Sexual Health Needs Assessment
Suffolk

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Executive Summary

Commissioning of sexual health services is the responsibility of Local Authorities. This health needs assessment has been undertaken in order to better understand the level of need and demand and to inform commissioning decisions and delivery of Suffolk sexual health services.

In general, sexual health in Suffolk is characterised by low prevalence rates for STIs and HIV and lower rates of teenage pregnancy in comparison to other parts of England. However, this broad picture hides significant areas of need within the population and challenges to service commissioners and providers. Key issues identified in the health needs assessment includes:

- Ipswich and Waveney have higher rates of sexually transmitted infections and of teenage pregnancy than other parts of the county; Ipswich is also higher than the national rate
- Suffolk has consistently fallen below the national target for chlamydia detection
- Suffolk has a downward trajectory for STI testing rates
- Suffolk has consistently not met the goal of less than 25% of new HIV infections classified as late diagnosis and in 2012-14 this has risen to 50.5%
- Suffolk is worse than the regional and national rate for HIV testing within GUM,
- There is an increasing trend in repeat abortions in those aged under 25 years compared to static picture for regional and national figures
- Among NHS funded abortions, the proportion of those under 10 weeks gestation was 75.7%, which is worse than the England proportion of 80.4%
- Patient flow and out of area activity as an indicator of service provision suggests improvements are required in the amount and type of services available in the county

The public and stakeholder consultation also raised some key issues:

- Uptake of services by marginalised and high risk groups
- Fragmented patient pathways
- Ability of current provision to meet need
- Workforce development across services and organisations
- Developing public knowledge and awareness about sexual health

Recommendations - Key Lines of Enquiry and Action

There were a number of emerging themes highlighting concerns and potential areas for improvement, namely:

Understanding need and demand

- Further investigation of how to better meet the needs of marginalised and at risk of disadvantage groups, particularly BME groups, transgender community and those with Learning Disabilities
- Better use of national and local data to develop a shared understanding of patterns/characteristics/needs of service users/Suffolk population and particular geographical areas
Deep dive exercise as to why Suffolk residents access out of area services

Accessibility
- Comprehensive, marketing of sexual health services that are available throughout the county from a variety of organisations – continuous messaging rather than campaigns
- Explore opportunities to deliver sexual health messages and services through other outlets to impact on accessibility and uptake for a range of different groups, including support to parents/carers, particularly GP practices
- Explore the potential for existing and new technology to increase methods of accessing sexual health information and services

Improving service provision
- Progress the integration and bringing together of sexual health services that is already underway
- Review service provision to ensure it meets local demand, reducing the impact of out of area activity
- Development of sexual health service provision within primary care, recognising their key role in prevention of unplanned pregnancies
- Review psychosexual counselling provision
- Increase uptake of STI testing, particularly for HIV and chlamydia
- Better use of data to target most in need and inform provision
- Involve service users in design of service response, including review of opening times, appointment system and methods of communicating with the sexual health services

Pathways and collaboration between services and organisations
- Integrate/coordinate commissioning arrangements across the health and social care system
- Develop robust sexual health pathways for seamless patient care across organisations and services
- Increase collaboration and joined up working between sexual health service and primary care
- Develop a Sexual Health Strategy Group and Network
- Ensure information, including web-based, about sexual health and relevant local services are consistent across organisations
- More joint working on cross cutting issues such as risky behaviours

Inequalities
- Apply the principles of proportionate universalism to ensure the needs of all residents are met (actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage)
- Develop robust, systematic, collaborative ways of working between practitioners, services and organisations working with more marginalised and higher risk groups
- Investigate potential for developing lay sexual health champions targeting particular groups
Ensure the principles of Your Welcome standards are embedded within provision

Workforce
- Use of Sexual Health Network to develop skills and cross over working for a county-wide sexual health workforce across organisations and services
- Develop on-line resource for public and professionals to promote evidence based practice

Public knowledge and awareness
- Proactively support schools to deliver high quality SRE
- Ensure strong local web presence with clear consistent messages shared across services and organisations
- Explore the use of technology in a variety of setting to promote sexual health messages and effect behaviour change
- Provide support to parents and carers so that they are well equipped to discuss sex and relationships with family members
- Develop community based initiatives to promote sexual health awareness and facilitate access to services

Stigma
- Develop local programme targeting the public and health and social practitioners to tackle ignorance and stigma related to HIV Educating staff around sexual health stigma
1. Introduction

From April 2013 Local Authorities were given the responsibility for the commissioning of sexual health services, ensuring that these services meet local population needs and reduce health inequalities. Part of this commissioning process involves a sexual health needs assessment (SHNA) which will inform the planning, commissioning and delivery of sexual health services across the county.

The aims of this SHNA are to inform commissioners and service providers to:

- Better meet need and demand
- Promote integration of planning, commissioning and delivery of services
- Identify barriers to access and opportunities for overcoming them
- Inform resource allocation
- Start a process of on-going engagement between stakeholders

Sexual health has been defined as

“...a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.” (WHO, 2006a)

This takes a holistic approach to sexual health incorporating positive aspects of personal relations as well as prevention of disease and unplanned pregnancy.

As well as improving population health outcomes, investment in sexual health services can deliver health and social care savings through the prevention of unplanned pregnancies and reducing the transmission of sexually transmitted infections (STIs), including HIV. Services designed to meet sexual health needs operate at 3 different levels (see appendix 1) in a variety of settings that cross a number of service pathways commissioned by different organisations. The commissioning and provision of sexual health services are informed by a number of key documents:

- **Making it work: A guide to whole system commissioning for sexual health, reproductive health and HIV** (Public Health England (PHE) commissioning framework published in 2014)
- **A Framework for Sexual Health Improvement in England**, published March 2013
- **Commissioning Sexual Health services and interventions: best practice guidance for local authorities**, published in 2013
- **Public Health Outcomes Framework**, with specific targets for sexual health:
  - Reducing under 18 conceptions
  - Increasing chlamydia testing and treatment in those aged 15-24 (target 2300 per 100,000 population, Chlamydia Testing Activity Data, 2012)
Reducing proportions of those presenting with HIV at late stage of infection (CD4 count <350/mm³ within 3 months of diagnosis)

The table below summarises the responsibilities of commissioning organisations to provide sexual health services.

Table 1: National & local policy context - commissioning arrangements – levels of service

<table>
<thead>
<tr>
<th>Local Authorities (LAs)</th>
<th>Clinical Commissioning Groups (CCGs)</th>
<th>The NHS England (NHSE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comprehensive sexual health services which include:</td>
<td>Abortion services</td>
<td>Contraception provided as an additional service under the GP contract</td>
</tr>
<tr>
<td>Contraception, including LESs (implants) and NESs (intra-uterine contraception) and all prescribing costs, but excluding contraception provided as an additional service under the GP contract;</td>
<td>Sterilisation</td>
<td>HIV treatment and care (including drug costs for post-exposure prophylaxis after sexual exposure)</td>
</tr>
<tr>
<td>Sexually transmitted infection (STI) testing and treatment, chlamydia screening as part of the National Chlamydia Screening Programme (NCSP) and HIV testing;</td>
<td>Vasectomy</td>
<td>Promotion of opportunistic testing and treatment for STIs, and patient-requested testing by GPs</td>
</tr>
<tr>
<td>Sexual health aspects of psychosexual counselling; and</td>
<td>Non-sexual health elements of psychosexual health services</td>
<td>Sexual health elements of prison health services</td>
</tr>
<tr>
<td>Any sexual health specialist services, including young people’s sexual health and teenage pregnancy services, outreach, HIV prevention and sexual health promotion, services in schools, colleges and pharmacies.</td>
<td>Gynaecology, including any use of contraception for non-contraceptive purposes.</td>
<td>Sexual Assault Referral Centres</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Cervical screening</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Specialist foetal medicine services</td>
</tr>
</tbody>
</table>

Local Authorities are required to provide open access sexual health services for everyone present in their area covering:

- free sexually transmitted infections (STI) testing and treatment
- notification of sexual partners of infected persons
- free contraception, and reasonable access to all methods of contraception
Open access services are essential to control infection, prevent outbreaks and reduce unwanted pregnancies and means that anyone who is in an area is entitled to use the sexual health services provided in that area regardless of residency and which GP they are registered with.
2. **Methodology**

Analysis of 4 sources of data and information was used to complete the SHNA:

- Epidemiological data that describes trends in sexual health by person, time and place
- Comparative data relating to regional and national trends
- Performance and activity data from Provider organisations
- Data and information gathered through stakeholder events, county wide questionnaires and focus groups with service users

The data and information gathered was used to examine 4 core elements (Department of Health 2007):

- Map need
- Map service provision
- Examine demand
- Assess the gaps

The SHNA examines the needs of the population of Suffolk and the provision of sexual health services within the integrated sexual health service and primary care. There are some specialist sexual health services that are outside the scope of the SHNA. These are:

- Sexual Assault Referral Centres (SARC)
- Vasectomy services
- Gynaecology, including any use of contraception for non-contraceptive purposes
- Contraception provided as part of the core service under the GP contract
- Promotion of opportunistic testing and treatment for STIs, and patient-requested testing by GPs
- HIV care and treatment
- Sexual health elements of prison health services
- Cervical screening
- Specialist foetal medicine
3. Suffolk Profile

3.1. Geography and Demography of Suffolk County

Suffolk is a rural county in eastern England. It has borders with the counties of Cambridgeshire, Essex and Norfolk and a coastline facing the North Sea. Main urban areas in Suffolk include the county town of Ipswich and the large towns of Bury St. Edmunds and Lowestoft. Elsewhere in Suffolk, the population is located in smaller towns and villages and in more isolated settlements in the countryside.

The main roads A14 and A12 cross the county, as does the main railway line from London to Cambridge and Norwich. The East Suffolk railway line runs from Ipswich to Felixstowe and Lowestoft. Felixstowe is the largest container port in the UK and there are also small ports at Ipswich and Lowestoft. The RAF and USAF have airbases in Suffolk but there is no commercial airport in the county.

A map of Suffolk County, including geographical features and boundaries of local authority districts, is shown below.

![Map of Suffolk County](image)

There are seven local authority districts in Suffolk County - Babergh, Forest Heath, Ipswich Borough, Mid Suffolk, St Edmundsbury, Suffolk Coastal and Waveney and a single police force covering the county.

There are three Clinical Commissioning Groups (CCGs) that cover Suffolk County: Ipswich and East Suffolk CCG, West Suffolk CCG, and Great Yarmouth and Waveney CCG.

There are 78 General Practices located in the county, of which 40 have PMS status and 38 GMS.
Population of Suffolk County

In 2014 the resident population of Suffolk County was 738,500. The population included 364,400 males (49.3% of total population) and 374,100 females (50.7% of total population).

Table 2: Population of Suffolk County 2014, numbers of residents by age and sex, numbers rounded to the nearest 100

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>0-12</th>
<th>13-18</th>
<th>19-24</th>
<th>25-34</th>
<th>35-44</th>
<th>45-54</th>
<th>5564</th>
<th>65-74</th>
<th>75+</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>55487</td>
<td>26354</td>
<td>24555</td>
<td>43829</td>
<td>43212</td>
<td>51592</td>
<td>44567</td>
<td>42586</td>
<td>32186</td>
<td>364368</td>
</tr>
<tr>
<td>Females</td>
<td>53243</td>
<td>24704</td>
<td>21616</td>
<td>41837</td>
<td>44238</td>
<td>52932</td>
<td>47517</td>
<td>45093</td>
<td>42964</td>
<td>374144</td>
</tr>
<tr>
<td>Persons</td>
<td>108730</td>
<td>51058</td>
<td>46171</td>
<td>85666</td>
<td>87450</td>
<td>104524</td>
<td>92084</td>
<td>87679</td>
<td>75150</td>
<td>738512</td>
</tr>
</tbody>
</table>

Source of data: Office for National Statistics, 2014 mid-year population estimates

Table 3: Population of Suffolk County 2014, % of all persons in age group

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>0-12</th>
<th>13-18</th>
<th>19-24</th>
<th>25-34</th>
<th>35-44</th>
<th>45-54</th>
<th>5564</th>
<th>65-74</th>
<th>75+</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>51.0%</td>
<td>51.6%</td>
<td>53.2%</td>
<td>51.2%</td>
<td>49.4%</td>
<td>49.4%</td>
<td>48.4%</td>
<td>48.6%</td>
<td>42.8%</td>
<td>49.3%</td>
</tr>
<tr>
<td>Females</td>
<td>49.0%</td>
<td>48.4%</td>
<td>46.8%</td>
<td>48.8%</td>
<td>50.6%</td>
<td>50.6%</td>
<td>51.6%</td>
<td>51.4%</td>
<td>57.2</td>
<td>50.7%</td>
</tr>
<tr>
<td>Persons</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source of data: Office for National Statistics, 2014 mid-year population estimates

Table 4: Population of Suffolk County 2014, % distribution by gender

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>0-12</th>
<th>13-18</th>
<th>19-24</th>
<th>25-34</th>
<th>35-44</th>
<th>45-54</th>
<th>5564</th>
<th>65-74</th>
<th>75+</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Males</td>
<td>15.2%</td>
<td>7.2%</td>
<td>6.7%</td>
<td>12.0%</td>
<td>11.9%</td>
<td>14.2%</td>
<td>12.2%</td>
<td>11.7%</td>
<td>8.8%</td>
<td>100%</td>
</tr>
<tr>
<td>Females</td>
<td>14.2%</td>
<td>6.6%</td>
<td>5.8%</td>
<td>11.2%</td>
<td>11.8%</td>
<td>14.1%</td>
<td>12.7%</td>
<td>12.1%</td>
<td>11.5%</td>
<td>100%</td>
</tr>
<tr>
<td>Persons</td>
<td>14.7%</td>
<td>6.9%</td>
<td>6.3%</td>
<td>11.6%</td>
<td>11.8%</td>
<td>14.2%</td>
<td>12.5%</td>
<td>11.9%</td>
<td>10.2%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Source of data: Office for National Statistics, 2014 mid-year population estimates

Distribution of population of Suffolk

This section provides a description of the distribution of the population of Suffolk by local authority district and in the large towns and rural area of the county.

The distribution of persons of all ages in Suffolk in 2014 by local authority district ranged from 8.5% in Forest Heath to 18.3% in Ipswich, as shown in the table below.
Table 5: Estimated resident population 2014, residents of all ages of local authority districts in Suffolk County, numbers rounded to the nearest 100

<table>
<thead>
<tr>
<th>Area</th>
<th>Males of all ages</th>
<th>Females of all ages</th>
<th>Persons of all ages</th>
<th>% distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babergh</td>
<td>43,300</td>
<td>45,600</td>
<td>88,800</td>
<td>12.0%</td>
</tr>
<tr>
<td>Forest Heath</td>
<td>31,700</td>
<td>31,100</td>
<td>62,800</td>
<td>8.5%</td>
</tr>
<tr>
<td>Ipswich</td>
<td>67,300</td>
<td>67,700</td>
<td>135,000</td>
<td>18.3%</td>
</tr>
<tr>
<td>Mid Suffolk</td>
<td>49,000</td>
<td>50,100</td>
<td>99,100</td>
<td>13.4%</td>
</tr>
<tr>
<td>St. Edmundsbury</td>
<td>56,200</td>
<td>55,900</td>
<td>112,100</td>
<td>15.2%</td>
</tr>
<tr>
<td>Suffolk Coastal</td>
<td>60,800</td>
<td>64,000</td>
<td>124,800</td>
<td>16.9%</td>
</tr>
<tr>
<td>Waveney</td>
<td>56,100</td>
<td>59,800</td>
<td>115,900</td>
<td>15.7%</td>
</tr>
<tr>
<td>Suffolk County</td>
<td>364,400</td>
<td>374,100</td>
<td>738,500</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

Source of data: Office for National Statistics, 2014 mid-year population estimates

Figure 1: Ethnic population composition of Suffolk County Districts

Source of data: 2011 Census Table KS201EW
3.2. Deprivation

The map below shows the distribution of estimated Index of Multiple Deprivation 2015 scores for LSOAs in Suffolk County.

Areas of most deprivation are concentrated in Ipswich, Lowestoft and some of the smaller towns in the county, including Bury St. Edmunds, Felixstowe, Haverhill and Sudbury. In addition, some of the rural areas in the east of the county where access to services is poor are also affected by relatively high levels of deprivation.

Figure 2: Multiple Deprivation 2015 scores for LSOAs in Suffolk County

Source of data: Map of estimated index of Multiple Deprivation in LSOAs in Suffolk 2015
Source: Indices of Deprivation 2015
4. Need

Sexual Health in Suffolk

In general, sexual health in Suffolk is characterised by low prevalence rates for STIs and HIV and lower rates of teenage pregnancy in comparison to other parts of England. However, this broad picture hides significant areas of need within the population.

Table 6: Overview of sexual health indicators by district

<table>
<thead>
<tr>
<th>District</th>
<th>Rank out of 326 LAs - new STIs*- 1 the being highest</th>
<th>Rate of new STIS /100,000 residents</th>
<th>% of pop. aged 15-24 years with new STIs**</th>
<th>Rate of LARC prescribing /1,000 women – Primary Care</th>
<th>Under 18 conception rate /1,000 females aged 15-17 years (2013 data)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babergh</td>
<td>252</td>
<td>378.3</td>
<td>52</td>
<td>39.2</td>
<td>15.4</td>
</tr>
<tr>
<td>Forest Heath</td>
<td>265</td>
<td>411.0</td>
<td>41</td>
<td>41.7</td>
<td>19.9</td>
</tr>
<tr>
<td>Ipswich</td>
<td>63</td>
<td>849.3</td>
<td>45</td>
<td>42.3</td>
<td>29.4</td>
</tr>
<tr>
<td>Mid Suffolk</td>
<td>296</td>
<td>351.1</td>
<td>44</td>
<td>30.4</td>
<td>16.3</td>
</tr>
<tr>
<td>St Edmundsbury</td>
<td>264</td>
<td>425.8</td>
<td>46</td>
<td>25.1</td>
<td>19.1</td>
</tr>
<tr>
<td>Suffolk Coastal</td>
<td>293</td>
<td>321.5</td>
<td>48</td>
<td>24.1</td>
<td>12.8</td>
</tr>
<tr>
<td>Waveney</td>
<td>172</td>
<td>535.5</td>
<td>43</td>
<td>34.8</td>
<td>23.3</td>
</tr>
<tr>
<td>Suffolk</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>19.6</td>
</tr>
<tr>
<td>East of England</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>35.9</td>
<td>-</td>
</tr>
<tr>
<td>England</td>
<td>-</td>
<td>797.2</td>
<td>46</td>
<td>32.3</td>
<td>24.3</td>
</tr>
</tbody>
</table>

Source of data: LASER Report 2014.
2014 data unless otherwise specified
*excluding chlamydia in 15-24 year olds
**GUM only

Public Health Outcomes Framework

Reducing Teenage Pregnancy - as shown in figure 3, rates of teenage pregnancy in Suffolk have been decreasing in line with the national trend.

Figure 3: Rate of conceptions per 1,000 females aged 15-17

Source of data: Sexual and Reproductive Health Profiles, Public Health England
Increasing chlamydia testing and treatment in those aged 15-24 (target 2300 per 100,000 population) – figure 4 shows that Suffolk has consistently fallen below the national rate.

Figure 4: Rate of chlamydia detection per 100,000 young people aged 15-24

![Chlamydia detection rate per 100,000 young people aged 15-24](image)

**Source of data:** Sexual and Reproductive Health Profiles, Public Health England

Reducing proportions of those presenting with HIV at late stage of infection (CD4 count <350 mm$^3$ within 3 months of diagnosis) – Suffolk has been consistently above the goal of less than 25% of new HIV infections classified as late diagnosis and in 2012-14 this has risen to 50.5%.

Figure 5: Percentage of adults (aged 15 or above) newly diagnosed with HIV with a CD4 count less than 350 cells per mm$^3$

![HIV late diagnosis percentage](image)

**Source of data:** Sexual and Reproductive Health Profiles, Public Health England
4.1. Unintended Pregnancy

Unintended pregnancy can have adverse social and health consequences. The young teenage mother is more likely to present to services late and has a greater chance of pre-term labour and a low birth weight baby both of which give the child and increased risk of hospital admission during the first 5 years of life. For women of all ages it has been shown that having 3 children under the age of 5 gives a higher risk for depressive illness and therefore women should be able to make informed decisions about if and when they wish to become pregnant.

Figure 6: Live births per 1000 women 15-64 – by LA comparison to England

Sources of data: live births: ONS VS1 tables; population estimates: ONS mid-year estimates based on 2011 Census

The percentage of pregnancies ending in legal termination for 2013 in Suffolk (15.4%) was lower than regional and national figures (18.6% and 21.2% respectively) and slightly lower than 2012 percentage (16.6%). This was mirrored in the picture for females aged under 18 years, at 44.0% for Suffolk and 51.2% and 51.1% regionally and nationally as shown in figure 6). However the under 18 conception rate is decreasing, up to 45% led to abortion in 2012 compared with 35.5% in 1998 which is similar to the regional and national average.
When broken down to age, abortion rates for Suffolk females in 2013 declined for all age groups except those aged 25-29 years which returned to the 2011 rate of 17/1000. The abortion rates for those aged 35+ years remained static over the last 3 years at 5/1000. Abortion rates were highest in the 20-24 age group (22/1000) followed by females aged 25-
29 years (17/1000). There was a significant decline of abortion rates for Suffolk females aged 18-19 years old, from 21/1000 in 2012 to 16/1000 in 2013. Legal abortions are performed by medical or surgical methods. In 2013 medical abortions accounted for 43% of all abortions in women of all ages in Ipswich and East Suffolk CCG, 63% in West Suffolk CCG and 63% in Great Yarmouth and Waveney CCG. In England as a whole in 2013 medical abortions accounted for 48% of all abortions in women of all ages.

The total abortion rate, access to NHS funded abortions at less than 10 weeks gestation, and under and over 25 years repeat abortion rates are indicators of lack of access to good quality contraception services and advice, as well as problems with individual use of contraceptive method.

In 2014, in Suffolk upper tier local authority (UTLA):

- The total number of abortions in 2014 was 1,489. The percentage change from 2013 was 3.12%.
- The total abortion rate per 1,000 female population aged 15-44 years was 11.8, while in England the rate was 16.5. The rank (out of 146* UTLA) within England for the total abortion rate was 136 (1st has the highest rate).
- Among women under 25 years who had an abortion in that year, the proportion of those who had had a previous abortion was 21.5%, while in England the proportion was 27.0%. Over time this figure for Suffolk has been slowly increasing as the number was 19.4% in 2012 and 20% in 2013 (see figure 9). The rank (out of 146* UTLA) within England for the repeat abortion proportion in women under 25 years was 131 (1st has the highest rate).
- Among women aged 25 and over who had an abortion in that year, the proportion of those who had had a previous abortion was 36.9%, while in England the proportion was 45.6%. The rank (out of 146* UTLA) within England for the repeat abortion proportion in women aged 25 years and over was 142 (1st has the highest rate).
- Among NHS funded abortions, the proportion of those under 10 weeks gestation was 75.7%, while in England the proportion was 80.4% (see figure 10). The earlier abortions are performed the lower the risk of complications. Prompt access to abortion, enabling provision earlier in pregnancy, is also cost-effective and an indicator of service quality and increases choices around procedure.

(*Due to small cell size data for some of the 152 UTLAs is not included).
Figure 9: % of under 25 years repeat abortions

Source of data: Sexual and Reproductive Health Profiles, Public Health England

Figure 10: % of NHS-funded abortions under 10 weeks

Source of data: Sexual and Reproductive Health Profiles, Public Health England
4.2. Teenage Conceptions

Both the regional and national rates for under 18 year olds have declined relatively sharply since 2007; the fall in Suffolk had been less dramatic up to 2012. However in 2013 under 18 conception rates sharply fell to stand at 19.6 per 1000 females aged 15-17 years.

Figure 11: Teenage conception rate for females aged 15-17 in Suffolk 1998-2013

<table>
<thead>
<tr>
<th>Year</th>
<th>Suffolk County</th>
<th>East of England</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998</td>
<td>37.5</td>
<td>37.9</td>
<td>46.6</td>
</tr>
<tr>
<td>1999</td>
<td>35.8</td>
<td>36.4</td>
<td>44.8</td>
</tr>
<tr>
<td>2000</td>
<td>30.6</td>
<td>35.1</td>
<td>43.6</td>
</tr>
<tr>
<td>2001</td>
<td>29.3</td>
<td>34.2</td>
<td>42.5</td>
</tr>
<tr>
<td>2002</td>
<td>33.0</td>
<td>34.6</td>
<td>42.8</td>
</tr>
<tr>
<td>2003</td>
<td>32.0</td>
<td>33.1</td>
<td>42.1</td>
</tr>
<tr>
<td>2004</td>
<td>32.5</td>
<td>32.4</td>
<td>41.6</td>
</tr>
<tr>
<td>2005</td>
<td>30.6</td>
<td>33.1</td>
<td>41.4</td>
</tr>
<tr>
<td>2006</td>
<td>29.9</td>
<td>33.4</td>
<td>40.6</td>
</tr>
<tr>
<td>2007</td>
<td>31.0</td>
<td>33.1</td>
<td>41.4</td>
</tr>
<tr>
<td>2008</td>
<td>30.2</td>
<td>33.0</td>
<td>39.7</td>
</tr>
<tr>
<td>2009</td>
<td>28.2</td>
<td>30.7</td>
<td>37.1</td>
</tr>
<tr>
<td>2010</td>
<td>26.1</td>
<td>29.1</td>
<td>34.2</td>
</tr>
<tr>
<td>2011</td>
<td>26.0</td>
<td>26.6</td>
<td>30.7</td>
</tr>
<tr>
<td>2012</td>
<td>24.8</td>
<td>23.2</td>
<td>27.7</td>
</tr>
<tr>
<td>2013</td>
<td>19.6</td>
<td>21.0</td>
<td>24.3</td>
</tr>
</tbody>
</table>

Source of data: Office for National Statistics, Conception Statistics

The 2013 under 18 conception rate of 19.6 for Suffolk County was below the regional and national rate (of 21.0 per 1000 and 24.3 per 1000 respectively). In 2012, Suffolk County was higher than the regional average (24.8 per 1000 compared to 23.2 per 1000), although below the national rate (27.7 per 1000).

In 2013 there were 252 conceptions in girls under the age of 18 in Suffolk and 111 terminations of pregnancy. Rates of conception and termination are decreasing both locally and nationally and between 1998 and 2013 the under 18 conception rate in Suffolk decreased by 47.7%.

All Suffolk districts have seen a drop in the under 18 conception rate between 1998 and 2013. The highest teenage conception rates are still within Ipswich and Waveney (29.4 per 1000 and 23.3 per 1000 respectively), and there is a correlation between deprivation and high rates within Suffolk. However these areas have seen their rates halve since 1998 (a 51.3% drop in Ipswich and a 45.7% drop in Waveney). The lowest teenage conception rates for under 18 year olds in Suffolk County are reported by Suffolk Coastal (12.8 per 1000) and Babergh (15.4 per 1000) districts.
Figure 12: Teenage conception rate per 1000 females aged under 18 in Suffolk districts, 1998-2013

Source of data: Office for National Statistics, Conception Statistics

At ward level, 10 wards had rates significantly above the England average rate and 4 wards are in Waveney district and 4 in Ipswich Borough.

Table 7: Teenage conception rate (TCR): conceptions among girls aged under 18 years per 1000 girls aged 15-17 years, 2010-11 (ward), 2012 (England)

<table>
<thead>
<tr>
<th>Ward Name</th>
<th>District</th>
<th>Number of conceptions</th>
<th>TCR</th>
<th>Lower limit</th>
<th>Upper limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Saints</td>
<td>Forest Heath</td>
<td>10</td>
<td>93.5</td>
<td>44.8</td>
<td>171.9</td>
</tr>
<tr>
<td>Harbour</td>
<td>Waveney</td>
<td>40</td>
<td>88.1</td>
<td>62.9</td>
<td>120</td>
</tr>
<tr>
<td>Bridge</td>
<td>Ipswich</td>
<td>31</td>
<td>74.5</td>
<td>50.6</td>
<td>105.8</td>
</tr>
<tr>
<td>Abbeygate</td>
<td>St Edmundsbury</td>
<td>12</td>
<td>69.4</td>
<td>35.8</td>
<td>121.2</td>
</tr>
<tr>
<td>Whitton</td>
<td>Waveney</td>
<td>26</td>
<td>65.3</td>
<td>42.7</td>
<td>95.7</td>
</tr>
<tr>
<td>Beccles North</td>
<td>Waveney</td>
<td>12</td>
<td>63.2</td>
<td>32.6</td>
<td>110.3</td>
</tr>
<tr>
<td>Normanston</td>
<td>Waveney</td>
<td>21</td>
<td>58.5</td>
<td>36.2</td>
<td>89.4</td>
</tr>
<tr>
<td>Priory Heath</td>
<td>Ipswich</td>
<td>32</td>
<td>55.1</td>
<td>37.7</td>
<td>77.8</td>
</tr>
<tr>
<td>Gipping</td>
<td>Ipswich</td>
<td>26</td>
<td>53.5</td>
<td>34.9</td>
<td>78.4</td>
</tr>
<tr>
<td>Westgate</td>
<td>Ipswich</td>
<td>27</td>
<td>52</td>
<td>34.3</td>
<td>75.7</td>
</tr>
<tr>
<td>England</td>
<td>-</td>
<td>87,875</td>
<td>30.9</td>
<td>30.7</td>
<td>31.1</td>
</tr>
</tbody>
</table>

Source of data: Office for National Statistics, Conception Statistics

Three in every five under 18 conceptions (60.0%) ended in abortion in Suffolk Coastal, followed by St Edmundsbury where 47.2% of conceptions ended in abortion. The lowest percentage of abortions was reported in Waveney (31.9%), and figures for both Forest Heath and Mid Suffolk have been suppressed due to the low numbers involved.
Figure 13: Teenage conception rates by ward

Teenage conception rates
Conceptions among girls aged under 18 years per 1000 girls aged 15-17 years
Residents of wards in Suffolk County
Pooled data for 2010-12
In 2013, Suffolk’s under 18 abortion rate was 8.6 per 1000 females aged 15-17 years, compared to 13.3 per 1000 in 1998. All districts in Suffolk (where data was published) recorded a decrease in the abortion rate between 1998 and 2013, with Ipswich having the highest rate in 2013 (of 12.9 per 1000) and Babergh the lowest (6.2 per 1000).

**Figure 14: Under 18 abortion rate at district level in Suffolk in 1998 and 2013**

![Graph showing abortion rates at district level in Suffolk in 1998 and 2013](image)

**Source of data:** Office for National Statistics, Conception Statistics

Between 2008-10 and 2011-13, the number of abortions to females aged 13-15 years in Suffolk remained unchanged at 109. At district level during this period, under 16 abortion numbers increased in Ipswich (from 22 to 30) and in Mid Suffolk (from 10-15), although numbers for some other districts were suppressed in one or both time periods.

**4.3. Sexually Transmitted Infections**

A reduction in the level of sexually transmitted infections (STIs) was seen in England though the 1960’s until the 1990’s when a year on year increase was observed. The past few years have seen a small reduction overall although increases are still seen for infections such as gonorrhoea and chlamydia. The national screening programme for chlamydia has influenced the recorded infection rates for this infection.

In Suffolk, the total number of new cases of all acute STIs diagnosed reduced by 13.2% between 2013 and 2014 (from 4,120 in 2013 to 3,577 in 2014). Between 2012 and 2013 the number of new cases fell from 4,157 to 4,120, a decrease of 0.9%. The rate of all acute STI’s was lower in Suffolk compared to the national rate, as shown in figure 9 below.

---

1 Under 16 abortions are shown in numbers for ease of reference.
Figure 15: Rate of all acute STIs (including chlamydia) per 100,000 population in Suffolk & England

Source of data: Public Health England, Genito-urinary medicine clinic activity dataset (GUMCAD)

Figure 10 shows the distribution of diagnosis of selected STIs by age and comparison with estimated general population for the catchment areas. The proportion of STIs was highest in the under 25 years old followed by the 25-44 years age group in all three GUM units providing services in Suffolk (Ipswich Hospital, West Suffolk Hospital and James Paget University Hospital in Great Yarmouth). The distribution of STI’s in this age group was twice their age distribution in the general population. Nationally the highest rates of STI’s were also found in this age group.

The age and gender distribution of selected STIs (table 9) shows that the proportion of STIs was highest in the under 25 years age group both among males and females in all three GUM units followed by the 25-44 years age group. However it is interesting to note that females had a higher proportion of STIs in the under 25 years, whereas males had a higher proportion of STIs in the 25-44 years and over 45 years age group.

Notes: [1] previously both Suffolk and England data were residence based, but data for England is now service based and therefore the figures for England are slightly higher than in the previous version of this chart; [2] Data before 2012 is not comparable with data from 2012 onwards because of different sources used and because of differences in age groups (only 15-24 n 2009-2011, all ages from 2012 onwards).
Figure 16: Distribution of diagnosis of selected STIs by age and comparison with estimated general population for the catchment areas, persons of all ages 2011-13

Table 8: Diagnoses of selected sexually transmitted infections in GUM clinics in Suffolk - distribution by age and gender, 2011-13

<table>
<thead>
<tr>
<th></th>
<th>Males</th>
<th>Females</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ipswich Hospital NHS Trust</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;25 years</td>
<td>48.1%</td>
<td>63.9%</td>
</tr>
<tr>
<td>25-44</td>
<td>43.0%</td>
<td>29.6%</td>
</tr>
<tr>
<td>45+</td>
<td>8.9%</td>
<td>6.5%</td>
</tr>
<tr>
<td><strong>West Suffolk Hospital NHS Trust</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;25</td>
<td>50.8%</td>
<td>60.1%</td>
</tr>
<tr>
<td>25-44</td>
<td>40.2%</td>
<td>32.4%</td>
</tr>
<tr>
<td>45+</td>
<td>9.1%</td>
<td>7.5%</td>
</tr>
<tr>
<td><strong>James Paget University Hospital</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;25</td>
<td>46.7%</td>
<td>63.0%</td>
</tr>
<tr>
<td>25-44</td>
<td>42.4%</td>
<td>29.4%</td>
</tr>
<tr>
<td>45+</td>
<td>10.9%</td>
<td>7.6%</td>
</tr>
</tbody>
</table>

Source of data: Public Health England, Genito-urinary medicine clinic activity dataset (GUMCAD)

The proportion of Black or Black British ethnic group with STIs was higher than their proportion in the estimated general population. The proportion of Asian or Asian British with STIs however was lower when compared to their proportion in the estimated general population.
Table 9: Distribution of the selected STIs at each GUM unit based on ethnicity and comparison of ethnicity distribution in the estimated general population for IHT, WSH and JPUH catchment area, 2011-13

<table>
<thead>
<tr>
<th></th>
<th>IHT</th>
<th>WSH</th>
<th>JPH</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% STIs</td>
<td>% general population</td>
<td>% STIs</td>
</tr>
<tr>
<td>White</td>
<td>88.0%</td>
<td>94.0%</td>
<td>95.9%</td>
</tr>
<tr>
<td>Black or Black British</td>
<td>4.3%</td>
<td>1.1%</td>
<td>0.9%</td>
</tr>
<tr>
<td>Asian or Asian British</td>
<td>0.7%</td>
<td>2.4%</td>
<td>0.3%</td>
</tr>
<tr>
<td>Mixed</td>
<td>5.2%</td>
<td>2.1%</td>
<td>1.8%</td>
</tr>
<tr>
<td>Other ethnic groups</td>
<td>0.2%</td>
<td>0.4%</td>
<td>0.8%</td>
</tr>
<tr>
<td>Not specified</td>
<td>1.6%</td>
<td>0.0%</td>
<td>0.3%</td>
</tr>
</tbody>
</table>

Source of data: Public Health England, Genito-urinary medicine clinic activity dataset (GUMCAD)

When investigating geographical STI distribution of STIs in Suffolk, the local picture appears to mirror what has been found nationally, higher rates of STIs were found in more urban areas. Suffolk had a relatively lower rate of 486.1 per 100,000 population for all STIs (including chlamydia) compared to the rate of England at 797.2 per 100,000 population for the year 2014. However within Suffolk, Ipswich local authority had a higher rate of 849.3 per 100,000 population. Ipswich had high rates for each of the acute STIs compared to the rest of the county. Waveney had higher rates (535.5 per 100,000) than that of Suffolk County but was lower than the national and regional rates.

Figure 17: Rate of all acute STIs (including chlamydia) per 100,000 population for Local Authority districts of Suffolk 2014

Source of data: Public Health England, Genito-urinary medicine clinic activity dataset (GUMCAD)
Chlamydia

As seen nationally, in Suffolk, chlamydia was the most commonly diagnosed STIs, followed by genital warts, genital herpes, and gonorrhea.

The rate of chlamydia has increased over the past 5 years, but chlamydia is often a silent infection and therefore the rates of diagnosis have increased following the implementation of the chlamydia screening programme. Suffolk follows the national picture of chlamydia infection as most common in those aged under 24 years, although this could be attributable to the fact that the national screening programme targets only this age group.

Figure 18: Rate of chlamydia per 100,000 population, Suffolk County, Midlands and East PHER and England 2014

![Graph showing rates of chlamydia per 100,000 population for Suffolk County, Midlands & East PHER, and England, 2014.]

Source of data: Public Health England, Genito-urinary medicine clinic activity dataset (GUMCAD)

In 2009 Suffolk County had a chlamydia diagnosis rate of 2,153 per 100,000 population among 15-24 year olds, a slightly higher rate compared to the England rate of 2,087. In 2014, the diagnosis rate in Suffolk was down to 1299.6, much lower than the rate for England at 2,012. It is important to note that the 2014 chlamydia data cannot be compared with the past years as the data collection method changed considerably in 2012.

In Suffolk in 2014 20.0% of 15-24 year olds were tested compared to 24.3% in England. However there was significant variation in the percentage of population screened within Suffolk, 32.6% of the total number of people screened were screened in the Ipswich Local Authority (LA) area with other LA areas accounting for between 6.1% (Forest Heath) and 14.7% (Waveney) of the total county population screened. Although it is the highest area for screening, there has been a decrease in the number of screens in 2014 for Ipswich. The
equivalent figures for Ipswich in 2012 and 2013 were higher – 49.9% and 44.2% respectively. The percentage of the screened population testing positive was 8.3% for England compared to 6.5% for Suffolk as a whole.

**Gonorrhoea**

As stated previously, new diagnoses of gonorrhoea in Suffolk increased in line with the national picture. The number of new diagnoses of gonorrhoea climbed from 58 cases in 2009 to 102 cases in 2014, an increase in rate from 8.1 per 100,000 population in 2009 to 13.9 per 100,000 population in 2014. These diagnosis rates for gonorrhoea were however significantly lower than the rate for England (63.3 per 100,000).

**Figure 19: Rate of gonorrhoea per 100,000 population Suffolk County and England 2009-2014**

![Rate of gonorrhoea per 100,000 population Suffolk County and England 2009-2014](chart)

Source of data: Public Health England, Genito-urinary medicine clinic activity dataset (GUMCAD)

The rate of gonorrhoea per 100,000 population by Local Authority districts showed considerable variation among the LA districts in Suffolk. In 2014 Forest Heath had the highest rate of gonorrhoea closely followed by Ipswich. Forest Heath had a rate of 14.2 per 100,000 in 2013 which increased to 23.7 per 100,000 in 2014.
Figure 20: Rate of gonorrhoea per 100,000 population in local authority districts of Suffolk 2009-14

Source of data: Public Health England, Genito-urinary medicine clinic activity dataset (GUMCAD)

Genital Herpes

Figure 21: Rate of genital herpes per 100,000 population, Suffolk County and England 2009-2014

Source of data: Public Health England, Genito-urinary medicine clinic activity dataset (GUMCAD)
The rate of genital herpes also showed a gradual increase from 2009 to 2013, although it fell slightly in 2014. In 2012 a decrease of the genital herpes rate to 43.8 per 100,000 was observed. However the rate increased to 53.3 per 100,000 in 2013, the highest recorded rate since 2009. In 2014 the rate was 50.0 per 100,000.

Between 2009-11 and 2012-14 the genital herpes diagnosis rate increased in all districts as shown in figure 16, except for Waveney. Waveney observed a decrease from 61.6 per 100,000 in 2009-11 to 46.0 per 100,000 in 2012-14. Ipswich has the highest diagnosis rate in 2012-14 of 81.5 per 100,000.

**Figure 22: Local Authority Districts Diagnosis rate of Genital Herpes 2009-2014**

<table>
<thead>
<tr>
<th>Local Authority Districts</th>
<th>2009-11</th>
<th>2012-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babergh</td>
<td>39.2</td>
<td>44.6</td>
</tr>
<tr>
<td>Forest Heath</td>
<td>28.3</td>
<td>39.5</td>
</tr>
<tr>
<td>Ipswich</td>
<td>60.0</td>
<td>81.5</td>
</tr>
<tr>
<td>Mid Suffolk</td>
<td>37.8</td>
<td>39.2</td>
</tr>
<tr>
<td>St Edmundsbury</td>
<td>37.3</td>
<td>46.1</td>
</tr>
<tr>
<td>Suffolk Coastal</td>
<td>30.1</td>
<td>35.1</td>
</tr>
<tr>
<td>Waveney</td>
<td>61.6</td>
<td>46.0</td>
</tr>
<tr>
<td>Suffolk County Coastal</td>
<td>43.9</td>
<td>49.0</td>
</tr>
</tbody>
</table>

**Source of data:** Public Health England, Genito-urinary medicine clinic activity dataset (GUMCAD)

**Syphilis**

There has been a decrease in the rates of syphilis diagnosis in Suffolk; the diagnosis rate over the period 2012-14 was 1.5 per 100,000 compared to 1.9 per 100,000 in 2009-11.

Although the number of people diagnosed in Suffolk increased by 8 between 2012 and 2014, the annual rate of diagnosis is still below the national rate, which in 2014 was 7.8 per 100,000 for England and 2.0 per 100,000 in Suffolk.
The local authority districts with the highest syphilis diagnosis rate are Ipswich followed by St. Edmundsbury and Waveney. This picture remains the same for the periods 2009/11 and 2012/13 as seen in figure 17. Data from some of the districts have been restricted because numbers were too low.

Testing Rates

As STIs are often asymptomatic, frequent testing of risk groups is important. Early detection and treatment can reduce important long-term consequences, such as infertility and ectopic pregnancy. Testing rates and diagnoses rates are closely linked. The diagnosis rate measures how many chlamydia infections are found in a population. The diagnosis rate reflects both the coverage of tests and the percentage infected amongst those tested (positivity). The STI testing rate refers to the number of tests rather than number of episodes or individuals. An individual may have had between 0 and 4 tests.

Figure 24 shows a drop in the number of tests for sexually transmitted infections (excluding chlamydia) from 9,670/100,000 in 2013 to 9,400/100,000 in 2014. This equates to 43,829 tests in 2013 and 42,605 tests in 2014. The regional and national rates in 2014 were 11,934/100,000 and 15,366/100,000 respectively. Suffolk has the lowest value in the region.
In 2014 the proportion of the population aged 15-24 years screened for chlamydia declined to 20% from the 2012 figure of 21.8%. Chlamydia test coverage data represent the number of tests reported, and not the number of people tested and these figures equate to a drop from 18,205 tests in 2012 to 16,568 test in 2014.

**Figure 25**: Proportion of population aged 15 to 24 screened for chlamydia, measured separately in GUM and non-GUM settings
HIV

Suffolk is described as a low prevalence area for HIV at 0.9 per 1,000 population aged 15-59 years (PHE 2013).

Figure 26: Prevalence of diagnosed HIV infection in Suffolk per 1,000 among persons aged 15 to 59 years

![Graph showing prevalence of diagnosed HIV in Suffolk and England from 2010 to 2013.]

Source of data: Public Health England, Survey of prevalent HIV infections diagnosed (SOPHID) 2012

However the prevalence in some of the Local Authority areas in Suffolk was higher than the Suffolk average. The prevalence for Ipswich was 1.29 per 1000 population followed by Waveney at 0.85 per 100,000 population.

Table 10: Diagnosed HIV prevalence in Local Authorities in England by PHE Centre 2013

<table>
<thead>
<tr>
<th>Local Authority</th>
<th>Residents accessing HIV related care* (aged 15-59)</th>
<th>Estimated resident population in 1,000s** (aged 15-59)</th>
<th>Diagnosed HIV prevalence per 1,000 (aged 15-59)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Babergh</td>
<td>34</td>
<td>46.6</td>
<td>0.73</td>
</tr>
<tr>
<td>Forest Heath</td>
<td>41</td>
<td>35.9</td>
<td>1.14</td>
</tr>
<tr>
<td>Ipswich</td>
<td>113</td>
<td>81.9</td>
<td>1.38</td>
</tr>
<tr>
<td>Mid Suffolk</td>
<td>40</td>
<td>53.2</td>
<td>0.75</td>
</tr>
<tr>
<td>St Edmundsbury</td>
<td>54</td>
<td>63.2</td>
<td>0.85</td>
</tr>
<tr>
<td>Suffolk Coastal</td>
<td>33</td>
<td>64.2</td>
<td>0.51</td>
</tr>
<tr>
<td>Waveney</td>
<td>58</td>
<td>60.2</td>
<td>0.96</td>
</tr>
<tr>
<td>Suffolk County</td>
<td>373</td>
<td>405.2</td>
<td>0.92</td>
</tr>
</tbody>
</table>

* SOPHID - Survey of prevalent HIV infections diagnosed 2012, Public Health England
** Office for National Statistics (ONS) mid-2013 population estimate

The number of new diagnoses of HIV by gender showed that the numbers were higher in males compared to females.
Table 11: Number of new HIV diagnoses by gender for Suffolk, 2002 to 2013

<table>
<thead>
<tr>
<th></th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>35</td>
<td>25</td>
<td>26</td>
<td>17</td>
<td>23</td>
<td>14</td>
<td>27</td>
<td>36</td>
<td>25</td>
</tr>
<tr>
<td>Males</td>
<td>22</td>
<td>15</td>
<td>15</td>
<td>8</td>
<td>12</td>
<td>&lt;20</td>
<td>17</td>
<td>31</td>
<td>19</td>
</tr>
<tr>
<td>Females</td>
<td>13</td>
<td>10</td>
<td>11</td>
<td>9</td>
<td>11</td>
<td>&lt;5</td>
<td>10</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

Source of data: HIV and AIDS new diagnoses database (HANDD)

The distribution of new diagnoses of HIV according to age group showed that the trend varied over the years from 2005–2013. Initially the 25-34 years age group had the highest number of cases followed by the 35-44 years age group. However in 2012, the highest number of cases was seen in the over 45 years age group.

Table 12: New HIV diagnosis in Suffolk by age group from January 2002 to December 2013

<table>
<thead>
<tr>
<th></th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
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<tbody>
<tr>
<td>&lt;25</td>
<td>&lt;5</td>
<td>&lt;10</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>6</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>&lt;5</td>
</tr>
<tr>
<td>25-34</td>
<td>12</td>
<td>9</td>
<td>&lt;10</td>
<td>6</td>
<td>12</td>
<td>5</td>
<td>7</td>
<td>&lt;10</td>
<td>14</td>
</tr>
<tr>
<td>35-44</td>
<td>12</td>
<td>7</td>
<td>8</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>5</td>
<td>9</td>
<td>&lt;5</td>
</tr>
<tr>
<td>45+</td>
<td>&lt;10</td>
<td>&lt;5</td>
<td>12</td>
<td>6</td>
<td>8</td>
<td>&lt;5</td>
<td>9</td>
<td>16</td>
<td>6</td>
</tr>
</tbody>
</table>

Source of data: HIV and AIDS new diagnoses database (HANDD)

The distribution of HIV prevalent cases in Suffolk, by ethnic group, showed that black Africans had the highest prevalence of diagnosed HIV. They were 15 times more likely to have HIV when compared to black Caribbean’s and about 150 times more likely than the local white population. The age and gender distribution of new HIV diagnoses among the black population (African / Caribbean / Other) in Suffolk showed that the numbers were higher in females than in males by approximately 2:1 and the 25-34 year olds made up the largest number of newly diagnosed cases.

Table 13: New HIV diagnosis in Suffolk by ethnicity from 2002 to 2013

<table>
<thead>
<tr>
<th></th>
<th>2005</th>
<th>2006</th>
<th>2007</th>
<th>2008</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black African</td>
<td>15</td>
<td>7</td>
<td>9</td>
<td>5</td>
<td>12</td>
<td>&lt;5</td>
<td>8</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>All other</td>
<td>20</td>
<td>17</td>
<td>17</td>
<td>12</td>
<td>11</td>
<td>&lt;20</td>
<td>18</td>
<td>28</td>
<td>16</td>
</tr>
</tbody>
</table>

Source: HIV and AIDS new diagnoses database (HANDD)

**HIV Late Diagnosis**

Late diagnosis is the most important predictor of morbidity and one-year mortality among people with HIV infection (defined as having a CD4 count below 350 cells/mm³ within 3 months of diagnosis). Monitoring late HIV diagnosis is essential to evaluate and promote public health and prevention efforts to tackle the impact of HIV infection in Suffolk. It is also an indicator of the success of HIV testing. The consequences of late diagnosis are: early death as those diagnosed late have a ten-fold increased risk of death within 1 year of HIV
diagnosis compared to those diagnosed promptly; increased morbidity and increased risk of onward transmission.

For the period 2011-13, in Suffolk 44.2% of adults newly diagnosed with HIV had a CD4 count less than 350 cells/mm$^3$ compared to national figure of 45% and 51.5% of the East of England. However, audit data from Suffolk sexual health clinics in east and west Suffolk (2014/15) shows that of the 27 new HIV diagnosis, 16 patients fitted the criteria of late diagnosis. This equates to 59.2% of newly diagnosed patients.

**HIV Testing**

2014 data shows a figure of 73.3% uptake of HIV testing measured in GUM which is worse than the regional and national rate (79.3% and 77.5% respectively).

**Figure 27:** % of uptake of HIV testing measured in GUM*

*Source of data: Sexual and Reproductive Health Profiles, Public Health England*

*% of first time service users (of clinical based services) offered and accepting an HIV test (excluding those already diagnosed HIV positive)*

For men who have sex with men (MSM) at 94.7% it is similar to East of England and England (94.8% and 94.5%).
Figure 28: % uptake of HIV testing among men who have sex with men (MSM) measured in GUM

Source of data: Sexual and Reproductive Health Profiles, Public Health England

However for both men (77.3%) and women (69.8%) in Suffolk it is significantly worse than East of England & England (men 82.3% and 84.8%; women 76.6% and 71.5%). Suffolk has the lowest testing rate for women in the region.

Figure 29: % uptake of HIV testing among women measured in GUM

Source of data: Sexual and Reproductive Health Profiles, Public Health England
Figure 30: % uptake of HIV testing among men measured in GUM

Source of data: Sexual and Reproductive Health Profiles, Public Health England
5. Services and Demand

5.1. Sexual Health Services in Suffolk

From April 2013, Local Authorities have been responsible for commissioning levels 1, 2 and 3 sexual health services (see appendix 1). This includes open access sexual health services for everyone present in their area, covering free STI testing and treatment, notification of sexual partners of infected persons, free contraception and reasonable access to all methods of contraception. However, some elements of care are commissioned by Clinical Commissioning Groups (termination of pregnancy) and NHS England, (level 1 sexual health services in GP practices including oral contraception and emergency contraception, and HIV care and treatment.) Collaboration is therefore needed between commissioners and providers in order to provide seamless patient centred care that aims to improve the health of individuals and the wider population across these service pathways.

Previously to April 2013, all sexual health services were commissioned by Primary Care Trusts (PCTs) for residents within PCT boundaries; NHS Suffolk was responsible for service provision in East and West Suffolk and NHS Norfolk and Waveney covered the population of Waveney. Until recently service contracts reflected these historical commissioning arrangements.

Figure 31: Hub and spoke sexual health clinics in Suffolk

Until recently Suffolk County Council commissioned three specialist service providers to deliver sexual health services across Suffolk: Cambridgeshire Community Services (CCS)
providing an integrated sexual health service incorporating levels 1, 2 and 3 (complex specialist services) across the East and West of Suffolk; East Coast Community Healthcare (ECCH) providing level 1 and 2 in Waveney; James Paget University Hospital (JPUH) providing level 3 for Waveney residents. This also included HIV care and treatment in those services offering level 3 although, as previously stated, following the healthcare reforms, NHS England now have responsibility for the commissioning of HIV care and treatment.

From 1st May 2015, commissioning arrangements have changed following a retender of the service and Cambridgeshire Community Services are now responsible for the provision of an integrated sexual health service across the whole of the county. Suffolk County Council also commission more specialist contraception and chlamydia screening from General Practices and some pharmacies.

The model for an integrated sexual health service for Suffolk is based on a hub and spoke approach, with some work required by the new Provider to bring existing services into line with the new specification.

**East Suffolk**

This part of the county has already moved to the hub and spoke model. There is a consultant led integrated sexual health clinic (hub) in Ipswich at the Orwell Clinic (clinics were previously based at Ipswich Hospital and Trotman Court until May 2014) which provides both GUM (including HIV care and treatment) and contraception and sexual health services (CASH). There are also a number of spokes in the east of county consisting of services available in the Ipswich town centre (4YP in Lower Brook Street, Suffolk New College, and Terence Higgins Trust (THT) in Arcade Street) and also clinics in Felixstowe and Stowmarket.

**West Suffolk**

The west of the county is currently in a transition stage as arrangements for a central hub in the centre of Bury St Edmunds are finalised. Currently there is a consultant led service operating from Blomfield House Health Clinic in the town centre. Reproductive health spokes are provided in Haverhill, Sudbury, Mildenhall and Newmarket. Currently there are no GUM spokes in the west of the county.

**Waveney**

Currently in Waveney, sexual health service levels 1-3 of GUM including HIV treatment and care, is provided at the consultant led Bure clinic based at James Paget University Hospital (JPUH) in Great Yarmouth. The Bure clinic serves the population of both Great Yarmouth and Waveney. In Lowestoft, Level 1 GUM service is available at the Regent’s Road clinic. Level 1, 2 and 3 CaSH services (not including sonography) are also available at Regent’s Road. The Provider aims to develop an integrated sexual health service hub in Lowestoft within the next year.
### Table 14: Reproductive Health Clinics in Suffolk

<table>
<thead>
<tr>
<th>Place</th>
<th>Location</th>
<th>Opening Times</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Suffolk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bury St Edmunds</td>
<td>Bloomfield House</td>
<td>Mon: 12pm-2pm</td>
<td>Walk in &amp; appointments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Wed: 12pm-2pm</td>
<td>Walk in &amp; appointments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Wed: 5pm-7pm</td>
<td>Walk in &amp; appointments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fri: 9.30am-12.30pm</td>
<td>Walk in &amp; appointments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sat: 10am-12pm</td>
<td>Walk in only</td>
</tr>
<tr>
<td>Haverhill</td>
<td>Health Clinic</td>
<td>Mon: 6.15pm-8.15pm</td>
<td>Walk in &amp; appointments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Thurs: 6.15pm-8.15pm</td>
<td>Walk in &amp; appointments</td>
</tr>
<tr>
<td>Mildenhall</td>
<td>Health Clinic</td>
<td>Tues: 1pm-2.30pm</td>
<td>Walk-in only</td>
</tr>
<tr>
<td>Newmarket</td>
<td>Newmarket Hospital</td>
<td>Mon: 3.30pm-5.30pm</td>
<td>Walk-in only</td>
</tr>
<tr>
<td>Sudbury</td>
<td>Meadow Lane Surgery</td>
<td>Thurs: 6.30pm-8.30pm</td>
<td>Walk in &amp; appointments</td>
</tr>
<tr>
<td>East Suffolk</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ipswich</td>
<td>Orwell Clinic</td>
<td>Mon: 9.30am-5pm</td>
<td>Walk in &amp; appointments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tues: 1pm-7.30pm</td>
<td>Walk in &amp; appointments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Wed: 8am-5pm</td>
<td>Appointments only</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Wed: 1pm-5pm</td>
<td>Walk in &amp; appointments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Thurs: 9.30am-5pm</td>
<td>Walk in &amp; appointments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fri: 9.30am-3pm</td>
<td>Walk in &amp; appointments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sat: 9.30am-12.30pm</td>
<td>Appointments only</td>
</tr>
<tr>
<td>Felixstowe</td>
<td>Community Hospital</td>
<td>Mon: 9am-11am</td>
<td>Walk in &amp; appointments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Wed: 6pm-8pm</td>
<td>Walk in &amp; appointments</td>
</tr>
<tr>
<td>Ipswich, (young people under 25)</td>
<td>4YP</td>
<td>Wed: 9.30am-12.10pm</td>
<td>Appointments only</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Thurs: 4.30pm-7.30pm</td>
<td>Walk-in</td>
</tr>
<tr>
<td>Stowmarket</td>
<td>Stow Health</td>
<td>Mon: 5pm-7pm</td>
<td>Walk in &amp; appointments</td>
</tr>
<tr>
<td>Waveney</td>
<td>Regent Road</td>
<td>Mon: 9.30am-12pm</td>
<td>Walk in only</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Mon: 1pm-5pm</td>
<td>Appointments only</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tues: 11.30am-2.30pm</td>
<td>Appointments only</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tues: 3.30pm-7pm</td>
<td>Walk in only</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Wed: 9.30am-12pm</td>
<td>Appointments only</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Wed: 1pm-5pm</td>
<td>Walk in only</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Thurs: 10am-2.30pm</td>
<td>Walk in only</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Thurs: 3.30pm-7pm</td>
<td>Appointments only</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sat: 10.30am-2pm</td>
<td>Walk in only</td>
</tr>
</tbody>
</table>

### Table 15: Sexual Health (GUM) Clinics in Suffolk

<table>
<thead>
<tr>
<th>Place</th>
<th>Location</th>
<th>Opening Times</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Suffolk</td>
<td>Bloomfield House</td>
<td>Mon: 12pm-2pm</td>
<td>Walk in &amp; appointments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Wed: 12pm-2pm</td>
<td>Walk in &amp; appointments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Wed: 5pm-7pm</td>
<td>Walk in &amp; appointments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fri: 9.30am-12.30pm</td>
<td>Walk in &amp; appointments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Sat: 10am-12pm</td>
<td>Walk in only</td>
</tr>
<tr>
<td>East Suffolk</td>
<td>Orwell Clinic</td>
<td>Mon: 9.30am-5pm</td>
<td>Walk in &amp; appointments</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tues: 1pm-7.30pm</td>
<td>Walk in &amp; appointments</td>
</tr>
</tbody>
</table>

43
Sexual Health Promotion, Sexual Health Outreach and Chlamydia Screening

The Provider has a sub-contractual arrangement with the Terence Higgins Trust (THT) to provide level 1 outreach sexual health services targeting both young people and at risk of disadvantage adults including the chlamydia screening programme.

THT provide sexual health promotion in a range of settings such as youth clubs and schools and deliver community-based activities and sessions to targeted groups such as MSM, sex workers, BME, homeless, marginalised adults.

The sub-contracted service administers the C-card scheme (condom provision) aimed at young people and provides training and capacity building for professionals and organisations.

THT also run drop-in rapid HIV testing clinics once a week from their town centre base in Ipswich and from Regent Road in Lowestoft.

Psycho-Sexual Health

For the east of the county psycho-sexual therapy (PST) service (including counselling) is provided at the Orwell Clinic, in the West at the Bloomfield house and at the James Paget Hospital for the Waveney area. The service is by referral only either by a GP, the Sexual Health Service or another health professional. A psychosexual psychotherapy service for patients with secondary mental health issues and a psychotherapy service for patients with gender dysphoria are provided Suffolk wide by Norfolk Suffolk Foundation Trust.

5.2. Sexual Health Services in Primary Care

GP Practices

GP Practices are commissioned by NHS England and as part of their core contract are charged to supply:
- Advice about and prescription of the full range of contraceptive methods (excluding the fitting and implanting of intrauterine devices and implants)
- Advice about emergency contraception and where appropriate, the supplying or prescribing of emergency hormonal contraception or, where the GP has a conscientious objection to emergency contraception, prompt referral to another provider of primary medical services who does not have such conscientious objections
- Provision of advice and referral in cases of unplanned or unwanted pregnancy or where the GP has a conscientious objection to the termination of pregnancy, prompt referral to another provider of primary medical services who does not have such conscientious objections
- Advice about sexual health promotion and sexually transmitted infections
- Referral as necessary for specialist sexual health services, including tests for sexually transmitted infections

Within Suffolk, GP Practices offer level 1 sexual health services and some practices offer a more comprehensive service including long acting reversible contraception (LARC) and other level 2 services. Figures 20 and 21 map the location of GP practices by GMS and PMS status and their associated branches in Suffolk County.

Of the 64 GP Practices in east and west Suffolk, 39 are contracted under the Personal Medical Services (PMS) contract and 25 under the General Medical Services (GMS) contract. In Suffolk, unusually the PMS contract includes the provision of LARC and chlamydia screening as part of its core offer. For those GP Practices on GMS contracts there is a contractual arrangement with Suffolk County Council similar to the NHS Locally Enhanced Service (LES) for the provision of fitting, monitoring, and removal of LARC and chlamydia screening. In 2014/15, all but one of the GMS Practices in East and West Suffolk provided this enhanced service.

In Waveney, all GP Practices offer level 1 sexual health service and most practices offer a more comprehensive service including LARC and other level two services. In 2014/15, of the 14 GP practices in Waveney, all but one had a contractual arrangement with the Local Authority for the provision of chlamydia screening for 15-24 year olds, fitting and management of LARC and removal of contraceptive implants.

**Pharmacies**

Pharmacies offer the opportunity to improve access to sexual health services and have a particular value in more rural areas such as Suffolk. There are 149 pharmacies in Suffolk, of which in 2014/15, 112 pharmacies offered emergency hormone contraception (EHC), chlamydia screening service and sexual health advice and information through a contractual arrangement with Suffolk County Council.
Figure 32: Main General Practices in Suffolk County (June 2015)

Main surgeries in Suffolk County as at July 2015

GMS surgery
PMS surgery
Suffolk County boundary

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Figure 33: Branch General Practices in Suffolk County (June 2015)
5.3. Demand for Sexual Health Services

Demand relates to those people who are willing to use services. The data presented below describes the usage of Suffolk sexual health services which may not reflect where there is demand but no or insufficient supply. Due to the open access nature of sexual health services, not all service users of Suffolk sexual health services will be residents of the county.

There are a number of different data sources to inform our understanding of demand for sexual health services. This health needs assessment has focused on data from:

- Genitourinary Medicine Clinic Activity Dataset
- Health and Social Care Information Centre
- Provider activity data – iCaSH Suffolk and East Coast Community Healthcare

Genitourinary Medicine Clinic Activity Dataset (GUMCAD)

GUMCAD is the mandatory STI surveillance system for all GUM clinics in England. The dataset includes information on all STI diagnoses made and services provided alongside demographic characteristics for every patient attendance at a clinic. The data is non-patient identifiable.

The information detailed in table 16 shows the number of patients and total attendances recorded on GUMCAD at the three GUM clinics in Suffolk in 2014-15.

<table>
<thead>
<tr>
<th>Location</th>
<th>Number of Patients</th>
<th>New Attendances</th>
<th>Follow-up Attendances</th>
<th>Total Attendances</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orwell Clinic Ipswich Hospital</td>
<td>5,903 1,773</td>
<td>6,473 1,704</td>
<td>2,753 464</td>
<td>9,226 2,168</td>
</tr>
<tr>
<td>West Suffolk Hospital</td>
<td>3,760 3,584</td>
<td>4,085 3,714</td>
<td>1,862 2,024</td>
<td>5,947 5,738</td>
</tr>
<tr>
<td>James Paget Hospital*</td>
<td>1,234 1,032</td>
<td>1,478 1,271</td>
<td>680 579</td>
<td>2,158 1,850</td>
</tr>
<tr>
<td>Total</td>
<td>10,897 13,323</td>
<td>12,036 14,793</td>
<td>5,295 5,880</td>
<td>17,331 20,673</td>
</tr>
</tbody>
</table>

Source of data: GUMCAD

* data for Suffolk residents only. Data for Orwell Clinic and West Suffolk Hospital includes all patients regardless of residency, reflecting the open access element to the service.

There were 20,673 attendances by 13,323 patients recorded at Suffolk GUM services in 2014-15 with the highest activity in Ipswich.
**Sexual and Reproductive Health Services – Health and Social Care Information Centre (HSCIC)**

Data from the HSCIC covers activity taking place in the community at dedicated sexual and reproductive health (SRH) services, including activity at non NHS service providers where available.

SRH services include family planning services, community contraception clinics, integrated GUM and SRH services and young people’s services e.g. Brook advisory centres. They provide a range of services including, but not exclusively, contraception provision and advice, sexual health treatment and advice, pregnancy related care, abortion related care, cervical screening, psychosexual therapy, PMS treatment, colposcopy services, fertility treatment and care and gynaecological treatment and care.

The data excludes services provided in out-patient clinics, at community pharmacies and those provided by General Practitioners, unless otherwise stated.

Nationally 8% of the resident population of women between the ages of 13 and 54 had at least one contact with an SRH service in 2014. In Suffolk this figure was lower at 4% (see figure 17). Suffolk did follow the national trend whereby women aged 18 to 19 were most likely to use a SRH service, having at least one contact. However the Suffolk figure at 12% is lower than the national at 21%.

Over the last ten years, the proportion using LARC has been increasing and the proportion using user dependent methods has been decreasing. However, oral contraceptives (a user dependent method) are still the most common form of contraception item in use, being the main method for 45% women nationally and 46% in Suffolk (see figure 18).

**Provider Activity Data – iCaSH Suffolk**

The sexual health services Provider collates a range of activity data on a quarterly basis. Activity data for 2014-15 is summarised below. Please note that the data will look different to the GUMCAD and HSCIC data as it incorporates GUM, contraceptive and integrated services provided by their organisation only. In 2014-15 iCaSH Suffolk covered the areas of east and west Suffolk only.

**Table 17: Attendance at iCaSH Suffolk Health Services, hubs and spokes**

<table>
<thead>
<tr>
<th></th>
<th>Ipswich</th>
<th>West Suffolk</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>First</td>
<td>8,666</td>
<td>7,475</td>
<td>10,925</td>
</tr>
<tr>
<td>Follow up</td>
<td>4,129</td>
<td>3,655</td>
<td>5,009</td>
</tr>
<tr>
<td>Total</td>
<td>12,795</td>
<td>11,130</td>
<td>15,934</td>
</tr>
</tbody>
</table>

*Source of data: iCaSH Suffolk*
### Table 18: Persons using sexual and reproductive health services by Local Authority of patient residence and age group 2014-15

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>Total ages</th>
<th>u16</th>
<th>16-17</th>
<th>18-19</th>
<th>20-24</th>
<th>25-34</th>
<th>35-44</th>
<th>45+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women using Suffolk services (number in thousands)</td>
<td>7.5</td>
<td>0.2</td>
<td>0.7</td>
<td>0.9</td>
<td>2.0</td>
<td>2.1</td>
<td>1.0</td>
<td>0.6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>Total 13-54</th>
<th>13-15</th>
<th>16-17</th>
<th>18-19</th>
<th>20-24</th>
<th>25-34</th>
<th>35-44</th>
<th>45-54</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women using Suffolk services (% of resident population)</td>
<td>4</td>
<td>2</td>
<td>8</td>
<td>12</td>
<td>11</td>
<td>5</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

*Source of data: Health and Social Care Information Centre*

### Table 19: Women using sexual and reproductive health services by Local Authority of patient residence and main method of contraception 2014-15

<table>
<thead>
<tr>
<th>LARC</th>
<th>Percent with main method</th>
<th>User Dependent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total women in Suffolk with a main method in use (number in thousands)</td>
<td>Total</td>
<td>IU device</td>
</tr>
<tr>
<td>7.0</td>
<td>42</td>
<td>5</td>
</tr>
</tbody>
</table>

*Source of data: Health and Social Care Information Centre*

*Includes caps, diaphragm, spermicides (buy only when used on their own), natural family planning and vaginal ring*
In 2014-15 the total number of attendances recorded at iCaSH Suffolk services was 25,446 which included consultations for both GUM and reproductive health, a significant increase to previous years. However, this increase could reflect changes in reporting methods introduced in this period. The impact of reduced capacity at the Ipswich service may explain the drop in activity in 2013-14. For all years, the highest activity was in Ipswich.

Activity data for the Suffolk spokes shows a clear demand for sexual health services that are accessible outside of the three main urban areas of Ipswich, Bury St Edmunds and Lowestoft, although levels of attendance in 2014-15 have decreased in some areas.

Table 20: Spoke activity in Suffolk

<table>
<thead>
<tr>
<th>Location</th>
<th>2013-14</th>
<th>2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mildenhall</td>
<td>179</td>
<td>209</td>
</tr>
<tr>
<td>Sudbury</td>
<td>474</td>
<td>397</td>
</tr>
<tr>
<td>Newmarket</td>
<td>149</td>
<td>105</td>
</tr>
<tr>
<td>4YP, Ipswich</td>
<td>286</td>
<td>236</td>
</tr>
<tr>
<td>Bodywise, Ipswich</td>
<td>124</td>
<td>51</td>
</tr>
<tr>
<td>Felixstowe RH</td>
<td>776</td>
<td>468</td>
</tr>
<tr>
<td>Felixstowe GUM</td>
<td>83</td>
<td>62</td>
</tr>
<tr>
<td>Haverhill</td>
<td>1145</td>
<td>1104</td>
</tr>
<tr>
<td>Stowmarket</td>
<td>428</td>
<td>353</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>3644</strong></td>
<td><strong>2985</strong></td>
</tr>
</tbody>
</table>

Source of data: iCaSH Suffolk

In 2014-15 the total number of attendances for LARC fitting was 4,622, 50.8% of the total activity for contraception with a steady increase in IUS fitting in the period 2012-15. For contraceptive pills, in 2014-15, this figure was 49.2% for 4477 prescriptions, a steady decrease since 2012.

Table 21: Contraceptive activity at iCaSH Suffolk

<table>
<thead>
<tr>
<th>Contraception Activity</th>
<th>2012-13</th>
<th>2013-14</th>
<th>2014-15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of IUD's fitted</td>
<td>432</td>
<td>510</td>
<td>488</td>
</tr>
<tr>
<td>Number of IUD's removed</td>
<td>-</td>
<td>-</td>
<td>76</td>
</tr>
<tr>
<td>Number of IUS fitted</td>
<td>898</td>
<td>1010</td>
<td>1266</td>
</tr>
<tr>
<td>Number of IUS removed</td>
<td>-</td>
<td>-</td>
<td>144</td>
</tr>
<tr>
<td>Number of contraceptive injections administered</td>
<td>1390</td>
<td>1218</td>
<td>1270</td>
</tr>
<tr>
<td>Number of hormonal contraceptive implants fitted</td>
<td>1922</td>
<td>1764</td>
<td>1598</td>
</tr>
<tr>
<td>Number of hormonal contraceptive implants removed</td>
<td>-</td>
<td>-</td>
<td>428</td>
</tr>
<tr>
<td>Number of contraceptive pills prescribed (COC)</td>
<td>6734</td>
<td>5409</td>
<td>4477</td>
</tr>
<tr>
<td>Number of clients receiving Emergency Contraception (oral)</td>
<td>-</td>
<td>-</td>
<td>619</td>
</tr>
<tr>
<td>Number of clients receiving Emergency Contraception (device)</td>
<td>-</td>
<td>-</td>
<td>53</td>
</tr>
<tr>
<td>Number of referrals to abortion services</td>
<td>-</td>
<td>-</td>
<td>115</td>
</tr>
</tbody>
</table>

Source of data: iCaSH Suffolk
In 2014-15 recorded activity data shows a drop in attendances for psychosexual services at 895 compared to the 2013-14 figure of 1,135.

**Table 22: Psychosexual activity at iCaSH Suffolk 2014-15**

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>First</td>
<td>160</td>
<td>86</td>
<td>291</td>
<td>269</td>
<td>246</td>
</tr>
<tr>
<td>Follow up</td>
<td>482</td>
<td>167</td>
<td>1,007</td>
<td>866</td>
<td>649</td>
</tr>
<tr>
<td>Total</td>
<td>642</td>
<td>253</td>
<td>1,298</td>
<td>1,135</td>
<td>895</td>
</tr>
</tbody>
</table>

*Source of data: iCaSH Suffolk*

**Provider Activity Data –East Coast Community Healthcare (ECCH)**

ECCH as the Provider for Level 1 GUM and Level 1, 2 and 3 reproductive health services in Waveney recorded basic attendance data.

**Table 23: Attendance at ECHC CaSH, Waveney**

<table>
<thead>
<tr>
<th>Year</th>
<th>Attendances</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013-14</td>
<td>6919</td>
</tr>
<tr>
<td>2014-15</td>
<td>6150</td>
</tr>
</tbody>
</table>

*Source of data: ECHC*

**Primary Care**

NICE guideline advise that LARC methods, such as contraceptive injections, implants, the intra-uterine system (IUS) or the intrauterine device (IUD), are highly effective as they do not rely on daily compliance and are more cost effective than condoms and the pill. A strategic priority is to ensure access to the full range of contraception is available to all. An increase in the provision of LARC is a proxy measure for wider access to the range of possible contraceptive methods and should also lead to a reduction in rates of unintended pregnancy.

In 2014 the Suffolk rate of GP prescribed LARC was 64.8/1,000, higher than the regional and national rates of 60.9/1,000 and 55.2/1,000 respectively.

In 2014/15 GP Practices contracted with the Local Authority undertook 2,436 activities relating to LARC and 479 chlamydia screens.

For 2014/15 pharmacists undertook 201 chlamydia screens, 32 consultations for chlamydia treatments (Waveney only) and 626 consultations for Emergency Hormone Contraception (EHC).
Out of Area Service Activity

Out of Area activity refers to the principle of open access sexual health services for the benefit of all persons present in the area regardless of residency, which GP practice a person is registered with or other factors such as that they are an overseas national or are just visiting the local area. Open access services are essential to control infection, prevent outbreaks and reduce unwanted pregnancies.

It is important to consider here for 2 main reasons: firstly, the impact on Local Authorities’ resources and secondly, patient flow and out of area activity can indicate how successful local sexual health services are in meeting the needs of the local population.

Table 24 shows the flow of Suffolk residents out of the county. Most of the flow is to the neighbouring counties of Cambridge, Colchester and Norwich.

Table 24: Out of Activity for Suffolk residents

<table>
<thead>
<tr>
<th>Location</th>
<th>Total Attendances</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2012-13</td>
</tr>
<tr>
<td>Cambridge</td>
<td>1057</td>
</tr>
<tr>
<td>Colchester</td>
<td>393</td>
</tr>
<tr>
<td>Norwich</td>
<td>345</td>
</tr>
<tr>
<td>Dean Street, Westminster</td>
<td>64</td>
</tr>
<tr>
<td>Chelmsford</td>
<td>20</td>
</tr>
<tr>
<td>Mortimer Market, Camden</td>
<td>23</td>
</tr>
</tbody>
</table>

Source of data: GUMCAD
Figures 35, 36 and 37 illustrate the residency of patients accessing out of area services and shows that it is residents living near the boundaries that mostly use non-Suffolk services, namely Cambridge, Norfolk, and Essex. This could be due to a number of reasons including lack of sufficient provision closer to home, transport links or personal preference.
Figure 35: Purchase of Out of Area Patient Service to Norfolk and Norwich Hospital

Joint Strategic Needs Assessment

Out-patient attendances at Norfolk and Norwich Hospital (NNUH)
Out-patient attendances for sexual health services purchased by Suffolk County Council
Out-patient attendances during April 2014-February 2015
Persons of all ages
Distribution of out-patient attendances by postcode district of residence with boundaries of local authority districts (LADs) in area and Suffolk County overlaid

No. OP attendances at NNUH geography: postcode districts
- <6 (12)
- 6-9 (6)
- 10-19 (1)
- 20+ (3)

Boundaries of LADs in area
- Boundary of Suffolk County
- Large town in Suffolk County
- Small town in Suffolk County

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Figure 36: Purchase of Out of Area Patient Service to Cambridge University Hospitals NHS Foundation Trust

Out-patient attendances at Cambridge University Hospitals NHS Foundation Trust (CUH)
Out-patient attendances for sexual health services purchased by Suffolk County Council
Out-patient attendances during 1 August 2013-26 September 2014
Persons of all ages
Distribution of out-patient attendances by postcode district of residence
with boundaries of local authority districts (LADs) in area and Suffolk County overlaid

Note. 80 attendances had no postcode or erroneous postcodes.
One attendance with residence in postcode district SG8
(North Hertfordshire/ South Cambridgeshire/ Uttlesford area) not shown on map.
Figure 37: Purchase of Out of Area Patient Service to Colchester Hospital University Foundation Trust

Out-patient attendances at Colchester Hospital (CH)
Out-patient attendances for sexual health services purchased by Suffolk County Council
Out-patient attendances during May 2014-March 2015
Persons of all ages
Distribution of out-patient attendances by postcode district of residence with boundaries of local authority districts (LADs) in area and Suffolk County overlaid

No. OP attendances at CH geography: postcode districts
- <6 (10)
- 6-9 (2)
- 10+ (1)

Boundaries of LADs in area
- Boundary of Suffolk County
- Large town in Suffolk County
- Small town in Suffolk County

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6. Stakeholder and Service Users Engagement

Data and information was gathered from key stakeholders including commissioners, providers, clinicians and representatives of special interest groups as well as service users and potential users. This was achieved through a variety of methods across the county such as stakeholder events, questionnaires and service user focus groups.

6.1. Stakeholder Event – Key Themes

Commissioning and provider representatives from a range of services across Suffolk were invited to participate in a stakeholder event as part of an information gathering exercise to inform the Suffolk Sexual Health Needs Assessment. The event was well attended by 47 people from 17 different organisations representing a range of services and disciplines (see appendix 2 for detail).

The aims of the event were to:
- Capture local knowledge and identify key issues
- Prioritise key issues
- Identify mechanisms for engaging with service provider teams and service users

Attendees were asked to take part in two group work sessions:
1. What the data does not tell us
   - What works well
   - Unmet need
   - Groups at risk of disadvantage
   - Gap in service provision
   - Opportunities for joined up working

2. Developing key lines of enquiry considering
   - Impact on population health
   - Addressing inequalities
   - Evidence to support need
   - Evidence of effective practice

There were a number of emerging themes highlighting concerns and potential areas for improvement, namely: understanding need and demand; accessibility; improving service provision; pathways and collaboration between services and organisations; inequalities; workforce; public knowledge and awareness; stigma.

Working Well/Good Practice

Accessibility
- Availability of services
- Drop-in centres
- Sexual health services via GP practices are well received by patients, particularly as not all patients want to go to a family planning clinic
- Accessing sexual health in some schools
✓ Pharmacies delivering sexual health services

Service provision
✓ Quality of sexual health services
✓ Integrated clinics at Orwell Clinic
✓ C-card Scheme
✓ THT Outreach is good

Pathways and collaboration between services and organisations
✓ Positive relationships with acute hospitals

Inequalities
✓ Support for young mothers
✓ Family Nurse Partnership – preventing further pregnancies that are unwanted

Areas of Concern/Unmet Need/What Could be Better

Understanding need and demand
❖ Lack of understanding about the needs of specific groups such as Gypsies and Travellers and working age and older people
❖ Emerging picture of level of female genital mutilation (FGM) in Suffolk but extent still unknown
❖ 'you don’t know what you don’t know’ difficulties in identifying unmet need
❖ How many people aren’t making it to the right services? We don’t know numbers of service referrals /access - how many are ‘lost to follow up’

Accessibility
❖ Ipswich town centre access to sexual health services, particularly reproductive health
❖ Opening times of some sexual health services don’t reflect needs of service users e.g. before and after school, commuting population
❖ Some groups such as refugees and young people often cannot pay transport costs to access services
❖ Difficulty in accessing out of hours post-exposure prophylaxis (PEP) for HIV via A&E
❖ James Paget Hospital is too far for Lowestoft patients to access
❖ Rurality and accessibility to services, particularly for young people
❖ The Norfolk/Suffolk divide – services can be different in different areas and provision needs to be clear for service users as to which county they fall under/which service is accessible to them
❖ Lack of clarity regarding out of areas provision

Service provision
❖ Provision of free Emergency Hormone Contraception (EHC) in pharmacies is age limited
❖ There is variation in the quality and level of sexual health services provided in primary care. GP practices could have a positive impact on contraceptive uptake
❖ Impact of the loss of youth services in supporting young people
Shift to LARC instead of the pill at GPs – but are they still advocating condom use as well for STI prevention

The potential for a c card plus scheme for at risk of disadvantage adults

Local difference in service provision e.g. Ipswich and Waveney

More joint working, clinics open more often, don’t redirect people

More drop-in services that are young service user friendly and for different age groups – drop-in sessions at schools and colleges

Lack of awareness of available psychosexual counselling services and how to refer patients/clients – long waiting list – variability in qualifications of counsellors

Positive Choices Service are restricted as they can only work to prevent unwanted pregnancies if they have had a child already removed, not at risk of removal

Widen our support i.e. Family Nurse Partnership scheme can only work in Ipswich up to 19 years of age

Pathways and collaboration between services and organisations

Disjointed service pathway between primary and secondary care – greater integration with all primary care providers for provision of screening, vaccination, treatment e.g. in pharmacy

Pathways are not clear

Services are not joined up, skills not shared

Lack of awareness of the role of the voluntary sector in promoting good sexual health

Gap between mental health services and sexual health services

Joint working opportunities – one stop shop needed for people accessing services

Need to link more with GPs

More multi-agency family working

CAF (common Assessment Framework) Data could enhance Teenage Pregnancy information

How does Raising the Bar fit in? It should be linked in to sexual health strategies and services

Inequalities

Issue of sexual violence for people who are homeless

Uptake of sexual health services by men

Groups at risk of disadvantage – gay, lesbian & transgender, BME groups, English as a second language, Drugs & alcohol, men & young men, young people in care, homeless people, people not engaging in services, young people at risk of sexual exploitation, offenders, prisoners, people with Learning Disabilities, Learning Difficulties, hearing impairment & mental ill health

Transgender community reluctant to access mainstream services – the requirement to be classified as male or female a barrier

Gap in service to support older women at risk of disadvantage not served by the Family Nurse Partnership
Need tailored services and information for people with Learning Disabilities, Learning Difficulties and hearing impairment
Lack of support for young fathers
Needs of care leavers
Number of repeat abortions in some groups
Recognise that same sex relationships exist at a young age and also need to protect against STIs

Workforce
Professionals/practitioners are not aware of range of services available to support good sexual health and how to signpost or refer their patients/clients

Public knowledge and awareness
Variation in the level and quality of sex and relationships education in schools resulting in postcode lottery of provision – not enough young people receive excellent SRE in schools/colleges/other educational institutions - use of PSHE Framework is inconsistent
Parents/carers are not well supported/informed to discuss sex and relationships with members of their family
On-line safety/exploitation
Service users are often not aware of range of services available to support good sexual health – there are inconsistent messages for people
Many young people remain unaware of services available
Late HIV diagnosis in older people – think of condoms only as a pregnancy preventer not in terms of STI prevention
More online support/information

Stigma
Stigma associated with attending a sexual health clinic for some people
Stigma attached to a sexual health clinic for the older generation
Issues surrounding confidentiality – GP receptionists in rural areas may know many clients - GP receptionists in both rural and urban areas asking misleading and very personal questions when on the phone in order to prioritise appointments

Key Lines of Enquiry and Action
Understanding need and demand
- Explore possibility of reviewing data collection systems to make them more inclusive for transgender community
- Look beyond the data to understand patterns/characteristics/needs of service users/Suffolk population and particular geographical areas – use this to target most in need and inform provision
- Map how patients travel across the county to access services to service provision
- Stakeholder events useful to facilitate communication
- Involve service users in design of service response, including review of opening times, appointment system and methods of communicating with the sexual health services
Monitor and measure progress and success

Accessibility
- Marketing of sexual health services – continuous messaging rather than campaigns – directory of services held by and shared by one Provider
- Utilise other services/building to increase access in rural areas e.g. GP Practices, mobile units
- Explore the potential for online booking system for sexual health services to make it discreet and that they have appointment times
- Map and disseminate information regarding out of hours service provision

Improving service provision
- Ensure patients continue to have choice and are able to access all family planning services via GPs, including implants and IUCDs
- Review psychosexual counselling provision

Pathways and collaboration between services and organisations
- Map how well we coordinate commissioning arrangements
- Better joined up working between services and organisations – should include the voluntary sector
- Once pathway is developed need to keep communication links open – e.g. annual or bi-annual meeting for all Providers - service users to also be involved
- Work with 111 service provider to ensure they hold details of local sexual health services
- Better utilisation and integration of pharmacy network, particularly for access to EHC and chlamydia screening
- Provide information on range of available sexual health services

Inequalities
- Tailoring service response to different needs. For example explore the possibility of supporting older women at risk of disadvantage similar to the Family Nurse Partnership and training for service providers to ensure accessibility of provision
- Joined up ways of working between those practitioners working with groups at risk of disadvantage
- Local community could support engagement with more marginalised groups
- Principles of Your Welcome standards within provision (good practice for services for young people)

Workforce
- Better use of skills and cross over working, developing a county-wide sexual health workforce across organisations and services
- Develop training programme to support the wider sexual health workforce, utilising the skills and knowledge of a range of professional from different organisations, particularly for skills relating to initiating conversations about sexual health
Develop an on-line resource for public and professionals that details sexual health pathways, available services, referral details, contact information – also data, guidance and evidence/best practice

Public knowledge and awareness
- Develop comprehensive programme to support all schools (including independents) in their delivery of sex and relationships education, with a particular focus on those schools with highest need and non-mainstream educational outlets. Explore the role of school governors in this work and early intervention in primary schools (resilience, relationships, confidence building) – share existing good practice
- Disseminate appropriate web based resources
- Utilisation of technology e.g. apps
- Use different approaches to target messages to population groups
- Involve the community and take the information to where people are e.g. children’s centres/places where people meet/ gyms/sports centres

Stigma
- Educating staff around sexual health stigma
- Ensure public confidence in confidentiality of services relating to sexual health

6.2. Primary Care Engagement – Key Themes

A questionnaire (see appendix 3) was sent to GP Practices across Suffolk to gather views from primary care providers on relating to sexual health need and service provision. GP Practices had the choice of either paper or on-line questionnaires. There were a total of 53 responses from primary care practitioners across Suffolk. They identified that the 3 most frequent presenting sexual health issues in GP practices were:

- Contraception (45.28% response rate)
- Discharge (15.38% response rate)
- Chlamydia (7.55% response rate)

It was reported that approximately a third of the issues presented in the GP practice were dealt with in the Practice, a third were referred to specialist sexual health services and a third referred elsewhere such as gynaecology. Of those referred to specialist sexual health services, the main referrals were for psychosexual help, contact tracing, HIV and complex STI screening. Some GP Practices responded that they were more likely to refer to gynaecology outpatients than to the family planning clinic. Mostly the Practices were aware of the location of the sexual health services but did not have much contact with them.

Of those GP Practices that responded, there were mixed views on the current commissioning arrangements for LARC in GMS practices.

"the lack of support for nurses to train in sexual health leaves the services disjointed if the GP is not here"
“as good as it will get, we need to ask the commissioners to take active interest. Training will be an issue”

There were also mixed views on the current commissioning arrangement for PMS practices. Some of the positive views were:
“Contraception-LARC and IUS/IUD are well provided for as well as other contraceptive services. Testing for STD is limited to services in Gorleston”
“LARC only recognized, also would like to provide services for clients from other practices where their staff do not have the skills to provide services”
“It works very well for both the practice and our patients; in particular this relates to contraceptive advice and provision both for planned and emergency requests”

And some disagreed by saying:
“Doesn’t work for the practice and, if the PMS contract is changed, may not work for patients.”
“N/A salaried GP, but my impression that coil fitting is not viable for smaller practices unless doing at least 4-5 a month”
“Badly - for coils pts do not always want to go to FP”
“Not clear about Mirena coils, yes included for contraception but not for heavy menstrual bleeding which it should be.”

Practices were asked for their requirements for training in sexual health. Practices identified training needs for GPs and Practice Nurses and included:
- General updates on sexual health
- LARC fitting and removal
- Identifying early GUM symptoms
- How to speak to young people about sexual health
- Face to face training with senior clinicians
- HIV testing
- Information regarding local sexual health services and web based resources

Respondents identified a number of improvements that they thought could be made to sexual health services in primary care: These included:
- Increase collaboration and joined up working between sexual health service and primary care
- Training in sexual health and its application in primary care
- Better understanding of what sexual health services are available and how to access them - “Community condom scheme is not very visible in primary care”
- Improve accessibility - “better services in the whole of Waveney” – “local services i.e. not at the hospital” – “A clinic is needed in the town centre” (Ipswich) - “The sexual health services are not accessible for patients in the west of Ipswich
- More evening and weekend clinics in sexual health clinics – “we provide a much greater range of appointments in primary care and access is much easier for patients - this needs to be the case for other services too”
- Invest in primary care sexual health services
6.3. Focus Groups – Key Themes

Focus group research involves organised discussion with a selected group of individuals to gain information about their views and experiences of a topic. Group discussion produces data and insights that would be less accessible without interaction found in a group setting. Listening to others’ verbalized experiences stimulates memories, ideas, and experiences in participants. Focus group interviewing is particularly suited for obtaining several perspectives about the same topic.

Thirteen focus groups (see appendix 6 for details) representative of groups who were less likely to take part in formal questionnaire consultations were set up. Five of the focus groups were made up of service providers who worked closely with more marginalised groups; eight groups were made up of representatives of those communities. In all 76 people took part. The groups were asked to consider the following:

 What is your knowledge of service availability?
 What is your understanding of the service?
 Can you tell us about your experience when using the service?
 What did you like about the service?
 What didn’t you like about the service?
 How do you think the service could be improved?
 Is there anything else you would like to say about local sexual health services?

Service Providers

Accessibility

 Barriers to clients at risk of disadvantage accessing sexual health services included language, stigma, fear that service providers would not accept them, negative previous experiences with services and cultural sensitivities
 Some communities were not aware of the services available and some service users reported poor experiences
 Young people with Learning Disabilities were not signposted to the C-Card Scheme
 Clinics needed to be easily accessible and with a range of locations and opening times
 There are issues with getting through to clinics on the phone, waiting times and information regarding service provision
 Services needed to be young people friendly
 Rurality and opening times are an issue
 Participants cited examples of GPs refusing to see YP without an adult
 Although young people in Waveney are aware of the GUM clinic at James Paget Hospital and there are good transport links, it is expensive. Staff were sometimes transporting their clients to services. Concerns were also raised about waiting times.
 Young people in the rural areas were often reluctant to go to their local GP because of the small community and fear of someone finding out.
Improving service provision

- Experience of service provision for service users with Learning Disabilities was reported as mixed. Whilst there has been some good engagement with one organisation around sexual health promotion, participants reported experiences where service providers did not adequately address the needs of this client group. Service providers were described as “not LD friendly”.
- Sexual health clinics do not accept the C-card scheme – so YP don’t go there for free condoms as they have to sign up to a different scheme
- Need level 3 sexual health service provision in Lowestoft
- There is disparity in sexual health provision through the school nursing service in schools

Pathways and collaboration between services and organisations

- Range of service providers had limited knowledge of local sexual health services and how to signpost their clients there
- Need to improve working relationships between services and teams working with key client groups
- Participants working with young people with Learning Disabilities reported that there was little collaboration between services supporting the sexual health needs of this client group. Feedback to support staff was difficult due to confidentiality.
- Relationships and trust are important for more clients at risk of disadvantage and simple signposting means that service users often do not make the journey to the sexual health service. More support is required. Also some service users do not cross refer clients.
- Sexual health services could work with other service providers to provide services, possibly outreach in these settings
- There is scope for increased communication and collaboration between school nurses and GPs

Inequalities

- Young people with Learning Disabilities do not have access to the same level of sex education as young people in the mainstream. Staff and school nurses at special schools do seek to provide sex education but students with Learning Disabilities have additional needs in terms of time (key messages need repeating), resources and skilled workforce. Consequently support can be often reactive rather than proactive and preventative. In mainstream schools the extra support required may not be there.
- Participants expressed a concern for young people with Learning Disabilities at college where they have more freedom but less support to navigate relationships and services.
- In terms of sexual health, users of the Marginalised and Vulnerable Adults Service commonly presented with: unwanted pregnancies, lack of knowledge of sexual health services and issues relating to sexual health. However, although sexual health is part of the client assessment, it is often not the most pressing need and can get left out.
- There is a gap in support for some groups such as young offenders
Workforce

- There is a training need to enable service providers to engage and interact with people with Learning Disabilities and more groups at risk of disadvantage in order to make services more accessible, messages understood and treatment appropriate.
- Specialist staff (from non-sexual health services) would benefit from level 1 and 2 sexual health training.
- Sexual health training needs to take account of pre-existing knowledge and expertise.

Public knowledge and awareness

- There was concern expressed about the variability of PSHE provision in schools.
- Appropriate sexual health resources were not regularly used with young people with Learning Disabilities and there was not enough support given to parents, particularly for those parents with Learning Disability. Sex education for young people with Learning Disabilities seemed to focus on more fearful aspects of what could happen to them rather than the more positive aspects of relationships. Relationships between young people with Learning Disabilities were discouraged in schools.
- Need usage of better sexual health resources that are visual with clear interpretation for people with Learning Disabilities.
- Need to use different language to give messages about sexual health to other communities’ e.g. healthy relationships instead of sexual health.
- Services need more prevention measures than reactive measures.
- Speak easy course to be more readily available to parents and teachers.
- Addressing self-esteem and healthy relationships needs to be embedded in work with young people.

Stigma

- Young people from some communities would not pick up free condoms unless it’s confidential due to stigma and embarrassment.

Service Users

Accessibility

- Among all the focus groups there was mixed knowledge of available local sexual health services, but many participants were not clear as to how to access these services. Many participants were not aware that pharmacies delivered sexual health services.
- Some women from the refugee support group had accessed sexual health clinics but most used their GP Practice. The Roma women had no knowledge of local sexual health services but did go to their GP for contraception. Both groups expressed an interest in knowing more about available services especially for contraception.
- Women from the refugee support group and Roma group identified key difficulties/barriers they have faced when accessing services: shy to speak to male GP or health professionals; gap in knowledge of where/what services are.
available; language barrier – e.g. nurse using google translator and it was not effective; majority of the group had negative experiences with GPs when they sought sexual health services – only information given, and multiple referrals to other services that could not help them or that they had difficulty in accessing. When asked how they would like the services to be, participants responded: free of charge services; centrally located for easy access – affordable to access; limit the number of referrals – one stop services; clear transportation links – able to find out how to get there; information on the internet.

- Participants from the male migrants group had no knowledge of local sexual health services other than the support they could receive at the Marginalised and Vulnerable Adults Service through one particular member of staff. One participant reported using his GP for a sexual health problem. The group was under the impression that they needed documents to access services. They were not aware that they can access sexual health services anywhere in the country.
- Participants from the male migrants group identified language as a key barrier to accessing sexual health services. They would prefer to speak to someone familiar i.e. the same translator they previously used – one specific person. They also reported difficulty in understanding public transport and how to get to services.
- People living with HIV reported that they were not aware of the availability of the range of local sexual health services and their settings. They had no objection to the proposal for one hub for all sexual health services, but they did express concern that they might be noticed accessing the services. Any hub would need to be central and be accessible outside of working hours.

**Improving service provision**

- Participants of all the focus groups were clear about what made a good a sexual health service: helpful, friendly and kind staff members; complete information/advice given enabling them to make informed decisions; good standard of practice; long enough appointments – considering any language barrier; only one visit to get all the help they need; short waiting times; non-judgemental and respectful staff.
- When asked about what was important to them for service provision, participants from the male migrants group reported: one specific person/professional healthcare staff that sees them for all their issues; the person in need needs to be pushed to go to services/ seek help; they would like kind, polite, well trained staff members; confidentiality; accessibility; discrete location; after working hours and weekends.
- People living with HIV reported good experiences at the GUM clinics. Staff were friendly and kind and for the majority, they had confidence in the treatment they received. – “they explain it thoroughly and spend the extra time with you until you understand the new medication”. This support was also extended to their partners. The majority of participants reported that they were content with the services they received in the clinic – but not outside it.
- People living with HIV reported some concern about the drug delivery services using their name on the medication which could be seen by others.

**Pathways and collaboration between services and organisations**
People living with HIV reported that communication between GUM and general primary care and other health specialities is inadequate. This is particularly difficult when they are prescribed new medication. No indication of their HIV status is on medical records and, for some, they prefer that the information is shared between appropriate people. Participants wanted more joined up/shared care arrangements.

Public knowledge and awareness
- Some of the women from the refugee support group had substantial understanding about contraceptives, others had limited knowledge.
- Participants from the male migrants group stated that whilst their children learnt about sex education at school, the older generation had limited knowledge.
- Unlike the women attending the focus groups, who would often seek support from family and friends, the participants from the male migrants group reported that they would not approach others for information as it is not something they would like to discuss openly. Rather they would prefer to access information via the internet and printed information (although language would be an issue) at a variety of settings such as GP Practices and European shops. Maps should be included to indicate where services can be found.
- Roma women reported that they share information within their community.
- People living with HIV felt that there wasn’t enough information readily available for family members and that leaflets and posters about HIV were not displayed in mainstream healthcare settings.
- Many participants reported using the internet for information and advice about sexual health

Stigma
- People living with HIV described their experience of healthcare (not GUM services) as one characterised by containing a high level of ignorance and stigma. There was also a fear of revealing their diagnosis to family members due to the stigma and lack of understanding prevalent among the wider community.

6.4. Questionnaire - Key Themes

Online questionnaires were designed for the public and key stakeholders to complete. These were available on the Suffolk County Council website and also distributed via emails and paper copies to key stakeholders, other services providers and local voluntary sector. An easy read version of the questionnaire was designed for the three specialist schools in Suffolk. See Appendices 3-5 for the questionnaires used.

There were 639 responses to the questionnaire in total, with a higher response from females at 63.7%, (33.7% were male, 1.13% transgender and 1.29% did not wish to disclose). Over half of the respondents (62.5%) were under the age of 25.
Figure 38: Age group distribution of Service User Questionnaire responses

620 answered the equality and diversity questions; 
- 7.1% reported to have a learning disability or difficulty
- 6.45% reported to have a mental health condition
- 2.9% reported to have a longstanding illness
- 1.29% reported to have sensory impairment
- 88% reported to be White British,
- 2% reported to be African, Any other Mixed / Multiple ethnic background and, White and Black Caribbean,
- 1% reported to be of any other White background, Gypsy or Irish Traveller, Indian, White and Asian, White and Black African and White Irish.
- 17.74% consider themselves to have a disability,
- 38.6% were in full-time employment,
- 28.6% in full-time education,
- 11.5% unemployed.

Figure Error! Reference source not found.39 shows the residential distribution of the respondents across Suffolk. A higher percentage of respondents resided in Ipswich, Waveney and St Edmundsbury districts respectively.
47.5% (303 out of 638 respondents) of the respondents felt that they were **Very well** informed about sexual health issues (figure 40) of which 27% are of the 16 to 18 years old age group. The same age group (16-18 years old) also had the highest **Don’t Know** percentage (41%) (Figure 41). This could be because the majority of the cohort where the 15 to 18 years old age group. From the 0.9% who reported to **Not at all**, 33% were 15 or under and 17% were of 16-18, 21-25, 26-35 and 36-45 age groups respectively.

**Figure 40: Knowledge of sexual health issues**

65% of females reported to be **very well** informed compared to 33% of male. However 67% of females reported to **not at all** compared to only 17% of males.
When asked where respondents would go if they required help or support for sexual health issues, GP Practice ranked 1st with a score of 6.4 out of 8 for the most preferred service provider for advice or help with sexual health issues. School nurse ranked last, coming in 8th position with the score of 2.3 out of 8. Figure 42 shows the order of preference for advice or help with sexual health issues.

When asked if they ever visited a service(s) for advice or help with sexual health issues, 61% reported to have accessed their Doctor’s Surgery, and 57.4% had visited their local sexual health clinic (Figure 43).
When service access is broken down into age groups, 59% of 56 to 65 year olds reported to have accessed their Doctor’s surgery for sexual health advice or help, whereas 41% of 26 to 35 year olds and 35% of 19 to 20 year olds went to the local sexual health clinic. 21% of the 15 or under age group have accessed pharmacies and school nurses respectively for sexual health advice or help. These are the top services followed by Doctor’s surgery with 18%.

Although we had a small percentage of transgender respondents, data shows high preference for more traditional services providers. 50%, 33% and 17% of transgender respondents have accessed the Doctor’s surgery, pharmacy and venue for young people respectively. 36% of females and only 29% of males have accessed the Doctor’s surgery for sexual health advice or help. 33% of male and females have accessed their local sexual health clinic for advice or help with sexual health issues.

Figure 43: Services used for advice or help with sexual health issues

<table>
<thead>
<tr>
<th>Service</th>
<th>Answered</th>
<th>Skipped</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your Doctor’s surgery</td>
<td>61.0%</td>
<td></td>
</tr>
<tr>
<td>Venue just for young people</td>
<td>7.6%</td>
<td></td>
</tr>
<tr>
<td>Your local sexual health clinic</td>
<td>57.4%</td>
<td></td>
</tr>
<tr>
<td>Your local acute hospital (Ipswich, Bury St. Edmunds or James Paget Hospital)</td>
<td>18.1%</td>
<td></td>
</tr>
<tr>
<td>Your community clinic</td>
<td>8.2%</td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td>14.3%</td>
<td></td>
</tr>
<tr>
<td>School nurse</td>
<td>7.6%</td>
<td></td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>3.2%</td>
<td></td>
</tr>
</tbody>
</table>

In total 50.9% would travel **more than 5 miles** to access sexual health help and advice and only 11.8% would travel less than 1 mile (Figure 44).
There is a relatively similar percentage of clinic time preference, with the highest preference for 09:00-12:00 (35%), 17:00-19:00 (32.7%) and Saturday clinics (30%). However 27% indicated a need for an early morning clinic i.e. before 08:30, the majority being from the 21 to 25 and 26 to 35 age group.

In the questionnaire there was a section for those who have used sexual health services, with the purpose of getting a thorough understanding of their experiences.

The majority of the people who used the services either drove/got a lift or walked.
A satisfaction average of 72% was reported for those who have used any of the sexual health services and completely received all the help they wanted.

Figure 46: Mode of transport used to access a sexual health service

Figure 47: Service User satisfaction
Only 1.5% felt like they did not get the help or advice they needed from the local sexual health clinics.

When asked what the service **did well**, the common words were (the size of the font has direct relation to the frequency of the word):

| Comfortable | Patient | Care | Test | Understood | Understanding |
| Treatment | Treated | Given | Contraception | Sorted |
| Friendly | Problem | Explained | Listened | Advice |
| Issues | Gave | Answered | Needed | Polite | Confidential |
| Offered | Clinic | Not Judgmental | Ease | Advised |

The common responses to what the services **did not do well**, (the size of the font has direct relation to the frequency of the word):

| Implant | Welcoming | Ipswich | Hospital | Rude | Location |
| Pharmacy | Wrong | Clear | Results | Treatment | Nurse |
| Progress | Clinic | Explain | Waiting | Service | Doctors |
| Busy | Took | Town | Contraception | Referred | Advice |
| Screening | Needed | Wont | Book |

97% of those who have used a sexual health service would recommend the services to family and friends, and only 2.8% would not (Figure 48).
6.5. Further analysis – Learning Disability and Difficulties

44 respondents identified themselves as having a learning disability (LD) or difficulty. This was 7.1% of all the respondents. 48% were female, 43% males and 5% transgender and did not wish to disclose respectively.

30% of respondents were from the 16–18 years of age of which the majority were females (16%). The other high reporting groups in descending order were 15 or under, 19 to 20 and 21 to 25 year olds. Figure 49 shows the gender distribution in respect to the age of all the respondents with LD.

Figure 49: Age and Gender distribution of respondents with LD

![Age distribution of respondents with LD](Image)
When asked how well informed about sexual health issues they felt, 41% reported very well and 13% reported don’t know/ not at all.

**Figure 50: LD respondents’ knowledge of sexual health issues**

The majority of the respondents with LD reside in Babergh and St. Edmundsbury districts, with reporting percentages of 12% and 10% respectively. Suffolk Costal had the lowest percentage of 2%.

**Figure 51: District distribution**

This cohort used the more traditional services available, 32% sought sexual health advice/help from Doctor’s surgery, followed by 24% who used their local sexual health clinic.
When asked to rank their services preference if they required help or advice on a sexual health issue, friends and family was their top option followed by the internet and GP Practice (Figure 53). Local sexual health clinic ranked at 7th place.

Figure 52: Access to sexual health services

Figure 53: Services preference
6.6 Other Consultations

Key stakeholders in the sexual health agenda have shared the consultation work they have undertaken with the public and service users that is also useful to inform service commissioners and providers about what is important to users.

**Suffolk Young People's Health Project (4YP)**

In 2013, Ipswich based Suffolk Young People's Health Project (4YP), a local charity which supports young people throughout Suffolk undertook some engagement events with young people to collect views and experiences to inform work to reduce teenage pregnancy rates across the county. Key messages that came back from this engagement exercise were:

- Lack of information - young people should be better equipped with information about sexual health
- More than half of young people said they had used web search engines to look up information
- To talk to workers face to face and have a consistent message from workers
- To have a service where young people do not feel judged
- More education about sexual health in schools/at home
- Location of services e.g. rural areas to have a better access to services
- Sexual health learning at school to be more in depth
- Drop in service and weekend opening times convenient
- Clear/easy information in posters/flyers and websites

There was also specific feedback from young parents:

- Services were judgemental (some young people would then not engage)
- Information should be easier to access for young parents
- Need for information for young parents before and after having a child
- Need for groups where you can drop in
- Need for young parents groups (young person said normal groups “were mostly older, I felt looked down on”)
- A lack of sexual health education in schools and from parents/carers
- when asked ‘what do young parents think would help other young people choosing to be a young parent’ - young people said “more information”
7. Gap Analysis/Key Findings

Although Suffolk is a low prevalence area for sexually transmitted infections and has a lower than national rate for unplanned pregnancies and teenage pregnancies, there are a number of areas that warrant further investigation, namely:

- Ipswich and Waveney have higher rates of sexually transmitted infections and of teenage pregnancy than other parts of the county; Ipswich is also higher than the national rate
- Suffolk has consistently fallen below the national target for chlamydia detection
- Downward trajectory for STI testing rates
- Suffolk has been consistently above the goal of less than 25% of new HIV infections classified as late diagnosis and in 2012-14 this has risen to 50.5%
- For HIV testing measured in GUM, Suffolk is worse than the regional and national rate
- Increasing trend in repeat abortions in those aged under 25 years compared to static picture for regional and national figures
- Among NHS funded abortions, the proportion of those under 10 weeks gestation was 75.7%, while in England the proportion was 80.4%
- Patient flow and out of area activity as an indicator of service provision

The public and stakeholder consultation also raised some key issues:

- Uptake of services by marginalised and high risk groups
- Fragmented patient pathways
- Ability of current provision to meet need
- Workforce development across services and organisations
- Developing public knowledge and awareness about sexual health

**Teenage Pregnancy**

Despite the downward trajectory of teenage pregnancy rates in Suffolk, there are some variations in rates when broken down to locality and ward areas. Ipswich and Waveney continue to have the highest rates in the county, both above the regional rate and Ipswich higher than the national figure. At ward level, 10 wards had rates significantly above the England rate. The correlation between deprivation and high rates of teenage pregnancy within Suffolk remains.

**Termination of Pregnancy**

Although the percentage of pregnancies ending in legal termination in Suffolk is lower than regional and national figures (with a similar picture for those aged under 18 years) there is some variation in the county by age and by locality.

The figure is higher in those aged 20-24 years, which indicates, although following the regional and national percentage, this is a key group to ensure good access and promotion of reproductive health services.

In general most teenage pregnancies are unplanned and around half end in an abortion, in Suffolk the number of conceptions that resulted in a termination for this age group varied
across the county, with higher percentages found in Suffolk Coastal and St Edmundsbury and lower in Waveney. Actual abortion rates however (rate of abortions per 1000 females aged under 18 years) were highest in Ipswich and St Edmundsbury.

In 2013, at 49%, Great Yarmouth and Waveney CCG were above the national rate of 45.3% for repeat abortions. This rate is an indicator of lack of access to good quality contraception services and advice as well as problems with individual use of contraceptive method.

In 2014, among NHS funded abortions, the proportion of those under 10 weeks gestation was 75.7%, while in England the proportion was 80.4%. The earlier abortions are performed the lower the risk of complications. Prompt access to abortion, enabling provision earlier in pregnancy, is also cost-effective and an indicator of service quality and increases choices around procedure.

**Sexually Transmitted Infections**

The number of new cases of all acute STIs diagnosed has been steadily decreasing in Suffolk with a sharper reduction of 13.2% between 2013 and 2014. The picture is the same for all STIs excluding chlamydia. This is significantly lower than the national figure. However there is concern that there has also been a reduction in STI testing rates in the county for the same period which is significantly lower than the national rate and is the lowest in the region. This decrease in testing rates may mask the actual prevalence of STIs in the county. There has been a 16% reduction in chlamydia diagnosis in Suffolk between 2013 and 2014. Further investigation is required to understand the reasons and implications of this change.

The proportion of STIs diagnosed in Suffolk GUM units was highest in those under 25 years for both males and females. The distribution of STI’s in this age group was twice their age distribution in the general population indicating that this cohort should be targeted in terms of health promotion and service provision.

**HIV**

Suffolk is classed as a low prevalence area for HIV. However there is some variation in terms of locality, gender, age and ethnicity for HIV prevalence:

- Ipswich and Waveney had higher rates than the rest of the county
- The number of new diagnoses of HIV were higher in males compared to females
- New diagnoses of HIV according to age group showed that the trend varied over the years from 2005–2013
- Black Africans had the highest prevalence of diagnosed HIV
- The age and gender distribution of new HIV diagnoses among the black population (African / Caribbean / Other) showed that numbers were higher in females than in males by approximately 2:1 and the 25-34 year olds made up the largest number of newly diagnosed cases

There is some concern about the number of late HIV diagnosis in Suffolk with local audits showing an increase in the number of patients fitting the criteria of late diagnosis in the last year. Combined with the percentage uptake of HIV testing which is worse than the regional and national rate, it is clear that further work needs to be undertaken to understand and improve the local picture.
Patient Flow
Data on the number of patients accessing sexual health services, particularly across the borders with Suffolk’s neighbouring counties indicates that current service provision does not meet demand. The biggest patient flow is from the west of the county to Cambridge and perhaps reflects that spoke provision in this part of the county currently does not provide GUM services. Provision in Waveney is also limited with patients needing to travel to the James Paget Hospital for GUM services and many Suffolk residents chose to travel to Norwich instead. The current picture indicates that services are not configured in the best way to meet needs and changes to service provision are required.

Uptake of Services by Marginalised and High Risk Groups
A number of stakeholders expressed concern regarding how groups who were more marginalised or at higher risk of sexual ill health accessed sexual health services. This was borne out by the findings from the questionnaires and focus groups:

- Young people under 18 years, despite having higher rates of STIs, had mixed knowledge of sexual health issues which perhaps reflects the disparity of provision of good quality sex and relationships education (SRE) across the county
- There was a mixed picture for people with Learning Disabilities. Of the 44 respondents with Learning Disabilities 41% reported feeling well informed about sexual health issues, however support staff expressed concern about the level of support to young people in particular for their sexual health needs
- Although a small number of respondents defined themselves as transgender in the questionnaires, they did raise significant concerns about inclusivity and accessibility of provision which was also raised during the stakeholder event
- Representatives of Black and Minority Ethnic (BME) groups identified key barriers to service uptake relating to awareness of cultural sensitivities, language difficulties and understanding how to navigate through services
- Testing rates indicate that key groups are not taking on sexual health messages regarding testing for HIV and STIs, particularly chlamydia

Patient Pathways
The stakeholder and public consultation showed that many had significant concerns about a disjointed service response and the subsequent impact on service users. There was a lack of understanding as to who was responsible for the commissioning and provision of services and where to signpost service users.

Service Provision
Stakeholders reported dissatisfaction with current service provision in terms of location and opening times.

Workforce Development
The consultation process identified some key issues for workforce development:

- Professionals/practitioners were not aware of the range of services available to support good sexual health and how to signpost or refer their patients/clients
There needed to be more opportunities for sexual health training of primary care professionals
Service users identified the importance of service providers actively demonstrating competency, confidentiality, sensitivity to gender, age and disability

**Public Knowledge and Awareness**
The lack of consistent, high quality SRE across all schools in Suffolk and its impact on the sexual health of young people was a recurring theme during consultations with stakeholders. Ensuring young people had the right information and advice was important but it was also felt that opportunities to support parents and carers to discuss issues relating to sexual health were not realised. In addition it was thought that messages to the public were inconsistent and that many people were unaware of available services.
8. Recommendations - Key Lines of Enquiry and Action

Understanding need and demand
- Further investigation of how to better meet the needs of marginalised and at risk of disadvantage groups, particularly BME groups, transgender community and those with Learning Disabilities
- Better use of national and local data to develop a shared understanding of patterns/characteristics/needs of service users/Suffolk population and particular geographical areas
- Deep dive exercise as to why Suffolk residents access out of area services

Accessibility
- Comprehensive, marketing of sexual health services that are available throughout the county from a variety of organisations – continuous messaging rather than campaigns
- Explore opportunities to deliver sexual health messages and services through other outlets, particularly GP practices, for a range of different groups, including support to parents/carers, to improve on accessibility and uptake, particularly GP practices
- to impact on accessibility and uptake for a range of different groups, including support to parents/carers, particularly GP practices
- Explore the potential for existing and new technology to increase methods of accessing sexual health information and services

Improving service provision
- Progress the integration and bringing together of sexual health services that is already underway
- Review service provision to ensure it meets local demand and reduces the volume of out of area activity
- Develop sexual health service provision within primary care, recognising their key role in prevention of unplanned pregnancies
- Review psychosexual counselling provision
- Increase uptake of STI testing, particularly for HIV and chlamydia
- Make better use of data to target those most in need and inform provision
- Involve service users in the design of service provision, including review of opening times, appointment system and methods of communicating with sexual health services

Pathways and collaboration between services and organisations
- Integrate/coordinate commissioning arrangements across the health and social care system
- Develop robust sexual health pathways for seamless patient care across organisations and services
- Increase collaboration and joined up working between sexual health service and primary care
- Develop a Sexual Health Strategy Group and Network
- Ensure information, including web-based, about sexual health and relevant local services are consistent across organisations
- More joint working on cross cutting issues such as risky behaviours

Inequalities
- Apply the principles of proportionate universalism to ensure the needs of all residents are met (actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage)
- Develop robust, systematic, collaborative ways of working between practitioners, services and organisations working with more marginalised and higher risk groups
- Investigate potential for developing lay sexual health champions targeting particular groups
- Ensure the principles of Your Welcome standards are embedded within provision

Workforce
- Use of Sexual Health Network to develop skills and cross over working for a county-wide sexual health workforce across organisations and services
- Develop on-line resource for public and professionals to promote evidence based practice

Public knowledge and awareness
- Proactively support schools to deliver high quality SRE
- Ensure strong local web presence with clear consistent messages shared across services and organisations
- Explore the use of technology in a variety of setting to promote sexual health messages and effect behaviour change
- Provide support to parents and carers so that they are well equipped to discuss sex and relationships with family members
- Develop community based initiatives to promote sexual health awareness and facilitate access to services

Stigma
- Develop local programme targeting the public and health and social practitioners to tackle ignorance and stigma related to sexual health and HIV.
# Glossary and List of Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>BME</td>
<td>Black and Minority Ethnic</td>
</tr>
<tr>
<td>CaSH</td>
<td>Contraceptive and Sexual Health</td>
</tr>
<tr>
<td>CCG</td>
<td>Clinical Commissioning Group</td>
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<tr>
<td>ECCH</td>
<td>East Coast Community Healthcare</td>
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<tr>
<td>EHC</td>
<td>Emergency Hormonal Contraception</td>
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<tr>
<td>GP</td>
<td>General Practitioner</td>
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<tr>
<td>GUM</td>
<td>Genitourinary Medicine</td>
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<tr>
<td>HIV</td>
<td>Hunan Immunodeficiency Virus</td>
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<tr>
<td>HSCIC</td>
<td>Health and Social Care Information Centre</td>
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<tr>
<td>iCaSH</td>
<td>Integrated Contraceptive and Sexual Health Services</td>
</tr>
<tr>
<td>LA</td>
<td>Local Authority</td>
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<tr>
<td>LARC</td>
<td>Long-acting Reversible Contraceptives</td>
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<tr>
<td>LES</td>
<td>Local Enhanced Service</td>
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<tr>
<td>LD</td>
<td>Learning Disability</td>
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<tr>
<td>MSM</td>
<td>Men who have sex with Men</td>
</tr>
<tr>
<td>NES</td>
<td>National Enhanced Service</td>
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<tr>
<td>NCSP</td>
<td>National Chlamydia Screening Programme</td>
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<tr>
<td>NHSE</td>
<td>National Health Service England</td>
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<tr>
<td>NICE</td>
<td>National Institute for Health and Clinical Excellence</td>
</tr>
<tr>
<td>PHE</td>
<td>Public Health England</td>
</tr>
<tr>
<td>Pop</td>
<td>Population</td>
</tr>
<tr>
<td>PSHE</td>
<td>Personal, Social, Health and Economic education</td>
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<tr>
<td>PHOF</td>
<td>Public Health Outcomes Framework</td>
</tr>
<tr>
<td>RH</td>
<td>Reproductive Health</td>
</tr>
<tr>
<td>SARC</td>
<td>Sexual Assault Referral Centre</td>
</tr>
<tr>
<td>SHNA</td>
<td>Sexual Health Needs Assessment</td>
</tr>
<tr>
<td>SRE</td>
<td>Sex and Relationships Education</td>
</tr>
<tr>
<td>SRH</td>
<td>Sexual and Reproductive Health</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>UTLA</td>
<td>Upper Tier Local Authority</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
</tbody>
</table>
References


6. Office for National Statistics. 2014. VS1 tables for 2010 to 2013


Appendix 1: Sexual Health Service Levels

Self-Managed Care
Service users of all ages will be able to access the following without the need to see a healthcare practitioner, although support must be available if needed. Those under the age of 16 must be seen by a worker trained to assess competence to receive sexual health advice and interventions in the absence of a parent or guardian and to ensure that safeguarding issues are identified and appropriately referred on.

- Health information
  - Generic information on pregnancy, STIs including and HIV prevention/safer sex advice
  - Information on the full range of contraceptive methods and where these are available
- Primary prevention initiatives to improve overall sexual health to the community
- Male and female condoms and lubricant
- Chlamydia home sampling kits for under 25 year olds
- Pregnancy testing kits

Some NHS self-managed services may be accessed online.

Basic and Intermediate Care (Level 1 and 2)
- Information on services provided by local voluntary sector sexual health providers including referrals and/or signposting
- Full sexual history taking and risk assessment (all practitioners)
- Pregnancy testing
- Supply of male and female condoms and lubricant
- All methods of oral emergency contraception and the intrauterine device for emergency contraception
- First prescription and continuing supply of combined hormonal contraception (combined and progestogen only) including oral, transdermal, transvaginal methods of delivery and a choice of products within each category where these exist
- First prescription and continuing supply of injectable contraception
- IUD and IUD uncomplicated insertion, follow up and removal
- Diaphragm fitting and follow up
- Uncomplicated contraceptive implant insertion, follow up and removal
- Assessment and referral for difficult implant removal
- Natural family planning
- Cervical cytology
- Direct referral for antenatal care
- Direct referral for abortion care and to support self-referral
- Counselling and direct referral for male and female sterilisation
- Domestic abuse screening and referral (all practitioners)
- Assessment and referral for psychosexual issues
- Assessment and referral for Brief Alcohol Interventions (BAIs)
- Referral for Female Genital Mutilation (FGM) specialist advice and care
- STI testing and treatment of symptomatic but uncomplicated infections in men (except MSM) and women excluding:
  - Men with dysuria and/or genital discharge
  - Symptoms at extra-genital sites e.g. rectal or pharyngeal
• Pregnant women (except women with uncomplicated infections requesting abortion)
  ○ Genital ulceration other than uncomplicated genital herpes

- Chlamydia screening for sexually active under 25 year olds
- Case Management of uncomplicated Chlamydia
- HIV and syphilis testing and pre and post-test discussions (with referral pathways in place)
- Initiation of Post Exposure Prophylaxis with referral to Level 3 for on-going management
- Promotion and delivery of Hepatitis A and B vaccination, with a particular focus on key target groups
- Hepatitis C testing and discussion (with referral pathways in place)
- Uncomplicated contact tracing/partner notification
- Management of first episode uncomplicated vaginal discharge (low risk)
- Management of contacts of gonorrhoea and TV (excluding symptomatic men)
- Assessment & treatment of genital ulceration with appropriate referral pathways for those at high risk of syphilis/LGV (Lymphogranuloma Venereum)
- Assessment and referral of sexual assault cases
- Holistic sexual health care for young people including child protection / safeguarding assessment
- Outreach services for STI prevention and contraception
- Problems with choice of contraceptive methods
- Management of problems with hormonal contraceptives
- Urgent and routine referral pathways to and from related specialties (general practice, urology, A&E, gynaecology) should be clearly defined. These may include general medicine/infectious diseases for inpatient HIV care
- Urgent and routine referral pathways to and from social care
- Regular audit against national guidelines

**Complex (Level 3) Service Provision in addition to Levels 1 and 2**

- Management of complex contraceptive problems including UK Medical Eligibility Criteria (UKMEC)
- Management of complicated/recurrent STIs (including tropical STIs) with or without symptoms
- Management of STIs in pregnant women (except women with uncomplicated infections requesting abortion)
- Management of HIV partner notification
- Management of sexual health aspects of psychosexual dysfunction
- Management of organic sexual dysfunction
- Coordination of outreach clinical services for high risk groups
- Interface with specialised HIV services as commissioned by NHS England
- Specialist contraception services e.g. IUD/IUS problem clinics, difficult implant removal etc. with appropriate diagnostic services (e.g. ultrasound) to support this
- Provision and follow up of post-exposure prophylaxis after sexual exposure to HIV
- Coordination of contraceptive and STI care across a network including:
  ○ Clinical leadership of contraceptive and STI management

90
- Co-ordination of clinical governance
- Co-ordination and oversight of training in SRH and GUM
- Co-ordination of pathways across clinical services
- Co-ordination of partner notification for STIs and HIV
## Appendix 2: Stakeholder Event; Organisations Represented

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Service</th>
<th>No of Rep</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cambridge Community Services (CCS)</td>
<td>Sexual Health</td>
<td>4</td>
</tr>
<tr>
<td>East Coast Community Healthcare (ECCH)</td>
<td>Health Improvement &amp; Young People</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Sexual Health</td>
<td>3</td>
</tr>
<tr>
<td>Great Yarmouth &amp; Waveney CCG</td>
<td>GPs</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Primary Care</td>
<td>1</td>
</tr>
<tr>
<td>Health Outreach NHS</td>
<td>Marginalised &amp; Vulnerable Adults Service</td>
<td>1</td>
</tr>
<tr>
<td>Healthwatch Suffolk</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>HMP Highpoint</td>
<td>Prison Health</td>
<td>1</td>
</tr>
<tr>
<td>Local Pharmacy Committee LPC</td>
<td>Aqua Pharmacy</td>
<td>1</td>
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<tr>
<td>Open Road</td>
<td>Drugs &amp; Alcohol Service</td>
<td>1</td>
</tr>
<tr>
<td>Phoenix Futures</td>
<td>Drugs &amp; Alcohol Service</td>
<td>1</td>
</tr>
<tr>
<td>Sexual Assault Referral Centre (SARC)</td>
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</tr>
<tr>
<td>Suffolk County Council</td>
<td>Children &amp; Young People’s Integrated Service</td>
<td>2</td>
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<tr>
<td></td>
<td>Children in Need (CIN) South/West Team</td>
<td>1</td>
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<td></td>
<td>Councillors</td>
<td>2</td>
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<td></td>
<td>Inclusive School Improvement Service</td>
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<tr>
<td></td>
<td>Make a Change (MAC) Team</td>
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<tr>
<td></td>
<td>School Nursing</td>
<td>6</td>
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<tr>
<td></td>
<td>Public Health</td>
<td>7</td>
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<tr>
<td>Suffolk GP Federation</td>
<td>Primary Care</td>
<td>1</td>
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<tr>
<td>Suffolk Refuge Support</td>
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<tr>
<td>Suffolk Young People’s Health Project</td>
<td>Young People’s Service</td>
<td>2</td>
</tr>
<tr>
<td>Terrence Higgins Trust (THT)</td>
<td>Sexual Health</td>
<td>2</td>
</tr>
<tr>
<td>The Matthew Project</td>
<td>Young People’s Drug &amp; Alcohol Service</td>
<td>1</td>
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<tr>
<td>West Suffolk &amp; Ipswich &amp; East Suffolk CCG</td>
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<td>1</td>
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</tbody>
</table>
Appendix 3: Service Users Questionnaire

Public Health Suffolk wants to improve the sexual health services available in our area. Sexual health services includes; information and advice; provision of a range of contraceptives (such as condoms, the pill or coils); screening and treatment of sexually transmitted diseases (such as chlamydia and gonorrhoea); and advice on pregnancy. Sexual health services are available in a range of settings such as specialist clinics, GP practices, pharmacies and some schools.

By answering this survey you would help us provide a service that is appropriate, accessible and of high quality.

All answers are confidential and you will not be identified from the information you provide.

Please answer all questions (unless stated)

Please return your completed survey using the freepost envelope provided.

1. How well informed do you feel about sexual health issues?
   - Very well
   - Not very well
   - Don’t know
   - Reasonably well
   - Not at all

2. Where would you go if you require help or support for sexual health issues?
   (please give 3 options in ranking order)
   1.
   2.
   3.

3. Have you ever visited any of the following for advice of help with sexual health issues?
   (please mark all that apply)
   - Your Doctor’s surgery
   - Venue just for young people
   - Your local sexual health clinic
   - Your local acute hospital (Ipswich, Bury St. Edmunds or James Paget)
   - Your community clinic
   - Pharmacy
   - School nurse
4. Where would you prefer to go for advice or help with sexual health issues? (please rank your first choice and so on, up to 8)

- Your doctor's surgery
- Internet
- Community clinic
- Friends or family
- A place just for young people
- Your local sexual health clinic
- Pharmacist
- School nurse

5. If you needed help or advice on sexual health issues, how far could you travel?

- Less than 1 mile
- 1 to 2 miles
- 2 to 5 miles
- 5 to 10 miles
- More than 10 miles

6. If you needed help or advice on sexual health issues, at what time would you prefer to be seen? (please mark all that would be suitable for you)

- Early morning before 08:30
- 09:00 to 12:00
- Lunchtime
- 14:00 to 16:00
- 16:00 to 17:00
- 17:00 to 19:00
- Evening after 19:00
- Saturdays

Other (please specify)

If you **HAVE** used a sexual health service before please answer questions 7, 8, 9, 10, 11
If you have **NOT** used a sexual health service before please go straight to question 12

7. When you visited the sexual health service(s), how did you get there? (please mark all that apply)

<table>
<thead>
<tr>
<th>Service</th>
<th>Driving</th>
<th>Got a lift</th>
<th>Walked</th>
<th>Cycled</th>
<th>Bus</th>
<th>Train</th>
<th>Other</th>
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<tr>
<td>Your doctor’s surgery</td>
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<td>Venue just for young people</td>
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<td>Your local sexual health clinic</td>
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<td>Your local acute hospital (Ipswich, Bury St. Edmunds or James Paget Pharmacy)</td>
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<tr>
<td>Community clinic</td>
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<tr>
<td>School nurse</td>
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<tr>
<td>Other (please specify)</td>
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</table>
8. When you visited the sexual health service(s), did you get the help you wanted? (please mark all that apply)

<table>
<thead>
<tr>
<th>Service</th>
<th>Yes, Completely</th>
<th>Partially</th>
<th>No, not at all</th>
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<tr>
<td>Your doctor’s surgery</td>
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<td>Venue just for young people</td>
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<td>Your local sexual health clinic</td>
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<td>Your local acute hospital (Ipswich, Bury St. Edmunds or James Paget)</td>
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<tr>
<td>Other (please specify)</td>
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9. What did the service(s) do well?

10. What did the service(s) NOT do well?

11. Would you recommend this service(s) to your family and friends?

☐ Yes  ☐ No

12. Are you?

☐ 15 or under  ☐ 21 to 25  ☐ 46 to 55
☐ 16 to 18  ☐ 26 to 35  ☐ 56 to 65
☐ 19 to 20  ☐ 36 to 45  ☐ 65 and above

13. Are you?
14. What is your ethnic group?
- ☐ White British
- ☐ Gypsy or Irish traveller
- ☐ White and Black Caribbean
- ☐ White and Asian
- ☐ African
- ☐ Any other Black background
- ☐ Bangladeshi
- ☐ Chinese
- ☐ Arab
- ☐ White Irish
- ☐ Any other White background
- ☐ White Black African
- ☐ Any other Mixed/Multiple ethnic background
- ☐ Caribbean
- ☐ Indian
- ☐ Pakistani
- ☐ Any other Asian background
- ☐ Other (please specify)

15. What is your sexual orientation?
- ☐ Heterosexual
- ☐ Gay
- ☐ Lesbian
- ☐ Bisexual
- ☐ Other (please specify)
- ☐ I do not wish to disclose this

16. Do you consider yourself to have a disability?
- ☐ Yes, Sensory impairment
- ☐ Yes, Mental health condition
- ☐ Yes, Longstanding illness
- ☐ Yes, Learning disability/difficulty
- ☐ No
- ☐ I do not wish to disclose this
- ☐ Yes, Other (please specify)

17. In which area do you live in?
- ☐ Babergh
- ☐ Ipswich
- ☐ St. Edmundsbury
- ☐ Forest Heath
- ☐ Mid Suffolk
- ☐ Suffolk Coastal
- ☐ Waveney

18. Please give the FIRST PART ONLY of the postcode where you live. E.g. IP14
   (This will not identify you but will help us plan better where services should go)

19. What is your employment status?
- ☐
Full-time Employment  □ Full-time Education  □ Retired □ Carer (Children)
Part-time Employment  □ Part-time Education  □ Unemployed  □ Carer (Adult)
Other (please specify) ____________________________

Thank you for taking part in our survey
Appendix 4: Primary Care Sexual Health Services Questionnaire

Suffolk Sexual Health Needs Assessment

Engaging with GP Practices

Public Health Suffolk is currently undertaking a piece of work to better understand the level and type of sexual health need across the county. The work will include consulting with service users and professionals to inform how services are commissioned and provided in future. We would be most grateful if you could take a few minutes to respond to the following questions.

1. What are the 3 most frequent presenting sexual health issues in your practice?

2. Are these issues that can be dealt with within the practice or are patients referred to specialist sexual health services?

3. Do you have much contact with local specialist sexual health services? Is there good knowledge of referral routes/location of clinics within your practice?

4. GMS practices only - How well does the current commissioning arrangements through the LES work for practices? And for patients?

5. Is there any training around sexual health that you would like for your practice?

6. In your view, what improvements could be made to sexual health services in primary care? And across the health system?
Appendix 5: Service Users Easy Read Version Questionnaire

Public Health Suffolk wants to improve the sexual health services available in our area.

Sexual health services includes:

**Information and advice;** provision of a range of contraceptives (such as condoms, the pill or coils)

**Screening and treatment** of sexually transmitted diseases (such as chlamydia and gonorrhoea)

**Advice on pregnancy.** Sexual health services are available in a range of settings such as specialist clinics, GP practices, pharmacies and some schools.

By answering this survey you would help us provide a service that is appropriate, accessible and of high quality.

All answers are **confidential** and you will not be identified from the information you provide.

**Please answer all questions (unless stated)** and please return your completed survey using the freepost envelope provided.
1. How well informed do you feel about sexual health issues?

- Very well □
- Reasonably well □
- Not very well □
- Not at all □
- Don’t know □

2. Where would you go if you require help or support for sexual health issues? (please give 3 options in ranking order)
3. Have you ever visited any of the following for advice of help with sexual health issues? 
*(please mark all that apply)*

- Your Doctor’s surgery
- Venue just for young people
- School nurse
- Your local sexual health clinic
- Pharmacy
- Your community clinic
- Other (please tell us)
- Your local acute hospital (Ipswich, Bury St. Edmunds or James Paget)

4. Where would you prefer to go for advice or help with sexual health issues? 
*(please rank from your first choice to last choice 1-8, continued on next page)*

- Internet
- A place just for young people
- Pharmacist
- Your doctor’s surgery
- Friends or family
- School nurse
5. Where would you prefer to go for advice or help with sexual health issues? 
(please rank from your first choice to last choice 1-8)

- Your local sexual health clinic
- Community clinic

6. If you needed help or advice on sexual health issues, how far could you travel?

- MORE THAN 10 MILES
- 5 TO 10 MILES
- 2 TO 5 MILES
- 1 TO 2 MILES
- LESS THAN 1 MILE
6. If you needed help or advice on sexual health issues, at what time would you prefer to be seen? (please mark all that would be suitable for you)

- Early morning before 8:30
- 09:00 to 12:00
- Lunchtime
- 2:00 – 4:00 PM
- 4:00 to 5:00 PM
- 5:00 to 7:00 PM
- Evening (after 7:00 PM)
- Saturdays

If you HAVE used a sexual health service before please answer questions 7, 8, 9, 10.

If you have NOT used a sexual health service before please go straight to question 12.
7. When you visited the sexual health service(s), how did you get there?
(please mark all that apply)

- Drove
- Got a lift
- Cycled
- Bus
- Train
- Other

- Your doctor's surgery
- Your local sexual health clinic
- Pharmacy
- School nurse
- Venue just for young people
- Your local acute hospital (Ipswich, Bury St. Edmunds or James Paget)
- Community clinic
8. When you visited the sexual health service(s), did you get the help you wanted? (please mark all that apply)

<table>
<thead>
<tr>
<th>Yes, Completely</th>
<th>Partially</th>
<th>No, not at all</th>
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</thead>
<tbody>
<tr>
<td>GP Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your doctor’s surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your local sexual health clinic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>School nurse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Venue just for young people</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your local acute hospital (Ipswich, Bury St. Edmunds or James Paget)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community clinic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please tell us)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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9. What did the service(s) do well?

10. What did the service(s) NOT do well?

11. Would you recommend this service(s) to your family and friends?

Yes ☐ No ☐
12. Are you?

15 or under □
16 to 18 □
19 to 20 □
21 to 25 □
26 to 35 □
36 to 45 □
46 to 55 □
56 to 65 □
65 and above □

13. Are you?

Male □
Female □
Transgender □
I do not wish to disclose this □
14. What is your ethnic group?

- White British
- White Irish
- Gypsy/Irish Traveller
- White & Black Caribbean
- White & Black African
- African
- Caribbean
- Any other black background
- Bangladeshi
- Pakistani
- White & Asian
- Chinese
- Indian
- Arab
- Any other Asian background
- Other
15. What is your sexual orientation?

- Heterosexual
- Gay
- Lesbian
- Bisexual
- I do not wish to disclose this

16. Do you consider yourself to have a disability?

- Yes, Sensory impairment
- Yes, Mental health condition
- Yes, Longstanding illness
- Yes, Learning disability/difficulty
- No
- I do not wish to disclose this
- Yes, Other (please tell us)
17. In which area do you live in?

- Hadleigh
- Ipswich
- Bury St. Edmunds
- Sudbury
- Ipswich
- St. Edmundsbury
- Mildenhall
- EYE
- Saxmundham
- Needham Market
- Woodbridge
- Newmarket
- STOWMARKET
- Brandon
- Suffolk Coastal
- Forest Heath
- Mid Suffolk

18. Please give the FIRST PART ONLY of the postcode where you live. e.g. IP14 (This will not identify you but will help us plan better where services should go)
What is your employment status?

- Full-time Employment □
- Part-time Employment □
- Unemployed □

- Full-time Education □
- Part-time Education □
- Retired □

- Carer (adult) □
- Carer (children) □

This survey was translated into easy-read by Ace (Anglia) LTD Using Photosymbols

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Appendix 6: Focus Group Questions

Questions to consider during the discussion:

- What is your knowledge of the delivery service availability?
- What is your understanding of the service?
- Can you tell us about your experience when using the delivery service?
- What did you like about the service?
- What didn’t you like about the service?
- How do you think the service could be improved?
- Is there anything else you would like to say about local sexual health services?