Engagement report: sexual health services re-commissioning

Thank you for taking part in the development of our specification for sexual health services. We have now put this out for tender and anticipate appointing a provider in February 2015. We had over 1230 responses during our listening exercise and have set these out as an Executive Summary and in detail below.

For further details on this report please contact the Sexual Health Commissioner at: publichealth@cheshireeast.gov.uk tel 01270 686 435

Our intended approach to Engagement & Consultation is set out below:

<table>
<thead>
<tr>
<th>Audience</th>
<th>Method</th>
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<tbody>
<tr>
<td>1/ All residents, sexually active or not in Cheshire East, [whether permanently or temporary resident</td>
<td>On line generic survey promoted by CVS, and Local Healthwatch and a Young Person specific survey</td>
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<tr>
<td>2/ Priority and Protected Characteristic Groups (identified through an EIA)</td>
<td>Utilise various internal and externally supported focus group opportunities in addition to the on-line survey</td>
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<tr>
<td>3/ Stakeholder/Service User representatives</td>
<td>2 events based on CCG footprints in addition to the on-line survey</td>
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<td>4/ Potential service providers</td>
<td>Early Market Engagement event at the start of our engagement work and a further event prior to the commencement of the procurement</td>
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Note due to low numbers booking onto events we decided to undertake 1 stakeholder event only.

Executive Summary

In total our engagement activity reached approximately 18k people (this includes those who visited the surveys but did not complete them and those reached by a Facebook ‘boost’) We subsequently received 1230 responses. The majority of these came through the young peoples survey (1021). Responses were also obtained by focus groups/partner engagement.

Note: The definition of ‘response’ does not include abandoned survey responses (did not commence) which in the case of the generic/detailed survey were 560 (full completion by those who started 63%). Figures for the Young People survey were 318 abandoned responses a ratio of about 1:3, the opposite of the detailed survey (3 abandoned for 1 completion)
From the generic/detailed survey there was strong agreement with contraception services being provided in the community through GPs or clinics (34% n16) with sexual health services being provided in community buildings 25%, n12) alongside other services. With regard to and with some STI treatments being provided by GPs there was a low response (9% n2), and much stronger support for both contraception advice (55% n26) and treatment (86% n19) to be provided by a sexual health service in a hospital setting.

Key themes to emerge from the ‘ways to improve access to services’ were (scoring at least 30% of responses):

Close to home, near to school/college/workplace, car parking nearby, opening times to suit, confidentiality, telephone advice/support, support for partners, drop-in service, same day appointments, on-line booking, private consultation space.

Using wordle software which groups responses by frequency of use (as a proxy for level of interest), the following themes emerged regarding; ‘How to improve services for contraception/STIs’; offering more appropriate times/more flexible appointments, having the right people to provide services (skilled communicators to help with a sensitive subject), provide more services at GPs ie at times where they can be accessed by everyone (working age, young people)

Using the same technique the following themes emerged from the ‘Any other comments’ question: be consistent in the way in which you provide services, staff should make service users feel comfortable when accessing services and be as helpful as possible as coming into treatment can be very daunting.

For young people, pharmacies could provide safe sexual health advice and information with strong support for ‘free condoms’ (90% n925), Chlamydia Screening (64%, n659), Contraception advice (66%, n673) and Free starter packs for women to start on contraceptive pill (59%, n604) but less support for ‘relationship advice’ (34%, n345). Pharmacies, community sexual health services, GPs, schools, colleges and University were all popular responses to ‘Where should young people obtain Chlamydia screening kits’. The use of social media (twitter/facebook etc) and telephone were not universally popular ways to provide health advice and information to young people, with most preferring to use face to face contact (66% n625) or trusted sources on the internet (61%, n572)

We asked ‘How could we ensure doctors surgeries are more welcoming to young people?’ and were told similar things to the detailed survey;

We need to provide more appointments at times which suit young people ie after school in places they happy to go ie GP/Pharmacy. Young people said its sometimes difficult to access sexual health services which have been designed specifically for them as anonymity can be a problem.
Engagement with people with Learning disabilities found that they expressed similar needs to the general population and young people. The main difference is that they would not see themselves accessing services directly but much more likely to do so with a worker/carer/parent. This suggests that any new services should include a strong emphasis on supporting carers/parents/staff to manage sensitive interactions with clients to enable them to access services/enjoy a healthy sex life.

Similarly, engagement with BME communities suggests that first contact with services is unlikely/if at all with some communities and again a strong emphasis should be made to supporting voluntary/community groups trusted by communities to enable potentially vulnerable people to access appropriate services (inc safeguarding)

Feedback from LGBT communities suggest on-going worries about confidentiality and visibility (being recognised accessing services), as well as other access issues such as timing of clinics (lack of after-work provision) and the loss of emphasis on HIV prevention are of concern.

Cared-for young people/care leavers felt that it was very difficult to access discreet sexual health services, that sex education was very variable in quality and scope and that knowledge of how to access services was low amongst peers. Most information is accessed via the internet or through word of mouth ie there was little/no recall of any printed sexual health information.

**Findings from Generic Survey**

We received 110 completed generic surveys. We have noted that a small number of these responses may have been provided by organisations on behalf of their members/clients etc. It is not possible to be positive about this as we did not require respondents to indicate if they were a service provider. 18% of respondents provided further comments (Q 19-21) and of these 2/3rds appear to have been from professionals working in sexual health.

Some questions included very small numbers of responses due to routing. Where this is the case findings have been aggregated.

75% of respondents were female, 1% indicated they were now in a different gender to that they were born with, 90% declared their ethnicity as White/British, 85% of respondents said they were heterosexual, 4% gay/lesbian, 5% bisexual and 5% prefer not to say. The majority of respondents found out about the survey through social media 37% or through service providers inc schools, 40%.

Approximately 60% of respondents had used sexual health services in last 12 months, for contraception advice/supplies 46%, STI infection advice/test/treatment 21%, cervical screening 19%
Of those requiring contraception advice supplies approximately 30% accessed GPs, 30% via East Cheshire Centre for Sexual health (Macclesfield Hospital), 20% from Leighton Hospital - Centre for Sexual health and 20% from a community clinic (n8)

Of those requiring a cervical smear 50% went to their GP and 50% to either Leighton or Macclesfield Centres for Sexual Health.

We requested postcodes from respondents and were able to match 38% (n72) of records to a LAP. See below. With these small numbers it is not possible to be confident of the representativeness of the insight in relation to specific LAPs. Subsequent data is therefore not split by LAP.

In response to the question regarding why respondents had not used services, the most significant response were ‘not at risk of pregnancy/not at risk of an STI’

The top 3 responses to ‘Where was your main source of information about contraception/STIs’ were: GP 39%, local sexual health service 56%, internet 37%

Top 4 responses to ‘How do you know where to go to get advice about contraception/STIs’ were: from a service i’ve used before’ 48%, website/on-line 35%, Health worker 40%, friends/word of mouth 21%

In response to; ‘Where do you think EHC should be available’ the top 4 responses were; GP 80%, Community Pharmacy 77%, Community Sexual Health service 81% and school nurse 54%
Most respondents found location, opening times, quality of service from doctors and nurses good or very good. Approximately 25% of respondents felt the appointment systems were unsatisfactory. (50% had accessed services at the hospital 25% via their GP and 14% at a community clinic)

Numbers of response regarding the welcome provided by services were low but a number of respondents rated the welcome at GP slightly worse than the hospital service.

Respondents suggested the following opening times 8-10am 30%, 10-4pm 30% and 6-8pm 60%

Key issues to improve access to services were (scored by at least 30% of respondents):

Close to home, near to school/college/workplace, car parking nearby, opening times to suit, confidentiality, telephone advice/support, support for partners, drop-in service, same day appointments, on-line booking, private consultation space,

Using wordle software which groups responses by frequency of use (as a proxy for level of interest), the following analysis has been undertaken on ‘How to improve services for contraception/STIs’;
Discounting use of words from the question, revisiting key themes provides the following insight. Respondents felt that services should offer more appropriate times/more flexible appointments, having the right people to provide services (skilled communicators to help with a sensitive subject), provide more services at GPs ie at times where they can be accessed by everyone (working age, young people)

Using the same technique the following themes emerge from the ‘Any other comments’ question:

Again discounting use of words from the question, revisiting key themes provides the following insight: services should be consistent in the way in which they provide services, staff should make service users feel comfortable when accessing services and be as helpful as possible as coming into treatment can be very daunting.

**Findings from the young people’s survey:**

Through joint working with a young people focused provider we have been able to generate a large number of responses using paper copies.

A total of 1021 surveys were returned. There were 318 abandoned responses online, a ratio of about 1:3, the opposite of the detailed survey (3 abandoned for 1
completion)

Responses to ‘what services could pharmacies provide to help young people have safe sexual health’ were spread evenly across options with exception of a higher response for ‘free condoms’ and a lower response for ‘relationship advice’ (the other options were; Chlamydia screening, contraception advice/supplies, appointment booking, info about STIs)

In response to ‘Where should young people obtain Chlamydia screening kits’, options were equally popular with exception of youth support service and social venues (options included; pharmacies, community sexual health services, GPs, schools, colleges and University)

We asked ‘How could we ensure doctors surgeries are more welcoming to young people’ and were told;

Discounting words from the question and then revisiting key themes provides the following insight which was supported by the detailed survey;

We need to provide more appointments at times which suit young people ie after school in places they happy to go ie GP/Pharmacy. Young people said its sometimes difficult to access sexual health services which have been designed specifically for them as anonymity can be a problem. Services should be staffed by professionals who can work with credibility amongst young people and not be judgemental.
Finally we asked; ‘Which method was the best way to provide health advice and information to young people’. All options were popular with exception of social media (twitter/facebook etc) and telephone. Popular options included; face to face, printed material, the internet, text messages, and smart phone apps.

**Priority groups for additional insight**

Our initial assessment of the *priority groups* that could be disproportionately affected by changes to service provision is as follows:

- Children and Young People Cared for and Care leavers
- Young People and adults with a Learning disability
- Lesbian, Gay, Bisexual and Transgender
- Minority Ethnic groups

We have completed focus groups with Learning disability and LGBT groups and a partner organisation has provided feedback from minority ethnic groups and children and young people cared for/care leavers

**Findings from learning disability groups** (30 participants);

- The range of disabilities covered by the term learning disability makes it very difficult to generalise. Many of those attending groups were living independently whilst others were profoundly disabled. Whilst these groups may experience different levels of access to services, the group agreed that people with LD are unlikely to access services independently and the first point of contact for service users was likely to personal/social care providers not mainstream health services (GPs) and certainly not specialist services (GUM). Participants and their staff/carers find the subject area very difficult to manage and more support should be provided by sexual health services to service providers such as those working in daycare/personal care. For example safeguarding procedures are paramount in LD work and yet this may sometimes be a cause of conflict over the rights of people using services to have relationships.

- Some participants report that the patient passport scheme works well to support people using hospital services and that this could be extended to include access to sexual health services. However, this scheme was not widely understood within the LD community at present and some concern was expressed about the passport being ‘patient held’
People with learning disability and their carers report use of telephone and to some extent smart phone and digital technology however popular applications were for gaming rather than accessing healthcare.

Group participants stressed the importance of friendship and relationships being a key part of their care plans and in most cases reported that these were discussed with key workers/social workers/personal assistants and/or mum and dad. One of the groups attended included parents and volunteers. Both reported concern regarding their knowledge, skills and experience to enable them to respond to young people who wish to form close/personal relationships with friends.

Parents and volunteers suggested a telephone helpline would be very helpful to both clients and carers to provide advice and support where friends wished to develop a close/personal relationship.

Group participants stressed the importance of not relying on a single method of information provision for example printed material (even in easy-read format) should be supported by face to face reinforcement from a trusted worker. Role play was suggested as a particularly useful technique for reinforcement.

Workers and volunteers participating in the groups voiced strong support for availability of policies and procedures for dealing with issues such as disclosures of abuse/incident management as well as low level advice and guidance/sex education. These policies and procedures should also be available to all professionals likely to be involved in incident management ie the police.

Participants felt that use of alternative pathways for healthcare ie use of GPs and Pharmacies may prove quite challenging for clients and families who have experience of using the hospital for healthcare. Role models or champions from the community who use GP/Pharmacies might provide a useful way forward.

The groups felt that self-care for people with learning disabilities relies on the rest of the community to be very supportive. The development of ‘safe-zones’ in cities such as Liverpool (for lost children and adults/children escaping violence) could be expanded to provide information and signposting to health services including sexual health within the new specification.

Parents and carers felt very strongly that sexuality, gender image, sexual abuse should all be covered more thoroughly in the sex and relationship education given to young people in school/college.
Findings from LGBT group (5 participants);

Participants reported high levels of concern over data sharing between services and general need for assurance of confidentiality regarding medical records.

Access to primary care services was reported as good however, some concern was expressed about the ability of primary care to ‘do more with less’ If the plan is to do more in primary care instead of the hospital there should be no loss of quality of service. There was also some concern about primary care referring anyone with sexual health query straight to hospital without exploring the ability to manage this at the practice.

Participants reported some concern over the amount of paperwork required at each attendance, the timing of GU provision (after work), some reflections on poor customer care (at hospital), test result notification and a lack of enthusiasm for use of social networking sites for sexual health information. ‘There is a time and place for this and it should be accessed when I want it not when you want to provide it’.

The group felt very strongly that vertical integration wasn't as much of an issue as integration with for example mental health services. They would like to see much stronger pathways to/from statutory and vol/comm. sector services

In terms of prevention the group felt that HIV still presents a huge risk for young people gay or straight and the access to pornography via the internet depicting risky sexual behaviour is fuelling risk taking for adults and young people. This misinformation (that HIV is no longer a risk) needs to be countered.

Findings from Pathways CIC (90 persons): Insight provided by Pathways CIC;

Over 90 persons consulted within Cheshire East, 80% of whom were aged between 18-40. Majority female as many males would not comment due to the sensitive nature of the topic.

Many of the younger females engaged of South Asian ethnicity had raised that they would like to be better informed of local services and general sexual health. However due to the sensitivity of the subject, it was suggested it would need to be delivered in a controlled environment/manner as cultural limitations such as arranged marriages, religious beliefs prohibit discussions. There is a high degree of embarrassment when discussing sexual health, family environments limit conversations, some young persons engaged suggest that when in education, they are unable to partake within sexual health classes as parents had requested their withdrawal. Families that have resided within Cheshire East for many years had in some respect adopted 'some' westernised behaviours and therefore the topic of sexual health services has slightly advanced. Women in general appear to be more open minded however are limited by the direction of their partners.
There is a real misinterpretation of the term sexual health, and its connotations. Our social inclusion coordinators had to structure most of the consultations in such a manner that we had to deliver incredibly brief interludes on the meaning of sexual health. Lack of knowledge of the types of sexual health services and types of infections across all ethnicities was evident.

Many of those consulted suggested they would visit their GP first for information who would refer into specialist services. There is a level of embarrassment with this however, and a further barrier for those with limited levels of English, and where translator support was necessary.

It was identified by some of those engaged of Polish ethnicity, that they would travel back to native country services to speak directly with a Gynaecologist. This can risk the potential of conflict when attending services within the UK as services operate very differently.

Ethnicities engaged: Zimbabwean, Polish, Bangladesh, South-African, Slovakian, Chinese, Thai, Spanish, Arab, Irish, Slovakian, Nigerian.

The views/opinions appeared more linear to how services are delivered within the UK and meeting patient expectations within those of a younger age. Many of those consulted over the age of 40, limited the conversations and felt that we were not the right people to be discussions such sensitive issues with, often suggesting that GPs were. Any engagement with men was incredibly difficult.

**Findings from Cared for Children/care Leavers** (9 participants) **Insight provided by the Children’s Society**;

Young Advisors’ Report -Children in Care Council -

The group worked with had an age range of 17-21 and was 2/3 male. Participants were Cared for young people in residential units; age 14-16.

Problems with the current service in schools:

- They felt current sexual health education was poor; feeling it was too brief and missed things out.
- There was differing opinions about how helpful school nurses are as some were described as fantastic and others missing and unapproachable.
- One young person mentioned as to how their sexual health education had been delivered by an IT teacher and important elements such as contraceptive options weren’t included.
- Another important issue is that the young people felt as though people with special needs do not receive enough attention in sexual health education but
this also went as far as to say services do not do enough to help them in general following school.

- The young people also raised concern to the lack of sexual health education given to those who had low attendance at school as they simply didn't receive their education.

- Young people who had experienced sexual health assemblies said they did not work well as students did not take it seriously.

Suggested ways to improve current service, in schools:

- Ensure all students receive a thorough sexual health education regardless of attendance.

- Make school nurses a more prominent figure in schools and have the nurses deliver the education rather than general subject teachers.

- Provide a sexual health education which is accessible to all children despite their differing needs - paying extra attention where necessary.

- Young people expressed an interest in sexual health services being advertised in schools, for example informational leaflets being available.

Drop-in Clinics:

- The young people felt these should be advertised well and felt there should be one of these or a sexual health clinic available every day of the week.

- Young people expressed that the advertisement of services weren’t good enough as they did not know the time, or location, of their nearest drop-in centre,

- Convenient as the hospital can be difficult to get to, and also many young people said that they disliked attending the hospital.

- They highlighted that their doctors surgery would be the best place to access the service as they could hide the sexual health nature of their visit to others. Doctors opening times would be ideal and a Saturday proved to be the most popular day.

- They said that they would be less likely to attend a clinic or a youth club to access the service.

- Young people did not like the drop-in at Crewe youth hub as it was not private enough and everybody knew what they were going for. It is also open only one day a week for a short period of time which is inconvenient.

Waiting times:
Should be same day or next day maximum, instant treatment popular.

They all felt strongly that contraception should be available on the door and be easily accessed. Some young people said that they would prefer to receive contraception at a confidential appointment, where they could receive more information.

What services should be available in the future?:

- Free contraception readily available, large emphasis on the need for this in schools and colleges too and the positive of Reaseheath College already supplying this.
- Clinics/doctors surgeries with services on offer between 4-9 pm

Advertising the service:

- Posters in schools, colleges and youth clubs - toilets seemed to be a popular place for these to be displayed.
- Leaflets about the service - ideally discreet. They should have information about where advice, free contraception and where clinics or other service providers can be found.
- All social media/internet.
- Billboards/TV also suggested.

Final list of key problems with current service:

- Appointments aren't instant and should be.
- Crewe Youth Hub is adequate but is too hard to discreetly access.
- The Youth Hub's times also mean that those wishing to access services there that go to college or school are unlikely to be there in time. The offer of services only one day a week is also received poorly.
- The hospital is too far away and its times are also poor for those in full-time education.
- Young people did not like attending the hospital for drop-in, as it made them feel as though they had an illness.
- Not advertising to full potential, all services on offer not clear.
• Does not consider those in education which now represents nearly all those aged 10-18.

Further work with Care Leavers found:

• They mentioned the value of having access to services at college. One yp stated it used to be really good at college but recently you did not know when it was open and the services were limited.

• They reiterated the importance of services being in their own unit to maintain confidentiality - not in youth clubs.

• Suggested using large chemists to provide services.

• Need more information; website or application.

• Leaflets; separate information for boys and girls as have different issues.

• Counselling available for when there is a problem. They touched on sexual assault services and explained they would be separate specialist services. Young people did feel counselling and advice was needed for other issues.

• LGBT information and specialist services needed.

• drop in after school; 4-8 pm

• utilise online chat to give advice.

The following information was gained from 3 young people on a one-one basis so the feedback is more centred around what the young person felt comfortable discussing. The main issues raised were:

• Venues:

  All young people stated that they did not like attending Crewe Hub for Sexual Health Services as everyone would know why you were there, it did not feel very private and they did not feel comfortable attending and one young person stated ‘everyone knows your business’. One young person said she preferred to use the service at the hospital and another
when asked about community clinics said ‘do you mean like family planning – yes that would be fine’.
Services should be available at central locations in main towns that were not in really obvious places. One young person gave an example of another health service that was situated in a large building where other organisations and business operated out of so it was not immediately obvious why you were there. Another young person said services should be in ‘small places dotted around and one big one in the centre.

- Times:
  Young people seemed to prefer after school; such as 4-7pm.
- Information:
  The young people said they currently get information through the internet or friends.
  They think more information should be at school – one comment said there was ‘no information in schools’.
  One young person had very little information and said ‘don’t know what these services are – think there’s one in Manchester’.

Throughout the consultation the general feedback and interpretation of comments was that although there seemed to be some information about available services they did not feel there was enough information. This was apparent in the low level of knowledge of what services were available to them and how or when they could access them.

**Stakeholder Engagement**

The stakeholders identified were:

- Local Health Watch
- Voluntary Community Faith Groups
- Patient / Support and Carers Groups
- Councillors
- Local Medical Committee
- General Practices
- Local Pharmaceutical committee
- Pharmacies
• Sexual Health Service Providers
• Clinical Commissioning Groups
• NHS England Local Area Team
• Public Health England
• Criminal Justice System - Neighbourhood Policing Units, Sexual Assault Services
• Children & Family Services, Youth Services and Education Services
• Schools, Colleges, Universities
• Family Nurse Partnership & Multi-Systemic Team
• Adult Services
• School Nurses
• Substance Misuse Services

We undertook a Stakeholder Engagement event 3/9/14 and obtained the following feedback:

• Focus on young people re education and health promotion also commissioning services across the towns with clear pathways to other services as needed.

• Strong joined up commissioning to make sure there are clear seamless pathways between services.

• Commission school nurses to deliver “clinic in the box” in schools, and work collectively to provide key messages and information about access to services

• Commission more service from Primary care e.g. HIV screening and consider with GPs how services via practices could be a part of the whole sexual health system

• Commission pharmacies to deliver more services

• Don’t forget our older population needs

• Having an anonymous / confidential contraception service is important, particularly when living in rural areas with small village issues

• Services need to be more local, think about natural journeys and travel options
Service needs to be ‘trusted’

All that is needed is a suitable room, qualified person, testing kit and recording ability.

It’s not one solution in terms of location of services or model of service that’s needed and it’s not always about medical staff delivering some aspects of these services

Choice needs to be the guiding principle

**Market engagement**

We undertook an early market engagement event 18/8/14. The summary points were as follows:

- Might need to define our definition of an integrated service
- Social marketing for behaviour change needs to start before the services actually begin to change
- Social media access
- YP not accessing SHS for screening
- OP & Safer Sex & STIs.
- Innovative ways of dealing with screens & treatment
- Recognition that repeat visits to a specialist service is not good practice as ‘engagement’ and on-going support should be taking place elsewhere
- Contract length is important
- Decent mobilisation period
- TUPE implications need to be included in service specification
- Would be helpful to have Integrated Pathways between Services
- A tapered target reduction would be better with a phasing out of testing as capacity is increased elsewhere
- If capability is to be created in primary care engagement/interest/funding to incentivise/support GPs needs consideration
- Lead provider specialist who is able to co-ordinate and oversee what the whole sexual health service does.
• Clear understanding of pathways – what are they currently & what do they need to be to effect change – in and out of whole system services and self care.

Ends