td>
</tr>
<tr>
<td>2009</td>
<td>25000</td>
<td>9806</td>
<td>10284</td>
<td>21639</td>
</tr>
<tr>
<td>2010</td>
<td>21639</td>
<td>866</td>
<td>20773</td>
<td>26200</td>
</tr>
<tr>
<td>2011</td>
<td>1158</td>
<td>399</td>
<td>1180</td>
<td>24134</td>
</tr>
<tr>
<td>2012</td>
<td>1180</td>
<td>333</td>
<td>1147</td>
<td>22954</td>
</tr>
</tbody>
</table>

**Total Tests by Health Setting**

Figure 10 shows the total number of chlamydia tests conducted by health setting location. The setting in which the highest number of tests was conducted was sexual health services (40%), followed by the chlamydia screening programme (29%), and GPs (23%). These health settings together accounted for 82% of all chlamydia testing, thus meeting National Chlamydia Screening Programme (NCSP) benchmarks for engaging >60% of core services.

Further settings included outpatient departments (3.6%), the acute trust (2.9%), family planning clinics (1.5%), and midwifery or unknown locations (both accounted for 0.1% of tests).

Table 9 shows the positivity rate achieved in each of these settings. Where cell numbers are too small, total positivity rates over the whole time period (and not by year) have been presented to prevent individual identification. Health settings are ranked by positivity (highest to lowest).
Table 9: Total tests conducted by health setting (2008-2012) with positivity rates

<table>
<thead>
<tr>
<th>Health Setting</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>Grand Total</th>
<th>Total Positivity (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Midwifery</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive</td>
<td>0</td>
<td>&lt;5</td>
<td></td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>7.0</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>10</td>
<td>-</td>
<td>9</td>
<td>13</td>
<td>-</td>
<td>7.0</td>
<td></td>
</tr>
<tr>
<td><strong>Sexual Health</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive</td>
<td>242</td>
<td>259</td>
<td>427</td>
<td>609</td>
<td>780</td>
<td>2,317</td>
<td>6.3</td>
</tr>
<tr>
<td>Total</td>
<td>3,576</td>
<td>3,929</td>
<td>6,789</td>
<td>10,014</td>
<td>12,453</td>
<td>36,761</td>
<td></td>
</tr>
<tr>
<td><strong>Family Planning Clinic</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>7</td>
<td>13</td>
<td>37</td>
<td>60</td>
<td>4.5</td>
</tr>
<tr>
<td>Total</td>
<td>-</td>
<td>-</td>
<td>167</td>
<td>374</td>
<td>642</td>
<td>1,339</td>
<td></td>
</tr>
<tr>
<td><strong>Chlamydia Screening Programme</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive</td>
<td>68</td>
<td>129</td>
<td>304</td>
<td>334</td>
<td>215</td>
<td>1,050</td>
<td>4.0</td>
</tr>
<tr>
<td>Total</td>
<td>1,301</td>
<td>3,274</td>
<td>9117</td>
<td>9,429</td>
<td>3,331</td>
<td>26,452</td>
<td></td>
</tr>
<tr>
<td><strong>Acute Trust</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive</td>
<td>9</td>
<td>11</td>
<td>22</td>
<td>18</td>
<td>18</td>
<td>78</td>
<td>3.4</td>
</tr>
<tr>
<td>Total</td>
<td>377</td>
<td>322</td>
<td>534</td>
<td>518</td>
<td>564</td>
<td>2,315</td>
<td></td>
</tr>
<tr>
<td><strong>General Practice</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive</td>
<td>70</td>
<td>63</td>
<td>92</td>
<td>174</td>
<td>117</td>
<td>516</td>
<td>2.4</td>
</tr>
<tr>
<td>Total</td>
<td>2,156</td>
<td>2,277</td>
<td>4287</td>
<td>6,162</td>
<td>6,183</td>
<td>21,065</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Positive</td>
<td>&lt;5</td>
<td>14</td>
<td>14</td>
<td>10</td>
<td>10</td>
<td>52</td>
<td>1.6</td>
</tr>
<tr>
<td>Total</td>
<td>-</td>
<td>399</td>
<td>729</td>
<td>844</td>
<td>933</td>
<td>3,244</td>
<td></td>
</tr>
</tbody>
</table>

‘Family planning’ services refers to community-based contraception clinics, though is probably a historic label as all services offer integrated sexual and reproductive health services across East Sussex.

The total number of tests conducted in midwifery services is low, but with a high positivity rate: possibly women are presenting with symptoms of co-infections (such as gonorrhoea) and are being screened for Chlamydia. Integrated sexual health services still return the highest number of positives detected, at 6.3% of all tests conducted in ‘sexual health’, and 4.5% of those conducted in ‘family planning clinics’ (though these are providing integrated SRH services). While GP generates a high number of tests, the overall positivity rate is low, but this is to be expected in generalised settings where routine rather than targeted testing strategies are being used.
Figure 11 shows trends in diagnosed positives over the past five years (2008-2012). These map a worrying trend of declining numbers of positives detected through two of the main testing settings: GP and the chlamydia screening programme. This could be the result of the retraction in funding for these programmes, but has been accompanied by a steep rise in positives from sexual health services. This could be because of service reorganisation (more community-based clinics), increased attendances at sexual health services by those who need treatment, or better case detection in sexual health. This pattern corroborates the service user engagement, which found high demand across all groups for full STI and HIV screening within sexual health services.

5.3.2 National Chlamydia Screening Programme

A Note on Data
The NCSP was established in 2003; in 2012, it started to pursue a policy of integration into core services, namely integrated sexual health services and primary care, focusing on testing and diagnosis among 15-24 year olds. The data reported here are via the National Chlamydia Testing Data (CTAD), available from Public Health England. Since 2012, this dataset has been de-duplicated to prevent repeat testing counts, and thus is not comparable with previous years. CTAD reports data from both GUM and non-GUM settings, and thus may duplicate results presented here in other sections.

The current ‘Public Health Outcomes Framework for England: 2013-2014’ includes an indicator for the diagnosis rate for Chlamydia testing, which is:

- numbers of tests conducted per 100,000 population (aged 15-24 years, CTAD being more than 2,300 tests per 100,000 population)

This indicator replaces previous ‘Vital Signs’ indicators (including the positivity rate and coverage of the population aged from 15-24 years of age).
Table 10: Chlamydia testing by LA, 15-24 year olds (2012), benchmarked against regional data for South England/England

<table>
<thead>
<tr>
<th>Area (LA and Upper Tier Authority)</th>
<th>Chlamydia Tests</th>
<th>Positive Tests Reported</th>
<th>Total Chlamydia Testing Data</th>
<th>15-24-Year Old Population Estimates (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Non-GUM Tests (a)</td>
<td>GUM Tests (b)</td>
<td>Total Tests (a+b)</td>
<td>Non-GUM Positives (c)</td>
</tr>
<tr>
<td>Eastbourne</td>
<td>1,488</td>
<td>1,870</td>
<td>3,358</td>
<td>85</td>
</tr>
<tr>
<td>Hastings</td>
<td>1,289</td>
<td>1,750</td>
<td>3,039</td>
<td>83</td>
</tr>
<tr>
<td>Lewes</td>
<td>1,734</td>
<td>813</td>
<td>2,547</td>
<td>101</td>
</tr>
<tr>
<td>Rother</td>
<td>932</td>
<td>794</td>
<td>1,726</td>
<td>55</td>
</tr>
<tr>
<td>Wealden</td>
<td>1,343</td>
<td>1,167</td>
<td>2,510</td>
<td>79</td>
</tr>
<tr>
<td>East Sussex</td>
<td>6,786</td>
<td>6,394</td>
<td>13,180</td>
<td>403</td>
</tr>
<tr>
<td>South of England</td>
<td>284,221</td>
<td>131,700</td>
<td>415,921</td>
<td>16,723</td>
</tr>
<tr>
<td>ENGLAND</td>
<td>1,253,752</td>
<td>528,370</td>
<td>1,782,122</td>
<td>80,679</td>
</tr>
</tbody>
</table>

Source: Public Health England (CTAD)

CTAD shows that, firstly, the diagnosis rate is much higher in Eastbourne and Hastings than elsewhere in East Sussex, which could be indicative of good GUM access in these areas. Overall, the chlamydia diagnosis rate, which in East Sussex is 1,712 per 100,000 population aged 15-24 years, is well below the recommended threshold of >2,300. As a ‘low’ diagnosis area, East Sussex should consider expanding testing policies to include testing through ‘core’ services, according to current guidance issued by the NCSP. This would include primary care and pharmacies.

CTAD provides a breakdown of positives diagnosed by ‘core’ service for 2012. Benchmarks have been provided (using CTAD data): an average rate for Kent, Surrey and Sussex.

Table 11: Chlamydia tests conducted and positives diagnosed by setting and Top Tier Authority (2012)

<table>
<thead>
<tr>
<th>LA Name</th>
<th>GUM</th>
<th>CHS</th>
<th>GP</th>
<th>Pharmacy</th>
<th>TOP</th>
<th>Not Known</th>
<th>Other</th>
<th>Primary Care, SH, and GUM</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Sussex Positives Rate</td>
<td>6,394</td>
<td>117</td>
<td>2,404</td>
<td>9</td>
<td>&lt;5</td>
<td>165</td>
<td>4,088</td>
<td>68%</td>
</tr>
<tr>
<td>East Sussex Positives Rate</td>
<td>593</td>
<td>6</td>
<td>120</td>
<td>0</td>
<td>0</td>
<td>14</td>
<td>263</td>
<td></td>
</tr>
<tr>
<td>Kent, Surrey, Sussex Positives Rate</td>
<td>927</td>
<td>513</td>
<td>499</td>
<td>0.0</td>
<td>0.0</td>
<td>849</td>
<td>643</td>
<td></td>
</tr>
</tbody>
</table>

CTAD data strongly suggest that measures to both increase routine screening through GUM (for those patients who have previously tested for chlamydia) and expand access to tests in other ‘core services’ are needed. The numbers of tests conducted in pharmacies and for those attending termination-of-pregnancy services are particularly low.
Table 12: Rates of diagnoses of males/females/total population aged 15-24 years per 100,000 population (2012). Source: Public Health England (CTAD)

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>Male 15-19</th>
<th>Female 15-19</th>
<th>Total 15-19</th>
<th>Male 20-24</th>
<th>Female 20-24</th>
<th>Total 20-24</th>
<th>Total by Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Sussex</td>
<td>653</td>
<td>1,668</td>
<td>1,112</td>
<td>2,329</td>
<td>2,339</td>
<td>1,143</td>
<td>1,468</td>
</tr>
<tr>
<td>Eastbourne</td>
<td>1,103</td>
<td>1,895</td>
<td>1,492</td>
<td>2,854</td>
<td>2,517</td>
<td>1,316</td>
<td>1,951</td>
</tr>
<tr>
<td>Hastings</td>
<td>628</td>
<td>2,156</td>
<td>1,381</td>
<td>3,351</td>
<td>2,909</td>
<td>1,590</td>
<td>1,989</td>
</tr>
<tr>
<td>Lewes</td>
<td>652</td>
<td>1,255</td>
<td>928</td>
<td>2,184</td>
<td>2,727</td>
<td>1,162</td>
<td>1,389</td>
</tr>
<tr>
<td>Rother</td>
<td>630</td>
<td>1,586</td>
<td>1,024</td>
<td>2,449</td>
<td>1,812</td>
<td>1,045</td>
<td>1,496</td>
</tr>
<tr>
<td>Wealden</td>
<td>371</td>
<td>1,396</td>
<td>794</td>
<td>1,326</td>
<td>1,639</td>
<td>713</td>
<td>837</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Rates of diagnoses for chlamydia are highest among both men and women aged 20-24 years, who importantly, may not be readily accessible through young-people focused provision (e.g. those located in youth clubs, schools or colleges).

6. PEOPLE LIVING WITH HIV

A NOTE ON DATA
The Survey of Prevalent HIV Infections Diagnosed (SOPHID) began in 1995 and is a cross-sectional survey of all individuals with diagnosed HIV infection who attend for HIV-related care within the NHS in England, Wales, and Northern Ireland within a calendar year. SOPHID collates residence and limited epidemiological data on those seen for HIV-related care. These data only count people who have been diagnosed as HIV-positive and are receiving HIV-related care. They will not reflect true prevalence of HIV in any area as Public Health England currently estimates that approximately 24% of all HIV infections in the UK remain undiagnosed. The data used here are for 2011. Any cells with fewer than five cases are reported as <5 in order to prevent identification.

6.1 People Living with Diagnosed HIV and Accessing Care
SOPHID reports that in 2011 there were 528 PLHIV (354 living in ESDW and 174 living in Hastings and Rother (H&R)). This is a 25% increase since 2007 (421 diagnosed PLHIV). Overall, men tend to bear the burden of HIV, with over 75% of people diagnosed with HIV being male; this proportion has shown little change since 2007 (when 73% of those diagnosed with HIV were male). This presumably reflects the high numbers of MSM PLHIV accessing care in the area. The most rapid increase in people accessing care for HIV in the East Sussex area was in 2009-2010, with an increase of 11% (and nearly 16% in H&R).

If we extrapolate the current national reported rate of those who are HIV-positive but unaware of their infection (24%), there may be a further 127 PLHIV in East Sussex (giving a possible total of 655)\(^{13}\). If the local picture echoes current trends, it is likely that the rate of undiagnosed PLHIV is also higher among male populations.

Figure 12: Numbers of people diagnosed and living with HIV in East Sussex (2007-2011)

![Graph showing numbers of people diagnosed and living with HIV in East Sussex (2007-2011)]

Source: SOPHID

6.2 Ethnicity, Age and Deprivation of Individuals Seeking HIV-related Treatment

Figure 13: People diagnosed with HIV accessing care by age groups (0-55 plus years), 2007-2011

![Bar chart showing age ranges of those diagnosed with HIV accessing care, 2007-2011](image)

Figure 13 shows the age ranges of those diagnosed with HIV accessing care. The proportion of younger people (under 25 years) diagnosed with HIV has either remained unchanged or decreased over the period described: under-25s accounted for 21% of all cases in 2007, but only 16% in 2011. Conversely, there has been a rapid increase in the older age groups of people diagnosed with HIV in East Sussex. Those aged 45 years and above constituted 45% of all patients in 2007, a figure which increased to 54% in 2011. The rate of increase in the population over 55 years has been particularly pronounced, increasing from 2010-2011 by 24%. If a crude rate of increase is applied to this population, it is expected that there will be over 200 PLHIV aged 55 years and over in East Sussex by 2015.
Table 13 shows the ethnicity of those accessing care over the last five years, with rates of increase over that time period. White males (presumably MSM) account for the largest proportion of those accessing care (at 62%), followed by Black African women at 15%. The high rates of increase in some groups, such as Black African men, could also be reflective of a ‘lag effect’, as men in this group tend to be diagnosed at a later stage. There is a marked increase in the ‘male other’ category, but overall numbers remain low.

Table 13: Number of people accessing care for HIV by sex and ethnic group (2007-2011)

<table>
<thead>
<tr>
<th></th>
<th>White M</th>
<th>White F</th>
<th>Black African M</th>
<th>Black African F</th>
<th>Other M</th>
<th>Other F</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>262</td>
<td>31</td>
<td>36</td>
<td>75</td>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>2008</td>
<td>270</td>
<td>34</td>
<td>44</td>
<td>67</td>
<td>12</td>
<td>5</td>
</tr>
<tr>
<td>2009</td>
<td>287</td>
<td>32</td>
<td>46</td>
<td>75</td>
<td>13</td>
<td>8</td>
</tr>
<tr>
<td>2010</td>
<td>309</td>
<td>36</td>
<td>52</td>
<td>86</td>
<td>17</td>
<td>11</td>
</tr>
<tr>
<td>2011</td>
<td>328</td>
<td>39</td>
<td>51</td>
<td>80</td>
<td>20</td>
<td>10</td>
</tr>
</tbody>
</table>

% of all patients | 62.1% | 7.4% | 9.7% | 15.2% | 3.8% | 1.9% |
% change (5 years) | 25.2% | 25.8% | 41.7% | 6.7% | 122.2% | 25.0% |  

If we apply a crude rate per 1,000 based on East Sussex’s ethnic population groups, the current rate of PLHIV equates to 0.7 per 1,000 for the white population, and 73 per 1,000 for the Black African population, reflecting the greater burden of HIV among this latter group14. However, it is expected that HIV among Black Africans will be declining nationally and within East Sussex for the foreseeable future, owing mostly to changes on immigration policy.

Figure 14 shows the diagnosed PLHIV accessing care by Index of Multiple Deprivation (IMD). This shows that diagnosed HIV tends to be slightly more concentrated in areas of higher deprivation – 53% of PLHIV live in the two most deprived areas. This graph also appears to show this increase ‘spiking’ in 2010. This could be the result of better access to HIV testing in these areas, normalisation of HIV testing, or in-migration. Mid-level and more affluent groups of PLHIV may also be migrating into specific areas. The SOPHID data on residence shows that diagnosed PLHIV tend to cluster in certain areas (Hastings, Eastbourne and Lewes).

---

14 These rates were calculated using the Office of National Statistic’s Census Data for the East Sussex local authority area (available from: [http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-286262](http://www.ons.gov.uk/ons/publications/re-reference-tables.html?edition=tcm%3A77-286262)). However, please note that SOPHID reports on PCT boundaries, which are not completely contiguous with local authority areas given in ONS population statistics.
6.3 Routes of Transmission

The routes of transmission for HIV in East Sussex have remained proportionately unchanged since 2007 to 2011. In 2011, the predominant route of transmission was sex between men (at 55%), followed by sex between men and women (39%). All other routes of transmission total up to 6% of total diagnosed PLHIV (including mother-to-child transmission, Injecting Drug Users (IDUs) and blood products) and also show relatively no change over the past five years.

6.4 Site of Treatment

Figure 16 presents site of treatment for the most recent year (2011) for those accessing care. Most PLHIV (43%) are choosing to access their care within East Sussex, with most of those (28% of all patients) attending Avenue House in Eastbourne. A significant minority access their care in Brighton (16%). These proportions have remained relatively unchanged over the last five years.
6.5 Areas of High Prevalence

‘Areas of high prevalence’ are defined by Public Health England as areas with more than two people diagnosed with HIV per 1,000 population (aged 15-59). Table 14 presents the prevalence by the five districts and boroughs of East Sussex county council area. In 2010, three areas in East Sussex were either at or over the HIV high prevalence threshold.

### Table 14: HIV prevalence per 1,000 population aged 15-59 in East Sussex county districts (2010)

<table>
<thead>
<tr>
<th>County District Area</th>
<th>HIV per 1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastbourne</td>
<td>2.2</td>
</tr>
<tr>
<td>Hastings</td>
<td>2</td>
</tr>
<tr>
<td>Lewes</td>
<td>2.2</td>
</tr>
<tr>
<td>Rother</td>
<td>1.1</td>
</tr>
<tr>
<td>Wealden</td>
<td>0.8</td>
</tr>
</tbody>
</table>

6.6 HIV Late and New Diagnoses

Reducing late diagnosis is a target within the current “Public Health Outcomes Framework Healthy Lives, Healthy People: Improving Outcomes and Supporting Transparency”. Data for 2009-2011 collected against this indicator show that in England, 50% of all new diagnoses are classified as ‘late’, as are 49.3% of all new diagnoses in East Sussex county council.

Further data were requested in order to analyse whether late diagnoses were the result of immigration from other sites of care or late diagnoses within East Sussex. This analysis is based on data from East Sussex specialist HIV clinics only, and thus provides a limited insight into late diagnoses, as those newly diagnosed patients living in East Sussex may choose to access care elsewhere. For instance, SOPHID (which presents data from all sites of treatment) shows that 38 patients had a Cluster of Differentiation 4 (CD4) count of <350 mm$^3$ in 2011, but data from East Sussex services for...
2012 only had 10 patients with such a low count. Of these, four were diagnosed very late (with a CD4 count <200 per mm$^3$).

With such small numbers, and no data from other centres of care, it is difficult to assess the contributing factors to late diagnosis though this does suggest that in-migration of new patients from other centres of care is certainly contributing to late diagnosis. A three-year trend would provide better insights as would data from frequently used centres of care (e.g. Brighton).

7. CONTRACEPTION, CONCEPTION AND ABORTION

7.1 Conceptions

Overall Conceptions

The overall conception rate in East Sussex in 2011 was 76.9 per 1,000 women aged 15-44, which equates to 6,751 conceptions, slightly fewer than in 2010. The conception rate is slightly lower than the overall rate for England (which is 80.4 per 1,000 women) and the rate for the South East (which is 78.1 per 1,000 women)$^{15}$.

Under-18 Conceptions

In 2011, there were 299 conceptions to women aged under 18 years in East Sussex. Between 2001 and 2011, the under-18 conception rate in East Sussex (the green line in Figure 16) peaked in 2008 at 39.4/1,000, and declined until 2010 when it was 31.3/1,000. There was then a slight rise to 31.8/1,000 in 2011.

For most of this period, rates in East Sussex were lower than the England average. However, in 2011, the East Sussex rate slightly overtook the England rate (which was 30.7/1,000: see Figure 17). Rates in East Sussex are higher than for the South East as a whole, where the under-18 conception rate was 26.1/1,000 in 2011.

There is wide variation in under-18 conception rates within the area: the rate in Hastings was 57.0 conceptions per 1,000 women in 2011, and the rate in Wealden was well below the English average at 15.7/1,000.

Hastings and Eastbourne both saw an increase in the under-18 conception rate in 2011, following three previous years of decline. The increase is particularly marked in Hastings, where it has risen from 45.0/1,000 women in 2010, to 57.0 in 2011 – which is almost twice the rate for England. Rates in Lewes, Rother and Wealden continue to decline (see Figure 18 below) and are all below average for the county.
Figure 18: Conception rate (per 1,000 women aged under 18), 2001-2011, East Sussex and constituent districts, and England and the South East

![Graph showing conception rate](image)

Source: Office of National Statistics

The most recent data on under-18 conceptions at ward level come from 2008-2010. The spatial variation of under-18 conceptions by ward across the county is presented in Figure 23 (p.47), which shows whether rates are higher or lower than the English average. These data are already being used to target efforts to reduce teenage pregnancy.

Wards with teenage pregnancy rates higher than the English average are clustered around Hastings and St Leonards (Central St Leonards, Braybrooke, Gensing, Castle, Hollington) and Eastbourne (Devonshire, Hampden Park). Hailsham East and Sidley ward (on the outskirts of Bexhill-on-Sea) also have higher-than-average rates. Eastbourne, Hastings and St Leonards and Sidley are targeted by the C-Card scheme because of their high rates of teenage pregnancy.

East Sussex has a comprehensive ‘Teenage Pregnancy Beyond 2010’ Implementation Plan (for 2010-2013\(^\text{16}\), which will be updated in the latter half of 2013). Objectives include increasing uptake of Long-acting Reversible Contraceptives (LARCs) among young people, and improving access to sexual health services (including increasing evening and weekend provision, and branding and publicising services).

7.2 Abortions

Of all conceptions in East Sussex in 2011, one-fifth (20.9%) led to an abortion (the same percentage as for England as a whole, and slightly higher than the figure for the South East, which was 19.1%)\(^{17}\).

In 2011, both H&R (20.6 per 1,000 resident women aged 15-44) and ESDW (18.3/1,000) have higher abortion rates than the English (17.6/1,000) or South East Coast SHA (17.1/1,000) rates\(^ {18}\). Data on NHS-funded terminations in East Sussex are also collected in the British Pregnancy Advisory Service’s (BPAS’s) enhanced datasets, covering the period 2009-2012.

The data show that in 2012, just over half (52%) of abortions were for women aged under 25 years, 43% were for women aged 25-39, and 5% were for women aged 40 years and over. These proportions have not changed substantially over the past four years.

Data were analysed to map GP practices and wards with the highest termination rates for women aged 15-44 and women aged <20. There is significant geographical variation, with Eastbourne Station Health Centre and Hailsham East ward having the highest rates of abortion for all ages. In 2012, 24% of terminations undergone by under-25-year-olds were repeat abortions. This figure has not fluctuated more than a percentage point in the last three years. For 54% of over-forty-year-olds, this was not the first time they had had a termination. This figure has risen from 2010 when it was 32%.

7.3 Under-18 Abortions:

Of those women aged 15-17 in East Sussex who conceived in 2011, 59.5% had an abortion. This is higher than the overall figure for England (49.3%) and the South East (51.7%). The under-18 abortion rate in East Sussex is 18.9/1,000 women aged 15-17. This is higher than the England (15.1) and South East England (13.5) rates. As well as rises in teenage conceptions, Eastbourne and Hastings have also seen an increase in the abortion rate among 15-17-year-olds between 2010 and 2011: Eastbourne saw the steepest increase (from 15.8/1,000 women in 2010 to 28.0 in 2011). The other parts of the county have seen a decline in the under-18 abortion rate over the last year (see Table 15).

| Table 15: Under-18 abortion rate per 1,000 women in age group (2004-2011) |
|---------------------------------|---------|---------|---------|---------|---------|---------|---------|
| Area of usual residence        | 2004    | 2005    | 2006    | 2007    | 2008    | 2009    | 2010    | 2011    |
| England                        | 19.2    | 19.4    | 19.8    | 20.9    | 19.7    | 18.2    | 17.2    | 15.1    |
| South East England             | 16.2    | 17.1    | 17.0    | 17.3    | 16.8    | 15.0    | 14.6    | 13.5    |
| East Sussex                    | 16.6    | 16.6    | 20.2    | 20.2    | 20.3    | 17.2    | 18.1    | 18.9    |
| Eastbourne                     | 19.2    | 16.6    | 25.2    | 29.3    | 19.6    | 19.7    | 15.8    | 28.0    |
| Hastings                       | 23.2    | 20.5    | 26.3    | 24.9    | 28.4    | 20.4    | 20.7    | 27.3    |
| Lewes                          | 11.7    | 15.7    | 19.9    | 19.0    | 21.2    | 15.9    | 20.8    | 17.4    |
| Rother                         | 15.4    | 18.7    | 19.4    | 21.8    | 23.0    | 17.1    | 18.8    | 17.2    |
| Wealden                        | 14.7    | 13.8    | 14.5    | 11.6    | 13.7    | 14.7    | 16.0    | 9.9     |

Source: Office of National Statistics

\(^{17}\) Source: Conception Statistics for England and Wales, 2011

7.4 Contraception Attendances by Health Setting and Type

**A Note on data:**
The most recent period for which Sexual and Reproductive Health Activity Dataset (SHRAD) data are available for the whole of East Sussex is April 2012 to February 2013, to ensure comparability with data available from other sources (in particular, Prescribing Analysis and Cost Tabulation (ePACT) data, which contain primary care prescribing data).

**Sexual Health Services**
The SHRAD consists of anonymised patient-level data collected from services providing NHS community contraception and community-based sexual and reproductive health care services.19

From April 2012 to February 201320, 11,464 contraceptive consultations were carried out at specialist sexual health services, and for 31% of these, LARC was the main method of contraception provided.21 This is a rise of 288% from the figure reported in the 2008 SHNA, when only 4% of contraceptives dispensed were LARCs. Among 15-24 year olds, 26% of contraceptives dispensed at sexual health clinics were LARCs. Of the other methods dispensed (for all ages), 45% were combined or progestogen-only pills, and 16% were condoms. Other methods (natural family planning, contraception patch and diaphragm) make up the final 8% of contraceptives dispensed at sexual health clinics.

**Table 16: Main types of contraception dispensed by sexual health clinics in East Sussex, by age (April 2012 to February 2013)**

<table>
<thead>
<tr>
<th>Contraception type</th>
<th>15-24 years</th>
<th>All ages</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>LARC</td>
<td>1,779</td>
<td>25.56</td>
</tr>
<tr>
<td>Pills</td>
<td>3,664</td>
<td>52.64</td>
</tr>
<tr>
<td>Condoms</td>
<td>1,113</td>
<td>15.99</td>
</tr>
<tr>
<td>Other</td>
<td>405</td>
<td>5.82</td>
</tr>
<tr>
<td>Total</td>
<td>6,961</td>
<td>100</td>
</tr>
</tbody>
</table>

**Source:** SRHAD

**Benchmarking LARC in community services**
The NHS Information Centre Contraceptive Services 2011/12 data provides analysis from SRHAD data. This shows that of first contacts for contraception reasons only, 25% of women in ESDW and 26% of women in H&R were prescribed LARC. This is higher than the South-East-Coast rate of 22%, but lower than the average for England, which is 28%.22

**Primary Care**
ePACT data, which capture the number and type of contraceptives prescribed in primary care, were also analysed. Table 17 shows the proportion of all contraceptive methods prescribed in primary care that are LARCs.23

---


20 This was the latest available time period of data covering the entire East Sussex area

21 This includes injectable, implant, intrauterine device, intrauterine system and vaginal ring


23 Condoms have been removed from the analysis as data on condoms was not available in the ePACT dataset. The two datasets are not directly comparable, as SHRAD records the main method of contraception prescribed to an individual,
The table shows that GPs provide a large number of LARCs, at over 11,000 methods over an 11-month period, although the proportion of all contraceptive services they provide that are LARCs is lower than at sexual health clinics. ePACT also counts procurements and not dispensation, and so may over-estimate contraceptive use.

Table 17. Percentage of all contraceptive methods dispensed (excluding condoms) that are LARCs (over one year) by health setting

<table>
<thead>
<tr>
<th>Method</th>
<th>Sexual health services (SHRAD)</th>
<th>Primary Care (ePACT data)</th>
</tr>
</thead>
<tbody>
<tr>
<td>LARCs</td>
<td>3,525 (37%)</td>
<td>11,234 (14%)</td>
</tr>
<tr>
<td>Pills</td>
<td>5,211 (54%)</td>
<td>70,455 (86%)</td>
</tr>
<tr>
<td>Other</td>
<td>891 (9%)</td>
<td>101 (0.001%)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>9,627 (100%)</td>
<td>81,790 (100%)</td>
</tr>
</tbody>
</table>

Figure 19 presents contraception by health setting. Please note that these use different sources of data (ePACT and SHRAD) and are as such not directly comparable.

Figure 19: Proportion of contraceptive methods provided which are LARC in sexual health services, and proportion of contraceptive methods prescribed which are LARC in Primary Care (2011-2013)

Benchmarking LARC in GPs
The rate of GP-prescribed LARC is reported by the Public Health England. This data shows that ESDW and H&R both have higher rates of GP LARC-prescribing than the South East Coast SHA area and England as a whole. Rates have been rising over the last five years, and have reached 63.1/1,000 in ESDW, and 56.6 in H&R (see Figure 20).
Figure 20: Rate of GP-prescribed LARC, per 1,000 registered female population aged 15-44 (2007-2012)

LARC are also prescribed by BPAS. The latest data are from 2009-2012. During 2012, BPAS dispensed 617 LARCs (up from 357 in 2009), which accounts for roughly 4% of LARCs dispensed in the county annually. It is not possible at present to disaggregate data from hub and spoke sexual health clinics, which would have enabled comparison of LARC prescribing rates across different clinics in the county.

**Condom Distribution**

The C-Card scheme aims to improve access to condoms and confidential sexual health advice for young people (13-25 years old) (see Box below for additional aims). It aims to adopt the ‘You’re Welcome’ standards for youth-friendly services, and should provide young people with information about a full range of contraceptive services and where they can be accessed locally. Condoms are provided for free to young people registered on the scheme, distributed from trained Targeted Youth Services (TYS) and other youth services, pharmacists, sexual health clinics and GPs.

<table>
<thead>
<tr>
<th>Aims of the C-Card Scheme&lt;sup&gt;24&lt;/sup&gt;:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- To increase access to condoms for vulnerable population groups, e.g. MSM</td>
</tr>
<tr>
<td>- To reduce unplanned, unintended pregnancies and STIs, especially amongst those identified as being most-at-risk and vulnerable</td>
</tr>
<tr>
<td>- To increase the availability and acceptability of condoms and information on sexual health issues to young people and vulnerable population groups thus enabling them to make safe informed choices about their sexual health</td>
</tr>
<tr>
<td>- To ensure that young people and vulnerable population groups who access the scheme are aware of local contraceptive and sexual health services in East Sussex.</td>
</tr>
</tbody>
</table>

The latest data available on the C-Card scheme have been reviewed, covering the two quarters up to September 2012. As the data on C-Card contacts comes from a wide variety of services, there is some concern within the East Sussex County Council public health department about the accuracy and completeness of these data<sup>25</sup>. However, they give an indication of the range of activity under the C-Card scheme:

---

<sup>24</sup> Taken from the ‘Service Specification for the Under 25s C-Card Scheme 2012/13’

<sup>25</sup> For instance, data from SONAR are not included in these quarterly figures, as there is uncertainty as to what type of registrations they constitute new or repeat clients
- Of the 107 pharmacies in East Sussex, 95 (89%) had been trained in C-Card
- Of the 104 GP surgeries in the county, 59 (57%) had been trained in C-card
- All GUM (2), TYS (98) and other young people’s services (11) had been trained
- During the six months in Quarters 1-2 (Q1-2) 2012/13:
  - 26,281 condoms had been dispensed under the scheme – this is an equivalent of eight condoms per client. Of these, the following number were given out in teenage pregnancy hot spots:
    - 3,818 in Eastbourne
    - 4,184 in Hastings and St Leonards
    - 1,362 in Sidley
  - 2,148 clients had been provided with condoms at pharmacies, 20% of whom visited just one pharmacy (Pharmacy@Station Plaza) (see Annex 1 for a list of pharmacies and the number of C-Card clients they saw during these six months)
  - 3,233 young people had been seen (60% were repeat clients, 40% were new) (this does not include clients seen at pharmacies)
  - Of those whose age was recorded, 41% were under 16 years, and 75% were under 18 years
  - Very low numbers of clients (less than five) self-identified as homosexual or bi-sexual
  - 43% of clients are female (though data on gender is not complete).

Numbers for MSM appear to be very low, but the service user engagement suggests that this reflects service user preference and the generally older population of MSM living in East Sussex. There is nothing to suggest that this group lacks awareness of the C-card scheme.

**Figure 21: Rate of GP-prescribed LARC, per 1,000 registered female population aged 15-44 (2007-2012)**

Annex I provides a list of pharmacies who recently dispensed condoms under C-Card, ranked according to the volume of condoms they distributed. This may be useful in terms of planning where to focus efforts to ensure that pharmacists signed up to the scheme are providing a high-quality service and making condoms readily accessible to the target groups.

---

26 Age was recorded for 1,482 clients
7.5 Emergency Contraception: Total Market Review

This section describes the total market for EC by comparing the volume of EHC dispensed in various settings. It does not include sales of EHC through pharmacies\(^{27}\).

Different methods of emergency contraception are available in East Sussex. Pharmacies with enhanced contracts can provide EHC to all women aged from 13-25 years with a valid East Sussex postcode. Intrauterine Device (IUD) insertion (up to five days after an Unprotected Sex Incident (UPSI)) can also be used as emergency contraception. EC is also available free of charge to all women from GPs and SRH services. In pharmacies, women over 25 years of age are usually charged for EHC.

**Figure 22: Proportion of EHC dispensed by pharmacies (free of charge), Primary Care and Sexual Health Clinics, (2011-2013)**\(^{28}\)

In sexual health clinics, there were 810 prescriptions for emergency contraception during the eleven months between April 2012 and February 2013, an average of 74 per month. Of these, 798 (98%) were oral hormonal forms (the remainder were IUDs). Of these consultations, 28% were to women aged 13-17 years, 47% to women aged 18-24 years, and the remaining 24% were to women aged 25 years and over; in total, over three-quarters of all EHC in sexual health clinics is prescribed to under-25-year-olds.

**Table 18: Oral hormonal emergency contraception dispensed from specialist sexual health services in East Sussex, by age (April 2012 - February 2013)**

<table>
<thead>
<tr>
<th>Age</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>13-17</td>
<td>225</td>
<td>28.2</td>
</tr>
<tr>
<td>18-24</td>
<td>378</td>
<td>47.4</td>
</tr>
<tr>
<td>25+</td>
<td>195</td>
<td>24.4</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>798</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

*Source: SRHAD*

---

\(^{27}\) In this section ‘EC’ refers to Emergency contraception which includes hormonal forms and insertion of IUDs, as well as ‘EHC’ which refers to ‘emergency hormonal contraception’ only (not including IUDs).

\(^{28}\) Data for different settings relate to slightly different time periods: see text in following section for further details. Data for sexual health clinics have been extrapolated to a full year (applying prescribing rates from 11 months of data).
Primary care: the most recent data for contraceptives prescribed in primary care relate to a full year, from Q4 2011/12 to the Q3 2012/13 (NHS financial year). During this period, 2,791 emergency oral contraceptives were prescribed. Of these, 2,616 (94%) were Levonorgestrel, and the remainder were ulipristal. As the latter is a much newer and more expensive method, this is not surprising. Data on age of the women to whom these drugs were prescribed are not available.

Pharmacies: To enable comparisons with primary care, data on EHC dispensed free of charge (under the Patient Group Direction (PGD)) from pharmacies for Q4 2011/12 to Q3 2012/13 were analysed. These data do not include sales of EHC to women not eligible for free EHC.

During this period, 478 EHC were dispensed free of charge from pharmacies in the county. Almost half (45%) were to women aged 17 and under. Forty-seven per cent of women were aged 18-24, and only 9% were aged 25 years and over. This age profile is younger than women attending specialist sexual health clinics (where only 28% of attendees were under 18 years). However, in terms of absolute numbers, more 13-17 year olds obtain Emergency Hormonal Contraception (EHC) from specialist sexual health clinics than from pharmacies.

Table 19: Oral hormonal emergency contraception dispensed from pharmacies in East Sussex, by age (Q4 2011/12 to Q3 2012/13)

<table>
<thead>
<tr>
<th>Age</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>13-17</td>
<td>214</td>
<td>44.8</td>
</tr>
<tr>
<td>18-24</td>
<td>223</td>
<td>46.7</td>
</tr>
<tr>
<td>25+</td>
<td>41</td>
<td>8.6</td>
</tr>
<tr>
<td>Total</td>
<td>478</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: SONAR

Total market: These data show that of all oral EHC prescribed/dispensed in sexual health clinics, primary care and pharmacists\(^{29}\), 68% were prescribed within primary care, 21% in specialist sexual health services, and 12% from pharmacies.

This suggests that the variety of health settings dispensing EC is working well to promote use (and thus avert episodes of unwanted pregnancy) but uptake could be higher in pharmacies. Results from the MS exercise (see Section 8.1) suggest that there are some access issues to be addressed.

In order to see whether EHC is being accessed in areas of high teenage pregnancy, and whether there is good access to EHC across the county, including in rural areas, the volume of EHC dispensed by pharmacies free of charge and by GPs was mapped (see Figure 22).

As would be expected given the high population density of these areas, dispensations of EHC are clustered in Hastings and St Leonards, and Eastbourne. Across the rural centre of East Sussex, there are few pharmacies/GPs to dispense EHC, and young women living in these areas need to travel to nearby towns.

\(^{29}\) SONAR and ePACT: Q4 2011/12 – Q3 2012/13, SHRAD April 2012 – Feb 2013. As data from SRHAD only relate to 11 months, they have been multiplied up to estimate the volume prescribed over a whole year in the calculation of these proportions.
Figure 23: Map of teenage conception rate by ward against emergency contraception dispensed in pharmacies and primary care

Given the higher-than-average rate of teenage pregnancy in Hailsham and Sidley, there are few dispensations of EHC in these wards, and quantities dispensed are low. It may be that young women prefer to travel to Eastbourne or Hastings to obtain EHC in a pharmacy where they are anonymous. However, it is worth investigating whether availability of EHC in these wards is adequate.
8. PUBLIC AND PATIENT ENGAGEMENT

8.1 Mystery Shopping – Emergency Contraception

This section describes the results of a ‘Mystery Shopping’ exercise for EHC in pharmacies, conducted by young women. The aim of the exercise was to assess the quality and availability of this service and to identify areas for improvement.

The PGD for EHC through community pharmacies\(^\text{30}\) outlines instructions for pharmacists administering Levonorgestrel to women below the age of 18 (and for women over 18 in exceptional circumstances, if they are unable to obtain a supply from another NHS source in time). Pharmacists must have completed courses on EHC, contraception and ‘Safeguarding Children’ in order to be accredited under this PGD. Of relevance to the MS exercise are the following criteria which must be met before providing EHC:

- Clients under 16 years old must be assessed as ‘Fraser competent’ (a measure of capacity to consent to a procedure if under-age), or if not assessed as Fraser competent accompanied by mother/female guardian who must also give consent to the treatment being given
- Are aged under 18
- The tablet is to be administered in the pharmacy
- Advice to be given to client, to include:
  - Written advice: patient information leaflet, Family Planning Association (FPA) leaflet on EC, information sheet on family planning clinics in the local area, information leaflet for young people
  - Discuss need for regular contraception and risks of STIs from unprotected sex.

The ‘Enhanced Service\(^\text{31}\)’ PGD includes:

- Providing Levonelle 1500 \(*\) free of charge to clients according to the PGD described above
- The pharmacy will provide sexual health information and advice, and may refer to specialist centres/other professionals if appropriate
- Explaining the C-Card scheme that young people can be registered with, and supplying condoms whether they are registered or not
- Supplying a chlamydia testing kit
- Putting on view a display board (provided by the PCT) indicating that the service is available
- Providing a quiet area for confidential consultation (not necessarily a separate room) with water and cups available to take the dose
- An accredited pharmacist should be available for 80% of core hours.

The PCT is required to: ‘provide details of relevant referral points which pharmacy staff can use to signpost service users who require further assistance’ and ‘disseminate information on the service to other pharmacy contractors and health care professionals in order that they can signpost patients to the service’.

8.1.1 Methodology

Audit tool: The design of the audit tool was informed by the Department of Health’s Quality criteria for young people friendly health services\(^\text{32}\). It covered service user experience assessed against

---

quality benchmarks at each stage of service provision, including: locating and accessing the service, consultation and service offer, information and advice, and staff attitudes. The audit used a largely tick-box format, with some open-ended questions requiring a narrative description to capture service user experiences. The audit tool has already been piloted and used in another area of the UK.

**Sampling frame:** OUK received two years of data from the SONAR database, which include data on EC dispensed by health setting and basic patient demographics (see Section 7.5). Pharmacies dispensing under the EHC PGD in East Sussex were ranked according to their average monthly dispensation of EHC (high/medium/low) (see Annex 1). Pharmacies were stratified by NHS area (ESDW/H&R) and by monthly dispensation rank. The following numbers of pharmacies were randomly selected from each rank/area category:

<table>
<thead>
<tr>
<th>Rank</th>
<th>Number of Pharmacies/NHS area</th>
</tr>
</thead>
<tbody>
<tr>
<td>High rank</td>
<td>1 pharmacy/NHS area</td>
</tr>
<tr>
<td>Medium rank</td>
<td>2 pharmacies/NHS area</td>
</tr>
<tr>
<td>Low rank</td>
<td>3 pharmacies/NHS area</td>
</tr>
</tbody>
</table>

This was to purposively sample pharmacies that were experiencing low service access to be able to provide recommendations on improving the service offer.

Twelve pharmacies were visited during the exercise:

**Table 20: Pharmacies included in the EHC Mystery Shopping Exercise**

<table>
<thead>
<tr>
<th>East Sussex Downs and Weald</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wyborns Pharmacy (BN7 2JU)</td>
<td>High</td>
</tr>
<tr>
<td>Newman Ltd (BN22 7QP)</td>
<td>Medium</td>
</tr>
<tr>
<td>Boots Pharmacy (BN21 4TX)</td>
<td>Medium</td>
</tr>
<tr>
<td>David Skinner Pharmacy (BN21 3JU)</td>
<td>Low</td>
</tr>
<tr>
<td>Kamsons Pharmacy (BN20 9PL)</td>
<td>Low</td>
</tr>
<tr>
<td>Cavendish Place Pharmacy (BN21 3TZ)</td>
<td>Low</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Hastings and Rother</th>
<th>Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kamsons Pharmacy (TN34 1NN)</td>
<td>High</td>
</tr>
<tr>
<td>Laycock Chemists (TN35 5BL)</td>
<td>Medium</td>
</tr>
<tr>
<td>Laycock Chemists (TN37 7LR)</td>
<td>Medium</td>
</tr>
<tr>
<td>Ore Village Pharmacy (TN35 5BG)</td>
<td>Low</td>
</tr>
<tr>
<td>Morrisons Pharmacy (TN6 1DP)</td>
<td>Low</td>
</tr>
<tr>
<td>Lloyds Pharmacy (TN37 7AN)</td>
<td>Low</td>
</tr>
</tbody>
</table>

**Recruitment and training of MSs:** Youth support workers were contacted to recruit participants. Eleven MSs were recruited and trained, and ranged in age from 13 to 20 years. The majority were aged 16 years, but four were under 16. For those who were under 16, parental consent was requested. OUK trained participants on use of the audit tool and different scenarios to be used during the exercise. They were clearly instructed not to take the EHC if provided, but to tell service providers that they would prefer to take it at home. They were instructed not to pay for the EHC if payment was requested, but to record cost data.

---

32 This is also known as the ‘You’re Welcome’ criteria

Mystery Shoppers used three scenarios:

- Scenario A: contraceptive failure “a condom was used, but split”
- Scenario B: no contraception was used “I did not use any contraception”
- Scenario C: non-consensual sex “I was drunk and did not know what I was doing but had sex”.

Participants were instructed to liaise with the MS exercise lead at OUK if there were any problems, and were given 24-hour contact details. All MSs were remunerated for their work and participation in the project.

**Data Collection:** Data collection took place over two weeks (late April-May 2013) at different times and days of the week. Twenty-four visits (two per pharmacy) were made: 12 used Scenario A, nine used scenario B and three used Scenario C. Forms were completed and sent to OUK. The MS lead followed up with each participant to verify data and clarify any queries.

**Limitations:** The MSs were instructed not to take EHC, but in a few cases the pharmacist requested that the participant take the medication in their presence (as per clinical guidance that states that EHC should be taken in front of the service provider). At this point, the MS was instructed to request that they would prefer to take the medication at home, and that if the pharmacist did not agree to this, they should make an excuse and leave the pharmacy without the EHC. The fact that MSs could not actually take the medication in the presence of the pharmacist limits the extent to which the MS exercise mirrors the experience of a client in real need.

**8.1.2 Results**

**Finding the service:** MSs were given the name and address of the pharmacy they were required to visit. Maps and opening hours were not provided. Some MSs searched for the location via the Internet, some knew the pharmacy from their knowledge of the local area, and others chose to visit the pharmacy after school, without researching the opening hours.

Overall, the MSs felt that the pharmacies were easy to find through Google Maps. Pharmacies were often located in main shopping areas and, as mentioned above, were already known to some MSs. Some MSs did comment, however, that although they knew the pharmacy location and did not have any problems finding it, those who were new to the area could find the pharmacy difficult to locate. For those pharmacies noted as difficult to find, reasons stated were that the pharmacy had changed its name or that the directions on Google Maps were not clear.

In terms of service accessibility, 83% of participants found opening times on display in the pharmacy window or door. In one case a participant could not access the service at all because when she arrived at the pharmacy it was closed. *[It was a Saturday, and the pharmacy closed at one; she was from the next town and hadn’t checked opening times before visiting.]*

---

33 Clinical Effectiveness Group (2011) “Emergency Contraception”, Faculty of Sexual and Reproductive Health, Royal College of Obstetricians and Gynaecologists (RCOG)
Branding of sexual health services: Participants were asked whether they thought it was clear that the service provided sexual health services. Fifty-eight per cent of MSs acknowledged that it was clear that sexual health services were provided (having seen the C-Card logo, or having seen a written sign saying that EHC/sexual health services were available), but only 16% thought it was clear from outside the pharmacy that the service provided emergency contraception.

Arrival at the pharmacy: Greeting on arrival is one aspect of quality of care, particularly for those who feel uncomfortable requesting EHC. All but one of the MSs thought they were greeted politely. The MS who felt she was not greeted politely mentioned that she had arrived when the pharmacy was approaching closing time, and therefore ‘felt rushed’.

Requesting the service: Only a third of MSs were able to request EHC without being overheard by other people (other customers and staff members in the pharmacy).

“Pharmacist publically asked the questions in front of other staff and customers – felt very embarrassed, there was a stand to the side and it was public, people could hear.” Mystery Shopper Report.

“Asked for a female – there wasn’t one. Went into consultation room, door was left open as there was only one person working in the pharmacy – I didn’t mind as I’m not from (East Sussex town) so no one would know me there.” Mystery Shopper Report.

Three-quarters of MSs were able to see a female pharmacist. The waiting time to be seen ranged from being seen straight away to waiting seven to eight minutes.

Obtaining EHC: Of the 24 visits conducted, in only half (12) were MSs given EHC for free and allowed to take it away from the pharmacy; five of these twelve MSs were aged under 16 years.

For the 13 who did not obtain EHC, the reasons were:

- Pharmacy closed (1)
- Refused access – told they would be charged/refused unless they took EHC in front of pharmacist (6)
- Refused access – told they were ‘too young’ as they were under 16 years (3)
- The young person was charged for the EHC (3)

“I asked for the morning after pill and the lady at the desk asked how old I was, I said I was 14 and the lady said, ‘Hold on,’ politely, she went to speak to a man, came back and said, ‘It’s best if you see your doctor, you’re not old enough.”’ Mystery Shopper Report.

For the three participants asked to pay for EHC, there was also variation in results:

- One MS was asked to pay £23 when she refused to take it in front of the provider; otherwise it would have been free, yet a second MS was not charged and was able to leave the pharmacy with EHC
- One MS was asked to pay £16 when she refused to take it in front of the provider; otherwise it was free, yet the second MS was refused free access and charged £16 (she was not offered the choice of receiving it for free if she took it in front of the pharmacist)
Another pharmacy wanted to charge both MSs £25 for EHC and recommended accessing EHC for free at Crowborough Hospital.

**The consultation:** MSs were asked how they felt the consultation went, what kind of questions they were asked by the pharmacist, staff attitudes and how useful the information given about EHC was. The vast majority felt that they were treated respectfully by the pharmacist and staff.

“I felt comfortable – the lady who asked all the questions was pleasant.” Mystery Shopper Report.

“Although they couldn't give the pill, they were friendly.” Mystery Shopper Report.

“Was not judged at all, felt I could talk to them.” Mystery Shopper Report.

However, two shoppers felt that the pharmacist was disrespectful – one because the consultation did not take place privately, and the other because she felt that the pharmacist was not polite because she was under 16.

“...I felt they didn't respect my privacy by talking about it in front of everyone... They should ask to speak to someone in private... it's an emotional topic.” Mystery Shopper Report.

“...They would have treated me differently if I was older.” Mystery Shopper Report.

When asked how useful they found the information about EHC, 30% of MSs reported that no/not enough information was given about EHC – this could be because, of these, only one had actually obtained EHC. However, it should be noted that 70% of participants felt that the information provided was sufficient and helpful in understanding how EHC works and the process of taking it, along with the side effects.

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was the EHC method clearly explained to you?</td>
<td>13</td>
<td>11</td>
</tr>
<tr>
<td>Were side effects explained?</td>
<td>16</td>
<td>8</td>
</tr>
<tr>
<td>Were time limits explained?</td>
<td>16</td>
<td>8</td>
</tr>
</tbody>
</table>

MSs also reported whether they were offered general sexual health advice (e.g. ongoing contraception, STI prevention, condom use). Results across the pharmacies were variable, but the majority of young women did not receive additional sexual health advice:

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Were you offered condoms?</td>
<td>11</td>
<td>13</td>
</tr>
<tr>
<td>Were you told about the C-Card scheme?</td>
<td>9</td>
<td>15</td>
</tr>
<tr>
<td>Were ongoing methods of contraception discussed?</td>
<td>8</td>
<td>16</td>
</tr>
<tr>
<td>Were you advised to have an STI screen?</td>
<td>6</td>
<td>18</td>
</tr>
<tr>
<td>Were you provided with any written information?</td>
<td>1</td>
<td>23</td>
</tr>
</tbody>
</table>

Only one MS was provided with a leaflet on advice for women taking Levonelle EC.
Recommendations from MSs: MSs were asked whether they would recommend the service to someone else, and what recommendations they had for improving the service for young women. Of the 24 pharmacies reviewed, 13 replied that they would recommend the service, whereas 11 responded that they would not.

There was a range of reasons for recommending the service:

“…it’s in a private area, ladies are nice, give you lots of information, was clear who to ask, leaflets around, information on door, it was really nice in there and I felt comfortable. In all, I believe this was the best place I visited as it was friendly, private, not humiliating and lots of advice was given, they also asked if I wanted additional contraception (condoms).” Mystery Shopper Report.

“…Even though the consultation was not done privately, I still feel that the staff were nice and friendly, and they gave me the information that I needed.” Mystery Shopper Report.

“…Pharmacist was great. Not good that you can’t take it outside of the pharmacy but glad to be offered. She had a very good sense of humour.” Mystery Shopper Report.

Attitudes and behaviour of pharmacy staff were the main factor in determining whether a MS would recommend a service. Although some MSs did not receive EHC for free, they were still likely to recommend a service to a friend because of the way they were treated by staff. Other factors included being seen privately and being provided with sufficient information regarding EHC and ongoing contraception.

Reasons for not recommending the service were similarly related to lack of privacy during the consultation, staff attitudes, and being refused EHC due to being under 16:

“…The consultation was in public and it was embarrassing... In all I believe this was the worst pharmacy I visited as the consultation was public so you were humiliated and it was scary.” Mystery Shopper Report.

“...It decreases self-confidence. It takes a lot for a teenager to request EHC and so staff should be friendly and not feel like they are being told off.” Mystery Shopper Report.

“...If this was a real situation and someone didn’t feel comfortable with going to their doctor and the chemist, because they said you are not old enough, you’d be a bit stuck if you didn't know any other chemists.” Mystery Shopper Report.

Suggestions for improvements were:

- Leaflets and posters with information about EHC available to take from the pharmacy
- Clear signs that sexual health service provision is available at the pharmacy
- All consultations made in a private setting
- More information available on the importance of contraception
- Free EHC should be made available at all pharmacies
- Staff who are more open to young people and less judgemental.
8.1.3 Discussion

This Mystery Shopping exercise has highlighted some critical areas where access to emergency contraception needs to improve in order both to give equal access to all those who are entitled to free EHC in East Sussex and to ensure that contact with providers empowers women to be able to make better choices about maintaining good SRH and well-being. Each contact with pharmacists should ensure that:

- Women who have low awareness of contraceptive methods leave with better knowledge of methods and where to access them in East Sussex
- Younger women/girls (under the age of 16 years of age) who are entitled to free EHC are able to access this without judgement
- Women are consistently signposted to comprehensive contraception providers and are encouraged to have a sexual health screen.

The results of this Mystery Shopping exercise found that younger women were not consistently able to access EHC, and were often refused on the basis of their young age. Closer attention should be paid to making pharmacies more accessible to young clients. The SONAR data show that 15% of those accessing EHC were under 16 years of age, and this suggests that despite barriers pharmacies still have a very valuable role to play in offering rapid and confidential access to EHC. This should include reviewing whether pharmacists are offering a private and confidential service, and, if not, how they could implement this. Young people’s services (such as Brook) have implemented many low-cost interventions (such as a menu of options where young people can point at the service that they would like without have to speak) that enhance privacy in SRH settings.

There was a worrying low offer of STI screens: only six women said that they had been offered one, and it is not clear whether these offers were for a chlamydia self-test kit or not. Similarly, there were also very low levels of small media information that could also enhance young women’s awareness of contraceptive methods.

Of the three women who were given Scenario C, none of them were asked if they had consented to sex, or the situation in which the UPSI had occurred. However, in some cases other mystery shoppers had been asked about the age of their partner and whether they had consented. This nonetheless demonstrates that pharmacists are potentially not implementing their safeguarding responsibilities.

It was apparent that access to pharmacists dispensing EHC would probably be easier if there were a consistent logo, marking out pharmacies who not only provide EHC but also do it with consistently high quality of care. OUK was not able to find a list of pharmacies where EHC is available, despite searching all of the websites cited in this report.

ESHT public health will need to consider how to ensure that quality of care and service access are maintained for young people. There was substantial variation, sometimes within the same pharmacy, in young women’s service access. Repeated mystery shopping exercises with provider feedback, or a local accreditation scheme with more comprehensive signposting to those who do offer consistently high quality of care could give providers a better incentive to attract clients.
8.2 Young People’s Service Engagement

8.2.1 Introduction
This section examines the service use and needs of young people (under 20 years) in the coastal towns of Seaford, Newhaven and Peacehaven. It explores factors behind the reported reduction in use of the Seaford sexual health under-20s drop-in service (5.30pm to 7.00pm on Thursdays). Young people’s sexual health needs, service use, and preferences are also discussed.

Young people’s views were explored during 12 FGDs involving 41 young people aged between 14 and 18 years of age. Thirty-two of the young people lived in the coastal area; the remainder were from Lewes and the inner East Sussex area. Fifteen respondents were female, 26 were young men. Groups took place at TYS youth clubs in Seaford and Peacehaven, and in the Lewes and Eastbourne campuses of Sussex Downs College. Relevant KI interviews with practitioners (see Section 9) also inform this section.

8.2.2 Sex Education and Sources of Information
Focus group sessions began with an exploration of views on Sex and Relationship Education (SRE) and Personal, Social and Health Education (PHSE). Positive experiences were reported by young people whose SRE/PHSE had been delivered by specialist or dedicated experts (e.g. TYS, a local GP, a PLHIV). Teachers who delivered SRE/PSHE were reported to either make pupils feel uncomfortable, or were not taken seriously/laughed at. Some of the young people felt sympathy for the teachers, who they perceived to be ill equipped for delivering SRE, or uncomfortable with talking about sexual relationships. It was remarked that Lesbian, Gay, Bisexual and Transgender (LGBT) issues were missing from some young people’s PSHE/SRE.

Young people reported that TV programmes (such as ‘Embarrassing Bodies’), leaflets, parents, youth workers and friends were sources of information about sexual health and services. A minority of people said they would use the Internet to find out about sexual health, more so when it came to finding out about local services. On the whole, young people had considerable knowledge about local services, and how to find out about them. The ‘FREE 2 B ME’ App was mentioned by a minority of respondents as a source of such information.

8.2.3 Services across the Area

**General Practice:** Young women were more likely than young men to say they accessed sexual health services via their family GP, although they also used specialist sexual health services for contraception. Only the youngest boys (14/15 year olds) said they would go to their GP for a sexual health issue. Other young men who had needed sexual health services dismissed their family GPs with comments such as: “I wouldn’t want to go where my parents go”.

**GP-based Sexual Health Drop-Ins:** The exception to this was when the GP was *not* the family doctor. The Circle Room and the Meridian Centre were widely mentioned as services that young people felt comfortable using.

---

34 [http://www.connexions360.org.uk/healthandadvice/sex/FREE2BME/Pages/FREE2BME.aspx](http://www.connexions360.org.uk/healthandadvice/sex/FREE2BME/Pages/FREE2BME.aspx)
Pharmacies, C-Card and TYS: Young men were more likely to mention that they used pharmacies than young women, primarily to obtain condoms. A minority of young women had gone to a pharmacy for EHC. Young men were also more likely to mention accessing chlamydia testing and condoms through TYS. The TYS outreach van was widely known for providing access to condoms and information. There was some confusion over eligibility criteria for C-Cards (regarding age and employment status). Young men at both college campuses could access free condoms and chlamydia testing during Freshers’ Week and health drop-ins. Younger men preferred to get condoms from their youth workers via C-Card. There were concerns about using a pharmacist, particularly in small towns (owing to embarrassment or fear of being seen by someone they knew). The majority of respondents knew that EHC was available at pharmacists, although there was some confusion about whether it was free and where to access it when pharmacies/clinics were closed.

Sexual Health Centres: Both Avenue House and Station Plaza Hastings were reported as being “good” and “very friendly” and “really helpful”. Several people used these services regularly, and the older respondents were willing to travel to them if needed. There were some complaints about long waiting times at Avenue House.

8.2.4 The Seaford Sexual Health Drop-In

Knowledge about this service was patchy across the focus groups. All respondents from Seaford knew of the service, although some were vague about its exact location or opening hours. There was an overall perception that the service was limited compared to the hub services. Some of the young people’s observations are inaccurate, which highlights their incomplete knowledge about the drop-in 35:

“The Seaford drop-in is from 6 to 8 which means you have to go out again after coming home from college and that makes my parents ask where I’m going.”

“It’s only for STI testing and has really limited hours.”

A couple of young people had been dissuaded from going to the Seaford drop-in following recommendations from friends: “My friend told me not to go to the Seaford drop-in because it is a bad service.”

However, the majority of the young men at the Seaford-based focus groups said they used the Seaford drop-in, primarily for C-Card registration and picking up condoms. Even so, negative perceptions and experiences were reported. One young man, speaking for himself and his friends, said: “it’s hard to get into so we’d mostly go to Avenue House”. Another young man said that he had heard: “...that it is going to go anyway because they’ve taken a nurse and a room away”.

35 Clinic is open Thursday 5.30-7.00pm (drop-in for under-20s) according to website – full range of services not available (basic FP and STI services). Connexions website says 5.30-7.30pm
Practitioners’ Views: There was consensus that attendance at the Seaford drop-in has decreased over the past year to eighteen months. The following factors were thought to have contributed to this decline:

- Alternative services attracting young people:
  - Drop-in provided by the Newhaven Community Development Association
  - Expanded opening hours and good reputation of Avenue House (with people attending Seaford being referred to Avenue House if they required additional services)
- Negative perceptions around the restricted services on offer and limited opening hours
- Lack of perceptions promotion in recent times, linked to the recent reduction in school nurse activity, especially when compared to the outreach and engagement that other services had undertaken (e.g. the Meridian Centre (Peacehaven), the Circle Room (Lewes)).

Core Service Users: Focus groups and practitioners recognised the importance of the Seaford drop-in for a core clientele of younger local boys (<16 year olds) who come for C-Card registration and to see the youth worker. This link between youth workers and sexual health services was valued, especially for the access it provided for younger boys, whose engagement with sexual health services is usually less frequent than young women’s. There was some concern that young men’s access to sexual health services could be restricted if they were referred elsewhere.

More broadly, the Seaford drop-in leads young people into the more extensive and accessible sexual health services offered by Avenue House. Comments indicated that young people move on to the latter as they become older, more mobile and more confident, and as their needs extend beyond the C-Card, or, in the case of young women, when their contraceptive needs change.

Practitioners recommended that instead of simply concluding that there was no local need for the drop-in, a programme of re-engagement with young people about the service should be attempted:

“Does it have a web presence? Are the local schools promoting it? Young people don’t look at posters, you need to get out and meet them.”

“We sometimes simply choose to cut back a service rather than looking at promoting it when activity declines.”

“We need to refresh our messages and the information we provide about services because you get a different population of young people every few years.”

“There’s only one consulting room there now and the session is only an hour and a half so there are longer waiting times.”

---

36 At present it is not possible to extract service use data about spoke clinics, as they are reported together with data on the hub services at Avenue House and Station Plaza.
8.2.5 Service Preferences

Young people were asked to design a sexual health service that would be appealing to them and their friends. They identified the following issues:

- **Age and gender:**
  - Appreciating the differences in needs between under-16s and over-16s, and between young men and women

- **Location of services:**
  - The youngest people had less mobility and were less willing to travel out of their immediate area, because of cost, personal transport access and lack of confidence. There were also constraints posed by being at school and having shorter periods of time when they could legitimately be away from their parents and carers. Although most respondents wanted local services (i.e. in their home town) the older respondents said that services near college (in Lewes or Eastbourne) would also be acceptable.

- **Staff:**
  - Young women wanted to see health staff of their own sex whereas this was not an important issue for young men. Both age groups and sexes preferred services geared towards younger people.
  - Reassurances of confidentiality
  - Non-judgemental and friendly staff

- **Service provision:**
  - Being seen on the same day
  - Waiting areas to be clean and pleasant with discreet reception access and seating bays

- **Opening Times:**
  - For school-aged young people: a service that opened as school closed (3pm)
  - Older respondents: later opening in the evenings, early morning slots, before college or work
  - Unanimous preference for some weekend, including Sunday morning, service provision

- **Service promotion:**
  - The young people all felt that services needed better promotion. The Circle Room and Meridian Centre’s promotional activities were highlighted (e.g. attending school assemblies and providing small business-card-sized information). Facebook and
social media were also recommended as modes of promotion, as were clinic visits and open days (arranged between schools and local services).
8.3 People Aged over 25 Years — Women

8.3.1 Methods
A FGD was conducted with eight women who were all over 25 years of age, recruited through a local company in East Sussex.

8.3.2 Influencing Factors
The women in this focus group were generally experienced users of contraception, predominantly accessed through primary care, and occasional users of other sexual health services/products, including walk-in level three integrated sexual health services, and EC. Attitudes towards sexual and reproductive health services had been partly influenced by the lack of targeted interventions for them when they were young women; in contrast to their younger peers, they felt that they were less inclined to routine STI testing.

“Because back when I was 16, 17 it wasn’t common practice to get tested, like it is nowadays. Young kids don’t think anything of it, do they? They just go and get tested. But you didn’t back then, did you?”

Many of the women (especially those who balanced work with their childcare responsibilities) said that time pressures meant that getting to services was difficult, and in a few instances, this had resulted in women not accessing screening services. As one respondent who had never had a cervical smear test (despite reminders from her GP) remarked:

“The roles that we were in before were really demanding, weren’t they, and you’re constantly on call and you couldn’t get the time away and when you did get the time away, you wanted to spend it with your loved ones.”

In terms of use of sexual health services, many respondents said that they were occasional and reactive users of services (in response to specific prompts such as the end of a relationship, or being symptomatic).

“And you just assume, oh, I’m going to get symptoms, it’s going to burn or itch and if I haven’t got that, then I must be fine and actually…”

“So, I suppose you think you don’t talk about it when you come out of a relationship.”

8.3.3 Information and Advice
As women who were often in long-term relationships, some of the women remarked that sexual health issues tended to be less discussed among their peers, and informal ‘word of mouth’ access to information was low. Despite perceptions that many women in this group had lacked access to comprehensive sexual health education in their early adult years, many also remarked that awareness of the importance of maintaining good sexual health (e.g. testing for STIs) had gained a lot more media attention.
In cases where there were any concerns, their local GP would be seen as a first line of enquiry, but many of the respondents also felt confident that they would be able to find NHS endorsed information online. Awareness of local services was mixed, however, with many being aware of larger ‘hub’ services (in Eastbourne and Avenue House) but very few being aware of spoke services in local areas, though more services in outlying areas was identified as a need by some.

8.3.4 Access and Use of Sexual and Reproductive Health Services

**STI testing in primary care**

Most women in the FGD had been low or occasional users of STI testing services. In a few cases, respondents had tried to access STI testing services through primary care, but had generally been disappointed with the lack or small number of STI tests available. It was clear that in cases where women did test they wanted to have a comprehensive range of STI testing available (a full screen), and also wanted primary care centres to be more proactive in requesting that patients test.

“Because the doctor wasn’t my normal doctor and they said, no... she refused to do it.”

“I think it’s not encouraged and I don’t think it happens. So, for example, I have a smear test I get a lecture about a smear test, but I’ve never been invited to have any other test, does that makes sense?”

In a few cases, women remarked that larger surgeries were able to have specialised nursing staff who ‘dealt with’ SRH services (such as cervical smears); demand for SRH services did not seem to be linked to numbers of nursing staff per se, but women did appreciate the specialist staff who routinely provided these services being available. Conversely, in some cases there was a lack of confidence in some doctors providing key services.

“I think I want something specialised. I’ve had a bad experience with my doctor doing a smear test on me. It was awful... I got the feeling afterwards that she had no clue what she was doing.”

“I’ve been quite lucky. In my surgery they have a select two nurses that deal with all the smears, everything like women’s problems like that, that the GPs would say, okay, you need that, book it with them. They don’t even attempt to do that kind of thing. They just go, go and see them, and they just take them down. So, they’re really good in that sense.”

8.3.5 Walk-in Integrated SRH Services

Many respondents were aware of the main ‘hub’ services in East Sussex, but were occasional users, with only one respondent saying that she tested routinely. Women were much more likely to access walk-in services for contraception. These services were generally well received, offering easy access and extended opening hours that women could more easily access out of work hours. The location of the Hastings clinic, alongside other health services, also offered a degree of anonymity that these women, as non-routine users, were slightly concerned about. In terms of contraceptive services, women were also very confident in the skills of the specialist staff on hand, and a few said that they would only access certain services, such as cervical smears and LARCs through these services. In a
few cases, women had very little idea of where they could access walk-in integrated services, as they had been in long-term relationships. As with the men’s group, concern about what a visit to SRH services entailed could be acting as a barrier to some women.

“I have no idea, to be honest. Absolutely no idea. I’ve never been to a clinic. I wouldn’t understand what to do if I got there. Wouldn’t have a clue. So, I’m ill-educated in that sense.”

8.3.6 Contraception
Many of the women in this group reported that they used short-term methods of contraception, most often the oral contraceptive pill. Reports of side effects and difficulties in adjusting to different methods of contraception appeared to be relatively high.

“I don’t think I would... I’ve heard too many horror stories about too many other things to want to use anything else. My sister fell pregnant on the pill. Apart from the hormones, she actually fell pregnant. She had a bad experience with the coil. There was a long list of things with crosses going through these bits of contraception.”

Most women appeared to access contraception through primary care, apart from those who wanted to access some forms of LARC (especially IUDs/Intrauterine Contraceptive Devices (IUCDs)), in which case there was low confidence in GPs to perform these insertions. Negative experiences with LARC insertions were widely talked about, and appeared to dissuade women from considering these forms of contraception. There was also consensus that GPs would often try to steer women towards injectables and implants.

“I’ve got the coil fitted and my doctor tried to fit it and he fitted it all wrong and then I had to go and have (contraception consultant) take it out for me and then we fitted again because it wasn’t fitted in the right place. So, I’d rather go somewhere that does it.”

“My GP’s been saying you can have the injection, you can have the pill and actually they’re probably trying to steer you into the injection.”

Emergency Contraception
Women in this study were very occasional users of EC. There appeared to be relatively good awareness of where EHC was available either for free or paid for, and in some cases pharmacists had sign-posted women to free providers. Women did not like paying for EHC but this did not appear to prevent them from using it, and in some cases they had opted to pay rather than wait longer in SRH services.

“I know somebody who’s accessed it recently. They just went down to the pharmacist and did it at Boots and found it really easy.”

8.3.7 Service User Preferences
Several recommendations emerged from this discussion group:
- Women appreciated rapid access to repeat prescriptions. There was some demand for pharmacies to provide repeat prescription schemes for OCPs, with an annual check-up with a GP.

- For SRH services: a few women reported difficulties in accessing services, despite longer opening hours. Working women wanted the re-assurance of an appointment, and there was strong support for a slot-appointment system (where women are given time slots for being seen) operated online, to be guaranteed being seen on certain days.

  “And then the last time, once again they had no one in in the morning. And I tried phoning them and saying, do you have people in? Well, you have to come in and find out. And then you walk in and they go, oh, there’s nobody in.”

- There was some demand for interactive information on accessing SRH services, so that women could understand what would be involved in a visit for a sexual health screen. Concerns about this may be dissuading some women.

  “So having more awareness, being invited and to come along to have that, being told what it involves, so a lot more informing really, highlighting the benefits of doing that.”

- Women were also concerned that smear tests be included in a full sexual health screen, and appeared to have higher confidence in mainstream SRH services to perform this.

- For GPs: women wanted to see more GPs involved in promoting sexual health testing, and ‘nudging’ them to consider doing this. This could include integrating offers of STI testing into smear tests, direct mail to suggest this option, or reminders/nudges when checking in for appointments. There was also some demand for STI tests ordered online.

- Women had low awareness of ‘spoke’ SRH services, but in some cases clearly did prefer a more local service. There is a need for women to be more aware of sexual health sessions offered through walk-in services.

  “It would be nice for there to be more sexual health clinics to be dotted over in, more regularly over the country. So, for example, people can walk to or catch a bus to for people that are unable to drive so that they’re absolutely accessible.”

- Demand for LARCs via GPs is likely to remain low, while there appears to be little promotion of these methods, and women lack confidence in GPs to conduct insertions. However, building specialisms within larger surgeries (e.g. offering nurse-led care for LARC insertions) appeared to have some support among this group.
8.4 People Aged Over 25 Years—Men

8.4.1 Methods
A FGD was conducted with eight men, who were all aged over 25 years of age. The discussion with men aged 25 years plus covered a range of topics, including:

- Concerns and issues to do with maintaining good sexual health
- Current access to services, including STI testing, condom use, emergency contraception use
- Male involvement in their partners’ contraceptive choices.

8.4.2 Influencing Factors
Some of the focus group respondents were in long-term relationships, but many were single. The main concerns expressed by the group revolved around sexual risk-taking, specifically not using condoms in sexual encounters, usually because of the influence of alcohol linked to the clubbing scene in East Sussex (mainly in Eastbourne). Awareness and concerns about STIs and HIV was high, and several respondents were concerned that men in their cohort may not routinely access STI testing (though their own testing rates appeared high).

“I know so many friends who’ve really recently found out that they’ve got (HIV) and it’s like, got to be careful then.”

“To be honest, HIV for me is scary but I don’t know, the one that I think is the most common that comes up is chlamydia, definitely.”

There was also some discussion around unwanted pregnancy, which was said to be high in general in East Sussex, but several respondents had themselves had sexual encounters that resulted in unwanted pregnancies.

“See, I did the same thing, when I was younger I’d run the risk. Now I have a four-year-old.”

8.4.3 Current Access to SRH Services
Advice/Information
Many of the respondents in this group felt that they had good access to advice and information, though later identified a lack of media messaging encouraging STI/HIV testing and condom use. Most said that their first line for advice would be the main sexual health clinics (Station Plaza or Avenue House) or the Internet, with many citing NHS websites (such as NHS Direct) as a preferred site.

Condom Use
Condom use, or rather the lack of it, was one key area that the men discussed in depth. Only one respondent routinely carried condoms when going out, but respondents felt that in general access to condoms was not an issue, but rather that sexual risk-taking was bound to happen in ‘the heat of the moment’, and was particularly linked to alcohol consumption. Many respondents felt that their decision on whether to use protection would depend on the woman’s insistence, rather than their own self-protection.
“Yes, because we’re men and this is going to sound so disgusting but if a sexy girl comes up to me and I haven’t got a condom on me and she says I’m not going to do it, I’m going to do everything in my power to try and do it (have sex with her), and if she turns round and says, all right then, I’m on the pill, then I’m going to put it in. Honestly, do you not know? I’m just being blunt.”

While the respondents felt that accessibility was not an issue, with most either being able to access free condoms, or willing to pay for them, many felt that there were not enough environmental cues to remind them of the importance of using condoms in these types of situations.

“If you’re going out clubbing that night you need to get a condom, but for you to get that condom you need something to mentally trigger in your mind. That doesn’t happen nowadays.”

“I think it’s just more advertisement. Advertising a lot more and getting down to the nitty-gritty serious points. It’s not... it’s seen as a joke.”

8.4.4 Attitudes towards STI Testing
Many respondents said that they were concerned about perceived high levels of diagnosed STIs/HIV in East Sussex. Some of the respondents identified themselves as ‘routine testers’, and tested every three to six months even if they also said that they were in long-term stable relationships. In other cases, respondents said that embarrassment and perceptions of the discomfort involved in using sexual health services could be deterring potential service users.

“I don’t find it embarrassing, though, to go there. I don’t mind if I had to walk into a place like that if it was just a sex clinic. That for me is someone caring about themselves.”

“I think they’re worried, they’re scared because they don’t... They hear so many stories like, oh, they jab something down there and they rip it out... the umbrella.”

There was a clear demand for a full STI screen among all respondents, even among those who do not routinely test, and the group clearly thus favoured accessing care through sexual health hubs. Those who routinely tested for STIs also pointed out that there was very little visible communication to encourage this among their peers, especially among those who were single and ‘on the scene’.

“I’m the only one out of my friends that has settled down and I don’t think the others realised how often they should get checked because there’s nothing there to say you should get checked every three months or every four months just to be on the safe side.”

“Depending on what sort of lifestyle you’re living. Because if you’re going out a lot and thinking, I’m going to get smashed tonight, take some bird back, you will literally do as many women as you can and you won’t know what you have and you don’t know who you’re going to pass it round to. Because when they ask you and you’ve got stuff and you’re like, ‘Who’s your sexual partners,’ you’re like, ‘Ummm.’ Literally got first names and first letters, does that help?”
Awareness of the main sexual health hubs (in Eastbourne and Hastings) was high, but echoing the women’s group, none mentioned other sexual health clinics. These services were well received, with respondents citing welcoming staff attitudes, longer opening times, and easy access as aspects of the services that were welcomed. Nonetheless, some recommendations for improvements to clinics were made, including calling patients by an assigned number and not name, and touch screens at reception for signing in.

“Also I’ve got a really unusual name and if you hear my second name it’s like, oh, I know what family you’re from. It’s like, for god’s sake, literally no one has my surname.”

**STI testing in GP services**

A few respondents had tried to access STI screening through their local GPs, but had been signposted onto sexual health clinics. Most of the respondents felt much more confident in sexual health clinics. There appeared to be little demand for increased access to STI testing through GPs, even though it offered greater anonymity.

“I’m sure the one at the GP would be fine but it just feels like because the ones on the sexual health clinic, that’s all they deal with, it just feels like they’re going to be more discreet, more knowledgeable about it, perhaps, more understanding. It just feels like that’s the best one to go to.”

**8.4.5 Attitudes towards Contraception**

Many of the men in this group stated that contraception would be their partner’s choice, but in some cases, it was evident that they were involved in discussions about continuing new methods. There was some mistrust of LARC methods, though it is unclear what influence this would have had on women’s reproductive decisions.

“I was the one that made her go and get the thing out of her arm. Honestly, she was a nutter on it. It changed her personality. She decided in the end. Ultimately it was her decision but I think without me pushing her to get it out she would have had it in there a lot longer. So I think in a relationship it’s definitely down to you.”

“The coil is a bit gross.”

“It’s not nice, sometimes you feel it. Your bellend hits it sometimes and you’re like, what is that? It’s not nice.”

Awareness of the low failure rates of long-acting contraception also appeared low, with some participants saying that the contraceptive pill was a ‘safer’ method. In a few cases, men were clearly relying on, and trusting, methods with a greater risk of unwanted pregnancy, such as withdrawal. Unplanned pregnancy was nonetheless a key concern to this group’s participants, who questioned their peers’ use of unreliable methods.

“I hate sex with condoms. So we have sex, we have sex regularly and I just pull out. She ain’t preggers yet.”
“I think I generally do believe what you’re told and I think we’re told that it’s 99.9%. I just assume that we take it for a given that the pill is reliable. I don’t even question it.”

“I don’t know anyone who’s had a baby who actually planned it.”

8.4.6 Future Service Preferences

In discussions regarding addressing future needs, the men in this focus group prioritised tackling sexual risk-taking, perceived high rates of STIs, and lack of use of condoms in situations where there was alcohol use. There was some support for making condoms more available, for instance, through vending machines, but most respondents agreed that visual cues and ‘nudging’ in venues would reinforce messages on using condoms in casual sexual encounters, or in places where people may be congregating (e.g. taxi ranks or clubs).

“One thing you guys said, and I think it’s one of the worst things, is that I never see advertising for it outside of a clinic. Except in colleges, that’s the only place I see it. I never see it in pubs or clubs or bus stops, anywhere.”

“If you’re going out clubbing that night you need to get a condom, but for you to get that condom you need something to mentally trigger in your mind. That doesn’t happen nowadays.”

Secondly, male respondents stated that their peers needed to have greater awareness of both the need for routine STI testing (time-based, rather than risk-based messaging, e.g. ‘do your annual MOT”) and clearer information about what to expect when accessing sexual health services.

“If you think about what goes on in the clinic when you have a full MOT, as it were, I think we’ll always gather there’s very little information on that because the amount of rumours that go around about what actually happens. I don’t think anybody knows actually what’s involved until you actually do it and then no one talks about it.”

“I think more people would go if they knew exactly what went on and what they were going for.”
8.5 Men Who Have Sex with Men – HIV Prevention in East Sussex

8.5.1 Methods
To engage with MSM, a FGD was held with three participants, and in-depth phone interviews were held with a further six. Respondents ranged in age range from 16-55.

Interviews principally covered: current access to and use of SRH services; HIV prevention and recommendations for its improvement in East Sussex; issues and support needs for PLHIV. The section below presents findings for gay men with and without HIV. The needs of other PLHIV are explored separately in Section 8.6.

8.5.2 East Sussex for Gay Men
Interviews with gay men opened with exploring their experiences of living as gay men in East Sussex. This informed later discussions about targeting, messaging and information/media channels.

Both young and older gay men said that, in general, East Sussex was a relatively tolerant place for them to live, with few incidents of homophobia. It was clear, however, that there are relatively few meeting points for gay men, with only one gay pub in the whole area: most men said that they would socialise in gay-friendly areas, such as London or Brighton. Many men in interviews (especially those who were HIV-positive) identified as being ‘anti-scene’, preferring to socialise within their own social networks rather than to travel to larger cities. Older men, and those living with HIV, tended to report feeling isolated and say that it was difficult to meet other gay men in the area.

Younger gay men appeared to have more widespread gay social networks, and to shun the few ‘gay’ venues in the area.

“I find that older gays are a little bit more bored, and I don’t really like that very much. I can see why girls don’t like it when older men come on to them and... it’s a little bit creepy, and you get that quite a lot in the [gay pub in Eastbourne] and I don’t like it... You don’t get the attention from the young nice ones who have been aloof in the corner, you get attention from the weird ones.”

Younger respondents were more likely to have used or currently be using young LGBT support groups, where messaging around sexual health and social support were well integrated.

Specifically targeting gay men is likely to be difficult in this context, and HIV prevention outreach services which use gay venues are likely to reach an older gay audience.

8.5.3 Attitudes to SRH
Gay men in East Sussex primarily viewed sexual health, and specifically HIV, as a topic that was not routinely discussed. This was partly linked to the demise of gay venues (linked to the increasing use of mobile apps/Internet technologies for meeting people), and to the difficulties of gay men in raising these issues. A few respondents (especially those living with HIV) said that gay men were thus less likely to be informed about SRH issues in the local area, compared to counterparts in London or Brighton,
“To be honest, I think, that kind of subject, it’s a little bit morbid. It’s a little bit talking about when you’re going to die. It’s just one of those things; unless you need to talk about it, why would it even come up?”

Many respondents nonetheless identified themselves as ‘savvy consumers’ of sexual health services, being more likely to have access to condoms and SRH screening than their heterosexual counterparts.

8.5.4 Perception of Risks and Drivers of the HIV epidemic

Gay men in these interviews appeared likely to view decisions about adopting preventive behaviours (e.g. using a condom during sex) as an individualised choice, based on an individual’s preferences or maturity, rather than as behaviour which was driven in certain risky environments (e.g. in clubs), or by wider social forces (e.g. the advent of Antiretroviral Therapy).

In cases where men did discuss their views on the drivers of the epidemic, these echoed the current national evidence in highlighting: a core group of ‘risk-takers’, who continue to engage in Unprotected Anal Intercourse (UAI), and links between UAI and drug/alcohol misuse. Men associated this with the ‘gay scene’, particularly in Brighton. In some cases, men linked this choice not to have protected sex to shifting attitudes towards HIV infection as a ‘manageable’ condition, and as part of a growing community of sexually active HIV-positive gay men who openly ‘sero-sort’ often through online media.

“It’s not a positive, or whatever – is, that they are aware that the guys that are positive, they know they are positive; none of them are hiding anything from each other, so they are just going crazy and doing crazy stuff. They know the risks.”

While qualitative engagement cannot be used to compare the frequency of preventive behaviours relative to other areas, these data suggest that the rates of SRH testing in East Sussex are relatively low. Many respondents referred to the lack of routine testing among their peers, even if they had exposed themselves to the risk of contracting STIs/HIV. These interviews also highlighted that initial contact with health services appear to have a great influence on later engagement with SRH services, sometimes over several decades. A few respondents had had stigmatising experiences when accessing health services as gay men (e.g. with GPs), and this may have influenced their later testing behaviours. Several respondents chose not to use local SRH services owing to negative experiences a few decades ago, whereas others felt that local services currently provided high-quality care.

8.5.5 Current Access to SRH Services
Access to Information and Advice

37 ‘Sero-sort’ refers to the practice of choosing sexual partners based on their HIV status, for instance, HIV positive men choosing to have a sexual partner who is also HIV positive. The practice often entails unprotected (anal) sex, though its effect on HIV incidence is still being researched.
The data on ‘advice and information’ tended to be contradictory. Many respondents felt that information on sexual health and HIV was widely available in the gay media ‘if people wanted to access it’, and that most gay men were aware of the need for using protection, regularly having an SRH screen, and of where they could do this locally. However, many respondents also remarked that visible messaging in East Sussex aimed at gay men tended to be very low, and that SRH information tended to be aimed at avoiding teenage pregnancy. HIV messaging was said to be particularly sporadic:

“You hear about this epidemic and then it just goes quiet for a whole other year. And it’s quite worrying that... the more that can be raised about this the better really. It’s not going away.”

Sexual health information was also said to be limited to a few areas – “It’s like if you go out, away from Lewes, it’s like a different place” – and lacking in areas such as Hastings and Eastbourne. A few respondents also said that testing rates were not high enough, and that messaging to encourage this was not being listened to:

“Well, it’s quite upsetting when you go to the sexual health clinic and it’s not busy, it’s not as busy as I want it to be... because it means that message of getting yourself tested is not going through.”

Respondents particularly pinpointed health settings, such as local GP surgeries, as locations where more could be done to promote testing messages.

Though this sample size was small, there were clear differences between older and younger gay men: younger men had often accessed LGBT support groups, where SRH testing had been discussed and promoted. These respondents appeared to be more concerned about maintaining good sexual health, including accessing routine SRH services.

“STIs and things like that, that’s the main thing that one worries about... Oh yes, I think because they know how to deal with it so they wear protection and things like that, but I think they’re just worried about this high risk of getting it now and there’s much more awareness about it so everyone’s worrying about it.”

Both PLHIV and younger respondents also talked about Terrence Higgins Trust’s (THT’s) ‘Positive Voices’, who conduct awareness sessions in school about HIV, as being a valuable intervention in promoting sexual health and well-being. However, younger respondents also said that sexual health information in schools had tended to ignore their sexual orientation, and use general health messages rather than specifically talking about gay sex. Gay men social support groups were felt to be more appropriate talking about gay sexuality.

8.5 6 Current Access to Sexual Health Services

Condom Use

Many respondents said that access to condoms was good, especially in gay venues. Several respondents chose to access free condoms in Brighton, through venues such as ‘Prowler’.
However, condom use was very much presented as an individual choice, with some men routinely deciding not to use condoms as a personal preference,

“I think, there’s a bit of a divide. I wouldn’t say it’s 50/50; I wouldn’t even be able to guess the percentage, but as near as I can tell, there are groups of people who use them and don’t use them and the ones that don’t use them, it’s either because they don’t see the need or because they just genuinely don’t like them.”

“No, they’re just not doing it because they’re ignoring it, they just don’t like it.”

Several respondents, including those diagnosed with HIV, said that those likely to not be using condoms were often HIV-positive themselves. A few respondents also said that they may have been willing to take more risks when they were younger. In one respondent’s case, lack of condom use was also linked to low self-esteem.

“So when people paid me compliments and wanted to sleep with me basically I used to just let them do what they want because I wasn’t in a good place mentally. It’s only more recently that I’ve become super safe, yes.”

### 8.5.7 Access to SRH and HIV Testing

Many of the respondents identified themselves as having regular SRH screens, but knew of peers who did not. Barriers to sexual health screens among this group primarily appeared to be perceptual – echoing the national data, those who had had positive experiences in accessing SRH services appeared to be more likely to carry on doing so, and conversely those who had experienced judgemental attitudes were less likely to do so.

“Probably, it’s probably like in the first step go in there because a lot of people get a bit nervous and they go like when I first went there I didn’t really know what to expect and I didn’t know what I was going to do, but I suppose once you take the first step and do it the first time you get used to getting check-ups and things like that.”

Respondents often said that symptoms were a frequent trigger for men to access

---

**Identified Barriers to Testing**

- Lack of concern/symptomless
  
  “Well, the main concern is I haven’t got any symptoms and I seem to be all right. If I’ve got an infection I would know, but it’s not been the case.”

- Fear of being seen by partners/others
  
  “Yes, because some of them are quite promiscuous. My friends, some of them, I’m not generalising, but some of them are quite promiscuous, even though they’ve got a partner.”

- MSM who are not acknowledging a gay identity
  
  “Well, I’ve got a friend who is married and keeps saying I’m not gay and he doesn’t want to have a check up, but I think it’s mostly ignorance on his part because he’s the one who is giving, and not respecting, so he thinks nothing is going to happen to him.”

- Previous negative experiences accessing health care (because of gay identity)
  
  “The last time I screened for it was about 15 years ago. Yes, [at that time] the test was so nerve-wracking, the questions that they ask you beforehand was very pointy-finger…when I went for the test a month ago with [THT worker] it was completely
SRH screens. However, anxiety about testing was also said to be a strong barrier. A few respondents said, for instance, that anxiety while waiting for results could deter them from accessing services. One respondent had not tested for the past 15 years, and in this case, support from a THT health advocate was key in supporting him to access SRH services. Some respondents felt that more could be done to promote an awareness that local SRH services are welcoming and non-judgemental, and widely perceived by those who use them to be of high quality.

“It makes it so much less painful going in, having, perhaps, been greeted with a smile and everything’s just so calm and cheerful; it’s lovely.”

There was also a lack of clarity about what the frequency of ‘routine’ checking should be: men talked about a wide variety of time frames, from every couple of years to every few months. There was also quite a strong consensus that gay men would value rapid testing, and that this could potentially attract them into services. Despite this, those who had tested had an overwhelming preference for accessing sexual health care in the main sexual health hubs (at Eastbourne and Hastings).

### 8.5.8 Accessing Sexual Health Services through Primary Care

Most of the respondents in this group said that they were registered with a GP, and had disclosed their sexual orientation to them with few concerns. In a few cases, men had not disclosed sexual orientation as they said that this was irrelevant to their care.

Attitudes towards GPs and sexual health were mixed, with some reporting good engagement and care (notably including some PLHIV), and others saying that GPs had generally been uninterested and disengaged from discussions about sexual health. In some cases, these attitudes were clearly informed by negative and discriminatory experiences, in this case, over several decades ago:

“He said I’m going to send you for psychosexual counselling, which I thought, ‘Okay, I’ll do it,’ because you do what the GP says, don’t you? So I did it and after six weeks of this intensive counselling the guy told me to look at page three and that was the end of my input.”

“The last time I went to my GP she was good, actually, and I had some tests there. She rang me up with the results so my GP was good the last time I went.”

There were also divergent views on whether GPs could and should be more actively involved in providing sexual health care.

“I don’t feel really comfortable talking to them about it, that’s all. It feels like they’re more like they should be dealing with foot problems and things.”

“A Sexual Health Clinic – j...I’m used to go to it, where it’s quite like practically on my doorstep, I don’t have an issue with going in for stuff like that sort of thing.”

Younger respondents seemed to be much more open to accessing sexual health care through their GP, but this needs to be explored further given the small sample size.
Many respondents also strongly supported a more interventionist stance, with HIV and SRH testing being actively offered to gay men, including by GPs, though this clearly depended on their perceptions of their relationship with their GP.

“I’m diabetic as well so every time I go to the GP, ‘How’s your blood sugar?’ So what’s the difference between saying how’s your sex life?”

A few respondents said that this would be the most effective way of reaching those men who have never tested for HIV/STIs.

8.5.8 Post-exposure Prophylaxis (PEP)
All respondents were asked what actions they would recommend if they felt that they had exposed themselves to the risk of infection. A few respondents (two) knew about PEP, or had had to use it themselves in the past. Most respondents had low or no awareness of PEP, or said that they would probably go for a check-up in the first instance. This strongly suggests that those who may need PEP may not be accessing it.

“But this is being asked if they feel like they would benefit from it, because, as I say, things like PEP, I didn’t really find out until I needed it and even when I went for an MOT, I didn’t know about it.”

Respondents wanted sexual health services in the first instance to raise awareness of PEP.

8.5.9 Future Service Preferences
Current research and guidance highlights that in order to address rising rates of HIV, there is an ongoing need to tackle rates of UAI (which have remained static over the last few years) and encourage HIV testing on a more routine basis.

This data show that gay men frame their sexual decision-making as a knowing individual choice, even when they are engaging in ‘high-risk’ behaviours. This echoes other research, which has found that gay men are very ‘independent-minded’ regarding sexual health issues38. However, public health approaches which focus on individual-level decision-making, and not the social contexts in which men decide to take risks (and the reasons for this), will probably be ineffective.

Men in these interviews had a number of recommendations, while others in this section have emerged based on the results of engagement.

Framing Approaches to sexual health and HIV
Respondents in these interviews, echoing other service user groups, wanted to have more visible support and greater numbers of prompts for the general population to increase their access to SRH.

---

This included ‘normalising’ the importance of maintaining good sexual health in the same way that other ‘risky’ behaviours have been addressed.

“If you’re smoking aware, drinking aware, sex aware.”

Part of this approach includes recommending full sexual health screens (rather than just HIV testing), and in the context of East Sussex, not singling out gay men in any media communications.

“Because everybody’s at risk; it’s not just gay men, and also would stigmatise, I think, that only gay men will get it. So, everyone else is sitting comfortably at home and doing all sorts of diabolical things and thinking, you know what? I’m not gay.”

However, gay men are unlikely to be receptive to ‘preaching’ messages, and respondents talked of the importance of staff attitudes in deciding whether they would test. For instance, while they wanted GPs to recommend testing and be able to take sexual histories, they said this should be done in a non-judgemental way.

**Encouraging Protective Behaviours**

Several respondents argued that MSM had to be taught about safe sex from a young age, and that interventions targeted at older gay men more set in their ways were too little too late.

“In all honesty, my feeling of how it really should be addressed, it’s quite difficult to instigate what I would suggest, which is to start telling, perhaps, teenagers, when they’re a bit younger, maybe, 11 or 12, when it’s likely that they’re going to start to have sex, and maybe just making them aware of what kind of facilities there are out there and then, maybe, just giving them, like, a basic understanding of what is involved in gay sex, even if it’s not as in-depth as straight sex.”

A few respondents living with HIV also wanted to address perceptions of HIV as a ‘normal’ condition, arguing that these are currently too benign.

“So there’s just... not so much a fear thing, but just, this is a picture of a guy that’s been living with HIV for 30 years, kind of thing, and he’s living with it and there’s certain signs that he has got HIV. And so that may not happen to you or someone you know, but it’s just because they’re popping five, six, seven pills a day to help them live, there’s some other issues surrounding the illness that they’re having to live with.”

While it is not clear how widely held these views are, there has been very good reception to ‘Positive Voices’ for young people’s SRE, and support for this should be maintained.

There was more support for promoting routine testing through using time- rather than risk-based messages. There is good evidence that MSM are more receptive to these types of messages over others, and this service user engagement suggests that risk-based messaging may deter two cohorts: men who may have exposed themselves to infection but are anxious about this, and older gay men who may simply not consider themselves to be at risk.
“Yes, I think, it makes it sound a bit more friendly and a bit more casual, like it’s nothing to be worried about; I think, that’s the main thing. I think, that, maybe, people were just a bit worried that if they do go down and get tested, then they know they’ve got something, or maybe it’s just denial, perhaps, but, yes, I think, calling it MOT makes it a lot less scary.”

Encouraging Access to SRH services

Mainstream Sexual Health Services

Several respondents said that more could be done to promote local services, which are widely perceived as offering high-quality care, and offering a warm, welcoming environment by those who do use them.

For those who already test routinely: respondents were very receptive to ‘MOT’ messaging, and said that services could do more to contact service users and remind them of when they should routinely test. MSM in this sample had very few concerns about this, and wanted more active engagement by health services in reminding men to test.

For men who have never tested, or test very infrequently: some respondents said it was most important to overcome initial barriers to accessing SRH services, especially for those who have never tested. Some respondents wanted to see better promotion of THT’s health advocate service, linking these men into care.

“Like I said before, it’s lack of advertising and just the lack of support to get support, if that makes sense, because if I’d seen a poster saying Terrence Higgins Trust is available for talking about sexual health for gay men or whatever then I would have called them long before I did, before I emailed [health worker].”

Some products, such as rapid HIV testing, were also said to encourage attendance.

GPs

Many respondents said that they wanted GPs to be more engaged, specifically in targeting men who have never tested for HIV. These respondents wanted to see GP’s surgeries providing more awareness of SRH, and for GPs themselves to actively recommend testing – but in a non-judgemental way. These respondents were well aware of the difficulties of engaging with gay men in East Sussex, and viewed this as being the most effective method of reaching gay men,

“Perhaps, this, as I say, perhaps if it was a case of, when people register with a GP, they ask their sexual orientation and then they offer them the option of sexual health information, but that’s probably the best thing you’re going to get, I think, in Eastbourne, where there isn’t so many readily available gay meeting places as there is in Brighton.”

“I think, personally, I’d rather have it from a walk-in centre, but, I think, you’re going to catch more people if you do it through the GP.”
There was some suggestion that this would, however, be better received if GPs were encouraging other groups to test as well.

“I’d just say it’s okay to be aware. You should be aware and it’s okay to want to get tested. It’s safe to get tested these days. You’re not going to have pointy-finger syndrome. It’s accepted. Not just gay people, but straight people as well. Obviously everybody.”

General Awareness

Many respondents said that there needed to be better awareness of sexual health in East Sussex. A few suggested either messages that use multi-media (as gay men tend to use websites/apps), or outreach in clubs/gay hangouts. A few respondents said that they also wanted to have specific information about access to PEP.

“But this is being asked if they feel like they would benefit from it, because, as I say, things like PEP, I didn’t really find out until I needed it and even when I went for an MOT, I didn’t know about it.”

Lastly, respondents also talked of rising concerns about Hepatitis C (Hep C), viewed as ‘the new HIV’ (owing to the stigma and severity of the condition). Several respondents said that people needed to have more awareness of Hep C, and of the need for protection among gay PLHIV.

“It’s lethal, isn’t it? It’s a killer. It kills you”. 
8.6 People Living with HIV

These results are based on two FGDs with PLHIV (total of six participants). Most participants were diagnosed long-term (for more than five years) and were in a stable condition, though one person had been diagnosed within the last year.

The main purpose of this engagement was to inform HIV prevention initiatives; however, a range of issues related to living with HIV were also covered and are presented in this section.

8.6.1 Living Well with HIV

Most of the respondents were long-term diagnosed, and while they had often accessed support on diagnosis, were currently in a stable condition. In one focus group, most of the respondents’ current concerns were about HIV-related ‘fitness to work’ assessments, and consequent cuts in benefits. Several respondents said that they were struggling to survive and maintain good health on very low incomes.

“Yes, I’ve had one. I scored nought out of 15. I got nothing.”

“Basically killing yourself won’t stop the government’s policies, but it does make you think about harming yourself, because you can’t see any way out of your situation.”

Several respondents consequently felt pressured to urgently seek work, but talked of the difficulties of doing this in the East Sussex area (particularly in Hastings). There was clear concern about how to address disclosure of HIV status in the workplace, though respondents felt relatively unconcerned about saying that they had HIV in other settings (e.g. with GPs).

“He’s always scared if the new owner finds out he’s HIV-positive. He doesn’t know his reaction. Maybe he get the job and after, because he might say, look, our worker is HIV-positive, maybe he can be sacked. It happened in the past, both of us, in the same place. We worked in the same restaurant before.”

Some respondents had not worked for many years, as a result of living with HIV and other issues, and in several cases stated that they would probably need further support to access work. In one case, a respondent’s GP had referred him on to specialist support (for those with long-term health conditions).

“And I said... she goes, you can’t come here without a CV. So I went to the job centre and a lady typed one up for me. So I went there and gave her... well, you haven’t worked for ten years, blah-blah-blah.”

Several respondents were also facing housing issues, including noisy neighbours, lack of privacy, and threat of eviction. In the latter case, support from THT’s health advocate had been essential in averting homelessness.

“Eviction notice, send me the letter, luckily (THT support worker) once again say, make a copy of all the documents you receive from housing benefit and send them. When I did that, they
say, ‘Okay, we apologise, we didn’t know.’ I didn’t want to say to them, I’m on benefits, because maybe the agency, they don’t accept you if you’re on benefit. That was the only complaint for myself’.

These results strongly suggest that including PLHIV in local housing policy has responded to an identified local need, but that better signposting to available housing services, such as floating support, could reduce this client group’s vulnerability

8.6.2 Support Groups
One focus group was organised through THT’s local PLHIV support network, and another through local sexual health services. Not surprisingly, respondents in THT’s social support group highly valued their monthly meetings, and the peer network that they could access there. Men in the other group, however, said that they did not want to access support groups, but did want to be able to meet other people living with HIV living locally.

Those accessing the support group were currently facing difficult life situations, such as mental health issues, social isolation, and immigration/housing issues, and THT offered valuable support. Respondents did remark, however, that groups often had low levels of attendance, and the extent to which clients have ‘complex’ needs is not clear.

8.6.3 Accessing Primary Care
Most respondents said that they were registered with their GP, and had disclosed their HIV status to them with relatively few concerns. Several respondents said that they had received good-quality care and were satisfied with their GP’s approach to their health as a PLHIV.

“Whereas GP, and I’ve gone maybe about four times in the last year just because I developed shingles and I had a really bad flu, like a chest infection. So those types of things, I went to the GP for that and revealed my HIV status because it’s so important... So that’s all been fine, using the GP for those when it’s clearly not a serious problem.”

In a few cases, respondents had experienced negative attitudes from their GPs, which apparently was particularly related to their employment status.

“My GP, he was actually a bit rude to me, like, ‘Why don’t you find work and why don’t you...’ I’d just moved here, but I did find it very hard to find work with the free ads paper”.

This respondent had nonetheless been well signposted into community mental health and access to work support.

There was a general consensus that GPs should be involved in promoting general health and well-being among PLHIV, but not a clear idea of what services they particularly wanted GPs to offer.

---

“Well, you need to take the right examination by yourself, keep you informed if there is something new about it, like a new cure or new treatment or new way to be more healthy, which can be food, exercise, flu jab, all those kinds of things which can give you the protection in that way, yes”.

8.6.4 PLHIV’s Views on Prevention
There were clearly divergent views on prevention according to the sexual orientation of people in the group. The views of gay PLHIV have been incorporated into Section 8.5. Heterosexual respondents, however, also strongly supported promoting greater awareness about HIV, and especially using THT’s ‘Positive Voices’ group, to talk about the realities of living with HIV, and address low levels of awareness of SRH among the general population.

“They’re going into school and they’re giving that kind of information. After they get a second thought and they start to think about. They start to go on the Internet, not just for chatting or Facebook. What is it about? They’re talking much about respect as well. Show respect towards somebody else’s life, because when you are in a relation, you deal with one life. Think about that. You don’t deal with somebody. You deal with a life”.
9. KEY STAKEHOLDER PERSPECTIVES
The following section summarises practitioner views on sexual health and related services in East Sussex. It explores issues including: gaps in services, vulnerable groups and meeting their needs, and ideas and preferences about service improvement. OUK focused on three other key areas, namely:

- SRE
- Sexual health and general practice
- Performance and need across the hub and spoke model.

The issues that emerged are presented alongside practitioners’ ideas for addressing them, and illustrative quotations from interviews.

9.1 Thoughts about Service Changes since SHNA 2008
There was an overwhelming consensus among practitioners that sexual health services had improved since the last SHNA of 2008, and there was a clear sense of pride in current services:

“Our service for sexual health in East Sussex is pretty good, open access, fully integrated, free at the point of delivery and available 8am to 8pm, five days a week.”

The main changes that were cited as responsible for the improvement were:

- the integration of genitourinary and contraception services
- the dual training of nursing staff
- the shift to being a nurse-led service
- extended opening hours
- the joined-up working of the hub and spoke model
- improvements to data reporting
- improvements to partner notification service.

“People used to work in isolated, individual ways, their own manner...that’s all changed now, spokes are all linked in with the Hub.”

Sexual health staff at all levels across East Sussex were described as dedicated, responsive and highly skilled.

“Things have really improved in the past five years despite all the background difficulties, and they can continue to do so as long as our managers continue to support us.”

The only notes of caution to emerge were as follows:

- **The doctor/nurse balance within nurse-led specialist services**: some respondents felt that there were too few doctors/doctor hours available
- **Increasing demand and workloads**
- **Widespread uncertainty about how services would operate in future**, in particular health improvement/prevention services, following their transition from NHS to local authority.
9.2 Barriers to Improving Sexual Health in East Sussex

Against this generally positive backdrop, respondents saw two main barriers to improving sexual health:

- **Inadequate communication of the service offer:** Respondents felt that as a result of recent service changes and a range of partners working across the area, communication about the range of sexual health services available was confusing and uncoordinated. This affected practitioners’ ability to signpost services, and may be contributing to declining service use in some clinics (e.g. Seaford). Many respondents recommended better service promotion and a re-launch of service information for the public, not only in light of service changes but because the range of services was something the county should be proud to promote.

- **Stigma around service access, particularly for young people:** Some respondents felt that young people’s concerns about stigma and confidentiality relating to sexual health issues (particularly regarding visits to GPs) continued to constitute a barrier to service access. For young people engaged with the TYS, these issues were less of a barrier owing to the trust between workers and clients. Practitioners recommended greater local promotion of service standards such as ‘You’re Welcome’, particularly among GPs, to re-assure young people about confidentiality.

9.3 What Else Can Be Done to Improve Sexual Health across The County?

KIs were asked for their thoughts on how sexual health could be improved in East Sussex. The major theme to emerge was a wish to see sexual health become the concern of a wider range of practitioners than sexual health specialists. This could improve the signposting to services and build the confidence of non-specialist front-line staff to engage with their client groups about sexual health. They saw opportunities for broadening responsibility for sexual health following its move into the LA:

“It’s about the whole pathway, it’s about the roles of all the various partners in the system, so whether they be a small voluntary group in a rural community or a GP or a pharmacy or the clinical services …to ensure that we’ve got the most appropriate level of service in the right place to encourage access to sexual health services.”

9.4 Vulnerable or In-need Groups

Practitioners reported that services had improved since 2008, and were now more appropriate for vulnerable groups including young people, people in smaller towns and people with HIV. Some concerns remain about the following groups:

- **The over 40s:** Practitioners reported that East Sussex was experiencing an increase in STI rates among people aged over forty, in line with national trends. Practitioners suggested that primary care and GPs need to be more skilled at offering sexual health screens to older patients (while recognising that many middle-aged people feel more comfortable visiting specialist services for sexual health issues).
• **Vulnerable Young People** (looked-after children and disengaged young people in rural areas): At the time of the SHNA, there were reports of a small rise in teenage pregnancies in Peacehaven and Hastings, coupled with reports of an increase in the sexual exploitation of young girls in some areas. There was also concern about a sub-group of out-of-school young people in rural areas, who were a vulnerable, but hard-to-reach group, who were unlikely to visit their GP for sexual health issues.

> “With the cutbacks and with thresholds re targeting and intervention rising, there are a lot of vulnerable young men and women who are slipping below the radar – they need outreach and more assertive support.”

Practitioners reiterated the “need to keep pressure on provider services to constantly think about young people”, including maintaining a focus on SRE in schools, and providing outreach services.

**9.5 Prevention and Health Promotion**

Discussions focussed on how health improvement programmes and staff training would be re-configured in light of the imminent disbanding of the ESHT Health Improvement Team. Many respondents believed non-specialist practitioners would have an increased role in sexual health, prompting concern about how training will be delivered and how standards and strategic approaches would be maintained.

It was felt that young people needed to be involved in developing health promotion campaigns, and that these campaigns should be more sophisticated in their design/technology and targeting (tailoring campaigns to local contexts or particular groups).

> “You look at some websites and they’re just cringingly kind of well... hey... young people. If you’re going to reach teenagers then technology is the way to do it but it has to be well designed.”

**9.6 Hub and Spoke: Service Pressure Points and Gaps**

The hub and spoke model, and the integrated service model, were seen to be working well. Specialist spokes were reported as being well used in Uckfield, Crowborough, Hailsham, Bexhill-on-Sea and Hollington. Recent changes have been made to opening hours in the latter to reflect peak times and capture the after-school demand. It was suggested that a similar change for the Seaford Clinic might improve service use. It was anticipated that the formalised HIV network, and the move to the Royal Sussex County Hospital for inpatient HIV care, would ease pressure points.

The following pressure points and gaps in sexual health services were identified:

• **Nurse resource**: If specialist nurses leave, they are replaced by new recruits, who need to be trained to meet the dual skills and standards of the integrated model. During training, existing nurses and staff, who are already working at full capacity, have to pick up the slack.

• **Drop-in and Appointments**: The shift to a largely drop-in service for specialist sexual health clinics was broadly approved of, for reducing non-attendance and making services
accessible for young people. However, it was acknowledged that waiting times could be inconvenient for some patients, and that there could be periods of slack for staff. Respondents agreed that bookable slots should be available for people who need them (e.g. those with childcare and work responsibilities, including the over-40s).

**Geographic Gaps:** Since the SHNA of 2008 considerable effort has gone into developing spoke services for sexual health. Practitioners felt that some gaps had been closed, but that in terms of specialist services, several remained:

- Around Heathfield
- For older people, the area north of Lewes (who may have to travel to Brighton or Eastbourne). (Under-25s have a service in Lewes.)
- Since the Rye service closed, a gap in the east of the county (although people in this area are thought to use services in Ashford)
- A limited service provided in Seaford.

**9.7 Commissioning: Specialist Services and the Role of Primary Care**

Overwhelmingly, two major themes were identified by practitioners around service commissioning and staffing. These were specialist services, staff balance and related issues; and primary care and its future role as a sexual health provider. Several respondents discussed the need for longer cycles of commissioning to enable services to plan ahead and develop programmes and relationships. Others felt that the current targeting of services according to the teenage pregnancy agenda was not necessarily beneficial to the wider sexual health agenda, as it does not cover STI spikes or enable longer-term, broader sexual health promotion.

**Specialist Services:** Respondents had concerns around future budgets and funding: “There’s a risk that the merge with Acute Trust might mean sexual health will have its budget raided.” It was suggested that a move to Payment by Results could mitigate this risk, and direct money to gaps in service provision. Another issue discussed on the subject of tariffs referred to the limitations imposed by their inflexibility, and how specialist services “missed out” on occasion in relation to the boundaries between sexual health and gynaecological work:

“And speaking we can’t fit a Mirena for heavy periods but only for contraception. Yet we’re experts at fitting coils and if we don’t do it, the woman has to get referred on, which costs the NHS more. Also, we get paid to put an implant in but not to take one out. That could be an issue if things go private – people will be putting them in willy-nilly but not interested in taking them out, which also takes longer!”

The pros and cons of being a nurse-led service were widely discussed. It was acknowledged that a nurse-led service is cost-effective, but situations inevitably arise when a doctor is needed. Some respondents felt that there were alternative ways of obtaining this support without having a full-time doctor on hand, and that to a certain extent, owing to good local working practices, a more flexible model was informally in operation.

“We need to be innovative; you could have an on-call expert across the area and even the neighbouring area.”

82
Another issue raised was that the flip side of raising skills among nursing staff is that doctors can become de-skilled, as they perform certain services less frequently. This has implications for primary care sexual health provision, and for referral into gynaecology and associated delays and costs.

Respondents raised the possibility of a wider range of people being trained to undertake sexual health work, similar to the model applied to the TYS, to include Healthcare Assistants (HCAs) and social workers, to add to the overall service offer. For instance, a wider range could be trained to perform chlamydia screening and give out C-Cards.

Primary Care: Both drop-ins delivered through GP practices in Lewes and Peacehaven (The Circle Room and The Meridian Centre) are being widely used; service uptake is increasing at both sites. The Crowborough pilot is less used at present but is still in its infancy. Practitioners across sexual health and related services had mixed views on the role of GPs in sexual health provision. Respondents’ views of the perceived benefits of GP involvement, and the notes of caution they sounded, are summarised below.

Perceived benefits:
- Primary care was seen as a way to fill gaps in provision across a large and rural county
- GPs might be more likely to recognise underlying medical conditions
- In some areas of the county, GPs’ care of HIV-positive patients and HIV testing is improving
- There are examples of GPs pushing the sexual health agenda and proactively promoting sexual health
- Some felt that GPs provide more cost-effective services than specialist services.

“It may well be cheaper for GPs to provide some sexual health services and this may take away business from specialist services but the point is that clients should come first and they should have choice.”

Notes of caution:
- Issue of quality control, particularly in relation to training – will GPs invest in this?
- Can GPs in busy practices become expert at sexual health?
- There will always be limited interest among GPs in providing sexual health services
- Time constraints: can the types of issues seen at specialist services (e.g. partner notification, pelvic pain) be adequately responded to in a quick GP appointment?
- Safeguards need to be in place to maintain standards if non-specialist services/practitioners are going to be involved in sexual health.

The issue of where practitioners thought people wanted to access services was discussed. Respondents felt that GP practices were not always the most appropriate setting, and that irrespective of primary care’s ability or interest in sexual health service provision, commissioners need to be mindful of maintaining a range of options for access.
9.8 LARC Uptake
Interviewees indicated that LARC uptake is healthy and increasing, across different clinics. The point was made that specialist nurses or doctors were needed “on the front line, explaining to young people and others about LARCs”.

9.9 Sex and Relationship Education
There have been major changes to the context of SRE in local schools, including:
- The decommissioning of the Pupil Wellbeing and Vulnerable Groups, Standards and Learning Effectiveness Service, to deliver and support targeted schools to deliver PSHE, including SRE
- Nationally, the government did not renew the statutory nature of SRE in 2010
- An unprecedented number of children with a child protection plan in East Sussex, which has stretched school nurse capacity at a time when school nurse input into SRE and sexual health has been drastically reduced.

Problems and concerns: Practitioners were concerned with both the quality of SRE provision, and actual sexual health support available through schools. The majority of interviewees perceived a potential crisis in relation to a lack of coordinated and systematic high-quality SRE and sexual health support in schools.

As a consequence of the situation with school nursing, the TYS now provides some school health drop-ins. TYS are also delivering SRE and PSHE in the coastal area (in non-targeted schools) although some schools were initially reluctant to have C-Card registration as part of this. TYS reported that since the reduction in school nurse presence, “sometimes [we] feel like we’re on the front line and the only ones left pushing the messages around SRE and safe sex”.

“They’re not getting the information, they’re not getting it delivered in a way they’re going to take in. I think otherwise [if SRE is not delivered well] we are in danger of kids... well, where do they get their information from? I don’t know.”

It was reported that there is a longer-term aim of reinstating proactive school nurse input into schools, although there will be a time lag while any new recruits are trained.

Some practitioners felt the impact of less school nurse provision and less proactive SRE and support was already being felt:

“We’ve had a little peak in TP [Teenage Pregnancy], TP has gone up again. The FNP [Family Nurse Partnership Programme] has referred four under-16s.”

Future Plans for School Support and SRE: Although some services have been decommissioned, considerable efforts are being made to ensure that SRE and sexual health support are maintained in schools. The LA has recruited a Children and Young Person’s Health Promotion Specialist to work with schools, the TYS and school nurses. Some primary care respondents suggested that schools were quite receptive to doctors coming into schools to deliver SRE. However, some practitioners were concerned that the new team:
“...may not be able to engage with schools and to deliver the whole PSHE including SRE agenda that is age appropriate and suitable also for vulnerable groups.”

Nationally, the aim is for schools to work together to provide excellence and expertise and to share this among themselves, including SRE. However, locally, it was noted that this may be particularly difficult in a large county with patchy coverage of trained teachers.

In terms of the sexual health role of the school nurses, as mentioned above, the current situation was reported to be a temporary one:

“[We’re] hoping by September this year we will be able to offer the full school nurse service again where every secondary school has a drop-in and within that drop-in, the school nurse can offer on-site sexual health provision. We want to get the ‘You’re Welcome’ charter, and long term to work to PGDs to provide repeat pill and LARC.”

Respondents suggested that a more coordinated approach is required, with various partners delivering SRE and sexual health support to schools and promoting local sexual health services:

“It would be great if it was a bit more joined up [the promotion side], it could be a full-time role in itself... I think there’s definitely a market for it.”

9.10 The Wish List
The following section presents a ‘wish list’ of the priorities or aspirations of interviewees, irrespective of real constraints and funding limitations. Most practitioners did not think huge changes were needed, and their ‘wishes’ are quite humble and realistic.

“I wouldn’t do it terribly different to the way we’ve got it... [What we] need to ensure is that we have adequate funds for training and enough staff to cover.”

Broadly, wishes and aspirations fell into five areas:

- **More specialist sexual health staff**, be they nurses, nurse consultants or doctors
- **More outreach (clinical and educational) and work with schools**
  - Extending responsibility for some aspects of sexual health to non-specialist staff and primary care
- **Coordinated promotion and communication**
  - “People need to know if they’ve got a new all-singing, all-dancing service on their doorstep”
- **Greater attention to service evaluation** and evidence-based commissioning
  - Regular reviews of SHNA and simple data reviews
- **Standards and quality control** to ensure standards are maintained at a time when roles within sexual health and health promotion are open to a wider range of people.
10. SERVICE USER PATHWAYS AND TOUCHPOINTS

This section reviews service configuration, ‘touchpoints’ and entry points, including phone lines and communications websites. This informs the ‘local picture’ and identifies where service users may experience difficulties in gaining information and access to SRH services.

10.1 Web and Phone Entry Points

There are four websites containing information about sexual health and contraceptive services in East Sussex. These are;

- The main East Sussex sexual health website
- The East Sussex sexual health site
- The Circle Room(s)
- Connexions 360

Table 21 shows that the provision of online information on sexual health services is patchy, with no one website containing comprehensive information.

Table 21: Signposting of sexual health services from the four main East Sussex sexual health websites

<table>
<thead>
<tr>
<th>Service Provider</th>
<th>East Sussex Sexual Health website</th>
<th>East Sussex Under 25’s website and the Circle Room website</th>
<th>NHS Choices website*</th>
<th>Connexions 360 website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crowborough Clinic</td>
<td>●</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uckfield Community Hospital</td>
<td>●</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hailsham Health Centre</td>
<td>●</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Anchor Sexual Health Clinic</td>
<td>●</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bexhill Health Centre</td>
<td>●</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Station Plaza Health Centre</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
</tr>
<tr>
<td>Arthur Blackman Clinic</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Avenue House</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>Seafor Health Centre</td>
<td>●</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haven Lounge (The Joff)</td>
<td>•</td>
<td>●</td>
<td>●</td>
<td></td>
</tr>
<tr>
<td>The Circle Room (Crowborough)</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>The Circle Room (Lewes)</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td>●</td>
</tr>
<tr>
<td>NCDA Youth Drop-in</td>
<td>●</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Services were searched for by using the term ‘STI testing and treatment’ and the relevant town, using the NHS Choices website.
Key:
● Direct mention of this service on the website
● Indirect link to this service via a link to another website which referred to this service

In this section, each website will be reviewed in terms of aesthetics, usability, ease of navigation, content and accuracy.

10.1.1 The Main East Sussex Sexual Health Website
www.eastsussexsexualhealth.co.uk

Aesthetics: Clear, appropriate and accessible for those with some visual impairment.

Usability and Ease of Navigation: The website is clear, written in plain English and includes an easy-to-use side menu. Some of the menu items would fall more appropriately under different headings for more intuitive navigation (e.g. ‘Chlamydia Free’ should also be included in the ‘under-25s’ page). Maps, photographs and contact details are shown to reassure the user and to ensure that they clearly understand how to find the clinic and when to access them.

The detailed, interactive map showing the availability of C-Card, chlamydia screening and EHC points is a useful resource, clearly presented for the user. However, there is no instruction to ‘click on a town’ to access further information, so not all viewers may realise that the map is interactive.

Currently, this section is accessed through the ‘C-Card’ header, which may not be intuitive for those seeking EHC access points, or for those who want to access condoms, but are unaware of the C-Card scheme. Although under-25s are signposted to attend a drop-in clinic to obtain a C-Card (under the heading of ‘Contraception’), detailed information about the C-Card scheme is not included anywhere on the site.
The ‘Contraception’ section of the website includes a wealth of helpful information. It may be beneficial for the user, however, for the links to the FPA to be shown as interactive links on the ‘Contraception’ main page on the main East Sussex Sexual Health Website (with links set to open in a new tab or window). Currently, information on contraceptive methods is available from the side menu, which suggests to the user that they will be taken to a page within the existing site. This would ensure continuity of the language and usability of the site.

**Content and Accuracy:** Despite detailed information enabling users to find the clinics, the website does not include detailed information on the services provided at each clinic, which may be problematic for service users. Despite the presence of the Anchor Sexual Health Clinic in Peacehaven, a link to this site has not been included.

Although the Seaford Health Centre, which offers an under-20s drop-in only, features on the main website (suggesting that all young people’s services are included), other young people’s services such as the Circle Room services, the Newhaven Community Development Association (NCDA) Youth Drop-in in Newhaven and the Haven Lounge service at Peacehaven do not feature on this site.

The ‘help us improve’ feature shows the user that their views and opinions matter and has the potential to contribute to a continually improving and interactive service.

The site includes a host of useful information for the user, including a ‘What’s Normal?’ section. This is written in plain, non-threatening language and could be very useful to users of the service. Although it is important to put the reader at ease, some of the comments in this section could potentially reinforce existing prejudices/stigma as opposed to dispelling myths and putting undue concern to rest. For example:

"Oh my God! Look at those lumpy bits. I'm gonna die, I've got genital warts or maybe it's syphilis! Why did I take that risk? How can I possibly go to the clinic? My life is ruined."

This could be interpreted as implying that you *should not* worry about having an STI – i.e. your symptoms may be normal – which may not necessarily be the most appropriate message here.

“The female genital area can be a minefield of anxiety and surprises. There are lots of lumps and bumps and glands that can cause alarm, particularly if they are looked for with a sense of guilt!"

This comment could be followed by reassurance that there is no need to feel guilty.
10.1.2 The East Sussex Sexual Health Website for Those Aged Under 25

www.eastsussexsexualhealth.co.uk/ari.htm

Aesthetics, Usability and Navigation: The site appears engaging and refreshing, and comprises of five (mostly external) links to some helpful, informative and appropriate sites. However, the way in which the headings constantly move may prove frustrating or wearing to those of us without the fastest of reflexes! Headings assume a degree of prior knowledge (e.g. The Circle Room, C-Card, Connexions 360) and descriptors may not differentiate enough between the links for the user to navigate the site effectively.

Content and Accuracy: The site includes a useful interactive map designed for those who wish to access chlamydia screening, condoms through the C-Card scheme or EHC (for more information, I this map is referred to in the main site review above). This information would be more useful for new users if a brief overview were included of what a C-Card is, how it is used, eligibility criteria, and how one could be obtained. The interactive map is also featured under the heading and descriptor of ‘C-Card’, which may prevent other potential users (those who wish to access EHC, for example) from finding this resource.

The information contained in the tables under the interactive map does not specify whether EHC is available free of charge from pharmacies, which is likely to be of interest to young people. The column titles (although explained at the bottom of each table) could be more clearly labelled. Despite a link to the Circle Room website, this website does not include information about the Seaford Health Centre, the NCDA Youth Drop-in or the Haven Lounge, despite these services being within East Sussex and also targeted at young people. Similarly, it may also be useful for young people to be informed that they are able to attend any sexual health clinic they wish, perhaps with a link back to the clinic section of the main site.

The ‘Chlamydia Free’ link on the main East Sussex Sexual Health website, includes clear and straightforward information with regards to chlamydia and testing, in a range of ways to suit young people. It may be useful to move the ‘Chlamydia Free’ link, featured on the main website, to the under-25s website in order to consolidate key information for young people.
10.1.3 The Circle Room Website

www.thecircleroom.org

**Aesthetics, Usability and Navigation:** The Circle Room website is attractively and appropriately presented with a youthful theme. The menu is comprised of a series of longer, descriptive links at the bottom of the page which may be less convenient or clear than a menu bar.

**Content and Accuracy:** While both services are advertised on the website as open on Tuesdays from 15.30-18.00, information obtained from the receptionist at The Circle Room in Lewes suggested that the service opened half an hour later.

Although the wording is clear and easy to understand, the website does not include a detailed description of the range of services provided by the clinics, which may prove to be a source of frustration for users. The ‘I am 25 or over, where should I go?’ link, takes the user to a page where the site suggests that the individual either goes to their GP or visits Avenue House in Eastbourne rather than signposting to the main East Sussex Sexual Health website, limiting the user to one sexual health clinic, despite the wide number of services available.

On the page containing information on EC, there is a link to the NHS choices website which purports to list ‘pharmacies in Lewes’ and ‘pharmacies in Crowborough’ where EC is available. However, these links take the browser to a generic services search page on the NHS choices website. For young people unsure of what search terms to use, this may be a barrier to identifying pharmacies where EC is available.

Despite a young demographic, The Circle Room currently has no visible Facebook presence.
10.1.4 The Connexions 360 Website
http://www.connexions360.org.uk

Aesthetics, Usability and Navigation: The website is well presented, with a style that is young and upbeat, yet clear and professional. The navigation menu changes from a horizontal bar to a vertical menu bar once a menu item is selected, which may prove to be confusing for some users.

This holistic website contains a host of information with regard to the everyday lives of young people. To find information on sexual health, the user must select the ‘Health and Advice’ header, then the ‘Sex, Relationships and Pregnancy’ header. This header may prove confusing to users of the service who wish, for example, to access STI testing, as this is not explicitly referred to in the header.

Content and Accuracy: The site includes links to relevant media clips and uses images and design in a thoughtful way to engage young people. The link to the very popular Connexions 360 Facebook page on the website is testament to the positive perception and relevance of the site to young people.

The site includes an explanation of the C-Card concept and information and advice on how one can be obtained; however, the link for C-Card registration and pick-up points now takes the user to an out-of-date link which cannot be used to find this information.

The site includes a convenient mix of external links and concise information, resulting in a generally smooth user experience. The ‘STI header’ is separate from a ‘chlamydia’ heading, which could prove to be confusing or more difficult to navigate. The STI section also includes specific information about chlamydia only (but omits the text service), and only signposts web users to two Circle Room clinics and the Anchor Sexual Health Service, despite the availability of two services designed for young people (at the Seaford Clinic, the NCDA Youth Drop-in and the Haven Lounge at Peacehaven). The site does include a link to NHS Choices although it is incorrectly labelled, but no link is included for the main East Sussex Sexual Health website.
Access to information about EC is also difficult on this website: on the ‘I think I’m pregnant’ page (which is not necessarily a very helpful title, as you might not think you’re pregnant after having unprotected sex, but you still might want EC) there is a link: ‘You can search for your nearest sexual health clinic or pharmacy on the Sex Worth Talking About’ However this link takes the browser to a page where it is still not clear how to search for EC.

10.1.5 Other websites
In addition to the websites detailed above, the following websites were also found when a general term (sexual health East Sussex) was searched using Google, a popular internet search engine:

www.eastsussex.gov.uk/socialcare/healthadvice/sexualhealth/default.htm
This East Sussex County Council website signposts to websites such as NHS Choices and Connexions, but does not signpost to other local sexual health websites.

www.esh.nhs.uk/sexual-health/
This East Sussex NHS Trust webpage states ‘Sexual Health services are available in Eastbourne and Hastings’ and signposts to only the two main clinics in East Sussex: Avenue House Clinic, Eastbourne, and Station Plaza Health Centre, Hastings. Opening times shown for these clinics differ from the times indicated on the main East Sussex Sexual Health website. The link to the main East Sussex Sexual Health website, www.eastsussexsexualhealth.co.uk has been included, but is in a non-prominent place at the bottom of the page.

www.escis.org.uk/Entry/View/East_Sussex_Sexual_Health_NHS/36893
The East Sussex Community Information Service website signposts users to the main East Sussex Sexual Health website.

10.2 Phone ‘Touchpoints’
All receptionists on the day of calling were helpful, polite and friendly. Service times given for most clinics more or less matched the information provided on their websites, although receptionists at several services (the Arthur Blackman, Seaford Health Centre and the Crowborough Clinic) claimed to close slightly earlier than advertised. Two exceptions to this statement were the Anchor Sexual Health Clinic (whose website claims that the clinic is open 5 – 8pm, whilst the receptionist advised that the service was open from 4.40 – 6.20pm), and the Haven Lounge in Peacehaven, where the NHS Choices website advertised clinics on a Wednesday and a Friday evening, despite a youth worker stating that service ran on a Tuesday, Thursday and Friday.

Receptionists at Hastings and Avenue House both initially greet users in a way similar to “hello/ good morning/ afternoon sexual health, how can I help?” – this is clear and friendly but as these clinics have satellite services, may be helpful to remind callers where they are through to, to avoid enquiries for opening hours being answered inadvertently for the wrong clinic. It may also be advisable for receptionists to warn all potential service users of the Arthur Blackman Clinic that the service is for contraception only to avoid disappointment.
10.2.1 The ‘FREE 2 B ME’ App

The ‘FREE 2 B ME’ app is not available via iTunes, and also seems not to be compatible with the iPad 2. Similarly, the app is also not compatible with Android 4 devices, preventing or discouraging some potential users of the app. If FREE 2 B ME is searched for on Google play (a popular app search engine) from an Android device, the app is not found, an issue which may also deter potential users.

This is corroborated by engagement with young people, a minority of whom reported knowing about or using the app. These findings were also echoed in qualitative interviews with adults over 25 years of age, who said that they were unlikely to use an app to find a sexual health service (see Section 8.2.2 for young people and Section 8.3 and 8.4 for men and women aged over 25 years of age).
11. CONCLUSIONS AND RECOMMENDATIONS

In this section, recommended areas for action and discussion are highlighted, in response to identified gaps and needs.

Operational Recommendations: Services

- **Seaford**: consider piloting a re-launch of the service with earlier opening hours to catch the after-school slot (so 3.30pm). If possible, increase the service offer; carry out concerted promotion and a publicity campaign in local schools, GPs, with social media, etc. Work with local Targeted Youth Support (TYS) on this. Clarify the range of services available.
- Work towards **You’re Welcome** charter across young people’s services and universal services to raise young people’s confidence in service access. This should include all pharmacies dispensing either the C-card scheme or emergency contraception.
- Explore options for **increasing appointment slots (where needed)**, possibly starting with a few days/week.
- Consider wider use of routine, text-based reminders to SRH service users to further encourage ‘MOT’ sexual health screens (particularly among ‘higher-risk’ groups, e.g. MSM).
- Maintain support for young LGBT groups to target appropriate sexual health advice and information and encourage good life-long sexual health habits.
- Maintain support for one-to-one interventions to engage with MSM who have never tested for HIV.
- All SRH services to raise awareness of the availability of PEP to most-at-risk populations, including MSM.
- **Data**: work with clinical leads in adjoining NHS areas to further analyse HIV data on late diagnosis to understand contributory factors (including migration from other services).

Communications and Promotion

- **Coordinated Publicity and Promotion Campaign** (to include schools, website etc.) promoting all the sexual health services offered by all partners (including GPs and pharmacies dispensing EC/C-card scheme). This should include urgently updating relevant websites so that they contain comprehensive and consistent information on services available and link to each other.
- Ensure that young people are signposted towards high-quality services, and invest in mechanisms to maintain quality of care for young people.
- Raise awareness of PEP and rapid access available through East Sussex’s SRH services, in particular targeting populations that are at higher risk, such as MSM.

Management, Monitoring and Evaluation

- Build in **evaluation and continual service monitoring/research** into any service changes and in a cyclical way (i.e. half-yearly reviews etc.).
- Ensure that service use data can be **disaggregated** by spoke/hub clinic, e.g. monitoring flow of service users and their age/sex profile, repeat visitors, to highlight variation in demand and allow a rapid response.
- Ensure that services have the human resources available to be able rapidly to access, assimilate, and analyse service data (and share appropriately with wider partners).
- **Payment by results** – conduct a review of detailed service activity data (or a ‘shadowing’ exercise, if this is not possible) so as to recommend whether SRH services would benefit from a shift to tariff.

**Human Resources**

- **Increase specialist staff capacity** but ensure there is increase in doctor-level support – either through another staff doctor or through a partnership with neighbours to provide ‘virtual’ on-call support service for nurses
- Look at introducing training and **skills enhancement for Health Care Assistants (HCAs)** in delivering aspects of SRH services.

**Coordination and Partnership**

- Use the findings of this needs assessment to start a dialogue as to how ‘core services’ (SRH services, GPs and pharmacies) might coordinate service provision to provide joined-up services, and specifically to:
  - Ensure that all health settings promote ‘key’ messages around sexual health screening, local SRH services, and available resources in rural/remote areas (especially for young people)
  - Identify key stakeholders in each sector within East Sussex who can build capacities to meet local SRH needs: this SHNA has found that some GPs and pharmacies have consistently outperformed other health providers and are committed to providing good sexual health services
- Establish professional leads who can work on a ‘clinical champion’ model to encourage implementation of national guidance, and monitor performance and standards.
- Ensure new **health improvement team/role** builds upon previous good work and relationships and works in partnership and in a coordinated way. Ensure TYS and School nurses coordinate activities so they complement and support each other.
Annex I
Number of C-Card clients by pharmacy (of those pharmacies with at least one C-Card client), Q1-2 2012/13.

<table>
<thead>
<tr>
<th>Number of C-Card Clients (Q1-2 2012/13)</th>
<th>Name and Postcode of Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-10</td>
<td>Day Lewis Pharmacy (TN31 7JF)</td>
</tr>
<tr>
<td></td>
<td>Kamsons Pharmacy (BN10 7LX)</td>
</tr>
<tr>
<td></td>
<td>Procter Health Care Pharmacy (TN21 8LD)</td>
</tr>
<tr>
<td></td>
<td>The Pharmacy (TN5 7AA)</td>
</tr>
<tr>
<td></td>
<td>Asda Store Pharmacy (TN37 7AA)</td>
</tr>
<tr>
<td></td>
<td>Morrisons Pharmacy (TN34 1RN)</td>
</tr>
<tr>
<td></td>
<td>Your Local Boots Pharmacy (BN24 6ET)</td>
</tr>
<tr>
<td></td>
<td>Boots Uk Limited (TN37 6AJ)</td>
</tr>
<tr>
<td></td>
<td>Laycock Chemists (TN37 7LR)</td>
</tr>
<tr>
<td></td>
<td>Your Local Boots Pharmacy (BN21 4TX)</td>
</tr>
<tr>
<td></td>
<td>Your Local Boots Pharmacy (TN39 3PU)</td>
</tr>
<tr>
<td></td>
<td>Ge Newman Ltd (BN22 7QP)</td>
</tr>
<tr>
<td></td>
<td>West St Leonards Pharmacy (TN38 0AH)</td>
</tr>
<tr>
<td></td>
<td>Cavendish Place Pharmacy (BN21 3TZ) Day Lewis Porter Pharmacy (TN34 3SB)</td>
</tr>
<tr>
<td></td>
<td>Sainsbury's Instore Pharmacy (BN22 9PW)</td>
</tr>
<tr>
<td></td>
<td>Your Local Boots Pharmacy (BN22 7PG)</td>
</tr>
<tr>
<td></td>
<td>St Annes Pharmacy (BN7 1RP)</td>
</tr>
<tr>
<td></td>
<td>Day Lewis Hirst Pharmacy (TN34 2PS)</td>
</tr>
<tr>
<td></td>
<td>Day Lewis Pharmacy (TN33 0EN)</td>
</tr>
<tr>
<td></td>
<td>Seaforth Pharmacy (BN27 1BH)</td>
</tr>
<tr>
<td>10-30</td>
<td>Boots Uk Limited (TN31 7JF)</td>
</tr>
<tr>
<td></td>
<td>Blooms Pharmacy (TN37 6RE)</td>
</tr>
<tr>
<td></td>
<td>Paydens (Steyning) Ltd (TN5 6AP)</td>
</tr>
<tr>
<td></td>
<td>Test Pharmacy ( )</td>
</tr>
<tr>
<td></td>
<td>Day Lewis Pharmacy (BN25 1LL)</td>
</tr>
<tr>
<td></td>
<td>Lloyds Pharmacy (BN8 4LA)</td>
</tr>
<tr>
<td></td>
<td>David Skinner Pharmacy (BN21 3JU)</td>
</tr>
<tr>
<td></td>
<td>Lloyds Pharmacy (TN34 3EY)</td>
</tr>
<tr>
<td></td>
<td>Kamsons Pharmacy (BN24 5DZ)</td>
</tr>
<tr>
<td></td>
<td>Lloydspharmacy (BN26 5AB)</td>
</tr>
<tr>
<td></td>
<td>Laycock Chemist (TN35 5BL)</td>
</tr>
<tr>
<td></td>
<td>Lloydspharmacy (BN8 5QN)</td>
</tr>
<tr>
<td></td>
<td>Asda Pharmacy (BN23 6JH)</td>
</tr>
<tr>
<td></td>
<td>Lloyds Pharmacy (TN37 7DA)</td>
</tr>
<tr>
<td></td>
<td>Lloydspharmacy (BN22 9NG)</td>
</tr>
<tr>
<td></td>
<td>Ore Village Pharmacy (TN35 5BG)</td>
</tr>
<tr>
<td></td>
<td>J Andersen’s Pharmacy (TN35 5LT)</td>
</tr>
<tr>
<td></td>
<td>Selbys Of Uckfield (TN22 1AT)</td>
</tr>
<tr>
<td></td>
<td>Kamsons Pharmacy (BN21 1SD)</td>
</tr>
<tr>
<td></td>
<td>RJ Williamson Pharmacy (BN10 8LD)</td>
</tr>
<tr>
<td></td>
<td>Your Local Boots Pharmacy (BN21 1BJ)</td>
</tr>
<tr>
<td></td>
<td>Your Local Boots Pharmacy (TN33 0AE)</td>
</tr>
<tr>
<td>30-100</td>
<td>Kamsons Pharmacy (BN23 8ED)</td>
</tr>
<tr>
<td></td>
<td>Otters Pharmacy (BN20 8QJ)</td>
</tr>
<tr>
<td></td>
<td>Tesco Stores Limited (TN22 1BA)</td>
</tr>
<tr>
<td></td>
<td>Clarity Pharmacy (TN37 6DU)</td>
</tr>
<tr>
<td>Number of C-Card Clients (Q1-2 2012/13)</td>
<td>Name and Postcode of Pharmacy</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td>&gt;100</td>
<td>Kamsons Pharmacy (TN34 1NN) Trackside (TN40 1EB) Pharmacy@station Plaza (TN34 1BA)</td>
</tr>
</tbody>
</table>