DRAFT DOCUMENT

Wolverhampton City Council

Sexual Health

Your Services ... Your Say

Evaluation Report

Wolverhampton

Sexual Health Consultation

Consultation Evaluation Report

3 November 2014 - 31 January 2015

Public Health Wolverhampton

Section One: Introduction

Introduction

This document outlines the findings from the consultation conducted by Public Health, Wolverhampton City Council, regarding the proposed remodelling of sexual health services in the city. The consultation ran for 12 weeks, between 3 November 2014 and 31 January 2015.

The intention of the new service model is to commission an integrated, joined-up sexual health system that will support Wolverhampton residents to live a healthy sexual and reproductive life. The proposed new system will support people in making confident, informed choices and will especially focus on vulnerable people.

Background

In March 2013, the Department of Health published 'A Framework for Sexual Health Improvement' which set out the national ambition for good sexual health. It provides a comprehensive package of evidence, interventions and actions to improve sexual health outcomes.

Sexual health is one of the five key national priority areas for public health. Our strategic vision is informed by the latest national policy and clinical guidelines. The key aims for Government are to improve the sexual health and wellbeing of the whole population by:

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

Our Challenge

Wolverhampton sexual health review (2013/14) identified particular needs within our population that includes:

- The current rate of teenage pregnancy in Wolverhampton is 42 per 1,000 population. Despite a significant improvement over the years, rates still remain above the regional (32 per 1,000) and national averages (28 per 1,000)
- The rate of teenage pregnancy varies by more than four times in different places across the city
- Almost 1 in 10 births to young women under 18 years are the result of a repeat pregnancy
- Abortion rates in Wolverhampton are consistently higher than the national average
- Wolverhampton's chlamydia positivity rates are higher than regional and national rates
- Almost 60% of HIV diagnosis is considered late
- A post-partum audit conducted on 354 maternity patient notes highlighted that 25% were 'vulnerable' mothers and additional resources are required to ensure vulnerable women access post-partum contraceptive advice

Section 1-Background

New proposed sexual health system

Overview

The planned changes are based on national research, new standards and local need. It is proposed that the services are remodelled into a city-wide 'sexual health system'. The rationale is to increase access to services and make every contact count. There will also be an increased focus on health promotion to improve outcomes for the city. The health promotion work will have two key aims: to increase awareness of available services, and to reduce the stigma attached to accessing services. This should lead to a higher uptake of sexual health services.

Nationally, the steer is for a model of one main building ('hub') with various sites ('spokes') in the community where both contraception and treatment for sexual infection will be available. In the main 'hub', all contraception and GUM services will be available for everyone. This will include people with complex issues, such as having an STI during pregnancy. 'Spokes' will offer more routine services, such as contraception and basic screening and treatment for STIs.

Additional services have been suggested to improve access locally and meet demand. All GPs will continue to offer routine services, but some GP practices will become specialists in contraception and treatment of STIs. This will provide greater choice and access to local services. Previously 'clinic in a box' was offered by youth services and voluntary organisations such as Base 25, Changing Lives and other health professionals (health visitors). These services will be rejuvenated as an integral part of providing essential contraceptive services and support in the community through a variety of 'natural settings' where particularly more vulnerable clients can be served. Some pharmacists will also expand their services to include chlamydia screening.

Further work will be required to develop sex and relationships education (SRE) in schools, this will established separately from this process and will include a focus on building young people's resilience with a particular emphasis on risky behaviours.

There will be one lead provider who must ensure that all aspects of the services described above are delivered. This includes one overarching clinical governance and risk management framework, quality assurance, contract management, consistent training, clearer service branding, marketing, communications and health promotion. The lead provider will also ensure services are delivered by GPs, pharmacies and any other providers, such as the voluntary sector.

Section 2- Consultation programme

This page summarises the activities completed during the consultation period. The consultation activity has involved a wide range of stakeholders including current service users and the general public.

Stakeholders	Activity
Public	Online public survey and information document published. This was promoted through Wolverhampton City Council social media
Public	Pop up shop, Mander Centre. Key questions from the survey were asked to the public
Public	City Direct centre managed phone calls and referred people to the interpreting service if required (from 8am-6pm Monday to Friday and 9am-2pm on Saturday)
GPs, pharmacies and voluntary/ statutory sector organisation	Stakeholder and professionals feedback forms published and promoted on the website
GP locality meetings across Wolverhampton	Introduction to sexual health model and commissioning process with initial feedback
Sexual Health workforce- delegates from GUM, CaSH, NCP, HIV prevention, GPs and pharmacies	One consultation workshop
Public and stakeholders events	Two consultation workshops
Local Medical Committee (LMC–GP forum) and Local Pharmaceutical Committee (LPC)	A presentation was given and the proposed model discussed with GPs and pharmacists
Team W (protected learning time for GPs)	Presentation and workshops with GPs
GUM/CaSH including other delivery sites e.g. colleges	Surveys and confidential boxes left for service users to complete
HIV prevention (Terence Higgins Trust), LGBT, substance misuse services	Surveys and confidential boxes left for service users to complete
Young people	Schools to facilitate focus groups 1 to 1 interview questionnaires with young people and young parents at Base 25 and Epic Café
Health Scrutiny panel	The panel scrutinised and endorsed the consultation plan

Section 3- Findings

Consultation workshops

Three workshops were held in total for members of the existing workforce, stakeholders and the general public, with delegates attending from GUM, CaSH, GPs, pharmacies local council and voluntary groups.

A total of 57 delegates attended the public and stakeholder workshops, however, there was limited attendance from the general public. Stakeholders who could not attend were asked to complete a feedback form and their responses are summarised below.

Delegates were consulted on the following categories:

- Integrating CaSH and GUM including developing identified 'spokes'
- Addressing the needs for vulnerable groups. including postpartum contraceptive care
- Training, competencies and quality measures across the system
- HIV prevention
- Community outreach and working with key partners
- GPs and pharmacies

Within each category, delegates were asked to reflect upon the following questions:

- Is this proposed model the correct approach? If not, why not?
- How would integration work in practice?
- Is this different for young people? If so, how?
- Is there anything we have not considered/missed?

Overall, there was support for the new model, with delegates agreeing that it was a positive move for local sexual health service delivery.

Integrating CaSH and GUM including developing identified 'spokes'

There was discussion around the stigma attached to GUM services. It was suggested that this stigma may decrease due to integration, as a service user could be attending for either CaSH or GUM. However, care must be taken to ensure that service users are not discouraged to attend due to the perceived stigma of a GUM clinic. There was some suggestion that the two clinics should remain split inside the facility. It was agreed that integration would result in a smoother referral pathway, with issues potentially being resolved in one appointment and the service user only having to attend one location.

The accessibility of the clinics, in terms of opening hours, flexibility of appointments and transport links was deemed very important. Discussions also focussed on the need for excellent promotion of services utilising modern technology. There was a strong consensus that there should be a central service directory or helpline, for both service users to access and for the workforce to use to signpost.

It was felt that we needed to ensure that the final model was deliverable to ensure that outcomes could be measured.

Addressing the needs for vulnerable groups including postpartum contraceptive care

It was agreed that there should be specific 'spokes 'for vulnerable groups e.g. young people only services, and that outreach should be used innovatively. Delegates spoke about the need to cater for vulnerable groups. It was suggested that existing contacts be developed for outreach work, for example, service users already accessing substance misuse services. The need for training around cultural awareness and cultural issues was highlighted, as well as potential challenges around interpretation.

Section Five: Findings

It was suggested that better co-ordinated services could be offered alongside CaSH interventions, for example, low level mental health support for those women who have had their babies removed from their care. A strong referral pathway and working collaboratively with midwifery and other health professionals was also recommended in order to encourage women to address their contraceptive needs earlier. Delegates also felt that service users with complex or additional needs (for example people with learning difficulties) could be co-ordinated through the main 'hub' with support from other providers.

Training, competencies and quality measures across the system

Delegates agreed that good training was essential for the new model. They told us that there should be a minimum level of training for all workers, and that training should be standardised and follow a competency framework dependent on the level of provision and role. However, it was suggested that the training programme needs to include how to engage with vulnerable groups.

There was some discussion about the feasibility of dual training for all CaSH and GUM staff, including sessional staff who cover absence and busy periods . It was important that every one was trained and could offer the full range of sexual health interventions.

HIV prevention

There was universal agreement that the stigma around HIV prevention and testing must be reduced. It was highlighted that testing for HIV should be available more widely, possibly as a routine test alongside other tests, or when a new patient registers with a GP. Delegates discussed the need to diagnose early and for health providers, particularly GP's and hospital staff, to be aware of the 'warning signs'. There was also discussion around addressing myths about HIV, for instance promoting the benefits of early diagnosis and that it is no longer a 'death sentence'. There were varied opinions regarding point of care testing, for example, in pharmacies where there may not be sufficient follow up support if a positive result is detected.

Community outreach and working with key partners

It was agreed that community outreach was an essential part of the new model. It was recommended that relationships with existing partners be expanded and their expertise utilised, for example, voluntary groups that may have existing contact with vulnerable people. Level 0 training could be offered to people within the community, such as foster carers and voluntary workers. There was a suggestion that a 'spoke' could be attached to a school or college. Emphasis was placed on providing services when and where users needed to access them, for example, at night time for 'sex workers'. Some delegates suggested that some users may feel uncomfortable using services close to home in case they were seen by friends or family, but this could be resolved by using a central, more 'anonymous hub' instead. Suggestions of partners to deliver 'spokes' included health centres, youth groups, pupil referral units, Looked After Children nurses, the leaving care team, hostels and supported housing.

GPs and pharmacies

It was suggested that GP and pharmacist training needed to be high quality and auditable. There may be a particular need for training around issues for young people, HIV and LGBT service users. There were some concerns about the availability of GP appointments and that pharmacists may need a separate consultation room to ensure confidentiality.

Section 3- Findings

Overall, the key findings from the workshops were:

- the importance of effective promotion of services
- one directory of services for users and professionals
- expansion of innovative outreach services
- targeted services for certain groups
- the importance of a robust quality assured training programme
- effectively managing the potential stigma of joint GUM and CaSH clinics

Recommendation 1: Effective communication and promotion of all services through the use of modern technology; investigate the potential to create a single point of contact (SPOC) directory for both service users and professionals to use for signposting

Recommendation 2: Develop a robust co-ordinated sexual health offer enhancing outcomes, particularly to vulnerable groups, by linking up with other key services such as maternity, Local Authority Children and Family Services, Drug and Alcohol Services and the Sexual Assault Referral Unit

Consultation with Young People

A series of young person specific consultation events were conducted in five schools, one special school, one young parent group and one drop in at Base 25, a young person's service base. There was overall support for the model of integrated CaSH and GUM and enhanced GP surgeries. Young people stated that they wanted services to be centrally located (although discreet) with good transport links. The 'spokes' would provide a local offer for those who favoured locally based services.

Confidentiality was a significant issue for young people, they perceived that there was a lack of understanding of their right to confidential services and that there was no trust that confidentiality would be maintained by professionals. Acceptance was raised as an important issue for young people, both by peers and professionals. Not wanting to be judged negatively was frequently highlighted and it was felt that greater social acceptability should be attached to taking care of your sexual health needs. One group stated that the fear of social reaction outweighed the fear of becoming ill. Participants indicated that there is a clear need to focus on communication, marketing and promotion of local services as this was cited as the main barrier to young people accessing services. Suggestions included better advertising of location and services offered.

The top three ways young people want to access information was through school/education, the school nurse and online. Youth settings, pharmacies and GP surgeries were also seen as a good source of information. The role schools can play was stressed both by those currently at school and those that had left.

Section Five: Findings

Responses were also evenly split between self-testing for STIs and testing by professionals. GPs were frequently cited as the way young people would access services currently, but often the main reason for this was that they were unaware of local alternatives.

Young people with physical/learning disabilities answered questions in a similar way to the rest of the sample except for they preferred a split waiting area. They also emphasised the importance of accessible transport for young people with physical/learning disabilities.

Overall young people wanted better information on what is provided and where in order to access services more effectively.

Recommendation 3 : Develop communication, health promotion and social marketing plans to address the stigma associated with sexual health amongst young people, encourage use of services and educate young people on their rights to confidentiality

Recommendation 4: Ensure that a young person focused offer is developed with particular links to young people services including schools

Recommendation 5: 'You're Welcome Standards' should be adopted to drive quality

Current service users of Terence Higgins Trust (HIV support)

Surveys were conducted with current service users of the Terrence Higgins Trust. The majority of service users believed it would be beneficial to have an integrated CaSH and GUM service. Although 64% of the participants approved of mixed gender waiting rooms, one of the key concerns around the integrated model was regarding confidentiality and seeing people you know at the clinic. Service users agreed that GPs could provide enhanced services but raised issues around availability of appointments and short appointment times.

A small number of service users raised concerns around confidentiality with their GP and that they wouldn't want their GP to know they had contracted an STI/HIV. Respondents indicated they would be happy to use 'self-service' to access condoms and although GPs are seen as important in delivering contraceptive methods, condoms and pregnancy tests, they were not rated as highly as a choice for STI/HIV testing. There was no response regarding access to EHC, which could suggest either the acronym isn't recognised or there is no awareness of emergency hormonal contraception.

Service users indicated that self-service chlamydia testing would be welcomed. Respondents wanted a mix of drop in and fixed appointments available with primarily telephone booking. The most important factor regarding location was accessibility and proximity to public transport. They also emphasised their desire for the service providers to listen to them, be friendly, welcoming, polite and for clinics to run on time.

Section 3- Findings

Primary Care

Local Pharmaceutical Committee

The Local Pharmaceutical Committee (LPC) supported the model but added that consideration should be given of how pharmacies can contribute to the model. They proposed providing EHC to young people with safeguarding training, the collection of samples for STI testing, oral contraception, free condom provision, chlamydia screening and treatment, testing for Blood Bourne Viruses and signposting to sexual health services.

The LPC requested that in the commissioning of services, consideration needs to be given to the time required to deliver a professional and sensitive service which should be reflected within a fair tariff. There was concern that time pressures could decrease the effectiveness of the service. Training was highlighted as key to ensure the standard of service is maintained, particularly for new staff.

Team W (protected learning for Wolverhampton GPs)

The proposed model was presented at the workshop feedback indicated that the integration of CaSH and GUM was viewed positively. However, GPs raised a number of concerns regarding the proposed role of primary care in the model, including:

- Lack of capacity within GP surgeries, with resources already over-stretched
- Routine HIV testing being too time consuming, especially with any additional counselling that may be required
- Concerns that standard GP appointment times of ten minutes was too short to provide a thorough sexual health examination as highlighted in the model

GPs suggested that if the model was put into practice, HIV testing and other sexual health services could be provided by non-GPs or nurses within the practice. This could include receptionists signposting how to get a HIV test or providing DIY testing boxes in the surgery, which is already underway in some surgeries for chlamydia testing. GPs wanted to understand the demographic of their patients in more detail and requested data for their surrounding areas regarding transmission and infection rates. It was suggested that a small number of selected surgeries could provide the enhanced services in areas of need, which may reduce unnecessary training for GPs where there is low demand for such services.

The general consensus was that level 2 services were too complex for most GPs to deliver at this point and that the current capacity would restrict provision of these services.

Recommendation 6: Expand sexual health services allocated to pharmacies in the new model

Recommendation 7: Scope further developmental work and training with GPs and Practice Nurses to ensure that engagement and capacity building is prioritised prior to rolling out the primary care element

Other feedback

Other feedback from a variety of sources has been positive. During the pop up shop, we asked members of the public two simple questions:

1. Is it a good idea that GUM and CaSH are delivered together?

2. How important is it for at least one building to be centrally located?

32 respondents out of 35 agreed that CaSH and GUM should be integrated and 30 respondents out of 35 indicated that the main 'hub' should be centrally located.

The new model was also reviewed by the Health Scrutiny panel who were supportive of the proposal particularly, in regards of the outreach work in areas of most need.

Public survey results

492 responses to the survey were received. The majority of the survey was completed by the following age groups 16 -24 (40% *n*=137) followed by 25-34 (25% *n*=86) and 35-44 (19% *n*=64). The majority of the participants were White British (63% *n*=208) followed by smaller numbers from the following ethnic groups; Asian British, Black Caribbean, Black British, Black African, Black and White Caribbean, Black British African and White Polish. Some analysis has been done by differentiating between White British and all other ethnic groups – however, this is caveated by the acknowledgement that within the non- White British group there are many differences, interests and backgrounds and therefore it is very difficult to draw any firm conclusions – rather, these statements are intended to raise issues to consider whilst commissioning, rather than to provide any firm 'findings' regarding various demographics.

Overall, there was support for the proposed model, with 79% (*n*=375) of respondents agreeing that a joint service under one roof was a good idea. The biggest concerns about an integrated service was a lack of privacy and a busier service, but respondents also acknowledged that it could be more convenient to refer between the two services under one roof. Concerns around enhanced GP services included insufficient appointment slots available and that GPs were already too busy. There were some concerns regarding not wanting their GP to know they had an infection and GPs lack specialist training in sexual health. However, 20% (*n*=49) of respondents said there would be no issues seeing their GP for their sexual health needs. A small majority (52% *n*=219) said that mixed male and female waiting rooms was a good idea and only 30% (*n*=123) specifically said they did not want mixed waiting rooms.

Concerns around mixed waiting rooms centred around feelings of embarrassment, but those who preferred mixed rooms said that being able to wait with your partner would be beneficial. Respondents who were not White British tended to be more likely to be opposed to mixed waiting rooms (38% *n*=40 said separate areas should be provided). The most important attribute of the clinic was to feel 'friendly', followed by 'professional' and 'child friendly'.

Section 3- Findings

There was equal preference for booked appointments only and a mixture of booked and drop in clinics, and booking by phone was by far the most popular option, with 353 respondents (83%) choosing that option, followed by online. (Respondents could select more than one option). The internet was the most popular option to find information regarding sexual health, although non-White British respondents were less likely to prefer the web, favouring face to face information as much as the internet.

Survey participants valued a central location, with parking and good public transport links. Some respondents said that they wanted the clinic to be central but located in a discreet or more private place. There was agreement that voluntary sector organisations should be used to help deliver sexual health services and when asked about where community services should be located, need was rated as the most important factor when considering location.

Pregnancy testing, Long Acting Reversible Contraception, and STI screening and treatment were the most popular sexual health services required from the GP. Respondents were more likely to use their pharmacy for free condoms and Emergency Hormonal Contraception. Overall, people aged 16 – 24 were more likely to use sexual health services at pharmacies than the general population. The most popular time for a HIV test would be when attending a sexual health clinic, followed by at a hospital appointment or when registering with a new GP. There was a limited response to this question.

There was equal preference to be tested for chlamydia by a professional and through a self-testing kit, which most respondents would prefer to collect from either a pharmacy or sexual health clinic. The most popular places to get free condoms and lubricant from were the sexual health clinic, GP and pharmacy and a third (*n*= 42) of 16 – 24 year olds said that the cost and/or availability of condoms and lubricant prohibits use. Overall, 35% (*n*= 123) of respondents thought that the changes would make them use the service more and 39% (*n*= 138) would use them the same amount. Participants thought that the changes would have a positive impact on members of vulnerable groups, primarily due to improved access to services.

Recommendation 8: Address equality gaps through an equality impact assessment that is shared with potential providers

Recommendation 9: Detailed summary of the survey to be distributed to potential providers in order to ensure that comments and suggestions are incorporated into service delivery plan

Section Five: Next Steps

This report will be published on the website below and presented to the Council's Health Scrutiny Panel. The next steps are highlighted in the commissioning timeline outlined below

Notice of re-commissioning and re-tendering	Commissioning Intentions have been notified to all current services in February/March 2015. Notice will be served in line with contractual requirements and the commissioners will work to minimise any uncertainty about services over the next 12 months.
Consultation	Public consultation on the sexual health proposed model ran between 3 November 2014 to 31 January 2015. Consultation findings/recommendations will inform the final specification.
Market day event	Invite Sexual Health providers to discuss model and commissioning intentions on 20 March 2015
Tendering process and contract awarded	May 2015 – December 2015
Start of new Sexual Health Service	June 2016

Section Six: Glossary

CaSH clinic: -Contraception and Sexual Health Clinic: an integrated Family Planning and STI clinic

Chlamydia: a sexually transmitted infection (STI) caused by bacteria

Contraception: a range of methods for preventing pregnancy, including use of hormones, surgery and devices

Commissioning: is the process by which Local Authorities decide how to spend the money they receive to get the best possible services and outcomes for local people to meet the needs of the community

Emergency Hormonal Contraception : commonly known as the "morning after" pill. Used to prevent pregnancy after unprotected (without a condom or other form of contraception) sex

GUM: genitourinary medicine: the diagnosis and treatment of sexually transmitted infections (STIs)

GUM clinic: Genitourinary Medicine clinic: also known as sexual health clinic - they provide a range of sexual health services to treat and prevent sexually transmitted infections. Sometimes combined with family planning clinics

HIV: Human Immunodeficiency Virus: a sexually transmitted virus that attacks the immune system and may lead to AIDS

LARC: Long Acting Reversible Contraceptives - A range of "fit and forget" contraceptives which can be used by all women for example implants or depo injection

Point of care testing (POCT): these are simple medical blood tests which can be performed in a non-clinical environment

Post-partum: the period beginning immediately after the birth of a child and extending for about six weeks

Procurement: the process of purchasing goods and/or services.

Service specification: a detailed description of the nature and scope of the service required, the user groups for whom the service, will be provided and the overall purpose and aims of the service.

Sexual health clinics: provide a range of sexual health services to treat and prevent sexually transmitted infections. Sometimes combined with family planning clinics-i.e. GUM

Sexually transmitted infections (STIs): infections passed by oral, vaginal and anal sexual contact

Tendering: the process of inviting parties to submit an offer to provide goods and/or services by public advertisement, followed by the evaluation of offers and selecting a successful bidder.

Your Services ... Your Say

Sexual Health

For more information contact:

Ravi Seehra

Public Health Commissioning Officer
Wolverhampton City Council

E-mail: phcommissioning@wolverhampton.gov.uk

Or telephone (01902) 557949 or 558667

Public Health Wolverhampton