



# **Integrated Sexual Health Service Specification**

## **Analysis of Public and Professional Engagement**

### **NHS Kingston**

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(Author's note: I have had no prior involvement in the Integrated Sexual Health Service Development or Local Engagement process. Therefore this report is an independent evaluation of the views of stakeholders as expressed during the Local Engagement process).

## Index

1. Executive summary .....	3
2. Introduction .....	6
3. Methods .....	8
3.1. Service Providers and Professional engagement .....	8
3.2. Public engagement .....	9
3.3. Data analysis .....	9
4. Partnership and user engagement .....	10
4.1. Professional response .....	10
4.2. Public response .....	10
5. Views of professionals .....	13
5.1. Modernisation of local sexual health services .....	13
5.2. An Integrated sexual health service .....	14
5.3. Service model .....	17
5.4. Are the tiers correct? .....	19
6. Views from the service users: Informing service delivery .....	24
6.1. First point of contact for sexual health help and advice .....	24
6.2. Where to go to for help and advice for a sexual health problem? ....	25
6.3. Important characteristics of sexual health settings .....	26
6.4. Accessibility .....	27
6.5. Self Care Facilities .....	29
6.6. Summary .....	30
7. Strengths and limitations .....	31
8. Conclusion and key recommendations .....	33
8.1. Recommendations for consideration under the service specification ..	33
.....	33
8.2. Recommendations for consideration under service delivery .....	34
Acknowledgements .....	35
References .....	35
Glossary of Terms .....	36
List of appendices .....	38

## 1. Executive summary

NHS Kingston wishes to commission comprehensive and integrated sexual health services on behalf of Kingston's population. A Local Engagement process was undertaken to obtain the views of stakeholders (both public and professional) on the service development and proposed Integrated Sexual Health Service model for Kingston (*Integrated Sexual Health Services in Kingston, Have your say. Engagement Document, NHS Kingston, April 2009*).

Stakeholders' views were obtained using self-completed questionnaires. A total of 31 professionals and 350 service users/members of the public responded. The key findings of the stakeholder engagement are presented in this report.

### View of professionals

Overall, there was a good level of support for the Integrated Sexual Health Service Specification. The majority of professionals who returned the questionnaire agreed there was a need to modernise local sexual health services in Kingston, there was support for an integrated sexual health service, and the majority agreed with NHS Kingston's vision for sexual health services. In addition, the majority of professionals felt that, if implemented, the new service model would promote improvements in sexual health.

A number of components were identified which respondents felt were missing from the model including;

- Young people sexual health school health services
- Partner notification
- Teaching and training programs
- Health education
- A clear vision of service delivery and care pathways

In contrast, only half of the respondents agreed that the service tiers were correct and a number of specific recommendations were proposed (full recommendations are presented in section 5.4 of this report).

A number of next steps were identified and these are listed below;

- (i) Clarity over the use of the terms “comprehensive” and “local community” in the NHS Kingston’s vision for sexual health definition is needed.
- (ii) The implications of an integrated sexual health service in Kingston raised by respondents needs to be considered.
- (iii) There is a need for agreement on which settings are included under the heading “community setting”, whilst considering the public demand for services in primary care.
- (iv) The content of the service model should be reviewed in light of the components stakeholders felt were missing from the model including, young people sexual health, partner notification, teaching and training, health education.
- (v) Further consideration of the service provided within each Tier is needed in light of the specific recommendations proposed in Section 5.4 of this report.

### **Views of the public**

Views from the public will help inform service delivery and the following recommendations were made;

- (vi) Service users/members of the public expressed a preference for sexual health services to be available via GUM clinics and general practices, in addition to family planning clinics
- (vii) When considering where to develop sexual health services the most important factors for service users/members of the public are confidentiality, availability of test results on the same or next day, ease of transport and central location, the opening hours (on Saturdays and late evenings).
- (viii) The provision of sexual health self care facilities should be considered as respondents (73.8%) expressed a high level of demand for such a service.
- (ix) Young people would prefer a walk in sexual health service, whereas the older age groups would prefer to telephone ahead for an appointment.

- (x) The most preferable times for a sexual health service were weekday evenings (60.8%) and Saturday clinics (37.1%).

These recommendations should be considered in the final integrated sexual health specification and implementation.

## 2. Introduction

NHS Kingston wishes to commission comprehensive and integrated sexual health services on behalf of Kingston's population. Whilst Sexual Health Services do exist in Kingston, it is recognised that change, innovation and integration is required to meet all the sexual health needs of the population.

An initial assessment of the sexual health needs of the Kingston population was completed in June 2008, which included user and provider consultations, a review of local service provision and measuring service performance against Government national targets. The needs assessment made a number of key recommendations on how to strengthen local sexual health services (*NHS Kingston comprehensive Sexual Health Needs Assessment, June 2008*).

Following these recommendations, it became clear that NHS Kingston needed to modernise local sexual health services to ensure appropriate and effective pathways between prevention, promotion and treatment services are provided.

NHS Kingston held a visioning event attended by key stakeholders in September 2008. Discussions resulted in the development of a local needs-led vision for sexual health services (see box 1) and a proposed **Integrated Sexual Health Service** model.

**Box 1. NHS Kingston Vision for Sexual Health Services.**

*"A clinically governed and comprehensive sexual health partnership offering modern, inclusive and accessible sexual health care; through a co-ordinated network across Kingston. Clearly communicated care pathways will deliver an integrated, patient focused, high quality service, delivered in a cost effective manner that is responsive to the sexual health needs of our local communities."*

The key components of the integrated sexual health service model include

- a.) A lead provider who will take responsibility for coordinating the multi-agency working and delivery arrangements.
- b.) A number of sites within the community, which provide comprehensive and cohesive sexual health services for users.
- c.) The Integrated provision will be made up of a range of sexual health services that share a common location, a common vision and agreed principles of delivering sexual health services.
- d.) A management structure which facilitates integrated working with the responsibility for appropriate clinical governance.
- e.) A commitment by partner providers to deliver integrated services.
- f.) Staff work in a coordinated way to address the needs of service users.

It was also stated that the integrated sexual health service will be expected to have good links with existing specialist services through shared care pathways and protocols, referral and sign posting.

A Local Engagement Process took place between April and June 2009 to obtain views of stakeholders (both public and professional) on the service development and proposed Integrated Sexual Health Service model (*Integrated Sexual Health Services in Kingston, Have your say. Engagement Document, NHS Kingston, April 2009*).

This report details the key findings of the Local Engagement within the context of the engagement document, and makes recommendations for consideration in the final integrated sexual health specification and implementation.

### 3. Methods

An Integrated Sexual Health Specification Board was convened in September 2008. One of the Board's aims was to agree the engagement process in order to obtain the views of both public and professional stakeholders on the Integrated Sexual Health Service Specification for Kingston (*Integrated Sexual Health Services in Kingston, Have your say. Engagement Document, NHS Kingston, April 2009*).

Separate questionnaires were developed to obtain the views of service providers/professionals (Appendix A) and service users/general public (Appendix B). The types of questions and format used were informed by previous successful sexual health questionnaires and a pilot among a small group of young people and professionals (n=10). The format for the young people postcards were designed so that they were simple and convenient for them to use. Both questionnaires could be returned freepost. Leaflets summarising the key information were also available for the general public (Appendix C).

The Local Engagement took place between the 27<sup>th</sup> April and 26<sup>th</sup> June 2009.

#### 3.1. Service Providers and Professional engagement

A total of 95 stakeholders, including those listed below, were sent a copy of the Integrated Sexual Health Services in Kingston Engagement document and invited to comment on the service model.

- KU19 and community contraception services
- Kingston Hospital Genitourinary Medicine Clinic
- General Practitioners in Kingston
- Local pharmacy providers of the Emergency Contraception Scheme
- Kingston Youth Councils
- Integrated Youth Support Services (includes Young Offending Teams, YISP, Youth Service, Connexions, Youth Bus)
- Local Teenage Pregnancy Coordinator

- Kingston University and Kingston College
- South West London (SWL) Primary Care Trust (PCT) Sexual Health Leads
- NHS London Sexual Health Programme
- HIV Commissioners Network
- Royal Borough of Kingston

(for a full list of stakeholders involved see Appendix D)

### **3.2. Public engagement**

All stakeholders were asked to distribute summary leaflets and postcard questionnaires to members of the public (Appendices B and C). A total of 2,000 leaflets and 3,000 postcards were distributed via stakeholders.

#### Public Drop In Sessions

Three public drop in sessions were held at NHS Kingston but these were poorly attended (a total of 7 people attended over the 3 days). The poor attendance may reflect the sensitivity of the topic area, but may also be a result of the decision to hold the events at NHS Kingston, a place not easily found by the general public. A more central location may have improved attendance.

### **3.3. Data analysis**

Professionals were asked to provide their name and institution. All views expressed in answer to the open ended questions were anonymised and included in this report. Four professional respondents stated they had not seen, or read, the engagement document and therefore their answers to questions specific to the document contents (Q. 3 to 8) were not included in the analysis.

All public questionnaires received by the closing date were included in the analysis. Responses from the public questionnaires were anonymous. A summary of the data collected from the members of the public is provided in Appendix E.

**Notes to tables.** Percentages were calculated based on the number of people who answered that question. Percentages may not add up to 100% because of rounding.

## **4. Partnership and user engagement**

The Sexual Health Needs Assessment completed in June 2008 recommended early involvement of partners in the development of the sexual health strategy and the need for continuing user engagement. The Visioning Event and Local Engagement process have contributed towards addressing early involvement of partners in the development of an Integrated Sexual Health Service for Kingston.

### **4.1. Professional response**

A total of 31 professionals responded to the engagement, 28 of whom returned the questionnaire. The majority (20/31) of the responses were from medically qualified professions including general practitioners, clinical consultants and nurses. There were a minority of responses from reception staff, pharmacists, youth workers and the voluntary sector. There was no response from health advisors, service managers or directors, or teachers. The poor response by stakeholders from non-medical backgrounds is disappointing and may mean a more pro-active approach is needed with these stakeholders to ensure their views are considered.

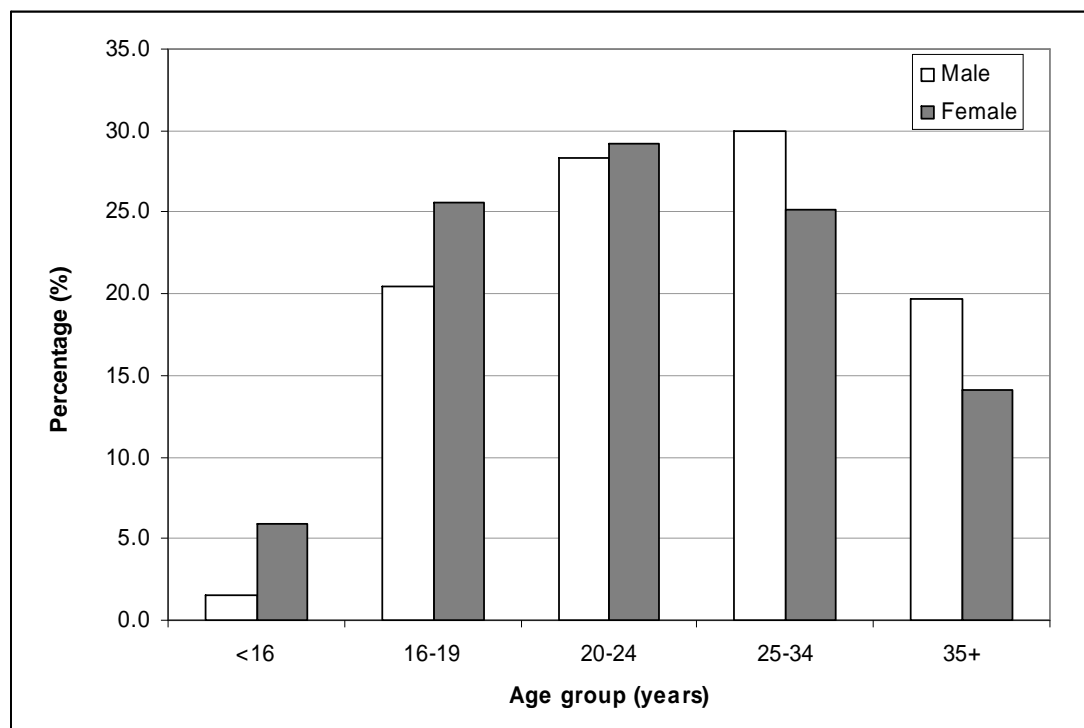
As with all qualitative studies the response received may not be representative of the views of all professionals.

### **4.2. Public response**

A total of 350 questionnaires were received by the closing date, giving a response rate of 11.7% (350/3,000). Two thirds of the respondents were female (female = 220 (62.9%); male = 127 (36.3%)).

The age and sex distribution of the respondents is shown in figure 1. The response was evenly distributed across the age groups with approximately 25% of respondents in the 16 to 19, 20 to 24 and 25 to 34 year age groups. There was no significant difference in the age distribution of respondents by gender (Chi<sup>2</sup> test p=0.156).

**Figure 1.** The sex and age distribution of service users/public respondents (N=346).

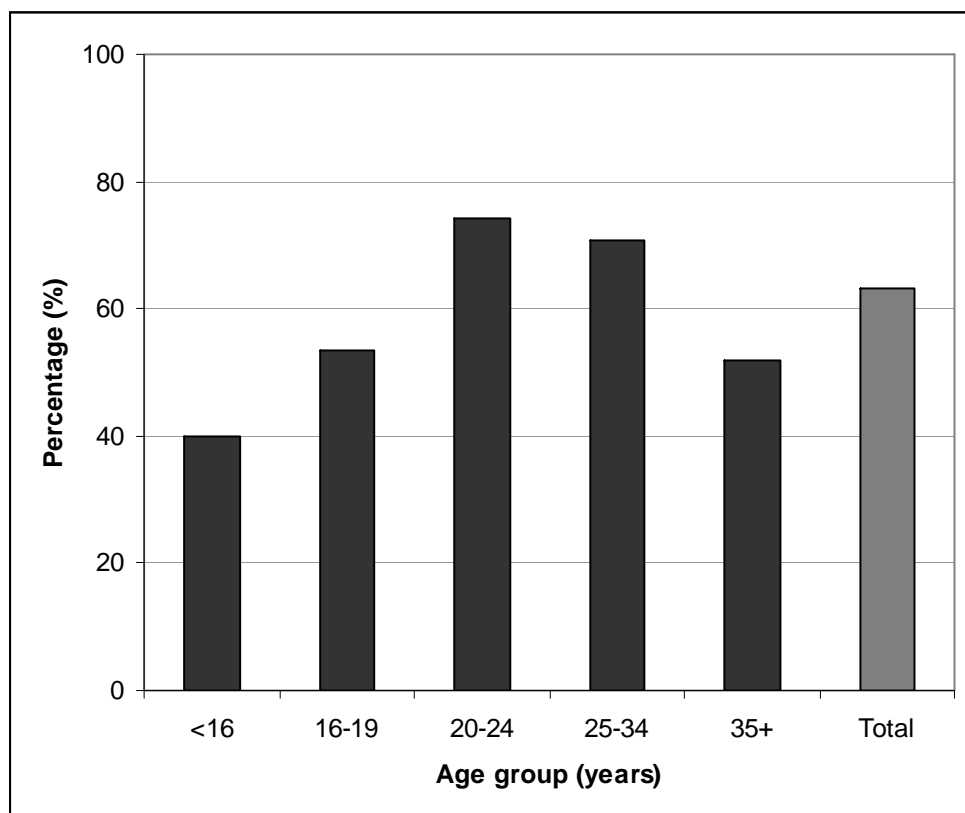


#### 4.2.1. History of sexual health service use

Two thirds of the respondents (63.3% n=221) reported they had had a STI check in the past. Of those, 27.8% reported their check-up had been within the last 3 months, 38.2% between 3 months and 2 years ago, and 28.3% between 3 and 5 years ago, with the remaining 5.7% reporting it was more than 5 years ago.

Marked variation in the proportion of respondents who reported ever having an STI test by age group was evident, and this is not likely to be due to chance (figure 2,  $\text{Chi}^2$   $p=0.002$ ). There was no difference by gender ( $\text{Chi}^2$  test  $p=0.772$ ).

**Figure 2.** The proportion of service users/public respondents reporting they have had a previous sexually transmitted infection check, by age group and overall (N=348).



## 5. Views of professionals

The views from professionals were obtained using a combination of tick boxes and open ended questions. Key themes reported by stakeholders are summarised here.

Overall, the response from professionals was positive (Box 2). However, some were of the opinion that, although overall the specification was “*very good*”, further collaborative development is needed for it to be “*an effective tool for commissioning and performance management*”.

### **Box 2. General comments on the sexual health service specification**

*“well written”*

*“very good”*

*“very exciting and welcome development”*

*“this is a good document, but I would like to see a lot more partnering with voluntary sector organisations”*

There is clearly some confusion about the service development process including the route of procurement, timescales and financial considerations e.g. *“If the complete specification is not affordable, there needs to be prioritisation of requirements for service delivery, e.g. is psychosexual counselling more important to develop than LARC?”*

Considering the views of some of the respondents, the service specification could have benefited from a clear description of the aim of a service specification, in general, and what is and is not included in a service specification i.e. that it outlines the model for service provision, and once agreement has been reached on the vision for the model, the process moves towards one of planning service development and delivery.

### **5.1. Modernisation of local sexual health services**

The majority of professionals who returned the questionnaire agreed with the need to modernise local sexual health services (22/28 responses) and agreed

with NHS Kingston's vision for sexual health (15/22 responses). Some respondents felt a clear definition of the term "local community", used in the NHS Kingston's vision, was needed and to ensure this term includes those visiting Kingston e.g. students.

Three respondents questioned how the sexual health partnership can be described as "comprehensive" in the vision statement "*without services for under 19s*".

**Next Steps (i):** Clarity over the use of the terms "comprehensive" and "local community" in the NHS Kingston's vision for sexual health definition is needed.

## 5.2. An Integrated sexual health service

The majority of professionals who returned the questionnaire agreed there was a need for an integrated sexual health service in Kingston (22/28 responses).

The key theme expressed when considering the "*integrated*" sexual health service in Kingston was a need to consider the appropriateness and implications of providing all services at all sites.

It may not be appropriate, nor possible, to provide all services at all sites. One professional highlighted the importance of building service provision on the need of the service users, and as such there may not be a need to provide all services within each setting based. Another respondent suggested that if "*a basic level of sexual health services [is available] at most places*" along with accurate "*signposting*", then delivery of all services in all settings may "*not always [be] needed*".

Another respondent highlighted the need to "*balance patient choice, access and quality of services*", suggesting that a critical mass (minimum number of clients) is necessary to ensure good quality services. A GP also considered the practicalities of delivering an integrated service, suggesting that some

services e.g. *“psychosexual counselling and vasectomy, may not be possible at too many sites”*.

In addition, the service specification states that integrated services will *“eliminate need for service users to attend multi-agencies”* (page 24). Three respondents expressed the opinion that this is unlikely as *“referral to specialist or community follow up services will always be needed, or patient choice may mean someone attends one service for STI but prefer to attend another for contraception”*.

**Next Steps (ii):** The implications of an integrated sexual health service in Kingston raised by respondents needs to be considered.

#### 5.2.1. Aims and objectives of the integrated sexual health service

The majority of professionals who responded to the questionnaire agreed with the aims (21/24 responses) and objectives (18/24 responses) of the integrated sexual health service, as outlined in the Engagement Document (pages 14 to 17).

The objective *“to deliver services in community setting wherever possible”*, listed under accessibility, was commented on in depth by three respondents (box 3).

#### **Box 3.** Comments for objective “To deliver services in community setting wherever possible”.

*“define community setting”*

*“reference the evidence base that services should be sited in this way”*

*“agree that more community settings should be developed”, but “patients need a choice of settings, and hospital and community settings both have value.”*

*“stating that community settings would be used “wherever possible” implies that hospital settings are not desirable”*

Three respondents felt that “*community should include clinics with easy access*”, and suggested the “*Wolverton Centre would be an excellent hub for both GUM and contraceptive services as it has good access, environment and clinical facilities*”. Another respondent reported the need for a university site to be included in the community venues.

There was also the view that the needs of patients, financial implications and training need more consideration. It may be that some services are more suited to be delivered in a community setting than others, and the financial implications of outsourcing services into the community setting will need to be considered.

From the comments received, there is clearly a need for justification, discussion and agreement on which settings are included in under the heading “community setting”.

The views from the public engagement can also be considered here, where it can be seen that general practice is the first place of choice among women, and second most common choice among men, place to go for help and advice for a sexual health problem (Sections 5.2 and 5.2). It may be suggested that some settings may be more suited to certain population groups than others e.g. MSM preferring to attend specialist GUM clinics, but this could not be determined from the public engagement as information on risk behaviours of the respondents was not recorded.

<p><b>Next Steps (iii):</b> There is a need for agreement on which settings are included under the heading “community setting”, whilst considering the public demand for services in primary care.</p>
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### 5.3. Service model

It is proposed that the new service will provide three tiers (levels) of sexual health services (*Integrated Sexual Health Services in Kingston, Have your say. Engagement Document, NHS Kingston, April 2009, page 17*).

#### 5.3.1. Will the model improve sexual health in Kingston?

The majority of professionals who responded to the questionnaire (16/22 respondents) felt that, if implemented, the new service model would promote improvements in sexual health. Two GPs highlighted that the provision of new services will generate new and increased demand, and other respondents highlighted the need for the new service model to be accompanied by ongoing sexual health education and collaborative working across all sectors. One respondent "*the model is very good, although alterations are needed, this is a good starting point*".

#### 5.3.2. What was missing from the model?

A number of respondents felt that the service model did not reflect packages of care which were discussed earlier in the engagement process, at the visioning event in September 2008. Examples included "*'bundles' of services in order to provide more flexibility between the Tiers/Levels.....(and) a "Tier Zero"*" (for signposting and info giving).

The key components which respondents felt were missing from the model included;

- Young people sexual health school health services
- Clarification of partner notification and management
- Teaching and training programs
  - Psychosexual counselling
- Health education
- A clear vision of service delivery and care pathways

A summary of the reasons given are provided below.

#### Young people sexual health school health services

There were strong views from three respondents that the service specification wrongly “*excludes the provision of sexual health services within the KU19 service*”. Respondents expressed that to exclude young people sexual health services is contrary to advice from the “*National Clinical Assessment Team national authority on sexual health*”, highlighting that this group “*amongst the most vulnerable and at high risk of sexual ill-health*” and are a major focus of DH sexual health initiatives including “*Teenage Pregnancy , Chlamydia Screening and SRE*”. The respondents expressed the opinion that the “*MCN (Managed Clinical Network) will not be able to take full responsibility for delivering key NHS SH (sexual health) targets that affect this age group if the MCN is tasked to deliver a specification that excludes KU19.*”

#### Partner notification

There is a lack of clarity around the management of partner notification. The exclusion of partner notification in the Tier 1 service was questioned by one respondent. Another raised concerns about the resources and time required to deliver partner notification within Tier 2 community settings e.g. general practice.

Further details on how partner notification will be managed in Tier 2 is needed.

#### Teaching and training programs

Three respondents expressed the need for more details on how teaching and training will be provided in the service model, in particular for psychosexual counselling. One GP also felt that practitioners and practices wishing to deliver Tier 2 will need to be accredited.

#### Health education

Two respondents identifying the need for clear education programmes to be included in the service model.

### A clear vision of service delivery and care pathways

Further discussion on service delivery e.g. number of clinics, where, when and by whom, in addition to care pathways, and how the model will link with other services including school health is clearly needed (box 4). One respondent expressed the need to manage clients effectively, making the suggestion that a “*central booking phone line*“ could be provided “*so patients [are] directed to [the] nearest and most appropriate service for their needs*”.

**Box 4.**      Comments supporting a need for a clear vision of service delivery

*“It is hard to expect service users to comment on a list of sexual health services without an overall idea of how they will work together and how they will be delivered ie. settings/days etc.”*

*“once it is clear where which service will be provided it will be easier to picture i.e. how much pharmacy will do”*

*“Links with SH services & School health/college need to be more than links”*

*“More information about care pathways [needed]”*

*“how can HIV patients who are stable can have shared-care with primary care, be monitored in primary care and referred back to specialist as appropriate”*

**Next steps (iv):** The content of the service model should be reviewed in light of the components stakeholders felt were missing from the model including, young people sexual health, partner notification, teaching and training, health education.

#### **5.4. Are the tiers correct?**

Respondents were asked if they agree with the tiers as described in the service model. The response was divided, with approximately half (11/23 respondents) stating they agreed with the service model and the remaining (12/23 respondents) reporting they disagreed or were unsure. This suggests that there is the need further consideration of the tiers of service. Many

respondents provided comments on specific aspects of service provision within each Tier and these are summarised below.

## Tier 1

### Overall

- a. The service specification states that Tier 1 services will occur in *some* primary care settings. Respondents highlighted that if all GPs are not included then it may result in inequalities in access to care.
- b. Some medical professionals who responded expressed a view that Tier 1 is too comprehensive for some settings .
  - o Three respondents felt that testing for symptomatic STIs is *“not appropriate in Tier 1”*.
  - o GPs expressed concerns that Tier 1 (and 2) were ambitious for primary care, and highlighted the pressures of time constraints within primary care (there may not be the time *“to do some of the testing and history-taking”*) and that providing *“freely available condoms may not always be practical in a GP setting”*.
  - o One respondent expressed a need for further discussion on the *“appropriateness”* and the provision of some services (including testing for blood borne virus, counselling, cervical screening, and referral for sterilisation) in colleges.
  - o One nurse suggested that Tier one *“could be broken down further”* with *“more pharmacists leading on projects”*.
- c. It was suggested that the sentence *“Full availability of contraception and contraception services including LARCs injectable contraception”* should be reworded to *“Full availability of contraceptive advice and hormonal contraception including injectable contraception.”*

### Suggestions for services that could be **included** in Tier 1

- d. Three respondents reported that the Kingston service specification for Tier 1 does not include risk assessment, whereas the Sexual Health/HIV National Strategy level 1 does.

- e. Respondents would like more detail on how partner notification will be managed within Tier 1.

#### Suggestions of services that could be **removed** from Tier 1

- f. Three respondents questioned providing IUD/IUS routine follow up under reproductive healthcare in Tier 1, stating that this should be done “*at point of insertion*” – which would be a Tier 2 service.

## **Tier 2**

### Overall

- a. The service specification states that Tier two is to be provided in community settings. One suggestion was that Tier 2 should be “*provided in accessible settings including primary, secondary and community locations*”, but again a clear definition of “*community settings*” is needed.
- b. The service specification states that Tier two will incorporate an expanded role for specialist nurses. One respondent felt that more “*detail on how nurses will be involved in Tier 2*” was needed. One GP questioned whether specialist doctors would also be needed, and others suggested it may be more appropriate to say an “*expanded role for healthcare staff*”. Many respondents were in agreement there is a need to ensure healthcare professionals delivering Tier 2 services were adequately trained, accredited and maintained continuing professional development.
- c. One GP felt there was a need to ensure that providing a Tier 2 service did not distract from patients receiving urgent or more specialised care where appropriate, suggesting the need for “*fast track access to Tier 3. e.g. reserve clinic spots so patients can be seen rapidly if Tier 3 service needed*”.

#### Suggestions for services that could be **included** in Tier 2

- d. Clarification that Implanon fitting is included under the LARCs available at Tier 2.
- e. Respondents would like more detail on how partner notification will be managed within Tier 2.

Suggestions of services that could be **removed** from Tier 2

- f. Respondents felt that psychosexual counselling “*may be difficult to include in all level 2 clinics*” and that it “*should be only available in Tier 3, with just referral in Tier 2*”. “*Psychosexual counselling & Management of organic sexual dysfunction should be in Tier 3 as part of a multidisciplinary psychosexual service so that all patients can be assessed medically & psychologically. Clinical diagnosis is essential, whilst some problems may be suitable for a purely counselling approach most will benefit from combined medical and counselling approach*”.
- g. Three clinical consultants felt two aspects of Tier 2 in the service specification were not appropriate for a nurse led service
  - o management of recurrent herpes simplex virus and initiation of suppressive treatment is “*not appropriate ... [as it] needs full consultant assessment of the patient*”.
  - o Access to PEP is only possible in a nurse led service “*with appropriate safeguards and appropriate back up from Level 3 specialist service with recognition that complex ARV decisions [with regards] resistance of partners could only be managed by a consultant*”, and that 24 hour access to specialist treatment for PEP should be centralised, due to the high cost and limited shelf life of treatment.
- h. The three clinical consultants also felt that “*urgent same day access for EHC/IUD is not required clinically (there is a 5 day window for emergency IUDs and 72 hour window for EHC)*” and that it may be difficult to maintain “*good access [to this service] while maintaining good clinical standards*” 7 days a week.
- i. One GP felt that TOP assessment and post procedure counselling should not be included in Tier 2, suggesting it would be more efficient if “*done, as now, by the service providers*”.

### Tier 3

Tier 3 is a specialist service with the focus and expertise to provide care for those with more complex, chronic or intensive needs.

#### Overall

- a. Further description of the services delivered under the term colposcopy is needed e.g. does this “*mean [colposcopy] for management of CIN or for investigation of abnormal lesions on vulva or cervix*”?
- b. The Tier 3 service should clearly state that procedures including “*difficult IUD/IUS insertions*” are included under the heading “Specialised contraception for those with complex medical conditions”.

#### Suggestions for services that could be **included** in Tier 3

- c. Tier 3 includes “local co-ordination and specialist back-up for sexual assault”. One respondent suggested the following should be included under the specification for sexual assault within a Tier 3 service
  - there should be provision for patients who would prefer to be seen locally, rather than attending a sexual assault referral centre
  - there should be follow up services available for patients who only attend the sexual assault referral centre once
  - there should be procedures in place to enable good partnership working occurs between the Tier 3 service and the sexual assault referral centre.
- d. One respondent felt that the training and support role of Tier 3 services needs to be recognised in the service specification. Highlighted that Tier 3 services will have a lead role in the provision of training, and provide “*a level of support .. to setting up any new level 2 services*”.

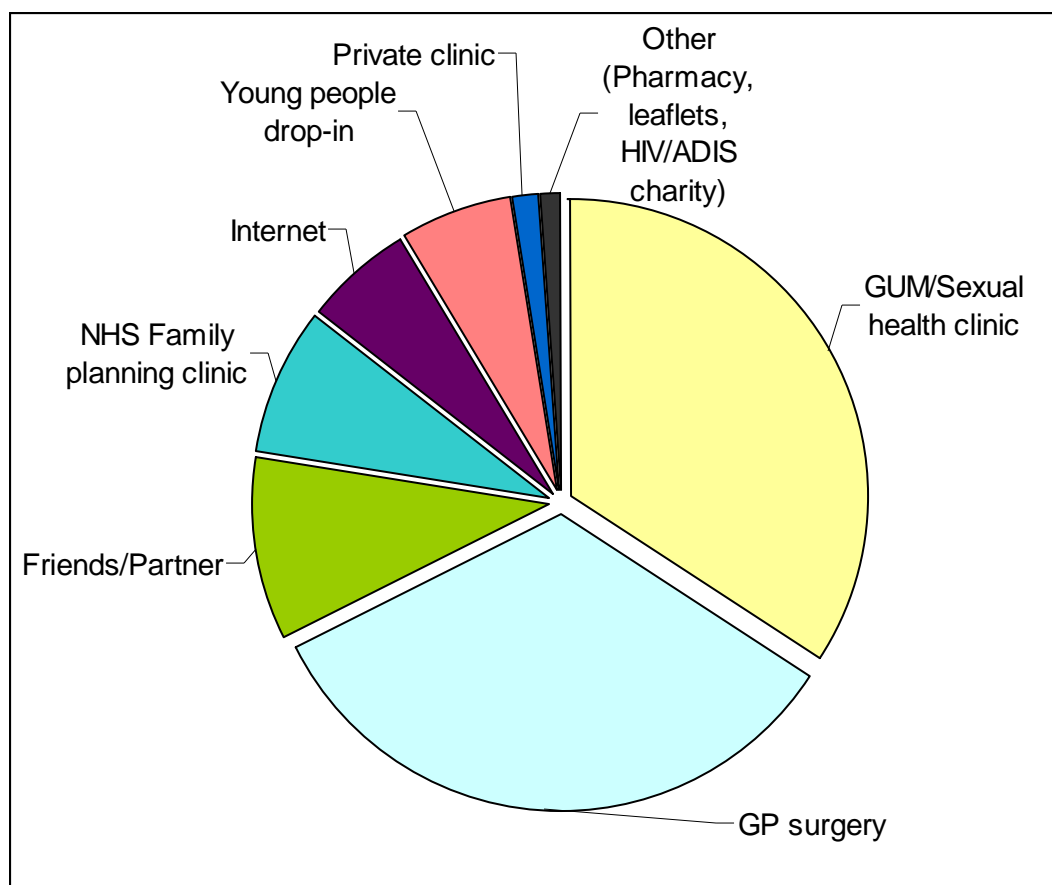
**Next Steps (v):** Further consideration of the service provided within each Tier is needed in light of the specific recommendations proposed in Section 5.4 of this report.

## 6. Views from the service users: Informing service delivery

### 6.1. First point of contact for sexual health help and advice

99.1% of respondents answered the question reporting who they would first go to for help with a sexual health problem. Overall, the places most commonly reported as an individual's first contact were the GUM/Sexual health clinic, GP surgery, followed by friends/partners and NHS Family planning clinics (Figure 3).

**Figure 3.** Different type of settings reported to be an individual's first point of contact if they have a sexual health problem (multiple categories allowed. Total responses = 468 from 347 respondents).



The most commonly reported setting among men was the GUM clinic followed by GP surgeries. Whereas, among women, the most commonly reported setting was GP surgeries followed by GUM clinics. The use of NHS Family planning clinics was an important point of contact for women (table 1).

**Table 1.** The top five types of settings reported to be an individual's first point of contact if they have a sexual health problem (multiple responses allowed).

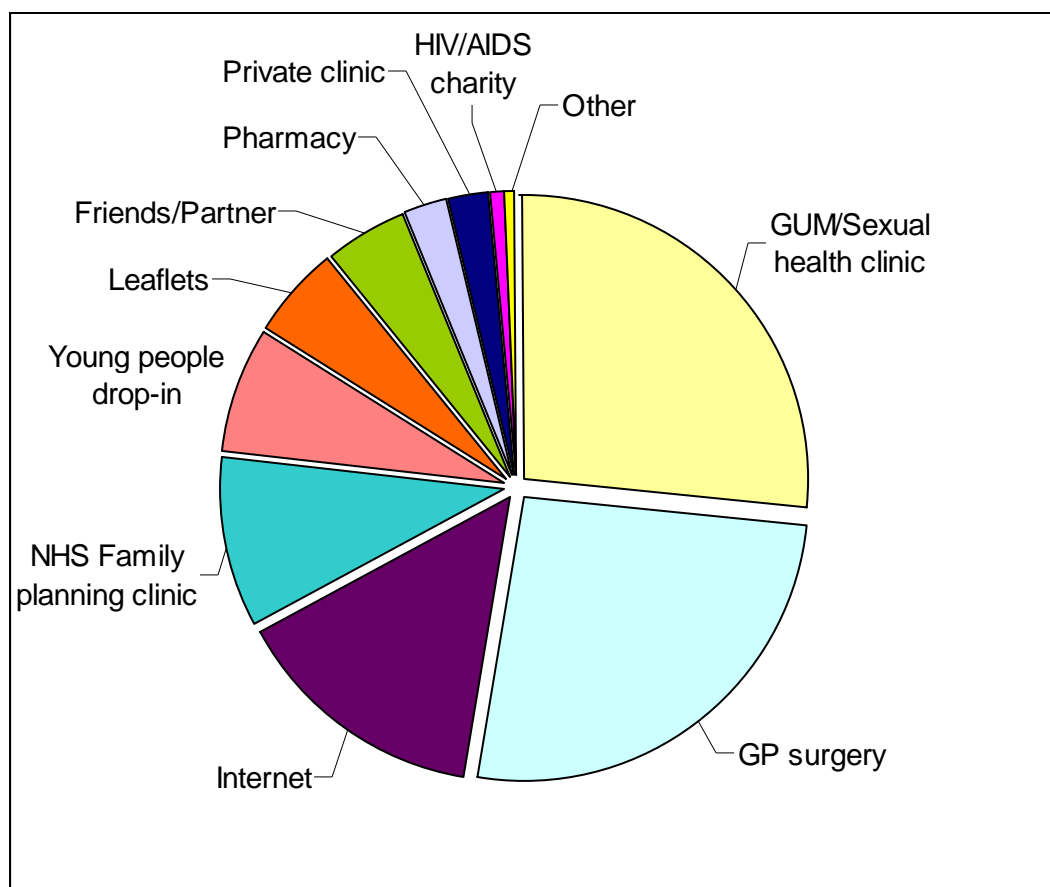
<b>MEN (166 responses from 127 men)</b>		<b>Women (302 responses from 220 women)</b>	
<b>Setting</b>	<b>% reporting that setting</b>	<b>Setting</b>	<b>% reporting that setting</b>
GUM/Sexual health clinic	53.5%	GP surgery	47.3%
GP surgery	40.9%	GUM/Sexual health clinic	41.8%
Friends and partners	11.0%	NHS Family planning clinic	16.4%
Internet	11.0%	Friends and partners	15.0%
Young people drop-in	6.3%	Young people drop-in	9.1%
Private clinic	3.9%	Internet	6.4%

### **6.2. Where to go to for help and advice for a sexual health problem?**

98.0% of respondents answered the question reporting where they would go to for help with a sexual health problem. Again, the most commonly reported places to go to for advice or help with sexual health issues were the GUM/Sexual health clinic, GP surgery, followed by the internet and family planning clinics (Figure 4).

The same pattern as for first point of contact was found, with men preferring GUM clinics followed by GP surgeries, whereas women preferred GP surgeries followed by GUM clinics. Family planning clinics were again an important point of contact for women.

**Figure 4.** Different type of settings individuals reported they would prefer get advice or help with a sexual health problem (multiple categories allowed. Total responses = 707, from 343 respondents).



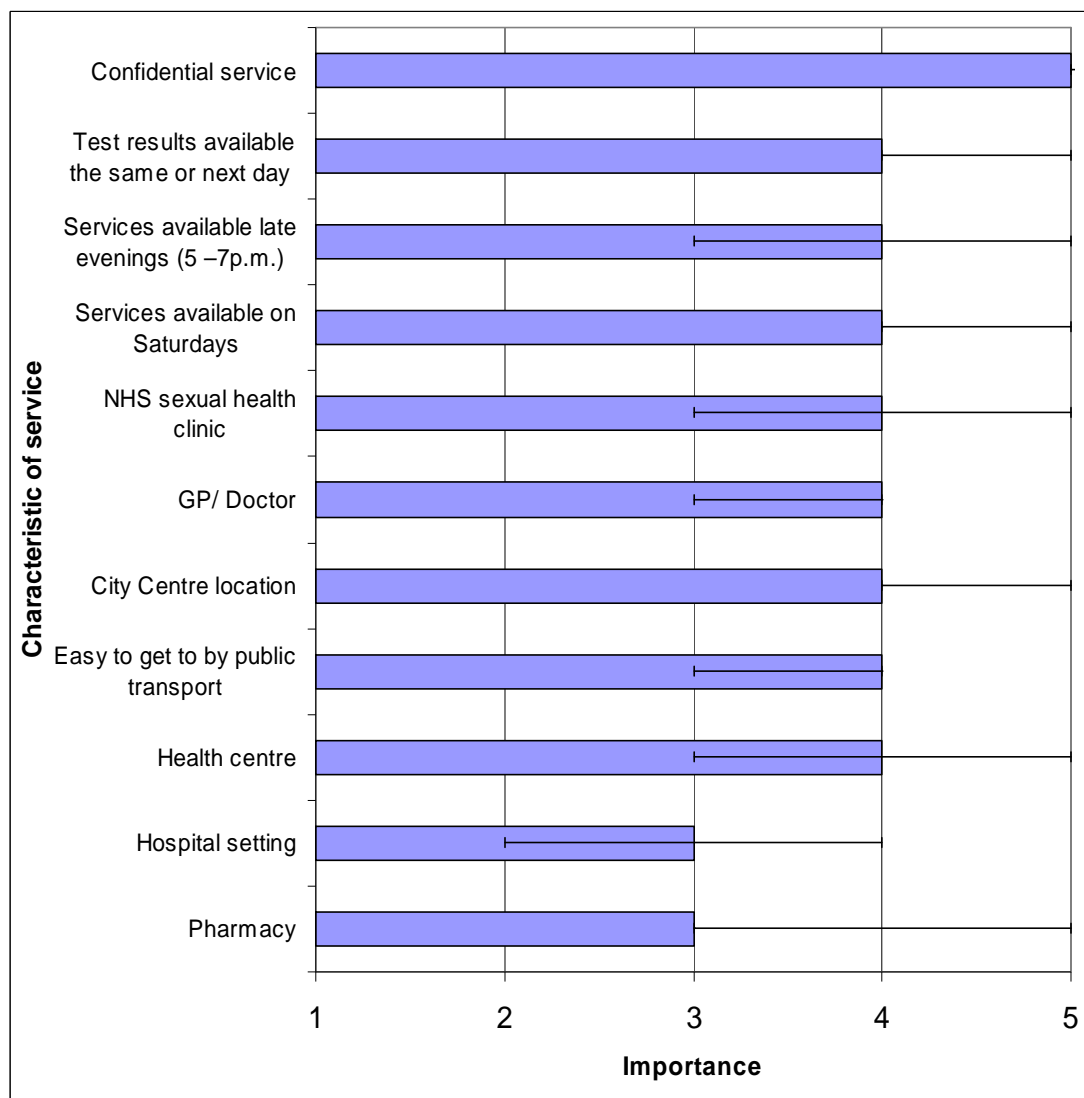
### 6.3. Important characteristics of sexual health settings

Confidentiality was the single very important factor when deciding on where to go for STI care and treatment. Many other characteristics were also considered important, including the availability of test results on the same or next day, ease of transport and central location, the opening hours (on Saturdays and late evenings).

Respondents were unsure of the importance of a hospital setting or pharmacy when deciding where to go to access care.

Other characteristics which were considered important included “friendly female staff”, being “open for under 18's more than one day a week”, “advice & education”

**Figure 5.** Median score for the importance of different characteristics of sexual health services (344 respondents).



#### 6.4. Accessibility

Respondents were asked how they would prefer to attend a sexual health service and when they would like them to be available.

The majority (56.5%, 187/331) of respondents would like to be able to walk in and be seen without having to make an appointment. A further third would prefer to telephone ahead for an appointment (37.5%, 124/331). Few respondents expressed a preference to walk in and book an appointment for later (6.0%, 20/331). There was no evidence of a difference in preference between men and women.

There were marked differences in how an individual would prefer to attend a sexual health service by age group. The proportion of respondents who would prefer to walk in without an appointment was highest in the under 16 year age group (86.7%) and this decreased with increasing age to 43.4% of those aged 35+ years.

The proportion of respondents who would prefer to telephone for an appointment was highest among the 35+ year age group (52.8%) and declined within decreasing age to 13.3% in the under 16 year age group.

Weekday evenings were clearly the best suited clinic time, with 60.8% of respondents reporting this was a favourable time to attend a sexual health service, followed by Saturday clinics (table 2).

**Table 2.** The number of positive responses by clinic times among 332 respondents (multiple responses were allowed).

Clinic time	Number of responses	Proportion of respondents
Monday – Friday evenings (5pm – 7pm)	202	60.8%
Saturday (9am -12pm or 12pm – 3pm)	123	37.1%
Monday - Friday mornings (9am – 12pm)	105	31.6%
Saturday (9am -12pm)	98	29.5%
Saturday (12pm – 3pm)	90	27.1%
Monday - Friday afternoons (2pm – 5pm)	81	24.4%
Monday - Friday lunchtimes (12pm to 2pm)	64	19.3%

## 6.5. Self Care Facilities

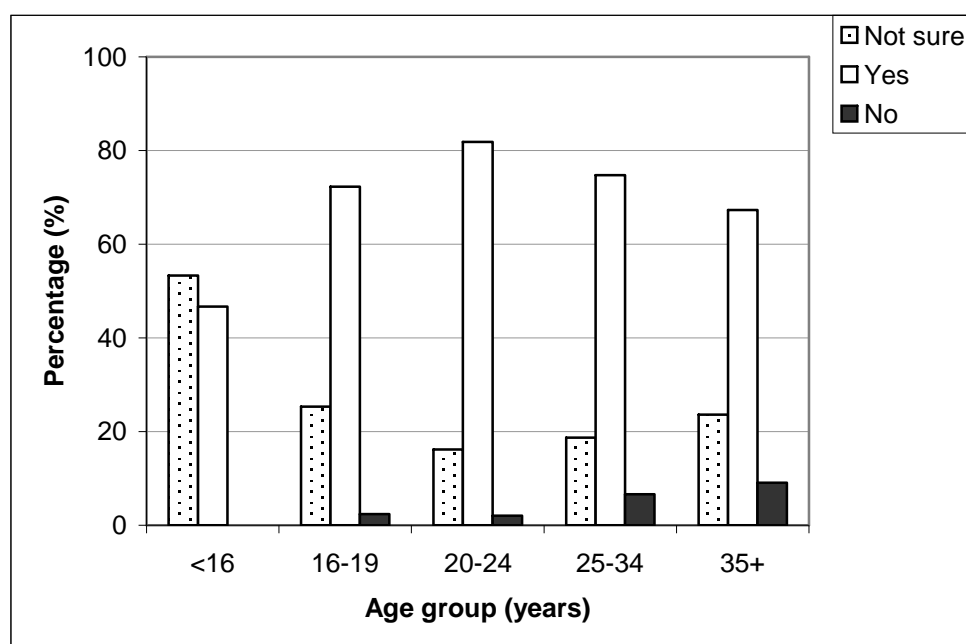
Self care facilities include access to condoms, pregnancy tests and Chlamydia screening tests, without direct contact with clinicians. This facility enables individuals to manage their own sexual health.

Demand for sexual health self care facilities is high, with 73.8% (254/344) of respondents reporting they would use self care facilities. A further 21.4% were not sure (75/344) with the number reporting they would not use self care facilities being very low (15/344 respondents, 4.4%).

A greater proportion of women reported they would use self care facilities, compared with men (79.1% compared to 65.1%,  $\text{Chi}^2$   $p=0.002$ ).

In addition, the proportion reporting they would use self care facilities was similar across those in the 16 to 19, 20 to 24 and 25 to 34 year age groups. The proportion who would not use self care increased with age, and the highest proportion of those unsure were in the less than 16 years age group (figure 6).

**Figure 6.** The proportion of respondents who would or would not use sexual health self care, by age group (N=344).



## 6.6. Summary

Service users/members of the public expressed a preference for sexual health services to be available via GUM clinics and general practices, in addition to family planning clinics.

Confidentiality was the single very important factor when deciding on where to go for STI care and treatment. The following characteristics were also considered important; the availability of test results on the same or next day, ease of transport and central location, the opening hours (on Saturdays and late evenings).

The majority (56.5%) of respondents would like to be able to walk in and be seen without having to make an appointment, and a further 37.5% would prefer to telephone ahead for an appointment. Young people would prefer a walk in service, whereas the older age groups would prefer to telephone ahead for an appointment.

Weekday evenings were the best suited clinic time, with 60.8% of respondents reporting this was a favourable time to attend a sexual health service, followed by Saturday clinics (table 2).

Demand for sexual health self care facilities are high, with 73.8% of respondents reporting they would use self care facilities.

## 7. Strengths and limitations

The strengths of this engagement include the well written document, attempts to consult with a wide range of stakeholders, and the short questionnaire focusing on key areas for consideration by service users/members of the public.

There was poor response from the comprehensive stakeholder list and this may reflect a need for a more pro-active approach to ensure that the views of those working with young people, who may not currently be providing sexual health services are considered.

There are a number of limitations in the service users/public questionnaire. Firstly, information on ethnicity and sexual orientation were not collected, which means it is not possible to determine if the views of minority groups are reflected in the local engagement process. This is an important omission because a component of the service delivery is aimed at addressing these groups e.g. “increase tailored SH outreach to target BA (Black African) communities, and MSM (men who have sex with men)”. However, it is recognised that within the constraints of a short, concise questionnaire there may not have been the opportunity to collect information on risk behaviours.

Secondly, the term “sexual health” was used throughout the service users/public questionnaire, but this term was not clearly defined. The engagement document considers it to include both sexually transmitted infections and reproductive healthcare services. However, the public’s perception of a “sexual health problem” may differ, and some may not consider contraception advice as a sexual health problem/issue.

Respondents were asked to provide multiple answers for a number of questions, which means results do not truly reflect preference but it does enable us to determine which settings the majority would access.

There are also a number of limitations of surveys which should be considered. Firstly, there is the possibility of response bias, i.e. the participant does not want to answer the question or their response is not true. This can be a significant limitation when asking members of the public about sexual health, and may also be a limitation in the professionals views as the questionnaires required the participants name and organisation – being able to be identified may deter an individual from reflecting their true concerns about the service development. Secondly, as with all questionnaires the representativeness of the views expressed should be considered. In this case it is likely that the questionnaires returned are from members of the public who are already in contact with sexual health services, and so may not be representative of the wider Kingston population.

## **8. Conclusion and key recommendations**

In conclusion, the Local Engagement process to obtain the views of stakeholders (both public and professional) on the service development and proposed Integrated Sexual Health Service model for Kingston (*Integrated Sexual Health Services in Kingston, Have your say. Engagement Document, NHS Kingston, April 2009*) was successful.

There was good response from both professionals (n=31) and service users/members of the public (n=350).

### **Views of professionals**

Overall, there was a good level of support for the Integrated Sexual Health Service Specification. The majority of professionals who returned the questionnaire agreed there was a need to modernise local sexual health services in Kingston, there was support for an integrated sexual health service, and the majority agreed with NHS Kingston's vision for sexual health services. In addition, the majority of professionals felt that, if implemented, the new service model would promote improvements in sexual health.

#### **8.1. Recommendations for consideration under the service specification**

The following recommendations were made for consideration in the final integrated sexual health specification;

- (i) Clarity over the use of the terms "comprehensive" and "local community" in the NHS Kingston's vision for sexual health definition is needed.
- (ii) The implications of an integrated sexual health service in Kingston raised by respondents needs to be considered.
- (iii) There is a need for agreement on which settings are included under the heading "community setting", whilst considering the public demand for services in primary care.
- (iv) The content of the service model should be reviewed in light of the components stakeholders felt were missing from the model

including, young people sexual health, partner notification, teaching and training, health education.

- (v) Further consideration of the service provided within each Tier is needed in light of the specific recommendations proposed in Section 5.4 of this report.

## **8.2. Recommendations for consideration under service delivery**

Views from the public will help inform service delivery and the following recommendations were made;

### Where to deliver sexual health services

- (vi) The most preferred settings to go to for help or advice on a sexual health problem is GUM clinics, general practice and family planning clinics.
- (vii) When considering where to develop sexual health services the most important factors for service users/members of the public are confidentiality, availability of test results on the same or next day, ease of transport and central location, the opening hours (on Saturdays and late evenings).
- (viii) The provision of sexual health self care facilities should be considered as respondents (73.8%) expressed a high level of demand for such a service.

### How to access to sexual health services

- (ix) Young people would prefer a walk in sexual health service, whereas the older age groups would prefer to telephone ahead for an appointment.
- (x) The most preferable times for a sexual health service were weekday evenings (60.8%) and Saturday clinics (37.1%).

These key findings and recommendations should be considered in the final integrated sexual health specification and implementation.

## **Acknowledgements**

Thank you to all professionals, service users and members of the public who completed and returned the questionnaires. Thanks also to Kim Drye, NHS Kingston, who completed the data entry.

## **References**

- NHS Kingston comprehensive Sexual Health Needs Assessment, NHS Kingston, June 2008.
- Integrated Sexual Health Services in Kingston, Have your say. Engagement Document, NHS Kingston, April 2009.

## Glossary of Terms

Abbreviation	Term	Definition
ARV	Antiretroviral	Antiretroviral drugs are medications for the treatment of infection by primarily HIV. When several such drugs, typically three or four, are taken in combination.
BA	Black African	Ethnicity
	Commissioning	The process of identifying, quantifying, monitoring and evaluating, a service within the NHS
	Consultation	Actively seeking, listening to, and taking into account the views of local people before decisions are made.
	Colposcopy	Colposcopy is a procedure that allows a physician to take a closer look at a woman's cervix and vagina using a special instrument called a colposcope.
	Continuing Professional Development	Part of a process of lifelong learning for all healthcare professionals helping them to care for patients.
DH	Department of Health	Government Department.
EHC	Emergency Hormonal Contraception	Contraceptive drug taken within 72 hours of sexual intercourse.
GP	General Practitioner	A local Doctor within Primary Health Care Services.
GUM	Genito-Urinary Medicine	Specialist in Medicine concerned with diseases and conditions, which result from sexual activity.
HIV/AIDS	HIV Human Immunodeficiency Virus	HIV (Human Immunodeficiency Virus) infects and gradually destroys an infected person's immune system, reducing their protection against infection and cancers.
	Integrated Service	Service taking a person-centred approach and seeking to meet all a person's sexual health needs
IUD/IUS	Intra Uterine Contraceptive Devices (IUD/IUS)	These are often referred to as the coil.
LARC	Long acting reversible contraception	
MSM	Men who have sex with men	
	NHS Kingston	A local NHS organisation responsible for managing local

		health services. NHS Kingston works with Local Authorities and other agencies that provide health and social care locally to make sure the community's needs are being met.
PEP	Post exposure prophylaxis	
	Pharmacists	Specialist health professionals who make, dispense and sell medicines.
	Provider or Service Provider	The name used to describe any organisation that provides a service to the NHS.
	Primary Care	Health services, which are first point of contact for patients, e.g. GP's Surgeries, Pharmacists, Local Dentists and Opticians.
SHNA	Sexual Health Needs Assessment	A formal process undertaken to assess the sexual health and care needs of the population.
	Specification	A document intended primarily for use in procurement, which describes the essential service requirements including the procedures for assessing whether service requirements have been met.
STI	Sexually Transmitted Infections	Infections transmitted from person to person during sexual activity.
	Stakeholder	A person or organisation with an interest in a particular issue.
	Service user	An individual who uses a health care service.
SWL	South West London	Includes: Kingston , Richmond and Twickenham, Sutton and Merton, Wandsworth and Croydon
	Tier	Levels of services placed one above the other in a series depending on need
TOP	Termination of Pregnancy	Termination of pregnancy (TOP) is a medically directed miscarriage.

**List of appendices**

- Appendix A.** Service Providers/Professionals questionnaire
- Appendix B.** Postcard questionnaire for the public.
- Appendix C.** Summary leaflet for the public.
- Appendix D.** List of stakeholders included.
- Appendix E.** Public questionnaire: data summary.

**Appendix A. Service Providers/Professionals questionnaire**

**INTEGRATED SEXUAL HEALTH SPECIFICATION  
QUESTION RESPONSE SHEET**

Please use this form to answer the questions below. This form can be emailed ([engagement@kpct.nhs.uk](mailto:engagement@kpct.nhs.uk)), faxed (0208 339 8102) or sent by post free to **NHS Kingston Sexual Health Modernisation, FREEPOST, SEA 13726, Surbiton, KT5 9BR**

**Contact Details (this is optional)**

Name .....

Organisation (if relevant) .....

Address .....

.....

Phone/ e-mail .....

**Questions for Service Providers/Professionals**

*(Service providers who the Integrated Sexual Health Specification will impact or stakeholders who would like to express a view)*

**Please state your profession:**

- |   |   |   |  |
|---|---|---|--|
| GP/local doctor <input type="checkbox"/>                                      | Clinical Consultant <input type="checkbox"/>            | Nurse <input type="checkbox"/>                    | Pharmacist <input type="checkbox"/>                      |
| Health Advisor <input type="checkbox"/>                                       | Teacher/Youth Worker <input type="checkbox"/>           | Service Manager/Director <input type="checkbox"/> | Charity/Voluntary sector worker <input type="checkbox"/> |
| Works with young people (not teaching or youth work) <input type="checkbox"/> | Reception/front of house Staff <input type="checkbox"/> | Other <input type="checkbox"/> (Please State)     |  |

- |  | YES                      | NO                       | NOT SURE                 |
|--|--------------------------|--------------------------|--------------------------|
| 1. Do you think that local sexual health services need to be modernised?         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do we need integrated sexual health services?                                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. In the service model are the tiers correct?<br>If no please explain:          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you agree with the service aim of sexual health modernisation in Kingston? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you agree with the service objectives in the Specification?                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Is there anything missing from the service model?<br>If yes please explain:   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

7. If the new service model is implemented, do you believe they will promote improvements in sexual health?

8. Do you agree with NHS Kingston's vision for sexual Health?

9. Please state if you feel any additional services or points need to be included in the service model

10. Please state if you feel any particular items/services need to be omitted from the service model

Additional Comments:

**Thank you for your time**  
**This Question Response Sheet can be returned to NHS KINGSTON**  
**FREE at the address below:**

**NHS Kingston Sexual Health Modernisation**  
**FREEPOST**  
**SEA 13726**  
**Surbiton**  
**Surrey**  
**KT5 9BR**

**FAX Number: 0208 339 8102 C/O Vanessa Cruickshank**

**DEADLINE FOR RESPONSES: 26<sup>th</sup> June 2009**

**Appendix B. Postcards Questionnaires for the public**



**IMPROVING SEXUAL HEALTH SERVICES IN KINGSTON**

**Have Your Say**

**Return to:**  
**NHS Kingston**  
 Sexual Health Modernisation  
 FREEPOST  
 SEA 13726  
 Surbiton  
 Surrey  
 KT5 9BR



**NHS Kingston would like to develop Integrated Sexual Health Services.**  
 Help us shape how sexual health services are delivered by completing the questions overleaf or log on to [www.kingstonpct.nhs.uk](http://www.kingstonpct.nhs.uk) or [www.younglavin.org.uk](http://www.younglavin.org.uk)  
**Engagement dates 27th April – 26th June 2009**

Please answer the following:

**1. Are you?**  male  female

**2. How old are you?**  under 16  16 – 19  
 20 – 24  25 – 34  35+

**3. Have you ever had a check up for sexually transmitted infections (STIs)?** (tick one box)  
 No  Yes If yes when was that?  
 In the last 3 months ago  
 Between 3 months and 1 year ago  
 Between 1 year and 5 years ago  
 Longer than 5 years ago

**4. Who would be your first contact if you had a sexual health problem/issue?** (Please tick the two preferred options)  
 GP surgery/local doctor  
 GUM/STI/Sexual health clinic  
 NHS Family planning clinic  
 Private clinic  
 HW/AIDS charity  
 Pharmacy  
 Internet  
 Leaflet  
 Young people drop-ins  
 Friends/Partners  
 Other (please specify) \_\_\_\_\_

**5. What are the important factors in deciding where to have a check up or treatment for Sexually Transmitted Infections** (Tick as many as apply)

	Very important	Important	Unsure	Not very important	Not at all important
Confidential service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Results available the same day or next day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Services available late evenings (5 –7 p.m.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Services available on Saturdays	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NHS sexual health clinic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
City Centre location	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospital setting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GP/ Doctor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health Centre	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pharmacy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easy to get to by public transport	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**6. What days and times are best for you when attending a sexual health service?** (Tick as many as apply)  
 Monday - Friday mornings (9am – 12noon)  
 Monday - Friday lunchtimes (12noon to 2pm)  
 Monday - Friday afternoons (2pm – 5pm)  
 Monday – Friday evenings (5pm – 7 pm)  
 Saturday (9am – 12pm)  
 Saturday (12pm – 3pm)

**7. Would you use sexual health self care facilities if they were available?**  
*SH self-care facilities include access to condoms, pregnancy tests and Chlamydia screening kits with information support, without direct contact with clinicians, to enable individuals to manage their own sexual health care*  
 Yes  No  Not Sure

**8. How would you prefer to attend a sexual health service?** (Please tick one)  
 Telephone to make an appointment for later  
 Walk in to make an appointment for later  
 Walk in and be seen without having to make an appointment

**9. Where would you prefer to get advice or help with sexual health issues?** (please pick the three preferred options)  
 Your GP/doctors' surgery  
 Internet  
 GUM/STI/Sexual health clinic  
 NHS Family planning clinic  
 Private clinic  
 HW/AIDS charity  
 Pharmacy  
 Young people drop-in  
 Leaflets  
 Friends/Partners  
 Other (please specify) \_\_\_\_\_

Additional Comments: \_\_\_\_\_

Thank you for your time. Now simply pop this postcard in the post box.  
 Feedback and comments will be available at: [www.kingstonpct.nhs.uk](http://www.kingstonpct.nhs.uk) from July 2009

## Appendix C. Summary leaflet for the public.

**6. What days and times are best for you when attending a sexual health service?**  
(Tick as many as apply)

Monday - Friday mornings (9am - 12noon)  
 Monday - Friday lunches (12noon to 2pm)  
 Monday - Friday afternoons (2pm - 5pm)  
 Monday - Friday evenings (5pm - 7pm)  
 Saturday (9am - 12pm)  
 Saturday (12pm - 3pm)

**7. Would you use sexual health self care facilities if they were available?**  
SH self-care facilities include access to condoms, pregnancy tests and Chlamydia screening kits with information support, without direct contact with clinicians, to enable individuals to manage their own sexual health care

Yes  No  Not Sure

**8. How would you prefer to attend a sexual health service? (Please tick one)**

Telephone to make an appointment for later  
 Walk in to make an appointment for later  
 Walk in and be seen without having to make an appointment


**9. Where would you prefer to get advice or help with sexual health issues?**  
(Please tick the three preferred options)


Your GP/Doctors' surgery  
 Internet  
 GUM/STI/sexual health clinic  
 NHS Family planning clinic  
 Private clinic  
 HIV/AIDS charity  
 Pharmacy  
 Young people drop-in  
 Leaflets  
 Friends/Partners  
 Other (please specify) \_\_\_\_\_

**Additional Comments:**

**Thank you for your time**  
**DEADLINE FOR RESPONSES: 26th JUNE 2009**  
 Please return this completed Leaflet to the address below.  
 Postage is Free

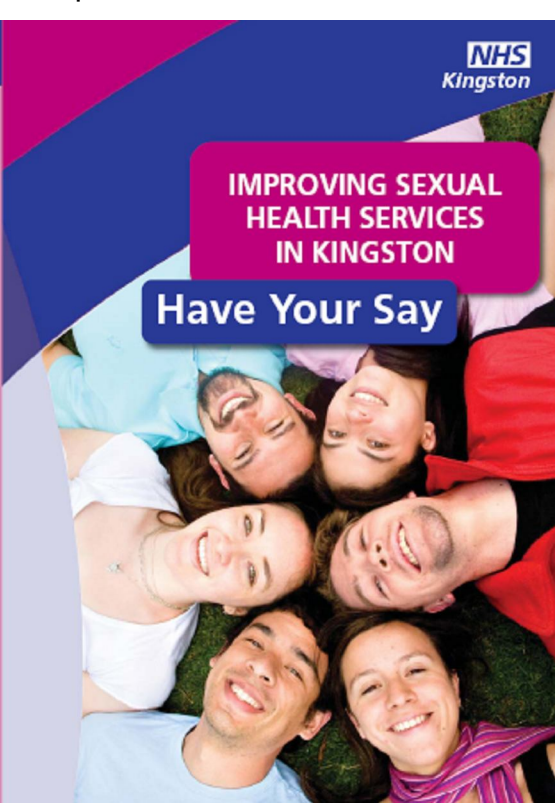
NHS Kingston Sexual Health Modernisation  
 FREEPOST SEA 13726, Surbiton  
 Surrey KT5 9BR





### IMPROVING SEXUAL HEALTH SERVICES IN KINGSTON

## Have Your Say



**SEXUAL HEALTH MODERNISATION IN KINGSTON**

Over the past 12 months considerable work has been undertaken to ensure there is clear direction from NHS Kingston on sexual health. This work has shown that we need to modernise our sexual health services. To make improved use of resources and ensure appropriate and effective pathways between prevention, promotion and treatment services are available.

**KINGSTON'S VISION FOR SEXUAL HEALTH SERVICES**

A clinically governed, comprehensive and equitable sexual health partnership offering modern, inclusive, and accessible sexual health care, through a co-ordinated network across Kingston. Clearly communicated care pathways will deliver an integrated, patient-focused, holistic and high quality service, delivered in a cost effective manner that is responsive to the sexual health needs of our local communities.

**WHAT IS AN INTEGRATED SEXUAL HEALTH SERVICE?**

The key feature of an integrated service is that it acts as a service hub for sexual health services by bringing together a range of sexual health services, sometimes under one roof.

Key components of an integrated sexual health service:

- A lead provider who will take responsibility for coordinating the multi-agency working and delivery arrangements.
- Comprehensive sexual health services
- The integrated provision will be made up of a range of sexual health services that share a common location, a common vision and agreed principles of delivering sexual health services
- Staff work in a coordinated way to address the needs of service users.

This will enable the delivery of a number of integrated sexual health settings with clearly defined patient pathways.

**HOW WILL IT WORK?**

The new service will operate under a tiered model of delivery. The proposal is to deliver a comprehensive three level service to deliver prevention, diagnosis and treatment of sexually transmitted infections and contraception and reproductive health care.

The service model will be established as highlighted below:

- Tier 1** - provided by GP and pharmacist. Enthusiastic access to STI testing treatment and contraception care and advice, partner notification
- Tier 2** - Fully integrated contraception and STI treatment and care, Chlamydia screening and sexual health promotion (where applicable patients will be tested and treated within the same day).
- Tier 3** - Consultant level advice and complex treatment and care of STIs and reproductive care and treatment (including level 2 and 1).

For a more detailed breakdown log onto [www.kingstonpct.nhs.uk](http://www.kingstonpct.nhs.uk)

**LOCAL ENGAGEMENT**

We want your feedback on what you think of our detailed proposals. Your views really do count. The proposals in this leaflet are not set in stone and comments are welcome.

We have set out the specific questions we would like you to comment on

At the end of this engagement process in June 2009, NHS Kingston will give full consideration to the comments it has received, both in writing and in the drop-in sessions, before preparing the final integrated sexual health specification.

The outcome of the engagement process will be published on [www.kingstonpct.nhs.uk](http://www.kingstonpct.nhs.uk) in July 2009

**Timescales are as follows:**

Local Engagement Period 27th April to 26th June 2009

Public Drop in Sessions will be held on the following dates:

- 28th April 10 am- 12 noon at: NHS Kingston 22 Hollyfield Road, Surbiton, Surrey KT5 9AL
- 26th May 2-5 p.m. at: NHS Kingston 22 Hollyfield Road, Surbiton, Surrey KT5 9AL
- 9th June 4 -7 p.m. at: NHS Kingston 22 Hollyfield Road, Surbiton, Surrey KT5 9AL

**NHS Kingston would like to develop Integrated Sexual Health Services. Help NHS Kingston shape how sexual health services are delivered by completing the questions below or log on to [www.kingstonpct.nhs.uk](http://www.kingstonpct.nhs.uk) or [www.younglives.org.uk](http://www.younglives.org.uk)**

Please answer the following:

- Are you?  male  female
- How old are you?  under 16  16 - 19  20 - 24  25 - 34  35+
- Have you ever had a check up for sexually transmitted infections (STI's)? (tick one box)  
 No  Yes If yes when was that?  
 In the last 2 months ago  
 Between 2 months and 1 year ago  
 Between 1 year and 5 years ago  
 Longer than 5 years ago
- Who would be your first contact if you had a sexual health problem/issue? (Please tick the two preferred options)  
 GP surgery/local doctor  Internet  
 GUM/STI/sexual health clinic  Leaflet  
 NHS Family planning clinic  Young people drop-ins  
 Private clinic  Friends/Partners  
 HIV/AIDS charity  Other  
 Pharmacy (please specify) \_\_\_\_\_

**5. What are the important factors in deciding where to have a check up or treatment for Sexually Transmitted Infections (Tick as many as apply)**

	Very important	Important	Unsure	Not very important	Not at all important
Confidential service	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Results available the same day or next day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Services available late evenings (5 -7p.m.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Services available on Saturdays	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
NHS sexual health clinic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
City Centre location	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hospital setting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GP Doctor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health Centre	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pharmacy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Easy to get to by public transport	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (please specify)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Appendix D.** List of stakeholders included.

NHS London Sexual Health Programme  
Sexual Health Leads (Primary Care Trusts) or SH links  
All general practices in Kingston  
All Pharmacies in Kingston  
KHT Genitourinary Medicine clinic  
Lead GU Consultant at Wandsworth PCT,  
SWAGNET GU Physician and Deputy Lead Clinician  
KU19 and community contraception services  
Consultant in Family Planning (Sutton & Merton)  
Regional Teenage Pregnancy Co-ordinator  
Hawks Road Clinic  
Teenage Pregnancy  
Looked After Children (LAC)  
Child Protection  
British Pregnancy Advisory Service  
HIV Commissioners Network  
HIV family support  
African Positive Outlook  
Supported accommodation  
Extended Schools Co-ordinator  
Barnfield Youth Centre  
Devon Way Centre  
Dickerage Adventure Playground  
Searchlight Youth centre  
School Lane Youth Centre  
Kingsnympton Youth Centre  
Fountain Youth Centre  
The Venner Youth Centre  
Kingston Youth Councils  
YMCA  
K-Links

Integrated Youth Support Services (includes YISP, Young Offending Teams (YOT), Youth Service, Connexions, Youth bus).

Kingston University

Kingston College

**Appendix E.** Public questionnaire: data summary

(Total respondents= 350)

Q.	Topic	Category	Number of people (% of total)
1	Sex	Male	127 (36.3%)
		Female	220 (62.9%)
		Missing	3 (0.9%)
2	Age group (years)	<16	15 (4.3%)
		16-19	84 (24.0%)
		20-24	101 (28.9%)
		25-34	93 (26.6%)
		35+	56 (16.0%)
		Missing	1 (0.3%)
3	Have you ever had a check up for STIs?	Yes	221 (63.3%)
		No	128 (36.6%)
		Missing	1 (0.3%)
	If yes, when was your last check up for STIs	In the last 3 mths	59 (27.8%)
		Between 3 mths and 2 yrs ago	81 (38.2%)
		Between 2 and 5 yrs ago	60 (28.3%)
		More than 5 yr ago	12 (5.7%)
7	Would you use sexual health self care facilities if available?	Yes	254 (72.6%)
		No	15 (4.3%)
		Not sure	75 (21.4%)
		Missing	6 (1.7%)
8	How would you prefer to attend a sexual health service	Telephone to make an appointment for later	124 (35.4%)
		Walk in to make an appointment for later	20 (5.7%)
		Walk in and be seen without having to make an appointment	187 (53.4%)
		More than one response <sup>a</sup>	14 (4.0%)
		Missing	5 (1.4%)

<sup>a</sup>Respondents who ticked more than one box were excluded from the analysis, as only one response allowed for this question.

*Multiple responses were allowed in the following questions.*

Q.	Topic	Category	Number of responses
4	Who would be your first contact if you had a sexual health problem?	Friends/Partners	47
		GP surgery/local doctor	156
		GUM/STI/Sexual health clinic	160
		HIV/AIDS charity	0
		Internet	28
		Leaflets	1
		NHS Family planning clinic	37
		Other	2
		Pharmacy	2

		Private clinic	7
		Young people drop-in	28
		Number of people with missing reply	3
5	Important factors in deciding where to have a check up or treatment for STIs	Other	49
		Pharmacy	311
		Hospital setting	319
		Health centre	313
		Easy to get to by public transport	314
		City Centre location	316
		GP/ Doctor	318
		NHS sexual health clinic	324
		Services available on Saturdays	328
		Services available late evenings (5 – 7p.m.)	332
		Test results available the same or next day	335
		Confidential service	343
		Number of people with missing reply	6
6	What days and times are best for you when attending a sexual health service?	Monday - Friday mornings (9am – 12noon)	105
		Monday - Friday lunchtimes (12noon to 2pm)	64
		Monday - Friday afternoons (2pm – 5pm)	81
		Monday – Friday evenings (5pm – 7pm)	202
		Saturday (9am -12pm)	98
		Saturday (12pm – 3pm)	90
		Number of people with missing reply	18
9	Where would you prefer to get advice or help with a sexual health problem?	Friends/Partners	34
		GP surgery/local doctor	182
		GUM/STI/Sexual health clinic	189
		HIV/AIDS charity	5
		Internet	103
		Leaflets	37
		NHS Family planning clinic	68
		Other	4
		Pharmacy	17
		Private clinic	17
		Young people drop-in	51
		Number of people with missing reply	7