Isle of Man Government

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Integrated Sexual Health Service Needs Assessment Report

Integrated Sexual Health Service Stakeholder Group

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Executive Summary

The Sexual Health Executive Steering Group was developed to refresh the sexual health strategy. The group agreed priority areas to undertake needs assessments that will inform the strategy, including the integrated sexual health services (ISHS), where staffing and sustainability issues were highlighted. To progress the ISHS needs assessment, an ISHS Stakeholder Group was created and agreement sought to report to the Department of Health and Social Care (DHSC) Commissioning Committee. The majority of the needs assessment was then undertaken by three further sub-groups of the Stakeholder Group, who gathered the necessary data and information.

One of the main gaps driving this needs assessment is the lack of integrated partnerships and formal referral pathways between the sexual health services on-island. Back in 2010, the Public Health White Paper highlighted a commitment to work towards an integrated model of service delivery to allow easy access to confidential, non-judgemental sexual health services in England. This approach was supported by the Department of Health (DOH), with Local Authorities being mandated to commission comprehensive open access sexual health services following guidance produced in 2013 (DOH, 2013b). This theme has continued, with the Faculty of Sexual and Reproductive Healthcare (FSRH) more recently highlighting the importance of integration as part of the vision for sexual and reproductive health care:

> "…establishing clear referral pathways between services so that care can be integrated around the needs of the individual, not institutional or professional silos."
>
> (FSRH, 2017:online)

For the purpose of this needs assessment it is important to understand this meaning of integration as it would be too easy to follow the 'one stop shop' approach that many services across the UK operate. Especially when considering the varying management structures for the sexual health services on-island, which operate through sub-divisions of the DHSC. The findings of this needs assessment will feed into a service specification and pathway for a localised ISHS, which may or may not be a one stop shop approach, but will provide:

> "…open access, cost-effective, high quality provision for contraception and prevention, diagnosis and management of sexually transmitted infections [and HIV], according to evidence-based protocols and adapted to the needs of local populations."
>
> (DOH, 2013b:10)

Evidence has shown that investment in preventative approaches to sexual health not only improves the overall health of the population, it is also cost effective (DOH, 2013; PHE, 2014; cited in: Leicestershire County Council, 2016). Especially when considering that the consequences of poor sexual health are costly. Current service costs and where available the budget amounts for 2015/16 have been included, totalling approximately £500,000 per year. The spend and budget comparison is not accurate as the FPC bank employee costs are not budgeted for and only an approximate figure for spend has been provided. Also, the figures for Pharmacy are for 2016/17 rather than 2015/16. There has been an attempt to benchmark these costs with Clinical Commissioing Groups however the results were not able to be compared due to the major differences for commissioning in England.

Data has been collected from the Genito-Urinary Medice (GUM), Family Planning Clincic (FPC) and Pharmacy services, some of which could not be included in this report for various reasons. The data presented in this report is in regards to service usage, contraception and pathology. Service usage shows the number of GUM attendances are increasing, the FPC attendances are remaining steady and the Pharmacy attendances are decreasing. On average there are approximately 800 new patients to the GUM service per year and approximately 300 new patients to the FPC service. It is difficult to compare the number of patients who return to these services as they are recorded in different ways. GUM record follow-up appointments and re-registered patients; with approximate figures of 1500 and 1200 per year respectively. The FPC do not separate follow-up appointments and categorise anyone who has attended previously as an existing patient; with approximate figures of 1500 per year. It is important to note that a significant proportion of the GUM workload is not captured by measuring clinic attendance figures alone, as the service has a responsibility to collect data for disease profile and public health surveillance. Further, the Pharmacy data is also not comparable as they include all attendances for emergency hormonal contraception (EHC) together, which may include those who have attended multiple times.

The contraception data shows that more people access the Pharmacy for EHC compared to the total number who attend GUM and FPC combined, for EHC as well as other forms of contraception. The pharmacy supply of EHC dispensed to patients has decreased from approximately 2500 per year to approximately 2000, whereas the FPC has increased from approximately 1500 to 1700, and GUM remain much lower with approximately 100. The pathology data for chlamydia highlights the number of non-GUM requests has declined for males and females, but has only declined for males from GUM requests, with the number of female requests from GUM remaining steady. The number of positive chlamydia results has decreased for both non-GUM and GUM requests.

The lack of consistency between services for data collection can be resolved through following a common core data set, as detailed by a service specification. Through introducing a service specification we can ensure the service is monitoring against the best standards and working efficiently with partners to offer a high quality service for the island residents and visitors. The FPC and GUM were self-reviewed against the relevant standards; the Faculty of Sexual and Reproductive Healthcare and the British Association for Sexual Health and HIV respectively. Concerns regarding the gaps in clinical governance with no specific clinical lead were highlighted for the FPC. On self-assessment, the FPC stated there was no waiting list for appointments. However, feedback from the sexual health services questionnaire, undertaken for the purpose of this needs assessment, highlights "2-3 months to get an appointment for change of contraceptive implant [as there are] very few GPs who offer this service so no alternative." The GUM service works within a clinical governance framework and highlights how waiting time is variable and the Lillie software provides a report to see whether the target of 48 hour access is being met. Although the FPC highlight they offer a patient focussed service, the questionnaire includes comments from previous clients who disagree, for example, "shouting names out in waiting rooms rather than a number system is appalling". Similarly, the FPC suggest they are a confidential service, with a previous client highlighting how there was a "questionnaire to fill in but the form was attached to a clipboard that had numerous blank copies of the same form below it… when filling out details they were transferred through to the sheet below". Further, GUM mention the concerns of full time medical cover lacking with the service currently staffed by locum doctors. As well as issues being identified around the clinic physical set-up which was not purpose built for

GUM, with previous clients suggesting "it is like a walk of shame as everyone knows where you are heading then a good long wait in a full waiting room".
Mapping of the services helped to acknowlege where there were duplications and gaps in the services offered. There are no shared records between the services which means a patients sexual health history will need to be captured for each of the services. Similarly, assessments and referrals will be duplicated, all of which could be highlighted on the service users record. There were no clear gaps highlighted during this exercise, however similar to benchmarking against the standards, this was a self-review for the services, with a few of the areas needing clarification. Including outreach services for sexually transmitted infection (STI) prevention and contraception, appropriate referral pathways, condom distribution and psychosexual counselling.

A key theme included in this needs assessment is access to sexual and reproductive health care as "…access to quality sexual health services improves the health and wellbeing of both individuals and population" (DOH, 2013b:6). During the weekdays, all services are accessible but availability of appointments may be a concern. For weekday evenings the services are available for at least one evening in Douglas which may not be accessible for service users outside of Douglas or suitable on the particular evening they are open. There is limited access to contraceptive services and no access to STI and HIV services over the weekend, however EHC is still widely accessible. Although services may be available, the key issue is in regards to the services that are available and whether these suit the needs of service users. Some of the perceptions from the general public include:

> "Restricted times not conducive to people who work, multiple appointments needed to fit coil. Very frustrating service that needs to move with changing life patterns and be accessible to stop unwanted pregnancy";
>
> "Difficult for those who cannot drive";
>
> "Douglas centred fitted round needs of part time staff not clients. Pharmacists could be used more";
>
> "GP service is deteriorating on the IOM in terms of availability of appointments to access GP's and this is of significant concern in respect of sexual health"; and
>
> "Unable to get appointment for such a long time I had to attend a UK clinic whilst on holiday for change of contraceptive implant".

The DOH highlights "General practice is the largest provider of sexual health services – particularly the provision of contraception – and is the most frequently chosen first point of contact for those with sexual health concerns" (DOH, 2013a:44). Therefore it is necessary to ensure that GPs receive appropriate training and support, with a clear pathway for referrals to sexual health services. In other areas of the UK, it is also common place in service specifications for pharmacists to offer pregnancy testing and ongoing contraception; both of which are not offered through the pharmacies on-island.

To gather a clear understanding of what does and does not work well in the current sexual health services, perceptions were sought from a number of professionals working in the field who were invited to attend the focus group and/or provide anecdotal feedback. To gather the views of the

current sexual health services from the general public, an online questionnaire was created, with paper copies available. The questionnaire received 782 responses; the overall response charts for the questions are shown in Appendix 12. For many of the questions, additional comments were received, which are presented collectively as themes, including integration, access, services, stigma, anonymity, discretion, education, awareness, inequalities, young people, advertising, advice and internet; examples of the quotes are shown in Appendix 13.

Numerous issues have emerged throughout this ISHS needs assessment. The more substantial issues are focused around the lack of a formalised pathway between the services; accessibility of the sexual health services; contractual concerns; client records and data collection; gaps in clinical leadership (particularly for FPC) and service awareness for the general public. To minimise these issues, four potential service configurations have been generated for an ISHS we can offer on-island. The four service configuration options include: no change – separate services; enhanced separate services; ISHS 'one stop shop' – Hub model; or an ISHS 'one stop shop' – Hub and spoke model. All service configuration options have the strengths and weaknesses highlighted as well as the required changes; resources; and costs to consider.

Introduction

The sexual health strategy is out of date and previous attempts to renew this have been limited in scope and driven by the need to react to specific issues. This earlier work identified a wide range of issues and emerging concerns, which led to the development of the Sexual Health Executive Steering Group[1]. Initially this group's aim was to undertake a joint strategic needs assessment (JSNA) to develop key objectives for an updated sexual health strategy covering a wide range of sexual health priorities. However, due to lack of funding this approach was put on hold and instead two areas were identified for fast tracking as needs assessments. This included Integrated Sexual Health Services (ISHS) where staffing and sustainability issues were highlighted, as well as the Sexual Assault Referral Service (SARS), where there are known gaps and issues around forensics. This report is in regards to the ISHS needs assessment, the SARS needs assessment report is available on request.

One of the main gaps driving this needs assessment is the lack of integrated partnerships and formal referral pathways between the sexual health services on the island. Back in 2010, the Public Health White Paper highlighted a commitment to work towards an integrated model of service delivery to allow easy access to confidential, non-judgemental sexual health services in England. This approach was supported by the Department of Health (DOH), with Local Authorities being mandated to commission comprehensive open access sexual health services following guidance produced in 2013 (DOH, 2013b). This theme has continued, with the Faculty of Sexual and Reproductive Healthcare (FSRH) more recently highlighting the importance of integration as part of the vision for sexual and reproductive health care[2] (SRH) –

> "…establishing clear referral pathways between services so that care can be integrated around the needs of the individual, not institutional or professional silos."
>
> (FSRH, 2017:online)

Other key elements of the FSRH vision include the patient experience[3] and having a well-trained workforce,[4] which should apply across the health sector where SRH is an element.

SRH can be more of a personal and private area for individuals, but when things go wrong it can affect the individual, their partner, children and families and potentially have an impact on the community. FSRH highlight that "maintaining good sexual health and well-being… can have profound and positive long-term effects on the individual, their family and the wider society" (FSRH, 2015:4). It is important to note that SRH matters to all of us at different stages in our lives, as SRH goes beyond the provision of contraception and the prevention and treatment of

[1] Terms of reference for the Sexual Health Executive Steering Group are available on request. For membership details of this group refer to acknowledgements.

[2] For a description of SRH refer to the glossary

[3] The patient experience - ensuring that patients have access to a full choice of contraceptive methods and can see a trained healthcare professional to discuss the full range of contraceptive options available to them without fear of harassment or stigma.

[4] A well-trained workforce - making sure that we are 'vision-ready' with the optimum skill mix to cater for a wide population demand.

sexually transmitted infections (STIs).[5] This is highlighted in the life course model (FSRH, 2015, see Appendix 1). For the purpose of this needs assessment, some of the services highlighted in the model are out of scope, with the focus being on those which cover many years of the life course – contraception, STIs, HIV and psychosexual care.

To progress this needs assessment, the Sexual Health Executive Steering Group agreed for the Department of Health and Social Care (DHSC), Public Health Directorate to co-ordinate and lead on this project. An ISHS Stakeholder Group was created including members from different services within the DHSC; as well as services from other departments, such as the Department of Education and Children (DEC) and the third sector. Engagement from the stakeholder group has ensured terms of reference were created and followed,[6] where the group made a successful request to report to the DHSC Commissioning Committee. To ensure the project was managed appropriately, a project charter was created in which the project was scoped out thoroughly (see Appendix 2). Some of the stakeholders also supported one or more of the three sub-groups that were created to undertake the majority of the data gathering for the needs assessment.[7] The results of which are included within this report, identifying the gaps to create options for a clear pathway and service specification.

[5] SRH includes supporting sexual wellbeing, no matter an individual's background or sexual orientation, and includes the planning of families. It begins with education and ends with encouraging post-reproductive health, truly reflecting a person's life course.

[6] Terms of reference for the SARS Stakeholder Group are available on request. For membership details of this group refer to acknowledgements.

[7] The three sub-groups include:

- **Quantitative statistics** - To gather quantitative statistics to cover population demographics and epidemiology/rates of specific STIs; HIV; contraception; and teenage pregnancy, with trends and future projections where possible.
- **Current Services** - To map current services and pathways; benchmark against best practice/quality standards, current activity and cost; and identify the gaps.
- **Qualitative data** - To gather qualitative data to cover service user and provider needs/views on sexual health services on the Isle of Man.

1. Epidemiology

1.1 Public Health Outcome Framework Indicators

The Public Health Outcome Framework indicators that relate to ISHS include:

- Under 18 conceptions
- Chlamydia diagnoses (15-24 year olds)
- People presenting with HIV at a late stage of infection

It has not been possible to compare against these indicators for this needs assessment. There is insufficient data to calculate teenage conceptions, as accurate abortion data for Isle of Man teenagers is unavailable. On-island, there is no chlamydia screening programme so the data is only likely to show the numbers for those who are symptomatic and have chosen to have a chlamydia test. The Family Planning Association (2017) note approximately 70% of infected females and 50% of males will not have any obvious signs or symptoms or they may be so mild they are not noticed. The numbers on-island can therefore not be comparable to the PHOF indicators. The HIV late presentation indicator has been calculated but due to small numbers it is not considered to be statistically accurate enough for inclusion within this report.

Data has been collected from the GUM, FPC and Pharmacy services. The data that is presented is in regards to service usage, contraception and pathology as shown in the remainder of this section. Data was collected for condoms, pregnancy testing and the post code level for the services, however this data has not been included for various reasons. The condom data was not comparable across the services similar to the post code level data which only GUM could provide. Data for the number of pregnancy test included low numbers and the numbers of those that were positive even lower where numbers under 5 would potentially identify patients. Based on the low numbers, it was decided that this data was not to be included.

1.2 Service Usage

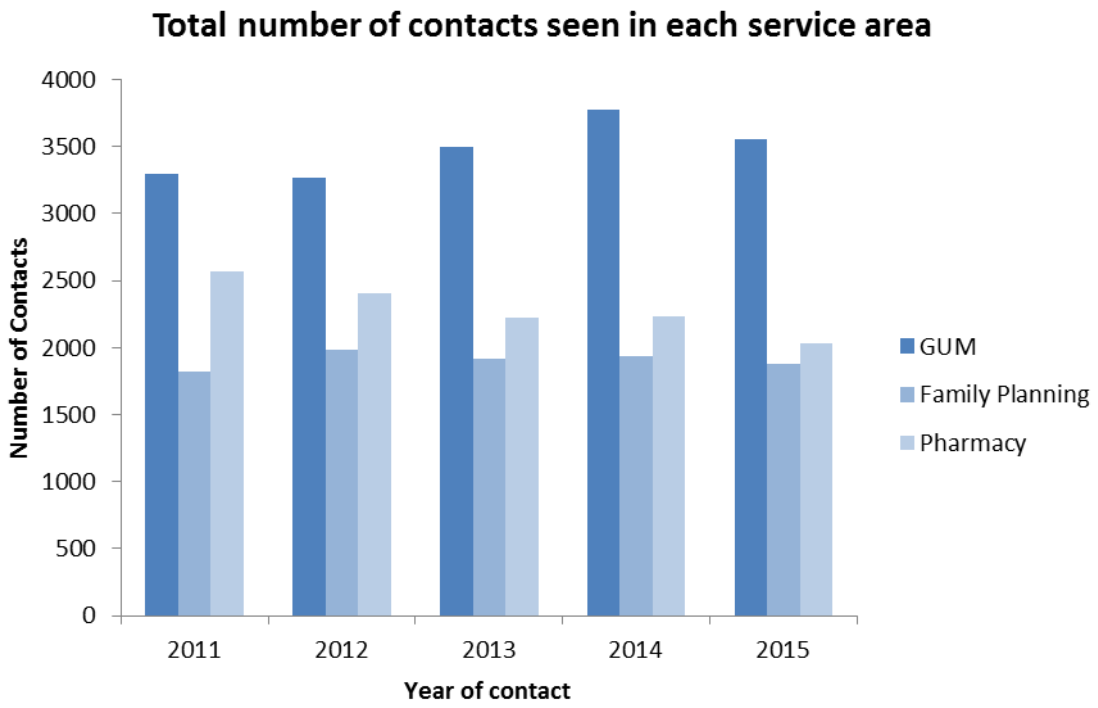


Figure 1. Total number of contacts seen in each service area

Source: calculated using data provided by GUM, FPC and Pharmacy

Figure 1 shows the number of GUM attendances are increasing; the FPC contacts are remaining steady; and the pharmacy contacts are decreasing. More detail on service usage is provided for each of these services.

1.2.1 Service Usage – GUM

GUM follows national criteria that UK GUM clinics use to establish their attendance criteria. On average there are around 800 new patients to the GUM service each year. It is important to note that a significant proportion of the GUM workload is not captured by measuring clinic attendance figures alone. The service has a responsibility to collect data for disease profile and public health surveillance. See 'current services and pathways' GUM section on page 19 for more information.

Table 1. Attendance at GUM by type of attendance

Attendances	2011	2012	2013	2014	2015
New + Re-registered	2096	1890	2064	2209	2037
Follow-up	1198	1375	1433	1565	1518
Total	3294	3265	3497	3774	3555

Source: GUM

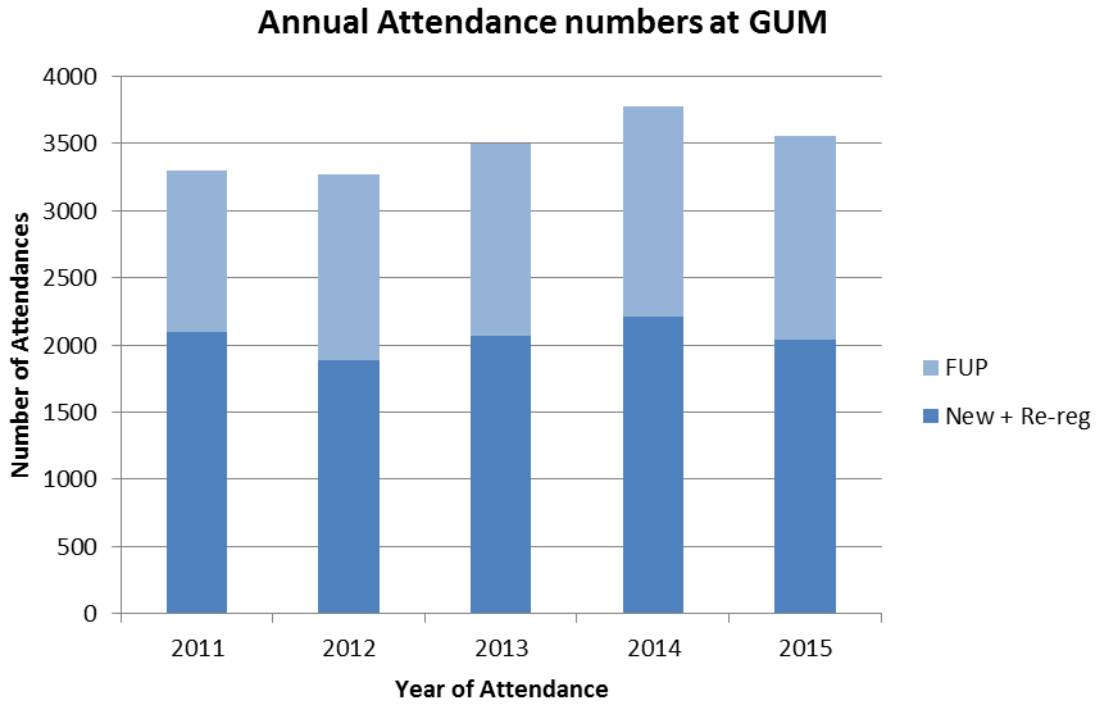


Figure 2. Annual Attendance Numbers at GUM

Source: calculated using data provided by GUM

In Table 1 and Figure 2, the new patients and re-registered patients have been grouped together. The difference is that new patients are brand new to the service who have never been to GUM before. The re-registered patients have previously attended and have been discharged but have now re-attended with a new episode of care; this can be weeks,

months or even years after the previous attendance. The follow-up patients are any attendance within an open episode.

1.2.2 Service Usage – FPC

Table 2. Attendance at FPC by type of attendance

Attendances	2011	2012	2013	2014	2015
New	331	310	375	345	292
Existing	1486	1677	1540	1588	1584
Total	1817	1987	1915	1933	1876

Source: FPC

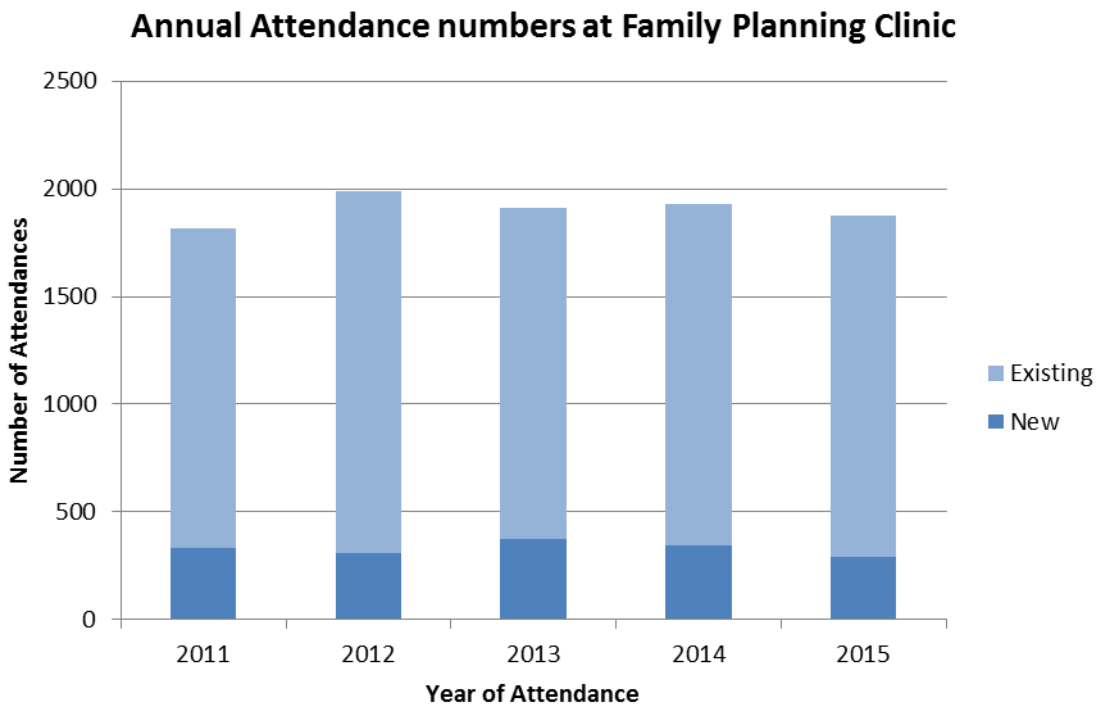


Figure 3. Annual Attendance numbers at FPC

Source: calculated using data provided by the FPC

In Table 2 and Figure 3 the new patients refer to those that are new to the FPC service and the existing patients are those that have attended previously, but not necessarily for the same reason.

1.2.3 Service Usage – Pharmacy

Table 3. Pharmacy annual EHC consultations

Contacts	2011	2012	2013	2014	2015
EHC Consultations	2564	2407	2222	2236	2036

Source: Pharmacy

Table 3 shows the number of consultations for Emergency Hormonal Contraception (EHC) whether or not EHC was supplied. This data includes those who have attended multiple times.

1.3 Contraception

Table 4. Contraception provided by service area

Contacts	2011	2012	2013	2014	2015
GUM	131	63	115	142	119
FPC – excluding EHC	1441	1604	1531	1568	1659
FPC – EHC only	35	17	40	37	37
Pharmacy – EHC supply	2513	2346	2173	2183	1983

Source: GUM, FPC and Pharmacy

In Table 4 the GUM data includes all contraception provided including EHC. The FPC data includes the EHC data separate to the data for other forms of contraception which includes the fitting; checking; and removal of the intrauterine device (IUD), the intrauterine system (IUS) or Implant. The pharmacy data only includes the EHC consultations where EHC was supplied.

1.4 Pathology – Chlamydia

Table 5. Non GUM requests for chlamydia testing

Gender	2011	2012	2013	2014	2015
Male	58	59	40	47	39
Female	1783	1830	1523	1391	1351
Total	1841	1889	1563	1438	1390
Total positives	*44*	*32*	*19*	*18*	*18*

Source: Pathology

Table 6. Requests for chlamydia testing from GUM

Gender	2011	2012	2013	2014	2015
Male	1450	1280	918	949	1016
Female	1101	1036	1107	1167	1143
Total	2551	2316	2025	2116	2159
Total positives	*151*	*151*	*129*	*139*	*127*

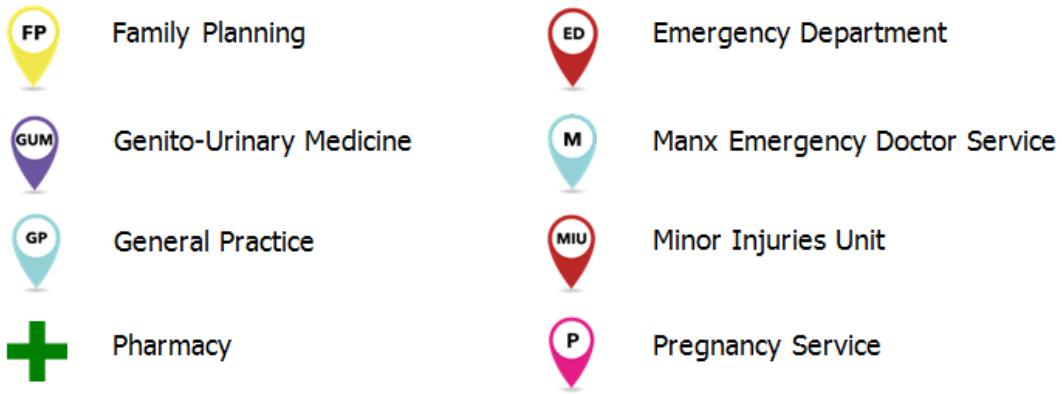
Source: Pathology

These tables show all chlamydia testing done in Pathology and whether the result of that test was positive; the results of which cannot be split by gender due to small number discoverability. Those tests not requested by GUM are from other areas of the hospital and primary care.

The pathology data for chlamydia highlights the number of non-GUM requests has declined for males and females, but has only declined for males from GUM requests, with the number of female requests from GUM remaining steady. The number of positive chlamydia results has decreased for both non-GUM and GUM requests.

2. Current Services and Pathways

The current sexual health related services[8] across the Isle of Man (IOM) include:



Within this section each of these services are explained briefly with further known details such as workforce and training being included in Appendix 3. Following these service overviews, the discussion focuses on the partnership arrangements, referral pathways and how accessible these services are, along with highlighting some of the areas for improvement.

2.1 Service Overviews

2.1.1 Family Planning Clinic

The Family Planning Clinic (FPC) provides contraceptive and sexual health services to all individuals of reproductive age. This includes specialist contraceptive guidance and availability of all current contraception methods to assist the individual to make an informed choice, whilst taking into account their social, family and medical history, lifestyle and preferences. Pregnancy testing, advice on unexpected pregnancies and pre-conceptual advice are also offered. Swabs can also be taken, however if a sexually transmitted infection (STI) is suspected, clients are signposted to and encouraged to attend the Genito-urinary Medicine (GUM) Service.

[8] The current sexual health related services shown only include those which are in scope for this needs assessment. Refer to the Project Charter shown in Appendix 2 for more information on what is in and out of scope.

The services offered are free and confidential, with a mixture of appointment only and drop in sessions. Some methods, such as the IUDs and implants require an initial appointment to discuss suitability. A second appointment is then arranged for the procedure to take place during an evening clinic. Although there is no specific clinic for young people, they are welcome to attend and be advised on sexual health and contraception matters. The diagram in Figure 4 has been adapted from the Nottingham model (Nottingham County Council, 2015) to highlight the levels of service offered through the FPC.[9]

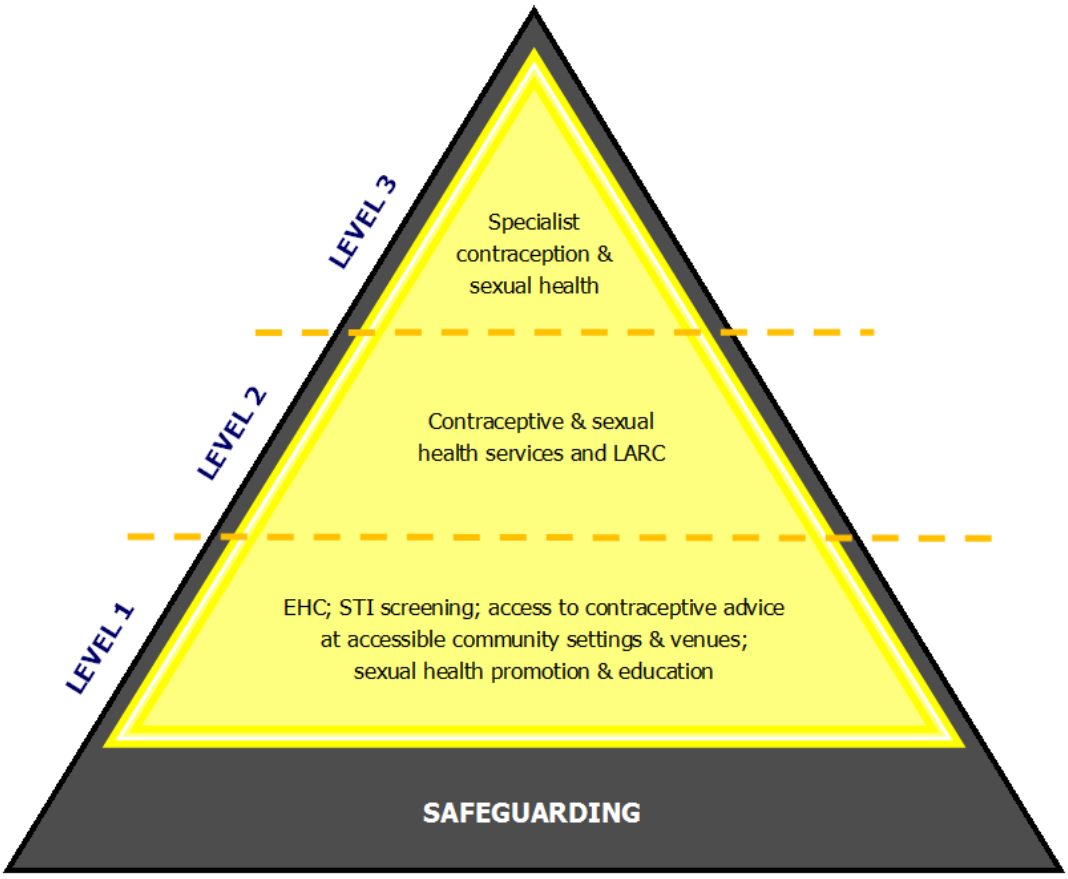


Figure 4. FPC – levels for services offered

Source: adapted from the Nottingham model using information provided by the FPC

Figure 4 highlights that safeguarding is key throughout all levels for the services offered through the FPC.

[9] Refer to the 'service content' section later in this chapter for further information on the services offered.

2.1.2 Genito-Urinary Medicine

GUM is a level 3 sexual health clinic which provides a free confidential service for testing, treatment, advice and management for all STIs including HIV. The clinic is accessed mainly by self-referral, but also has some formal referrals from other health professionals. The clinic operates an appointment system; a walk in service is not currently available. There is a telephone triage facility to ensure patients requiring more urgent appointments are seen as soon as possible. Clinics are mixed gender and for all age groups. There is not a specific clinic for young people, although young people are welcomed with a focus upon confidentiality, as highlighted on the government website. GUM will provide a bespoke service for vulnerable young people and will undertake domiciliary visits to looked after or other vulnerable children as required. Similar to Figure 4, the Nottingham model has been adapted to highlight the levels of service offered through the GUM service (see Figure 5), with more detail on the services offered included in Appendix 3.

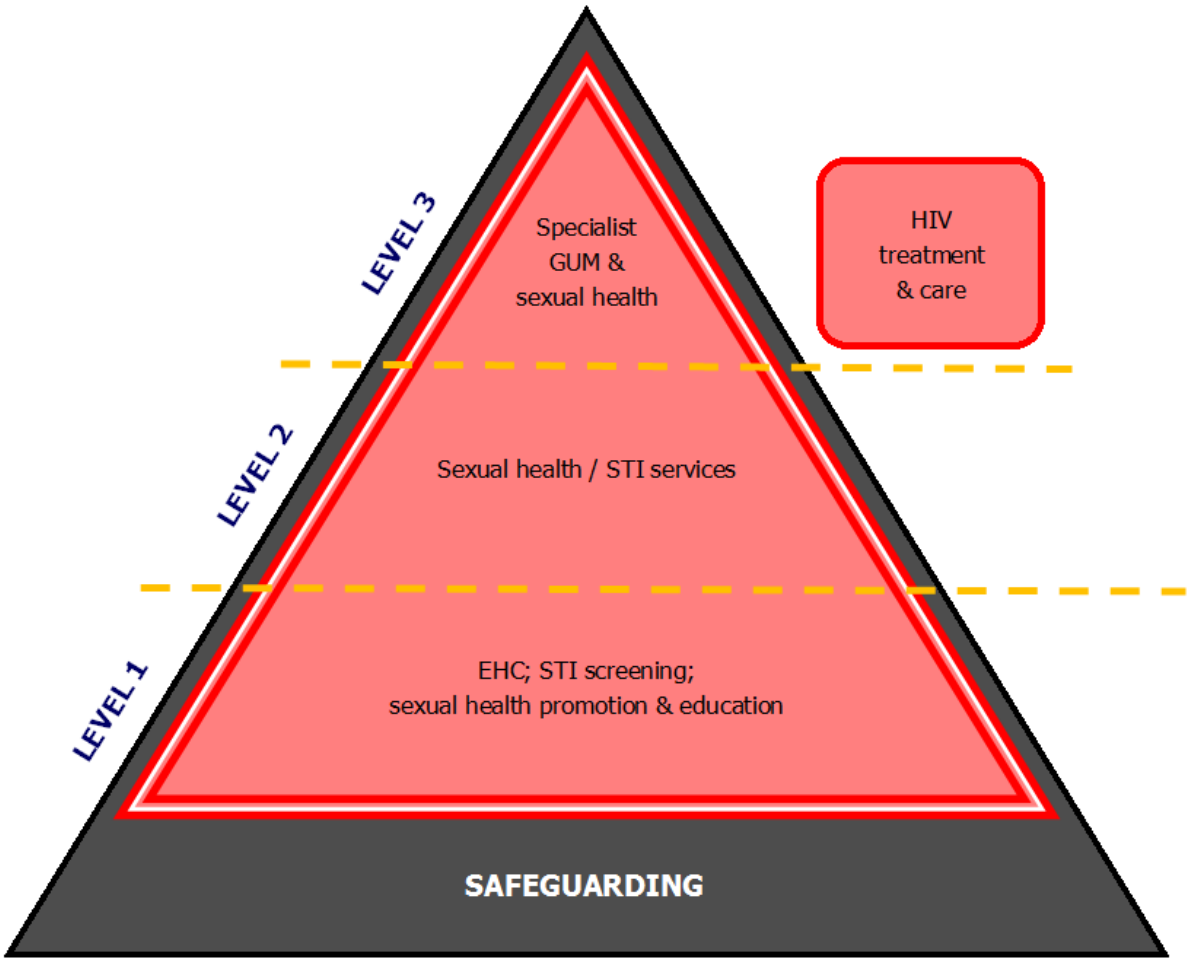


Figure 5. GUM clinic – levels for services offered

Source: adapted from the Nottingham model using information provided by GUM

Figure 5 highlights HIV treatment and care as a separate box to the 'services offered' triangle. The management of HIV infection is through the GUM service, with all treatment, testing and monitoring in accordance with BHIVA guidelines. However, the separate box is to indicate that some clients may go off-island if they become unwell and require hospital admission. This process involves being referred to the Royal Liverpool Hospital, Infectious Diseases Unit. Admission will be at the discretion of the admission team and bed availability. Patients with complex comorbidities, for example co-infection with Hepatitis C/B, will be treated via the Infectious Diseases Outpatient Unit.

Aside from the services offered for clients, it is important to note the significant proportion of the GUM workload in regards to the responsibility of disease profile and public health surveillance data collection. The service records attendance, tests undertaken, results, and then clinical coding is undertaken to comply with MEDFASH national quality standard five, Information Governance. There is also a significant number of follow-up telephone consultations e.g. following treatment for chlamydia to ensure treatment compliance and for partner notification purposes. Also, if a patient does not attend for an appointment, this may require time consuming efforts to engage with the patient/contacts of infection. This 'background' level of workload can be difficult to quantify, but is an important factor to consider when managing the rotas for the nursing staff to ensure enough non-clinical hours are made available to enable facilitation of this work.

2.1.3 General Practice

Across the island there are 14 General Practice (GP) surgeries,[10] with each GP surgery having at least 2 practice nurses within their Primary Care Team. These are experienced nurses performing a full range of procedures and healthcare, which may include aspects of sexual health. In addition to the practice nurses, all GPs are responsible for the provision of contraceptive services and will at minimum offer basic contraception. There is a GP inter-practice referral pathway in place to ensure patients on the island can receive long-acting reversible contraception (LARC), in particular intrauterine device (IUD) or implant insertions via a GP service. This may not be their own GP, as not all GPs or GP surgeries offer this service and therefore the referral pathway is in place so that if the patients GP or GP surgery does not offer LARC, they can then be referred to another GP surgery who does offer this service (see Appendix 4). Although this service is offered, there is no specific sexual health contract in place. The levels of service offered through the GP service are shown in Figure 6.

Figure 6In addition to contraception, all GP surgeries offer STI and HIV testing. Data on the surgeries requesting STI and HIV tests is included in Appendix 5. Although all GP surgeries

[10] For further information on GP surgeries: https://www.gov.im/categories/health-and-wellbeing/doctors/

offer this service, the table does not include Jurby or Onchan GP surgeries as they appear under Ramsey and Laxey respectively. Further, the Manager of the Family Practitioner Services maintains an up to date record of all GPs that have been vetted and are eligible to work on the island. As part of this process, special interests (both clinical and non-clinical) that each of the GPs may have are captured. These are updated from time to time, with a variable response rate, hence accuracy based on the GPs providing this information. Those GPs who have highlighted a special interest in sexual health are highlighted in Appendix 6.

For a patient to receive any sexual health related service from a GP, whether or not via referral, the patient would need to be registered with a practice. This may appear as a boundary however even patients from the UK who are temporary residents (for example on holiday or working for a period less than three months) on the island are able to register with and see a GP as a temporary resident. The importance of GP surgeries offering SRH is highlighted by the FSRH (2015:2), who suggest how "general practice in particular has a pivotal role in promoting high quality SRH and for many will be the first point of call."

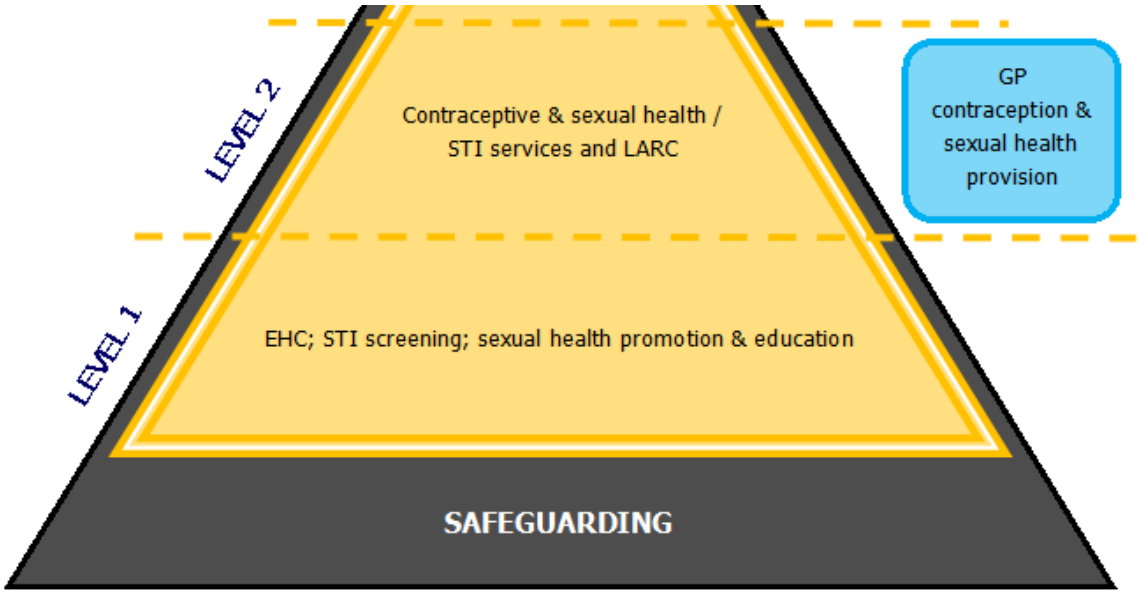


Figure 6. GP – levels for services offered

Source: adapted from the Nottingham model using information provided by the ISHS Stakeholder Group

2.1.4 Pharmacy

Pharmacies promote health and wellbeing and can help with a range of common conditions and minor injuries. They offer advice for those who are worried about symptoms and can alert service users to warning signs that may suggest they need to see a GP or seek further medical advice. They can also offer medicines for common conditions, if appropriate, under the Minor Ailment Scheme.[11] For sexual health this includes vaginal or oral thrush and

[11] When pharmacies provide medicines as part of a minor ailment scheme, you get the medicines on the NHS. That means if you normally pay a prescription charge, this charge will apply here.

urinary tract infections. Free of charge emergency hormonal contraception (EHC) is the main sexual health service provided by pharmacists. Figure 7 highlights the level of services offered by the pharmacies on-island.

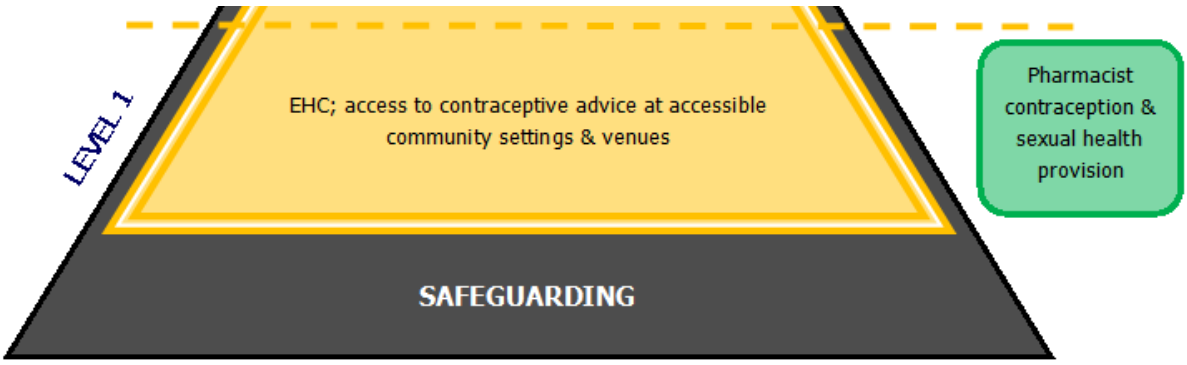


Figure 7. Pharmacy – level of services offered

Source: adapted from the Nottingham model using information provided by Pharmacy

Community pharmacists are widely accessible across the island, operating a Sunday and bank holiday rota. Being accessible is important as they are a key service for EHC, which is required within a limited time period. In addition to easy access they offer confidentiality as well as anonymity which some patients may prefer. 22 out of the 23 community pharmacies offer EHC. The pharmacy that does not offer EHC is unable to do so, due to the lack of a private area in which the EHC could be discussed with the client.

The IOM Pharmacy Contractors' Association (2017) website offers misleading information in regards to how 14 of the 23 pharmacies offer pregnancy testing for service users. This implies that pregnancy tests can be undertaken at particular pharmacies; however they only sell the pregnancy tests and signpost. Concerns have been raised by pharmacists in regards to how they are unable to do pregnancy testing or supply contraception. If a patient 'could' be pregnant, pharmacists are not funded to provide a test to exclude pregnancy and therefore refer on. Similarly, if patients need ongoing contraception they are referred on. There are potential savings if these onward referrals could be avoided.

2.1.5 Emergency Department

Noble's Hospital provides a dedicated 24-hour Emergency Department (ED) service for people who live on or are visiting the IOM. All patients are assessed by a nurse using the triage system and will then be seen by clinical priority. Understandably, the more serious injuries or illnesses are treated first. For the patient journey through the ED refer to Appendix 7. For any life threatening emergencies patients are encouraged to call 999 for an ambulance. The ED receptionists can be contacted directly, however more commonly the ED is accessed via a drop-in service.

The function of the Emergency Department is to treat patients who have either suffered a serious injury or accident, or, who are suffering from a sudden and serious illness or

condition. The IOM Government (2017) website includes a section for the ED which highlights what you should and shouldn't use the ED for. In regards to sexual health, patients might attend the ED if they have for example a needle stick injury and require PEPSE, heavy blood loss, head injuries or wounds caused by sexual activity. Patients can also attend for EHC, whereby levonelle 2 will be administered whilst the patient is in the ED. Over the last 12 months this has not been needed, there was only one potential case but following a risk assessment it was decided it was not required. The ED staff suggest "the success of the pharmacy programme has virtually eliminated the need for us to use it!!" For patients who are admitted, the ED would potentially refer to Gynaecology to consider the IUD.

2.1.6 Manx Emergency Doctor Service

The Manx Emergency Doctor Service (MEDS) is an 'out-of-hours' emergency service that will operate when GP surgeries are closed. The service is therefore available from 6pm to 8am Monday to Friday, with 24-hour cover over weekends and bank holidays. This service can only be accessed via an appointment, whereby the MEDS doctor on duty will offer medical advice over the telephone, or advise the patient to attend a consultation at the out-of-hours surgery (based at Nobles Hospital). In exceptional circumstances, the doctor may arrange a home visit.

No data has been collected for MEDS as they do not differentiate and code the types of consultation that are undertaken. The data which can be collected is an extensive list, including details of where patients are referred on to. However, these referrals are generally based on the GP's knowledge of other services and current practices in their usual practice and would not be useful at this stage. Although the consultations are not coded, the patients' notes are passed back to the surgery the patient is registered with, to be placed in their medical record. Figure 8 highlights the level of services offered through MEDS, which is generally in regards to contraception and sexual health concerns.

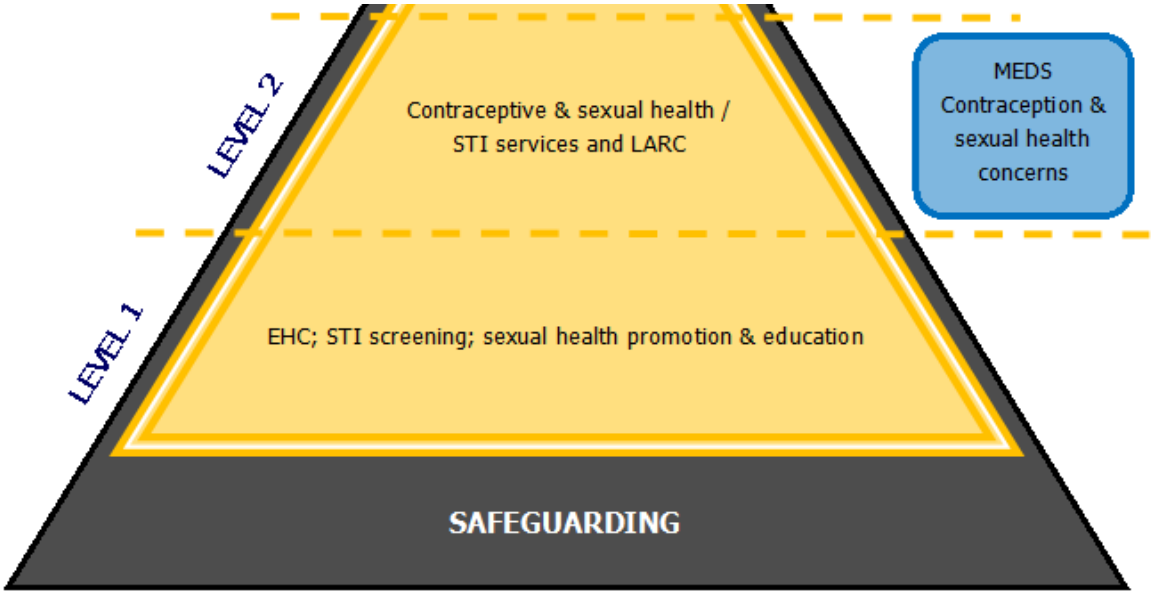


Figure 8. MEDS – level of services offered

Source: adapted from the Nottingham model using information provided by the ISHS Stakeholder Group

2.1.7 Minor Injuries Unit

The Minor Injuries Unit (MIU) is based at the Ramsey Cottage Hospital, where minor illnesses and injuries can be treated and health advice provided by an experienced nurse practitioner or GP. The MIU is open 8am to 8pm daily, including bank holidays. This is a drop-in service and appointments are not required, however the MIU can be contacted by telephone before attending if the patient wishes to call prior to attending. When the patient arrives at the MIU, the receptionist will direct them to the appropriate waiting area. If a patient attends outside of the opening hours, there is a yellow phone at the main entrance - through dialling '1' the call will go directly to the emergency services, or dialling '3' will go directly to MEDS.

In regards to sexual health, patients may attend the MIU for EHC. For other sexual health related visits, patients are signposted to the relevant service. EHC is offered via a Patient Group Direction for the administration of Levonorgestrel 1500mcg and the prescribers can administer Ella One up to 120 hours after unprotected sex when appropriate. There is also a proforma to follow, both of which are available on request. Figure 9 highlights the level of services offered through the MIU.

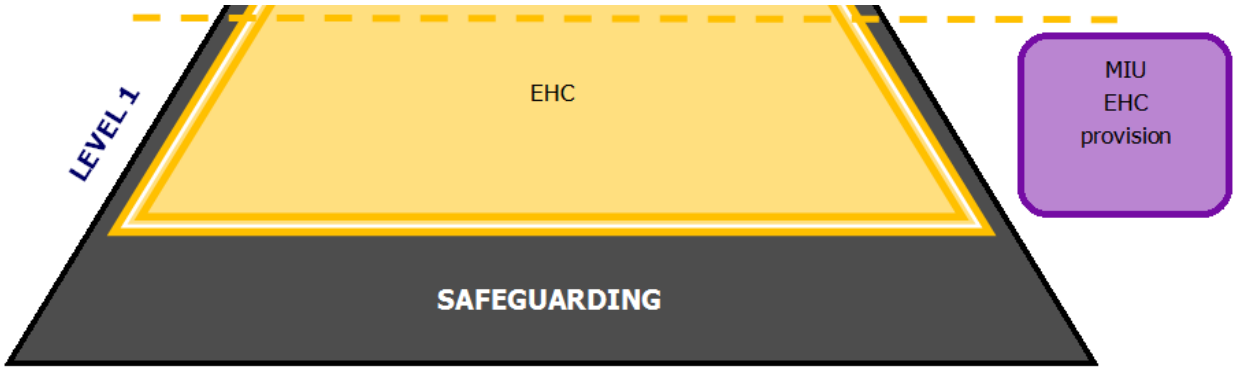


Figure 9. MIU – level of services offered

Source: adapted from the Nottingham model using information provided by the MIU

2.1.8 Pregnancy Service

The island's pregnancy service is heavily dominated by services offered for those who wish to continue with a pregnancy. There is a straightforward pathway for GPs to refer pregnant women to the midwives for antenatal care. Women can navigate the Government website to find out services available to them in regards to antenatal appointments and keeping their baby. However, if someone has an unwanted pregnancy, the main page they would go to is titled 'Pregnancy and Family Planning', which is an inappropriate judgemental title only offering one option. Within this webpage the only feasible options for them to choose from include the 'Family Planning Clinic' or the 'Jane Crookall Maternity Unit', which again

are inappropriate options where there is little choice and no further guidance. Through selecting the 'Family Planning Clinic', the only text related to unwanted pregnancy is minimal highlighting that advice will be offered. The 'Jane Crookall Maternity Unit' webpage does not even mention an unwanted pregnancy. A more appropriate way to explain the options available for pregnant women is shown through the Sexual Health Sheffield (2016), Pregnancy Choices website.

The reasons for unwanted pregnancy can vary, and for some women, this stage in their life could be extremely daunting. They may be more vulnerable after suffering a rape; may be in an abusive relationship; or possibly a teenager. Although the FPC offer advice on unwanted pregnancies, the title suggests otherwise, and not having straightforward access to support and information may add to the current trauma in their life. For some women, they may be in the process of decision making and want the support of a professional to discuss options with; again it is not clear where they can go. Further, there may be teenagers who want to remain pregnant and just need further guidance, but there is no support specific to young people until further through pregnancy.

Termination of Pregnancy

The Termination of Pregnancy (Medical Defences) Act (1995) is in the process of being reviewed; currently termination of pregnancy can only be carried out in certain circumstances.

2.1.9 Third Sector

There are limited third sector services on the island that offer sexual health related services, as the majority of sexual health support is covered through the Government run services already mentioned. In regards to the scope of this needs assessment, the only third sector service to mention is the counselling service Relate. On the island, Relate is the only service you can access for psychosexual counselling, however this comes at a fee to the service user. GUM will signpost to Relate, highlighting the fee, as there is no other services offering this support. Psychosexual counselling should be reviewed in order to diminish the inequalities caused through only having a private service available at a cost to the service user. Despite attempted contacts, Relate have not engaged in this needs assessment, thus minimal information provided.

2.2 Drivers for Integration of these Services

Mentioned previously, one of the main gaps driving this needs assessment is the lack of integrated partnerships and formal referral pathways between the sexual health services on-island. The importance of integration has been highlighted by the FSRH (2017) and the DOH (2013b) in regards to sexual health services. Figure 16, shown in service configuration option c, shows how sexual health services can be more accessible through being integrated. On-island, the DHSC (2015) Strategy also reinforces increased integration as a key theme:

> "The Isle of Man's health and social care service does not have to choose between providing better care and more efficient care. Integration is the key that unlocks both."
>
> (DHSC, 2015)

2.2.1 Partnership Arrangements

There are no formal partnership arrangements in place between the sexual health related services on the island. There are some general arrangements as highlighted in the service information tables (see Appendix 3), but these are generally to enhance the services working in silos rather than together. For example, the FPC has a general arrangement in place with Ward 4 for emergency coils, whilst the GP surgeries have an inter-agency referral pathway.

Similarly, referral pathways between GUM, Family Planning and GPs are informal, with the occasional formal letter, but no shared records. Pharmacy referrals to these services are also informal; the pharmacist can provide details and signpost to these services, but there is no formal documentation or process to follow. Since all of these services operate under the DHSC, as well as the majority of the other services previously mentioned, there is a great opportunity to integrate these services. However, at present they operate through subdivisions of the DHSC, with varying management structures that will need to be reviewed to allow for the integration of the sexual health services.

2.2.2 Service Specifications

It is important to highlight the lack of any formal service specifications for the sexual health related services. To ensure the service is monitoring against the best standards and working efficiently with partners to offer a high quality service for the island residents, the integrated service will need a service specification in place. There are no service level agreements in place for these services as they are all directly provided by Government. If any services were to be commissioned out from external providers, a detailed service specification and contract management arrangements would be required.

2.2.3 Service Content

Information about the services offered has been captured for the FPC, GUM and pharmacies. Each service was encouraged to complete the table containing various services offered for levels 1, 2 and 3, as well as self-care. This exercise helped to identify where there were duplications in services, as well as the gaps (see Appendix 8). A number of duplications are shown on the table which are likely to be inefficient for both the service user and professional. This includes the full sexual history taking; if there were shared records, the services may only need to update this information. There are also a number of assessments and referrals which are duplicated, including: for psychosexual issues, domestic abuse, sexual assault and antenatal care; which could be collected once and highlighted on the service user's record.

There were no clear gaps highlighted during this exercise, however this was a self-review for the services, with a few of the areas needing clarification. For example, the GUM service indicates they occasionally offer outreach services for STI prevention and contraception, however this may be seen as a gap as these are adhoc sessions. Similarly, a few of the services offered refer to 'appropriate referral pathways' – if formal pathways are not in place, this needs to be highlighted. Further, both GUM and the FPC indicate they supply condoms, however this is to those who attend an appointment; there is no condom distribution service on the island. NICE (2017) NG68 guidance recommends a range of condom distribution schemes to meet local needs, targeting those most at risk, including free condoms and cost-price sales schemes.

For GP surgeries (including practice nurses) information gathering has not been as thorough, and has focused on the processes all surgeries follow, such as the inter-practice referral pathway. During 2015, prior to this needs assessment, there was a data gathering exercise in regards to the sexual health services offered by GPs, however only one surgery responded to this request. Similarly to the GPs with a special interest in sexual health (see Appendix 6), there is no simple process to capture this information without there being a high number of inaccuracies.

2.2.4 Access

A key theme included in this needs assessment is access to SRH as "…access to quality sexual health services improves the health and wellbeing of both individuals and population" (DOH, 2013b:6). The following figures indicate when services are available comparing week days to: evenings; Saturdays; and Sundays/bank holidays. As all figures refer to the same key, this is included overleaf to avoid repetition.

FP Family Planning

ED Emergency Department

GUM Genito-Urinary Medicine

M Manx Emergency Doctor Service

GP General Practice

MIU Minor Injuries Unit

Pharmacy

P Pregnancy Service

Figure 10 highlights the services which are accessible during the weekdays. This includes being accessible anytime Monday to Friday at varying hours between 8.30am and 6.30pm.

During the weekdays, all services are accessible. Contraception can be obtained via GP/GP inter-practice referral pathway; or the FPC. STI and HIV testing can be undertaken via GP practice or the GUM clinic. EHC is widely accessible across the majority of services highlighted.

The opening hours for these services all vary with appointments available mornings, afternoons or during the lunch period. Availability of appointments may be the main cause for concern, unless a service user prefers a particular service that is not available when they wish to go.

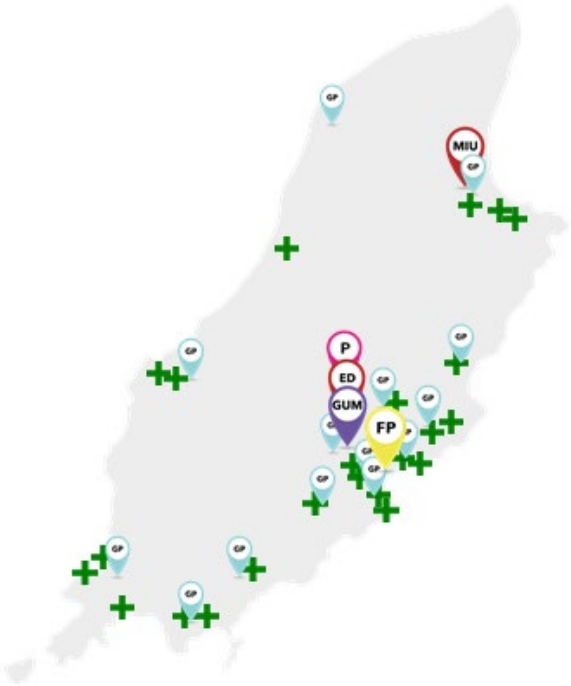


Figure 10. Services accessible during the weekdays

Source: created based on the information provided by the relevant services

Figure 11 highlights the services which are accessible during weekday evenings. This includes being accessible anytime Monday to Friday at varying hours between 6.30pm and 8.30am.

The map looks rather bare for weekday evenings, however it is important to highlight that all sexual health related services are available at some point during weekday evenings. The main concern is how widely accessible these services are for service users. Those who live outside of Douglas are required to travel to attend an appointment. The evenings the FPC and GUM clinic are open may not be suitable for the service users either.

It is important to note that if early evening was included (5-6.30pm), some GPs and pharmacists are also available.

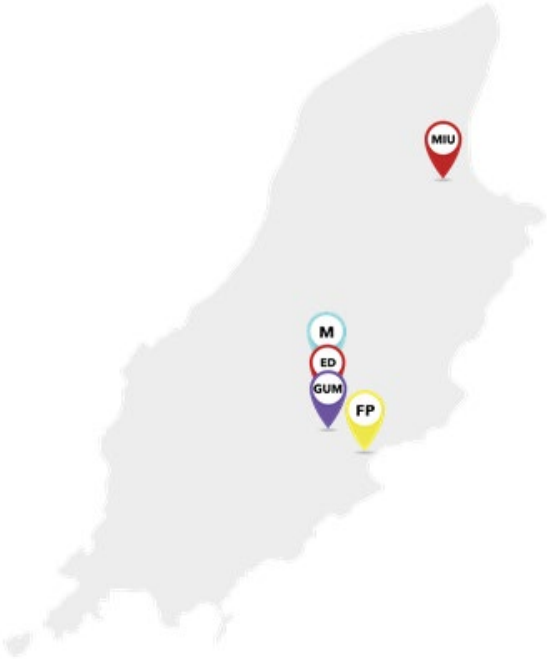


Figure 11. Services accessible during weekday evenings

Source: created based on the information provided by the relevant services

Figure 12 highlights the services which are accessible on Saturdays. This includes being accessible anytime on a Saturday.

Although GPs are closed on Saturdays, service users are able to access the FPC for contraceptive services. However, it is important to highlight that some people may find it difficult to travel to Douglas and the FPC may not offer what is required on a Saturday.

There are no STI and HIV services available on a Saturday.

EHC is still widely accessible across the pharmacies, FPC, MIU and ED, as well as any medical emergencies related to sexual health via ED or MIU.

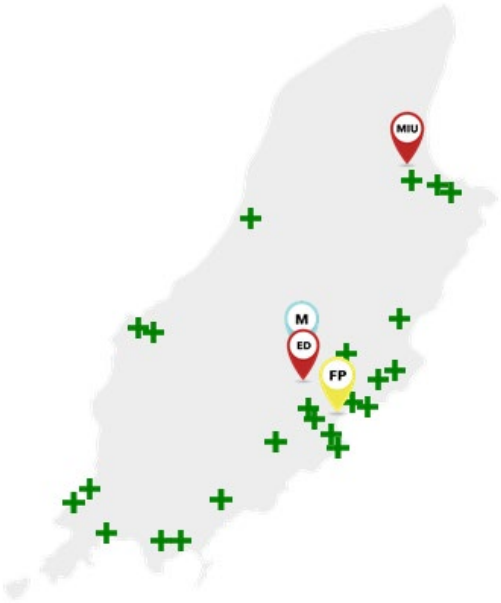


Figure 12. Services accessible on Saturdays

Source: created based on the information provided by the relevant services

Figure 13 highlights the services which are accessible on Sundays and Bank Holidays. This includes being accessible anytime on a Sunday or Bank Holiday.

Figure 12. Services accessible on Saturdays

Source: created based on the information provided by the relevant services

Figure 13 highlights that on Sundays and bank holidays, only EHC or medical emergencies associated with sexual health are available for service users. The consultant for GUM operates his clinic once a month on a Sunday, but this has not been highlighted as service users are referred for an appointment, rather than requesting one directly.

Port Erin is shown to be available on Sundays, this alternates each week with Castletown and Port St Mary. In Peel the two pharmacists also alternate weekly. Ramsey and Douglas remain the same each week.

Figure 13. Services accessible on Sundays and Bank Holidays

Source: created based on the information provided by the relevant services

Although these figures highlight that sexual health services are available through the majority of the week, the key issue is in regards to the services that are available and whether these suit the needs of service users. Views from the public are discussed later in the report.

3. Current Costs and Activity

Table 7 includes the current service costs and, where available, the budget amounts for 2015/16.

Table 7. Current service costs for 2015/16

SERVICE	ITEM	SPEND	BUDGET
Family Planning	Employee (Substantive) Costs	38,284	47,300
	Employee (Bank) Costs	*27,000	
	Supplies	35,500	33,100
		100,784	**80,400**
GP Contract	IUD Contraception	**62,083**	**57,000**
GUM Clinic	Employee Costs	153,861	189,800
	Supplies	182,303	143,600
		336,164	**333,400**
Pharmacy	EHC Service	***39,353**	***50,000**
OVERALL TOTAL (including FPC bank staff)		***538,384**	**520,800**

Source: Data provided by the IOM Government Finance Team, Community Health and Pharmacy

**Family Planning employee (bank) costs – the amount shown is based on the total staffing cost for FPC being approximately £65,000. No exact figure has been provided, as only the substantive employee costs are included in the FPC budget; the bank staff are paid from other budgets within the DHSC. Therefore an approximate figure has been included based on the total staffing cost being approximately £65,000 minus the spend for employee (substantive) costs of £38,284.*

**It has not been possible to gather information on the pharmacy budget amount for 2015/16. However the spend and budget amount for 2016/17 has been included.*

**The actual spend is more than budget as this includes the FPC bank employee costs which are not budgeted for, as mentioned previously.*

There has been an attempt to benchmark these costs with Clinical Commissioning Groups, however the results were not able to be compared due to the major differences for commissioning in England.

4. Benchmarking

This section focuses on comparing the island's current set-up with best practice in regards to an ISHS. The second paragraph in the introduction explained the importance of integration as "…establishing clear referral pathways between services so that care can be integrated around the needs of the individual, not institutional or professional silos." It is important to understand this meaning of integration as it would be too easy to follow the 'one stop shop' approach that many services across the UK operate. Especially as the findings of this needs assessment will feed into a service specification and pathway for a localised ISHS, which may or may not be a one stop shop approach, but will provide

> "…open access, cost-effective, high quality provision for contraception and prevention, diagnosis and management of sexually transmitted infections [and HIV], according to evidence-based protocols and adapted to the needs of local populations."
>
> (DOH, 2013b:10)

For the purpose of this needs assessment, it was important to compare against best practice guidance, not other services, to highlight the gaps in service integration. This included benchmarking against the relevant standards as detailed below. Another useful method, worthy of note for future benchmarking, is the quality outcome indicators from the National service specification shown in Appendix 9.

4.1 Standards

To achieve a high quality service, the primary services offering SRH and GUM were reviewed against the relevant standards as recommended by the DOH (2013b) – FSRH and the British Association for Sexual Health and HIV (BASHH) standards. This included the FPC who monitor against the FSRH standards, and the GUM clinic monitoring against the BASHH standards, the results of which are included for FSRH and BASHH in Table 8 and Table 9 respectively.

4.1.1 FSRH

The FSRH (2016) have developed service standards to support the safety and quality of sexual and reproductive health services. There are eleven general service standard statements which have been self-reviewed against by the FPC as shown in Table 8.

Table 8. FPC self-review against the FSRH standards

FSRH Standard	FPC Self-Review Comments
Leadership All sexual and reproductive health services should be led by appropriately trained clinical and managerial personnel to ensure quality of service provision, service development, training and clinical governance.	Concerns regarding the gaps in clinical governance with no specific clinical lead. Clinical supervision takes place, but due to various managerial issues over the years the medical post has not been specifically described. DOH (2013a:45) explain that it is essential that arrangements are in place to ensure that people receive safe, high-quality sexual health services provided within robust clinical governance systems.
Service Provision Service provision should include a range of sexual and reproductive health services.	Informed that this is all up to standard.
Patient Focus Services need to be patient-focussed ensuring good communication, clear patient information and working to FSRH standards on consent and confidentiality	Display boards and leaflets used to communicate information as well as the Government website.
User and Public Involvement Services should demonstrate that user and public involvement is fundamental to service development, provision, monitoring and evaluation.	Client feedback is displayed on a board at the clinic.
Access There should be easy and quick non-discriminatory access to sexual and reproductive health services for all	Informed that there are no waiting lists for procedures. Information provided on the telephone recording when the service is closed.
Training All staff working in sexual and reproductive health services should receive appropriate training and must maintain their skills.	Informed that all staff (including bank staff) are continually updating in house training and competencies, faculty training, and complete the annual PDR.
Clinical Practice Sexual and reproductive health service provision should be evidence-based, which will include the use of national and local guidelines and policies.	Informed that the Family Planning and Community Health policies, guidelines and standard operating procedures have gone through clinical governance, and are based

	on the FSRH National guidelines. These can be accessed on the DHSS shared area.

Confidentiality All users seeking sexual and reproductive health services should be made aware that their right to confidentiality will be respected and maintained in line with GMC, NMC and other professional bodies' recommendations.	Leaflets and information are displayed in the clinic, and confidentiality is discussed during consultation with all clients.
Record Keeping Record keeping in all services should be of a high standard, to provide maximum benefit in patient management, to facilitate audit & record process of obtaining valid consent.	Regular audit last done Dec 2016. Paper records used, stored securely. A form is signed for permission to text.
Nurse-Led Service Provision The role of nurses in sexual and reproductive health service provision should be enhanced.	Two nurse led clinics on Friday and Saturday mornings.
Monitoring and Evaluation All services should continually monitor and evaluate themselves in order to maintain and improve performance.	Audits carried out every two-three months by the Lead Nurse or a member of the Community team. These audits may include procedures, record keeping and infection control. The Lead Nurse and Service Manager respond to any recommendations made.

Source: FSRH (2016) Service Standards for Sexual and Reproductive Healthcare with self-review comments from the FPC

4.1.2 BASHH

The BASHH (2014) have developed standards for the management of STIs and HIV, which are applicable in all healthcare settings in which STIs are managed. These standards have also been developed to support the quality of the services offered and specify what the public can expect of the services they access.

There are nine general service standard statements which have been self-reviewed against by the GUM clinic, as shown in Table 9.

Table 9. GUM clinic self-review against the BASHH standards

BASHH Standard	GUM clinic Self-Review Comments
Access People with needs relating to STIs should have rapid and open access to a range of local confidential services for STI testing and treatment.	Waiting time is variable and can be seasonal. Lillie has the facility to create a report of overall waiting times for appointment to see whether the target of 48 hour access is being met.
Clinical Assessment People with needs relating to STIs should have a medical and sexual history taken which includes questions about sexual behaviour and other risk factors. Those with symptoms should be offered a genital examination. The minimum investigations, even if asymptomatic, are tests for chlamydia, gonorrhoea, syphilis and HIV and should include samples from extra-genital sites if indicated by the sexual history.	GUM has a standard sexual history proforma which facilitates obtaining a comprehensive sexual history with a sexual behaviour risk assessment. This is in line with BASHH recommendations. Some clinics do not offer a full range of services due to: lack of full time medical cover as the service is currently staffed by locum doctors and a part time UK based Consultant who is available for telephone consultation at any time. The service is supported with a Biomedical Scientist providing a microscopy service in the afternoon and evening clinics only. There is an informal arrangement with Microbiology that microscopy can be requested if required in the morning clinics. Patients are streamed in to appropriate clinics whereby symptomatic patients are given appointments when the full microscopy service is available.

Diagnostics People being tested for STIs should have the most accurate diagnostic test in its class (according to national guidelines) for each infection for which they are being tested. All diagnostic samples should be processed by laboratories in a timely fashion in order that results can be conveyed quickly and acted on appropriately.	The laboratory regularly reviews the testing protocols against BASHH guidelines, and consistently improving turnaround times, which is evidenced through annual audit. All urgent and significant results are released to GUM clinic as soon as results are available**.**
Clinical Management People using a service for STI testing should receive their results both positive and negative within 10 working days. Those diagnosed with an infection should receive prompt treatment and be managed according to current BASHH national guidelines, including the delivery of partner notification (PN).	GUM currently working to give results within two weeks (10 working days). PN audit 2015 GUM met the auditable outcomes required.
Information Governance Services managing STIs should ensure information collected about individual service users remains secure and is only shared with other professionals if it is in the service user's best interests or for public health reporting purposes.	GUM has its own bespoke IT system which meets standards.
Clinical Governance People should receive their care from high quality services managing STIs that are safe, well-managed and accountable.	GUM works within a clinical governance framework. Monthly meetings with the consultant, covering clinical governance issues which are shared with senior management.
Appropriately Trained Staff People with needs relating to STIs should have their care managed by an appropriately skilled healthcare professional.	Working towards achieving this. GUM aware of the training needs of the workforce. The competencies currently underway and completed are intermediate level only and cover uncomplicated conditions.
Links to Other Services People needing to be referred to another service for ongoing STI management should find this arranged for them quickly and easily. Similarly people with any other sexual health needs that the service is unable to meet (eg HIV treatment and care, contraception, abortion, psychology or sexual assault) should experience easy and timely referral (appropriate to circumstances) to a suitable service.	Links with FPC, Gynaecology/Medical Wards are informal and referral as necessary. Patients are referred to Royal Liverpool Hospital for inpatient HIV care as required.

Patient and Public Engagement People should be consulted about the development and delivery of services managing STIs in their community. Those using services should be encouraged to give feedback about them.	Recent patient satisfaction survey was excellent. Some issues identified around the actual physicality of the clinic (was not purpose built for GUM) and the opening hours. Staff interaction/engagement with patients received excellent feedback. GUM has links with IOM HIV support Group and Manx Rainbow Group. Referral occasionally to Sahir House, a charitable organisation in Liverpool specialising in HIV.

Source: BASHH (2014) Standards for the Management of STIs with self-review comments from GUM

The DOH (2013b) suggest service evaluation and audit need to be a regular occurrence for sexual health services, as services need to ensure they reflect updates in guidance and recommendations as and when produced. Further stating that for the provision of ISHS, other standards and guidance are highlighted to include:

- British HIV Association (BHIVA);
- Medical Foundation for HIV & Sexual Health (MEDFASH);
- Royal College of Obstetricians and Gynaecologists (RCOG);
- National Institute for Health and Care Excellence (NICE); and
- Relevant national policy and guidance issued by the DOH and PHE.
    - A thorough list has been included in Appendix 10, followed by an updated list of more recent guidance, highlighting the need to check updates for all appropriate professional bodies on a regular basis.

4.2 Services

4.2.1 Pharmacy

As mentioned previously, the pharmacists are unable to offer pregnancy testing or ongoing contraception, whereas in other areas of the UK these are common place in service specifications. An example from Calderdale and Huddersfield is available upon request.

It is estimated that just over half of all pregnancies in England are planned (PHE, 2016). The DOH estimates that the annual direct costs to the UK NHS of unplanned pregnancy are around £240m, with an estimated unit cost of around £1,600, which includes costs from abortions, maternity care, miscarriage and mental health problems (PHE, 2016). Not all unplanned pregnancies can be prevented but, more effective contraceptive methods can reduce prevalence.

4.2.2 General Practice

The DOH (2013a:44) highlight

> "General practice is the largest provider of sexual health services – particularly the provision of contraception – and is the most frequently chosen first point of contact for those with sexual health concerns."

Therefore it is necessary to ensure that GPs receive appropriate training and support, with a clear pathway for referrals to sexual health services.

4.3 Costs

Evidence has shown that investment in preventative approaches to sexual health not only improves the overall health of the population, it is also cost effective (DOH, 2013a; PHE, 2014; cited in: Leicestershire County Council, 2016). Especially when considering that the consequences of poor sexual health are costly. The following list includes some examples of costs for the UK NHS:

- It has been estimated that £1 invested in contraception saves £11.09 in averted outcomes (Bayer Healthcare, 2013, cited in: PHE, 2014).
- LARC methods are more clinically and cost effective than the combined oral contraceptive pill even at 1 year of use (NICE, 2005, cited in: PHE, 2014).
- PHE estimates that if 1,000 women switch from oral contraceptive to LARCs, 291 unplanned pregnancies could be avoided over 5 years. This leads to average net saving to the UK NHS of £29 per annum/per woman moving to LARC, total net savings of £143 over 5 years (PHE, 2016).
- The IUD, IUS and the contraceptive implant are more cost effective than injectable contraceptives (PHE, 2014).
- Contraception services save the UK NHS over £2.5 billion a year – for every £1,000 spent on contraception services, £11,000 is saved (DOH, 2010).
- Dual savings can be achieved when condoms are promoted to both reduce risk of an STI and prevent pregnancy (UNAIDS, 2015).
- Primary Care Trust's spend on contraception is low, with some spending as little as 18p per women per year on contraception, yet every teenage birth costs the UK NHS around £1,500 and every abortion £650. (Teenage Pregnancy Independent Advisory Group, 2010).
- The annual per person cost of providing HIV care was estimated to be around £9,000. Preventing one UK-acquired HIV infection would save approximately £0.36m in undiscounted lifetime treatment and clinical care costs (PHE, 2016).

- Condom schemes are cost effective – for a population of 100,000 aged 14-18, increasing condom use by 22% would lead to pregnancy-related savings of over £11 million (NICE, 2017).
- The consequences of poor sexual health cost the NHS an estimated £193m in unintended pregnancies in 2010 and approximately £630m in HIV treatment and care in 2012/13 (DOH, 2013a; PHE, 2014; cited in: Leicestershire County Council, 2016).

5. Perceptions on current services

To gather a clear understanding of the current services offered, perceptions were sought from service providers as well as the general public, who it is important to involve in service planning and improvement (DOH, 2013b). The definition of sexual health in the glossary highlights how broad this topic is, which may not be noticeable at a glance. Therefore a key aspect of gathering this information was to be as clear as possible focusing on the key topics in scope for this needs assessment. This includes but is not limited to services which offer family planning, contraception and the diagnosis and management of STIs including HIV. The approaches used to gather this information included a focus group solely for the service providers and an anonymous questionnaire applicable to everyone living in or visiting the IOM.

5.1 Focus Group

The focus groups were kindly facilitated by members of the Change and Reform Team from within the IOM Government, Cabinet Office. The objectives for the focus group were planned by the qualitative sub-group and adapted with the facilitators input, based on their suggestions from experience running focus group sessions. The focus for the planned session included feedback on services currently provided and thoughts on what an improved, integrated service in the future might involve. The attendees were given the opportunity to highlight any further comments anonymously via brief questions following the session, either via paper format or online using Survey Monkey. One session took place which included service providers working in this field able to attend, with an additional session for those services who could not attend the initial session. Refer to acknowledgements for those who were invited and those who attended the focus groups.

5.2 Questionnaire

The 'sexual health services in the IOM' questionnaire was created and adapted by the qualitative sub-group. The foundations of the questionnaire were based on the Sexual Health Services in Luton – Residents Survey (Luton Borough Council, 2015), which was adapted to suit our local needs. The Luton survey had a number of specific questions with

regards to a 'one stop shop', however the approach to adopt on-island has not yet been agreed. Therefore these particular questions were removed, as it would be unethical to seek opinions and potentially raise hopes on a service which may not go ahead. The questionnaire was created using an on-line platform 'Survey Monkey', which the Public Health Directorate hold an individual licence for. A copy of this questionnaire is available upon request.

A pilot of the questionnaire took place once the questions had been adapted. Initially being checked by the qualitative sub-group, it was then sent out to various service providers on the island, with final checks being completed within the Public Health Directorate. Following the pilot, the questionnaire was submitted to the Information Governance Manager for approval.

In preparation for the questionnaire going live, posters advertising this were circulated to all of the ISHS stakeholders, alongside distribution to GUM, FPC, GP surgeries, Pharmacies, the Hospital wards, Graih, Youth Service, UCM, St. Christopher's, The Children's Centre, Age IOM, manxretirement.org and Victim Support; some of whom also received paper copies of the questionnaire. There was a link to the questionnaire on the Government website which was promoted through further advertising via a Government press release. This was successfully picked up by IOM Today, Manx Radio, Manx.net, Isleofman.com, Energy FM and 3FM who also promoted a recorded audio clip of the Director of Public Health promoting the questionnaire. However the main source of advertising was Facebook where the Public Health Directorate paid for 11 days of advertising to cover the majority of time the survey was live (Friday 25th November to Monday 12th December 2016). The total cost was only £50 using a pay per click promotion. This reached 22,063 people, with 1,694 clicks on the post, resulting in 782 people completing the questionnaire.

5.3 Data Analysis

5.3.1 Focus Group

This section provides a brief overview of the themes that emerged from the focus group in regards to what does and does not work in the current services on-island. Appendix 11 includes some of the key comments raised to support this overview.

<u>Works well in the current services</u>

Pharmacy

The community pharmacists are a "stable/available workforce" who are accessible island-wide, providing "80-90% of EHC." There is already public awareness for the minor ailments scheme, as well as good communication and infrastructure in place with GP practices to enable growth of the service. It is also important to note that "pharmacist consultations are cheaper than a GP to the DHSC."

GUM

Access, services offered and staffing are the key themes, highlighting the number of clinics/hours available with easy access and self-referrals. They offer a "bespoke service –

quick to identify individual need" with "up to date patient advice." Having a "small team with low staff turnover" encourages the staff to have a "good rapport with long term patients." The staff have "substantive posts – not reliant on bank staff" and "every person in the team [is] prepared to step in and cover each other's role."

FPC
The "central Douglas location" was highlighted, with "no waiting lists for IUDs and implant." "All methods of contraception [are] available at FPC", with the services offered being the key theme. The "skills mix works well" was suggested as well as "good on-island training" via e-learning.

Pathology Lab
The key point highlighted is the "24/48hr turnaround time for samples (it used to be a week!)".

GP
Although there was a GP present, the only comment in regards to current services recorded was "cytology works well", which is out of scope for this needs assessment.

Does not work as well in the current services
The key theme is integration as there is "not a one stop shop available" and the services offered are fragmented. There is no hub and spoke model similar to the UK, with "better access needed – outside Douglas." Despite previous work to promote this, there is "lack of commitment to change at every level" as well as the "lack of transparency in the past." This has caused a "willing workforce [to] feel under supported."

"Sexual health education could be better" but there is a "lack of time for the services to provide this." The services are very clinic focused, with lack of resource to go into the community." If they do school visits, it is seen as more of a "box ticking exercise" for the school. A concern was raised for whether "people know where the FPC and GUM clinics are and what they do?" Rebranding the services might support this concern, as it was questioned "are the service names appropriate? Do they need to be rebranded?" as there may be some "stigma with the existing names."

Pharmacy
As "only EHC is available", the pharmacists "have to refer on if customer has further needs." As there is "no prevention [there are] missed opportunities" with "some coming back for repetitive service rather than receiving complete care at the first opportunity." It was mentioned that pharmacists are "under-utilising skills" and what we offer on-island is "not comparative with similar number areas in the UK over what pharmacy can provide." Ultimately there seems to be a "lack of understanding/knowledge on what the pharmacy can actually do."

GUM

One of the key concerns is that the "GUM clinic layout doesn't work: one shared toilet for 3 consultation rooms; not enough private space; limited (confidentiality) anonymity." Also the "IT system [is] out of date and needs to be updated – not meeting basic standards." The GUM staff are "having to manually text" and due to "paper records – lack of storage – starting to become a H&S issues." For clients, only having "appointments system might put people off" and "sometimes clinics will have to be cancelled if lack of skills available." Frustration was noted as "Doctors have locum status – a post 'disappeared' without explanation."

Following the focus group session, the GUM team provided further anecdotal feedback: "It should be noted that some young females attending GUM services are identified by staff as requiring a reliable method of contraception, but this is not always recognised by the patient. This could be due to lack of knowledge; lack or organisation and health seeking behaviour; to inability due to transport/school times to access contraception services. By comparison the females attending FPC appear to be more organised and already health seeking. It seems there is a missed opportunity in GUM to address the needs of the young vulnerable females who are either disorganised or unable to attend multiple sites."

FPC

The set-up for staffing needs to be improved as there are limited substantive contracts and the role is "a lot to expect from bank staff." The service "works well now but wouldn't cope with increase in demand – people not dual trained." An awareness was mentioned that "appointment times at FPC can overrun" and there is a need "to have more daytime clinics – reaching out to youth" also the issue with "phone calls for clinic only when clinic open." Other concerns include "inappropriate referrals to FPC from GP" and "urgent scans are not dealt with urgently." Further they "don't have access to medical records – have to rely on what the patient tells them" and similar to GUM using "paper records – lack of storage – starting to become a H&S issues."

GP

"GPs busy – discrepancy in services offered" and there is also a "lack of resources in GPs."

Attendees at the focus group created spider diagrams to highlight what they envisage an improved, integrated service in the future to include. Figure 14 shows a combination of these diagrams. The 'hub' highlighted as the centre of the diagram would be a level 3 service to cover STI; HIV; and contraception (including LARC). The levels highlighted in Figure 14 would be as follows:

- Level 1: basic STI screening (no symptoms); contraception; pregnancy testing
- Level 2: contraception including LARC; STI symptoms
- Level 3: HIV; complex STI and contraception

Through implementing the changes in Figure 14, the outcomes mentioned by the focus group included:

- Improved access to hard to reach groups
- Fewer late presenting (for example, HIV and pregnancy)

- Excellent standards of care – clinical standards, audit, clear clinical governance and pathway
- Appropriate referrals and signposting

The focus group follow up question responses highlighted the integration barrier with services being managed separately. It is also highlighted that budget holders should be made aware that service providers show commitment to change. The further contributors they mentioned included: the management team for GUM and FPC; Safeguarding Midwife; and the FPC reception staff.

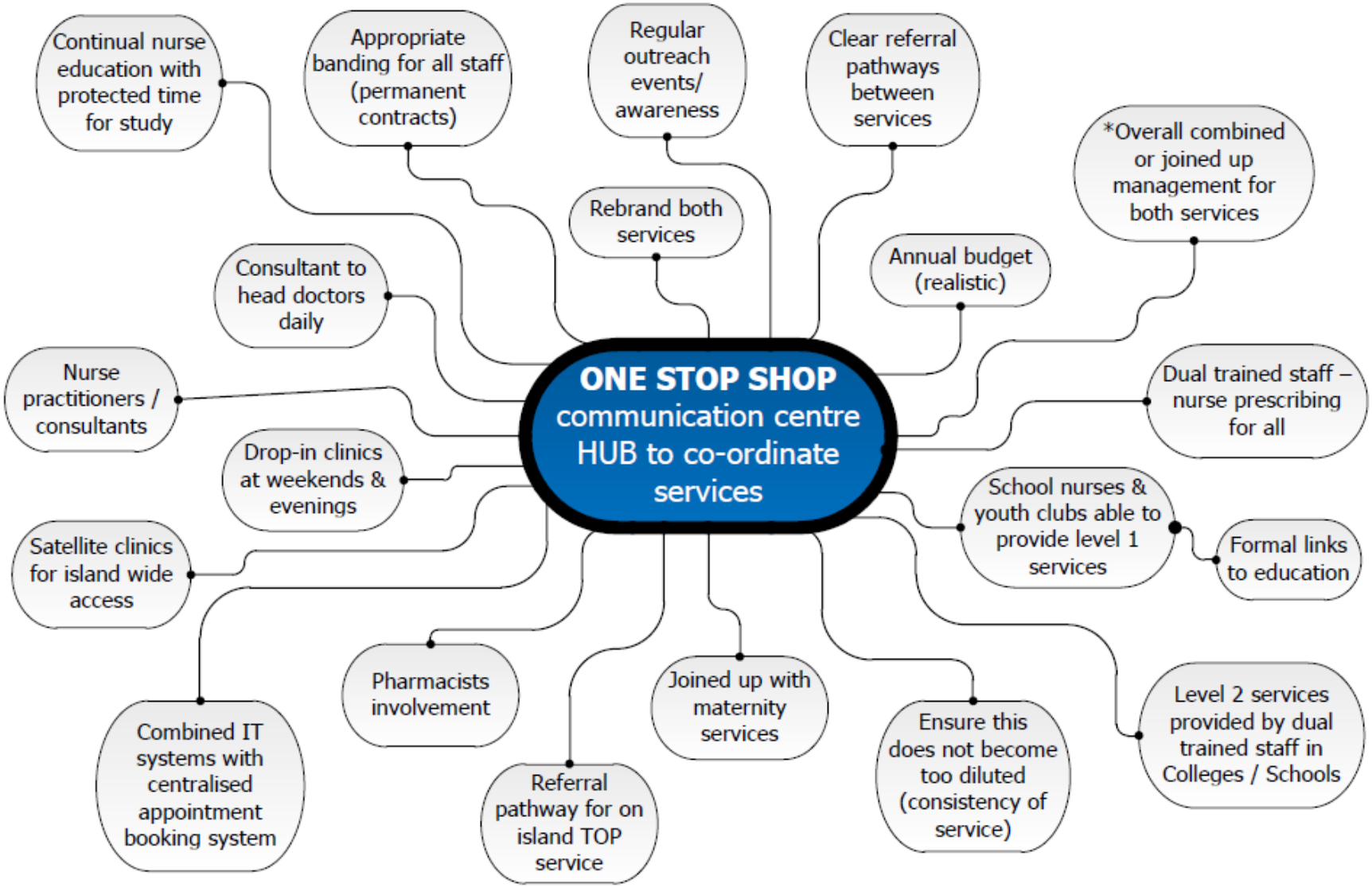


Figure 14. Future ISHS

Source: created based on a combination of spider diagrams designed in the ISHS focus group session

5.3.2 Questionnaire

The questionnaire received 782 responses, five of which were non-residents. Based on those who responded,[12] this included a variety of age groups and gender with different sexualities being represented. There were employment status variations and ten per cent of the respondents considered themselves to have a disability. Predominantly responses were received from those living in Douglas, followed by Southern, Onchan/Laxey and Central, with only roughly a quarter of responses from the North and West of the island (see Appendix 12). Three responses were disregarded as a result of data cleaning.

The charts displayed in Appendix 12 show the overall responses to the questions highlighted with key findings comparing postcodes following each chart. For many of the questions, additional comments were received which are presented collectively due to a number of the questions having similar key themes, that would have been repetitive if presented separately, see Figure 15. Examples of the quotes for the highlighted themes are shown in Appendix 13.

Figure 15. Themes from the qualitative data

Source: word cloud created using the themes highlighted through the sexual health questionnaire

[12] The 'about you' section in the questionnaire was voluntary with roughly 78% of the respondents completing this section. See Appendix 12 for the number of respondents who skipped each question.

5.4 Further data collected

Further data sources have been gathered to inform this needs assessment including the assessment of the island's homeless peoples' health needs, the GUM and FPC client feedback surveys and the Youth survey. The homeless peoples' assessment shows less than ten per cent of the participants as having had a sexual health check in the past year, with just over half of the participants knowing where they can access contraception or support around sexual health. Both of the client feedback surveys for GUM and FPC show positive results, with high customer satisfaction from those clients who use the services.

6. Emerging Issues

6.1 Access

- Limited access to services outside of Douglas including outreach services
- Limited access to LARC and available appointments
- Fragmented service for patients having to attend separate venues/services for contraception and STI screening
- No drop-in session/s for GUM
- No services specifically for those with inequalities eg. young people
- Limited condom distribution
- Limited psychosexual counselling
- Pharmacists cannot offer ongoing contraception
- Pharmacists cannot offer pregnancy testing
- One pharmacy cannot offer EHC due to no private area
- GUM clinic layout is unsuitable

6.2 Service Pathway

- Lack of integrated partnerships or shared care between the current services
- No formal referrals or networks

6.3 Staff

- Concerns regarding staff recruitment and retainment
- Use of bank staff and locum doctors
- Variations between services for banding of similar level roles
- Lack of clinical leadership for FPC and part-time consultant/locum doctors in GUM
- No service specifications for the current services

6.4 Awareness

- Lack of awareness and promotion of services
- Inappropriate information displayed when searching for 'abortion' or 'termination of pregnancy' on the Government website
- Stigma associated with sexual health related services

6.5 Client Records/Data

- No shared records between services
- Lack of storage space for paper records is becoming a health and safety concern
- No common core data is collected and recorded for all services

7. Service Configuration

Through carrying out this needs assessment potential service configurations have been generated for an ISHS on-island. Emerging issues have been highlighted in a previous chapter for the current services which operate independently. The service configurations developed all have underlying elements to integrate these current services; differences for the options are highlighted later in this section. To support an ISHS these need to be considered in combination with the points below which highlight areas that need to be implemented for all of the developed service configuration options.

- Implement one of the service configuration options, through:
  - Creating a clear service specification or service specifications to deliver the chosen service configuration pathway.
  - Refining the pathway to ensure it is robust with clear reporting mechanisms in place.
  - Considering alternative pathways so the ISHS is accessible for everyone on-island; including different age groups, sexualities, cultures, disabilities, gender or non-gender specific, and place of abode, for example.
  - Implementing the chosen pathway across all universal services offering support and training where necessary.
  - Ensuring the information is accessible to promote the islands ISHS and pathway to raise public awareness of the support available.
  - Ensuring the pathway is supported by formal contract arrangements, performance management and evaluation.
- All services to record data using the same methods and where possible utilising the same records and software.
- All services to follow the relevant standards and guidance as highlighted in Appendix 10

In summary, each of the pathway options will follow the relevant standards and guidance and have a similar route into the service/s, common core date collection process and marketing to promote the ISHS. The main differences between the service configuration options are where the services are offered, by whom, and the formal contract arrangements, performance management and evaluation systems.

For each of the service configuration options the following considerations are included:
- Required changes from the current set-up
- Strengths
- Weaknesses
- Required resources
- Overview of likely costs involved
- Risks

The four service configuration options include:
A. No change – separate services
B. Enhanced separate services
C. ISHS 'one stop shop' – hub model

D. ISHS 'one stop shop' – hub & spoke model

7.1 Option A. No change – separate services

Option A does not include any changes to the current set-up with the services remaining separate.

Required changes

If this option is chosen no changes will be made to the current set-up based on this needs assessment.

Strengths

The disruption of re-configuration will be avoided.

Weaknesses

This will include the emerging issues identified in this needs assessment including the lack of a formalised pathway between the services; accessibility of the sexual health services; contractual concerns; client records and data collection; and service awareness for the general public. Refer to the 'emerging issues' section on page 45 for further details.

Required Resources

Although no changes will be made based on this needs assessment, there will be additional resources required if the services remain separate. This may include software where the GUM service will be updating 6PM Lillie and the FPC will likely be moving to EMIS, due to the health and safety concerns with the storage of paper records.

Costs

The costs will be similar to those shown in the 'current costs and activity' chapter with annual increments.

Risks

If no changes are made to the current set-up, there will be concerns regarding the lack of clinical governance for the FPC.

7.2 Option B. Enhanced separate services

Option B includes the GUM and FPC remaining as separate services, with the addition of the GUM service offering contraception, the FPC offering asymptomatic testing, as well as enhancement of the Pharmacy and GP services offered on-island. Ensuring clinical leadership is in place and aligning contracts based on the variations between services, for banding of similar level roles, will be required; as well as more awareness of these services.

Required changes

The changes required to the current services are highlighted below.

Access:

- GUM and FPC will continue current services, with the addition of contraception services through GUM and asymptomatic testing through the FPC.
- Enhance the Pharmacy and GP services to be more accessible across the island. For example, the Pharmacy service also offering contraception and pregnancy testing and improving the GP intra-referral pathway.
- Consider options for all pharmacies to offer EHC.
- Improve the layout of the GUM clinic.
- Updating services to reflect updates in practice, for example, offering home testing kits for STI screening.
- Offer specific sessions for different groups, for example young people.

Service Pathway:

- Clarity of all services with formal referrals where necessary.

Staff:

- Dual trained staff.
- GUM and FPC staff to have equal contracts for the level of work they undertake. For example permanent contracts and pay grades.
- All services working towards service specifications with formal governance, accountability and professional support arrangements in place.

Awareness:

- Service/s promoted using various methods to suit the needs of clients for example social media and smart phone/tablet apps.
- Access to further information and guidance/self-help materials.
- Re-brand/change the service names and consider how to minimise stigma.

Client Records/Data:

- Common core data collected for all services.

Strengths

The strengths of adopting this approach include:

- Formal pathways (and awareness of staff of their existence) will make access for patients more consistent.
- Having dual trained staff to provide more services will be more accessible for the potential clients.
- There will be limited change to the current set-up.
- Following a common core data set will enable comparisons between services.
- Rebranding the services will hopefully remove some of the stigma.
- Clients will be more informed of the services offered, if promoted appropriately.

Weaknesses

The weaknesses with this approach include:

- Continuity of separate services with low number of dual trained professionals on-island
- Although the services may be more accessible, there will still be limited integration with the services being managed separately.
- Some individuals may not use the services on-island for confidentiality purposes. Need to consider how they can receive the relevant services. For example, professionals who do not wish to be seen by their own clients; or for those whose cultures may not agree with attending such services.

Required Resources

The resources required if this approach is adopted include:

- Creating clear service specifications for the services including performance management and evaluation.
- Refined pathway to suit the needs of all island residents and visitors.
- Methods shared for how and which data to collect.
- Performance management and formal contract arrangements for the service specification.
- Terms and conditions updated for staff to have equal contracts for the level of work they undertake.
- Training for front line staff on the pathway and available services.
- Marketing of the services – website, social media presence, posters, etc.

Costs

The costs will include those shown in the 'current costs and activity' section on page 30, with annual increments and additional costs to enhance the services. The additional costs will include:

- Dual training staff.
- Incorporating clinical governance.
- Marketing the services.

Risks

Having separate services will require a number of dual trained staff which may be difficult to sustain.

7.3 Option C. ISHS 'one stop shop' – hub model

Figure 16 shows the model for a 'one stop shop' which is adapted from the Nottingham model (Nottingham County Council, 2015), encompassing service elements for levels one, two and three. This is referred to as the 'hub model' with safeguarding and self-managed care as golden threads throughout all services and interventions.

Adopting this approach will allow for an ISHS where all STI, contraceptive and sexual health services will be under one roof; having one management structure and clinical governance framework. If for example the hub – 'one stop shop' is based at the FPC, the GUM clinic can still be used for the more specialised level three appointments as well as HIV treatment and care, if required. In addition to the 'one stop shop' there will still need to be GP and pharmacy provision to ensure there are local services available across the island. To enhance the services available outside of Douglas, the pharmacist service specification can potentially be enhanced to cover pregnancy testing and ongoing contraception.

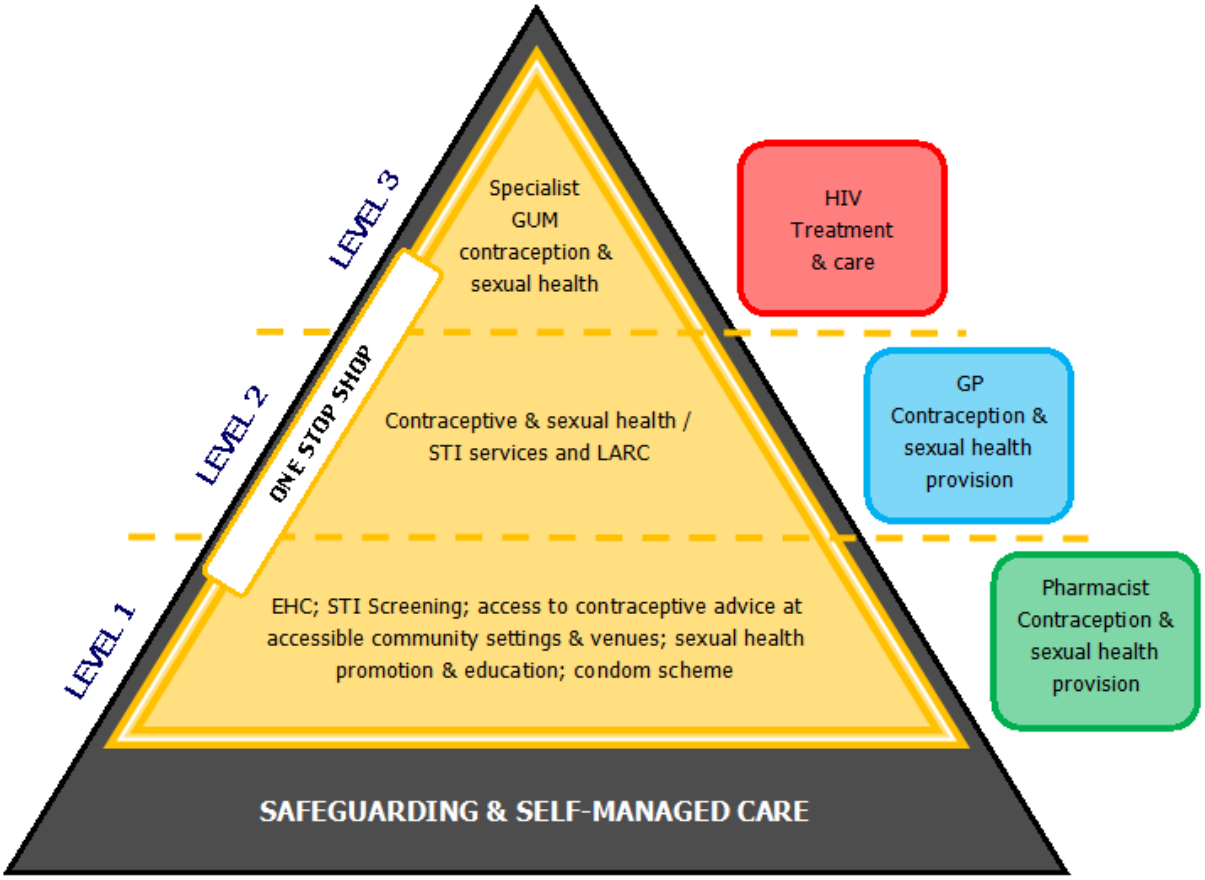


Figure 14. Option C, ISHS 'one stop shop' – hub model

Source: adapted from the Nottingham model to encompass the key elements of an integrated service on-island

Required changes

The changes required to the current services are highlighted below.

Access:

- GUM and FPC services to combine and the staff become dual-trained to offer a one stop shop for clients.
- Enhance the Pharmacy and GP services to be more accessible across the island. For example, the Pharmacy service also offering contraception and pregnancy testing and improving the GP intra-referral pathway.
- Consider options for all pharmacies to offer EHC.
- Consider the location/venue for the hub service.
- Updating services to reflect updates in practice, for example, offering home testing kits for STI screening.
- Offer specific sessions for different groups, for example young people.

Service Pathway:

- Set-up formal referrals to/from the hub where necessary.

Staff:

- Dual trained staff.
- GUM and FPC staff to have equal contracts for the level of work they undertake. For example permanent contracts and pay grades.
- The hub service working towards a service specification with formal governance, accountability and professional support arrangements in place.
- Training to update all staff on the referral processes, data collection and software package adopted.
- Review and integrate the management structure.

Awareness:

- Service/s promoted using various methods to suit the needs of clients for example social media and smart phone/tablet apps.
- Access to further information and guidance/self-help materials.
- Re-brand the service and consider how to minimise stigma.

Client Records/Data:

- Common core data collected for all services
- Integrated IT system/software package used for the hub service.

Strengths

The strengths of adopting this approach include:

- Having a one stop shop with dual trained staff to provide more services will be more accessible for the potential clients.
- More resilient service with dual trained staff.
- Having more formal referrals in place to enable clients to receive the necessary care easily, considering specific services for those with inequalities.

- Having shared records and the same software package will avoid duplications on sexual health history taking and other similar notes.
- Following a common core data set will enable comparisons between services.
- Rebranding the service will hopefully minimise the level of stigma associated with attending a sexual health service.
- Clients will be more informed of the services offered if promoted appropriately.
- One management structure and service specification with formal governance, accountability and professional support arrangements in place.

Weaknesses

The weaknesses with this approach include:

- Some clients may prefer to attend separate clinics.
- Some individuals may not use the services on-island for confidentiality purposes. Need to consider how they can receive the relevant services. For example, professionals who do not wish to be seen by their own clients; or for those whose cultures may not agree with attending such services.

Required Resources

The resources required if this approach is adopted include:

- Location – either GUM or FPC or potentially new premises if neither are suitable.
- Creating a clear service specification for the hub service including performance management and evaluation.
- Integrated IT system/software package for the hub service to use.
- Dual training staff.
- Refined pathway to suit the needs of all island residents and visitors.
- Methods shared for how and which data to collect.
- Performance management and formal contract arrangements for the service specification.
- Terms and conditions updated for staff to have equal contracts for the level of work they undertake.
- Training for front line staff on the pathway and available services.
- Marketing of the services – website, social media presence, posters, etc.

Costs

The additional costs to consider if this approach is chosen will include:

- Adaptations to the GUM or FPC premises or potentially new premises.
- Dual training staff.
- Incorporating clinical governance.
- Reviewing and integrating the management structure.
- Marketing the services.

Risks

A risk has been highlighted with creating a more formal ISHS whereby the GPs and/or Pharmacy service may pass on clients to the 'new service' rather than supporting the

clients. If this approach is chosen there will be a need to ensure there are formal referrals in place with pharmacies and GPs, as well as engaging them to enhance the sexual health services they offer.

7.4 Option D. ISHS 'one stop shop' – hub & spoke model

This model will include the 'one stop shop' hub in Douglas as described in option C as the core to the service with the addition of outreach 'spoke' services across the island. This may be in addition to or instead of focussing on enhancing GP and Pharmacy services as mentioned in option c. The spoke services across the island will include the majority of STI, contraceptive and sexual health services operating on a minimised schedule compared to the hub service.

The following highlights any additional comments that will apply in addition to option C.

Required Changes

The changes required to the current services are highlighted below.

Access:

- Outreach session's set-up across the island.

Staff:

- Potential for more staff being required or increase the number of hours for the current staff.

Strengths

The strengths of adopting this approach include:

- Having spoke services available across the island will be more accessible for the public.

Weaknesses

The weaknesses with this approach include:

- Current staff availability/recruiting staff with the required skills.

Required Resources

The resources required if this approach is adopted include:

- Appropriate venues/ locations for the spoke services.

Costs

The additional costs to consider if this approach is chosen will include:

- Additional staffing costs.
- Venues required for the spoke services.

Risks
There will still be the need for pharmacies to offer EHC and GPs to offer sexual health services including LARC as the client may need the service urgently or on a particular day/time. If this approach is chosen there will be a need to ensure there are formal referrals in place with pharmacies and GPs.

8. Acknowledgements

8.1 Sexual Health Executive Steering Group

Please note, this group identified the priorities for the needs assessments and then stood down to allow the needs assessments to be carried out.

Chair Mr R Peake	MHK
Dr H Ewart	Director of Public Health
Dr M Couch	CEO Health and Social Care
Mr M Kelly	CEO Home Affairs
Prof Ronald Barr	CEO Education and Children
Mr G Roberts	Chief Constable (or representative of Isle of Man Constabulary)
Mr T Mansfield	Director of Commissioning Health and Social Care
Ms A Howland	Public Health Strategic Lead

8.2 DHSC Commissioning Committee

The DHSC Commissioning Committee received updates during the needs assessment and was presented with the final report for option appraisal.

8.3 ISHS Stakeholder Group

Please note a number of the members highlighted in the stakeholder group below are corresponding members whereby they would be involved in the circulations and send through comments but not attend the meetings. Further professionals were also invited to be a stakeholder but did not feel it was appropriate for their role.

Department of Health and Social Care, Public Health Directorate

Chair Dr H Ewart	Director of Public Health
Deputy Ms D Bell	Senior Health Improvement Officer, Sexual Health Lead
Ms J Dunn	Senior Nurse Health Protection
Ms M Sayle	Senior Public Health Intelligence Analyst

Department of Health and Social Care, Corporate Services Division

Mr T Mansfield	Director of Commissioning

Department of Health and Social Care, Primary Care Directorate

*Dr I Kewley	Director of Primary Care
Ms A Philips	Lead Nurse Prison

Ms M Bell	Pharmaceutical Advisor
Ms C Glover	Community Health Services
*Mr S Chell	Senior Practitioner, Children and Families
Dr K Wilson	Doctor Family Planning
Ms C Horne	Lead Nurse Family Planning

Department of Health and Social Care, Acute Healthcare Division

Ms M Morris	Executive Director of Health
*Mr M Quinn	Medical Divisional Manager
Dr D Mandal	Genitourinary Medicine Consultant
Ms A Dawson	Genitourinary Medicine Clinical Nurse
Ms R Shields	Chief Biomedical Scientist
Ms J Sloane	Head of Midwifery

Department of Health and Social Care, Emergency Department

Dr D Hedley	Nobles Hospital, A&E Doctor

Department of Health and Social Care, Mental Health Directorate

Ms E McClean	Child and Adolescent Mental Health Service Manager
*Mr R Bailey	Professional Leadership Team

Department of Health and Social Care, Social Services, Adults Social Care

Ms J Bradford	Social Work Assistant

Department of Health and Social Care, Children and Families Social Care Directorate

Ms N Couling	Principle Social Worker Children and Families
*Ms J Frank	Service Manager, Initial Response Team

Department of Home Affairs

Ms M McKillop	Detective Inspector, Police
Ms S Barrass	Probation Service Officer

Department of Education and Children

Ms M Keary	Physical and Emotional Health Education Officer
Ms G Phillips	Student Welfare Officer, University College Isle of Man

Third Sector

Ms J Sloane	Crossroads Care Adults Representative
Ms H Murphy	Crossroads Care Children's Representative
Mr M Manning	Graih Representative
Mr T Watterson	IOM HIV Support Group Representative
Ms M Brabbs	Safe Strong Secure (3S) Representative
Ms A Seed	St Christopher's Representative
*Ms L King	The Children's Centre Representative
Ms C Brand	The Manx Rainbow Association Representative

* Dr I Kewley, Director of Primary Care has now retired
* Mr S Chell, Senior Practitioner, Children and Families, stepped down from the Stakeholder Group and Ms J McCune attended to represent the Health Visitors.

* Mr M Quinn is no longer the Medical Divisional Manager and has been replaced on the Stakeholder Group by Mr M Smith.
* Mr R Bailey, Professional Leadership Team for Mental Health, no longer attends. The MHS is covered by Ms E McClean.
* Ms J Frank, Service Manager, Initial Response Team, has retired and been replaced on the Stakeholder Group by Ms J McEwan.
* Ms L King, The Children's Centre Representative, nominated Mr M Meaghan to represent The Children's Centre.

8.4 ISHS Stakeholder sub-groups

Quantitative Statistics

Lead Ms M Sayle	Senior Public Health Intelligence Analyst
Ms A Dawson	Genitourinary Medicine Clinical Nurse
Dr K Wilson	Doctor Family Planning
Ms R Shields	Chief Biomedical Scientist
Ms M Bell	Pharmaceutical Advisor

Current services cost and activity

Lead Mr T Mansfield	Director of Commissioning
Ms D Bell	Senior Health Improvement Officer, Sexual Health Lead
Ms M Sayle	Senior Public Health Intelligence Analyst
Ms C Glover	Community Health Services
Dr D Mandal	Genitourinary Medicine Consultant
Ms A Dawson	Genitourinary Medicine Clinical Nurse
Ms C Horne	Lead Nurse Family Planning
Ms M Bell	Pharmaceutical Advisor

Qualitative Data

Lead Ms D Bell	Senior Health Improvement Officer, Sexual Health Lead
Ms J Sloane	Crossroads Care Adults Representative
Ms H Murphy	Crossroads Care Children's Representative
Ms M Keary	Physical and Emotional Health Education Officer
Ms J Bradford	Social Work Assistant
*Mr S Chell	Senior Practitioner, Children and Families
Ms G Phillips	Student Welfare Officer, University College Isle of Man
Ms C Brand	The Manx Rainbow Association Representative

* Mr S Chell, Senior Practitioner, Children and Families, stepped down from the Stakeholder Group and Ms J McCune attended to represent the Health Visitors.

8.5 Further Support

Ms J Wheeler	Change and Reform Programme Lead, Cabinet Office
Ms AM Goldsmith	Change and Reform Programme Lead, Cabinet Office
Ms P Smith	Change and Reform Officer, Cabinet Office
Ms K Gurry	Social Marketing Manager
Ms R Glassey	Marketing Officer
Ms C Collister	Public Health Intelligence Assistant
Mc E Bennett	Health Improvement Officer, Public Health
Mr J Davies	Corporate Communications Service, Communications Executive

8.6 Focus Group Attendees

Service Providers who attended the focus groups include:

- Family Planning
- GUM
- General Practice
- Public Health
- Pathology Lab
- Midwifery
- Pharmacy

Invited but could not attend / did not respond

Those who were invited to the focus group but could not attend or did not respond include:

- GUM consultant – GUM team were represented
- FPC Speciality Doctor – FPC team were represented
- MIU, Ramsey Cottage Hospital
- Emergency department
- Prison Nurse
- Practice nurses
- More GPs

Glossary

Sexual Health

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

(World Health Organization, 2015:online)

Sexual and Reproductive Health (SRH)

SRH is described by the FSRH based on two World Health Organization definitions of sexual health combined:

> "Sexual and reproductive health care supports all people in having a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of infection, coercion, discrimination and violence; enabling them to decide if, when and how often to have children by informing them of, and providing access to, safe, effective, affordable and acceptable methods of contraception of their choice. It also signposts women to necessary support and care to go safely through pregnancy and childbirth, thus maximising the chance of having a healthy infant."

(FSRH, 2015:3)

Abbreviations

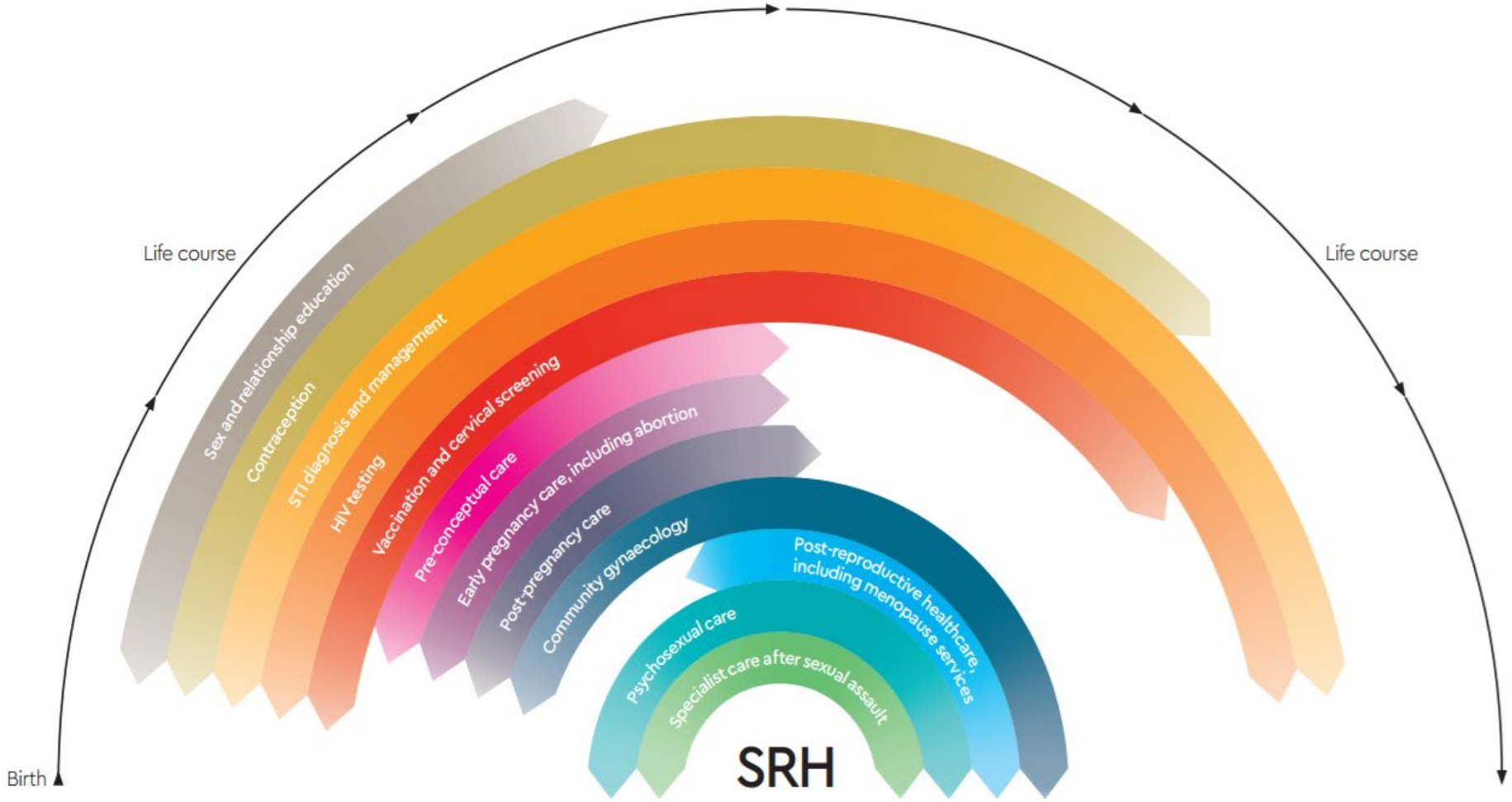
BASHH	British Association for Sexual Health and HIV
BHIVA	British HIV Association
DEC	Department of Education and Children
DHSC	Department of Health and Social Care
DOH	Department of Health
ED	Emergency Department
EHC	Emergency hormonal contraception
FPC	Family Planning Clinic
FSRH	Faculty of Sexual and Reproductive Healthcare
GP	General practice/practitioner
GUM	Genito-urinary Medicine
HIV	Human immunodeficiency virus
IOM	Isle of Man
ISHS	Integrated sexual health service
IUD	Intrauterine device
IUS	Intrauterine system
JSNA	Joint strategic needs assessment
LARC	Long-acting reversible contraception
MEDFASH	Medical Foundation for HIV & Sexual Health
MEDS	Manx Emergency Doctor Service
MIU	Minor Injuries Unit
NICE	National Institute for Health and Care Excellence
PEPSE	Post-exposure prophylaxis following sexual exposure
PHE	Public Health England
RCOG	Royal College of Obstetricians and Gynaecologists
SARS	Sexual assault referral service
SRH	Sexual and reproductive healthcare

STI	Sexually transmitted infection

Appendices

Appendix 1

Life course model



FSRH (2015:4)

Appendix 2

ISHS Project Charter

Project Name	Integrated Sexual Health Service (ISHS)
Project Description	To undertake a full needs assessment including epidemiology, current pathway and services, activity and cost, benchmarking against best practice and views of users and providers. To produce a specification and pathway for sexual health and human immunodeficiency virus (HIV) services across all levels of healthcare and to reconfigure the existing Family Planning and GUM service to form an ISHS as part of that pathway. To reduce the rate of STIs and unplanned pregnancy by making it easier for residents to access the services they need.
Project Justification	The project will improve the sexual health of the Island's population through: • A reduction in sexual health inequalities by integrating all elements of HIV and reproductive healthcare. • A reduction in the rates of STIs including the targeting of testing for those most at risk of sexual ill-health • A reduction in the prevention of late diagnosis of HIV • Increased access and take-up of a full range of contraception including long-acting reversible contraception (LARC) • A reduction in the rates of unplanned pregnancy and terminations This will support delivery to the Public Health Outcome Framework* (PHOF) indicators for: • Chlamydia diagnosis • Under 18 conceptions • People presenting with HIV at a late stage of infection.
Project Sponsors	Dr Henrietta Ewart
Project Lead	Danielle Bell
Project Manager	To be confirmed once appointed
Project Start Date	July 2016
Project Finish Date	March 2017

Outcomes	An ISHS that:
	• Provide evidence based health promotion and behaviour change interventions, tailored to meet the specific needs of groups and/or individuals within the Isle of Man (IOM);
	• Are welcoming and accessible and meet the needs of a diverse range of service users, including men and women of all ages and diversity;
	• Reduce inequalities in sexual health by working in partnership with a number of organisations to deliver a proactive approach to outreach that:
	  ○ Promotes engagement with vulnerable and/or at risk groups or communities within the IOM
	  ○ Tackles the stigma and discrimination associated with poor sexual health and HIV
	• Offers a '*one stop shop'* approach to sexual health and HIV services in one or more accessible locations. Ensuring that service users within a single visit have access to STI testing and treatment, contraceptive and sexual health promotion and where appropriate linking to reproductive health services delivered through Nobles Hospital.
	• Improve access to a full range of contraception services (including LARC).
	• Support people to plan pregnancy by providing accessible information and onward referral to maternity services.
	• Termination of Pregnancy and early pregnancy assessment services within the current legislation. Supported by the implementation and delivery of evidence based seamless pathways that include provision of contraception (including LARC).
	• Reduce the rates of STIs and HIV through the provision of integrated services for STI testing and treatment. Including services for contraception, provision of sexual health promotion and partner notification
	• Increase uptake and testing for STIs and HIV to enable early identification and to reduce onward transmission through effective treatment and partner notification.
	• Reduce the prevalence of undiagnosed HIV and late diagnosis through effective uptake of HIV testing across a range of settings and apply evidenced based approaches to testing in locations that will increase the HIV diagnosis rate.
	• Apply appropriate clinical governance, quality and patient safety standards and continuous service improvement.
	• Proactively engage service users, stakeholders and related services to inform and shape service design, service development and service evaluation.

Outcomes (continued)	• Are responsive to changes in the sexual health needs of the IOM population.
	• Develop and adhere to nationally recognised guidelines and standards for the delivery of sexual health and HIV services and are evidence based and delivered in accordance with current legislation and guidance.
	• Are coordinated and sustainable by:
	  ○ Maximising and enhancing existing workforce knowledge, skills and expertise through dual training in STI testing and treatment, contraception and sexual health promotion
	  ○ Ensuring that all staff delivering the ISHS are appropriately trained, accredited and professionally supported to deliver high quality care
	  ○ All staff are appropriately trained to work within agreed care pathways and Patient Group Directives (PGDs).

Key Relationships	• Sexual Assault Referral Service Stakeholder Group • Safeguarding Boards • 'Looking at Health' – Learning Disabilities sub-group • Stakeholder Engagement Quality Committee

Key Deliverables	• A needs assessment including:
	  ○ Analysis of data on STIs, HIV, contraception (including LARCs) and teenage pregnancy
	  ○ Completion of mapping of current services spend and activity
	  ○ Benchmark against best practice/quality standards spend and activity
	  ○ Qualitative input from service users and providers
	  ○ Gap analysis completed
	  ○ Identification of priority areas
	  ○ Needs of particular groups including LGBT and those with safeguarding and vulnerability issues identified
	  ○ Consider and make recommendations for the involvement of other services and professionals such as community pharmacists
	
	• Service specification for ISHS based on the needs assessment
	  ○ A clear pathway for sexual health and HIV services

Key Milestones	• Completion of focused needs assessment
	  ○ Completion of mapping against current services
	  ○ Benchmark against best practice/quality standards
	  ○ Gap analysis completed
	  ○ Identification of priority areas
	• Service specification and pathways agreed
	  ○ Passed to the DHSC Commissioning Committee for decision and funding

Project Scope	• Needs assessment for contraceptive services with LARC and EHC • Service specification for ISHS
Out of scope	The following are considered out of scope of this project: • Sexual health services for prisoners • Sexual Assault Referral Services • Cervical Screening • Specialist foetal medicine services • Abortion services • Vasectomy and Female Sterilisation services • Gynaecology, including provision of contraception for non-contraceptive purposes (for example for the treatment of heavy menstrual bleeding) • Infertility and assisted conception including In vitro fertilisation (IVF)
Stakeholders	ISHS Stakeholder Group
Support Required	IT support, social marketing, admin and secretarial support

Appendix 3

Known operational details for each of the current sexual health related services

Family Planning Clinic

Service	Family Planning Clinic
Location	Central Douglas, old Nobles Hospital site
Opening Hours	There are 5 clinics each week including: • 2 lunch time clinics during the weekdays (1 for drop-in and 1 for appointment only) • 2 evening clinics (appointment only) • 1 weekend clinic (drop-in clinic)
Services Offered	See Appendix 8
Partnership Arrangements	No formal partnership arrangements. General arrangement in place with Ward 4 (Gynaecology) at Nobles Hospital for emergency coils
Referrals	To Ward 4 for emergency coils. Informal referrals/signposting to/from GUM and GPs with occasional formal letters.
Workforce	Substantive post: • Band 7 Nurse: 0.5 FTE Bank posts: • 2x Speciality Doctors: 3 ½ sessions per week • 6x Band 6 Nurses: number of hours not provided • 1x Health Care Assistant: 2 sessions per week • Admin: 1.2 FTE
Training	CASH qualification completed by: • Band 7 Nurse (substantive) • 4 x Band 6 Nurses (bank) FSRH Diploma (online programme equivalent to CASH qualification) working towards: • 2 x Band 6 Nurses (bank) EKA[13] Competence (online): • Band 7 Nurse (substantive) CPD / Refresher Training: • Speciality Doctor attends conferences and provides updates to the team
Standards	The Faculty of Sexual and Reproductive Healthcare (FSRH) service standards
Software/Records	Only paper records used. Considering EMIS

[13] EKA – Electronic Knowledge Assessment – need to do this before they can do implants.

Contact Details	To make an appointment phone 01624 642186 during the clinics opening hours.

Genito-Urinary Medicine Service

Service	GUM Clinic
Location	Nobles Hospital, Douglas
Opening Hours	Clinics are by appointment only with no drop in facility available at present. This includes: • 4 afternoon clinics • 2 morning clinics • 1 evening clinic In addition there is a monthly full day Consultant led clinic usually on a weekend day.
Services Offered	• Management of HIV infection • Testing, treatment and management of STI's • Vaccination for Hepatitis A and B • Vulval pain management • Genital dermatological skin conditions management with biopsies as required • Management of the sexual health needs of victims of sexual assault • Assessment for all under 18 years age regarding vulnerabilities and risk assessment for child sexual exploitation • Post exposure prophylaxis for HIV following sexual exposure (PEPSE) • Cervical screening • Free condoms • Pregnancy testing • Contraceptive advice and occasionally contraception provision • Emergency contraception All asymptomatic patients attending GUM are routinely offered testing for : • Chlamydia (CT) • Gonorrhoea (GC) • HIV • Hepatitis B/C • Syphilis It should be noted that the blood borne virus testing offered is above BASHH recommended testing (i.e. routinely testing for Hepatitis B/C). The extra tests are undertaken at no extra cost due a laboratory procurement agreement. Symptomatic patients are offered (in addition to above) • Microscopy for males for Non Gonococcal Urethritis (NGU)/GC • Microscopy for females for GC, Bacterial Vaginosis (BV), Trichomonas vaginalis (TV), Candida. • Viral testing for herpes simplex virus (HSV) as required See Appendix 8 for further information.
Partnership Arrangements	Ad hoc contact with UK GUM clinics for the purpose of partner notification

Referrals	Referrals to the Royal Liverpool Hospital, Infectious Diseases Ward for HIV patients. Informal referrals/signposting to/from FPC and GPs with occasional formal letters.
Workforce	Substantive posts: • Band 8 Nurse: 1 FTE • Band 6 Nurse: 0.80 FTE (30 h/w) • Band 5 Nurse: 1.5 FTE • Admin: 1.6 FTE (20.5h/w) Bank post: • Consultant: 1 day per month <u>Notes:</u> • The Band 8 RN manages the department and also has a clinical workload. • The lead consultant is based off-island and visits once a month on a weekend or occasionally more often for meetings/training or if there is demand in the clinic. • Speciality Doctors - Currently there are 3 GP's workings on a locum sessional basis. On average these provide approx. 18 hours medical cover per week. 2 are undergoing training at present and still require some supervision.
Training	GUM BASHH competency based training completed by: • Speciality Dr • Band 8 RN Accredited training in contraception (but not BASHH GUM training) completed by: • Speciality Dr BASHH competency based training nearing completion: • Band 6 RN BASHH theory training completed by: • Two Band 5 RNs Integrated training package CPD / Refresher Training: • Consultant attends Annual BASHH Conferences and networks across the Mainland, providing updates to the team Notes: GUM are specifically planning for integrated services. Training completed and/or underway includes: • Two Band 5 RNs – they will now need to commence competency based training. It is envisaged that one of them will complete integrated training competencies as the other RN is already contraception trained/accredited. • The integrated training package became available in November 2016. Staff who have already completed BASHH will complete an add-on. See the following link for more information: http://www.stif.org.uk/STIF/Home/STIF_Competencies/STIFIntegrated_Competency/STIF/STIF_Integrated_Competency_Trainee_Information.aspx

Standards	The British Association for Sexual Health and HIV (BASHH) Standards for the management of STIs
Software/Records	Routine upgrades are about to be installed. This is more a routine system update without any enhancements. A business case to include updates/modernisation of the current system to facilitate electronic paper records (EPR) has already been submitted. The updates include bulk SMS texting facility, lab link for results directly into the electronic case file. EPR success depends on both of these elements. Nurses are currently texting patients individually, which is a risk and also very time consuming. The company providing the sexual health bespoke package is now called 6PM plc. The module is still called Lillie.
Contact Details	Phone 01624 650710 to book an appointment.

General Practice

Service	General Practice
Location	There are 14 GP surgeries across the island.
Opening Hours	Monday to Friday with hours varying between 8.30am to 6pm
Services Offered	General contraception; inter-practice referral pathway for the IUCD and implant; STI and HIV testing;
Partnership Arrangements	No formal partnership arrangements with other sexual health related services. However, GP's have a shared care arrangement with other GP surgeries for LARC.
Referrals	GPs refer to other GP surgies if necessary for LARC. Informal referrals/signposting to the FPC and GUM.
Workforce	Each GP surgery has 2 or more doctors practicing and at least 2 practice nurses in their team
Training	All GPs are trained for general contraception The GPs who provide LARC have undertaken a Diploma in this speciality
Standards	General Medical Council
Software/Records	EMIS
Contact Details	Family practitioner services: 01624 642612 All individual GP service contact details are highlighted through selecting the relevant link from this webpage: https://www.gov.im/categories/health-and-wellbeing/doctors/

Pharmacy

Service	Pharmacy (community)
Location	There are 23 widely accessible community pharmacies across the island. 21 of the 23 community pharmacies are wheelchair accessible.
Opening Hours	Monday to Friday with hours varying between 8.30am to 6.30pm; on Saturday's the hours vary between 8.30am to 5.30pm, with a few only open for the morning; and on Sunday's there are a few limited pharmacies open for part day.
Services Offered	All bar one community pharmacy offer EHC, the pharmacy which does not is unable to due to the lack of a private area to discuss EHC with the service user.
Partnership Arrangements	Good links with the GP surgeries
Referrals	Pharmacists report any safeguarding concerns. Fraser competencies are used and anyone under 13 is reported via safeguarding. Informal referrals/signposting to the FPC and GPs
Workforce	Stable/available workforce
Training	Pharmacists have to be registered with the General Pharmaceutical Council before they can practise. They have studied for five years to become experts in medicines and promoting healthy lifestyle choices. • Face to face clinical training and online learning and assessments – every 2 years • Pharmacists declare themselves competent to use the PGD • Accreditation certificates are issued by the Pharmaceutical Advisor • Safeguarding training – every 2 years
Standards	Royal Pharmaceutical Society
Software / Records	PGD requirements – records kept for 7 years. Anonymised down to post code and patient initials New software with a sexual health platform - capable of full sexual health service & will provide data on referrals
Contact Details	http://www.manxpharmacy.com/

Appendix 4

GP Inter-Practice Referral Pathway

Process for patients requiring IUCD / implant insertions

Patient contacts Practice and asks about IUDs

Patient advised of those GPs who provide IUDs and asked to make an appointment

Patient makes appointment with IUD providing Practice (Family Planning Clinic may do this for the patient)

IUD fitting Practice registers the patient as a TR

Patient assessed by fitting doctor using template on EMIS called 'IU counselling template'

IUD fitted

Fitting GP writes to patients GP enclosing a copy of the counselling template

6 week check undertaken by fitting doctor

Practices who provide implants	Will this Practice accept referrals from other Practices	GPs who provide this service
Palatine	Yes	Dr Blackman
Kensington	No	Dr Lunt
Ballasalla	No	Dr Farrant
Finch Hill	Yes	Dr D Heath Dr Freer Dr Dunstan
Ramsey	Yes	Dr Clarke Dr Drew
Laxey	Yes	Dr Wilson Dr Christian
Peel	No	Dr Anand
Southern	Yes	Dr Wignall
Castletown	Yes	Dr Sharp

Practices who fit IUCDs	Will this Practice accept referrals from other Practices	GPs who provide this service
Palatine	Yes	Dr Daniels
Kensington	No	Dr Lunt
Ramsey	Yes	Dr Maska Dr Armour Dr Drew
Laxey	No	Dr Wilson Dr Christian
Southern	Yes	Dr Wignall
Peel	No	Dr Anand
Finch Hill	Yes	Dr D Heath
Castletown	Yes	Dr Sharp
Ballasalla	No	Dr Farrant

Updated December 2016
To be reviewed December 2017

Appendix 5

STI & HIV requests received from GP + FPC

The table below includes the total number of STI and HIV requests made to the Pathology lab from GP surgeries and the FPC during 2015 and 2016.

GP surgery	Chlamydia	Gonorrhoea**	HIV
Family Planning	51	*	*
Ballasalla	88	*	6
Castletown	82	13	27
Finch Hill	149	12	18
Hailwood	130	*	9
Kensington	219	*	13
Laxey	106	7	13
Palatine	130	*	19
Peel	183	17	10
Port Erin (Southern)	111	*	14
Promenade	88	*	11
Ramsey	291	16	21
Snaefell	75	13	7

*Numbers too low to present

**Gonorrhoea (GC) testing is performed by default on all chlamydia requests, but is only reported where a specific testing request has been made. Any positive GC results that have not been requested are discussed directly with the requestor prior to reporting. This is based on recommendations from PHE and BASHH guidelines. The figures in the above table for GC only include the number of specific requests.

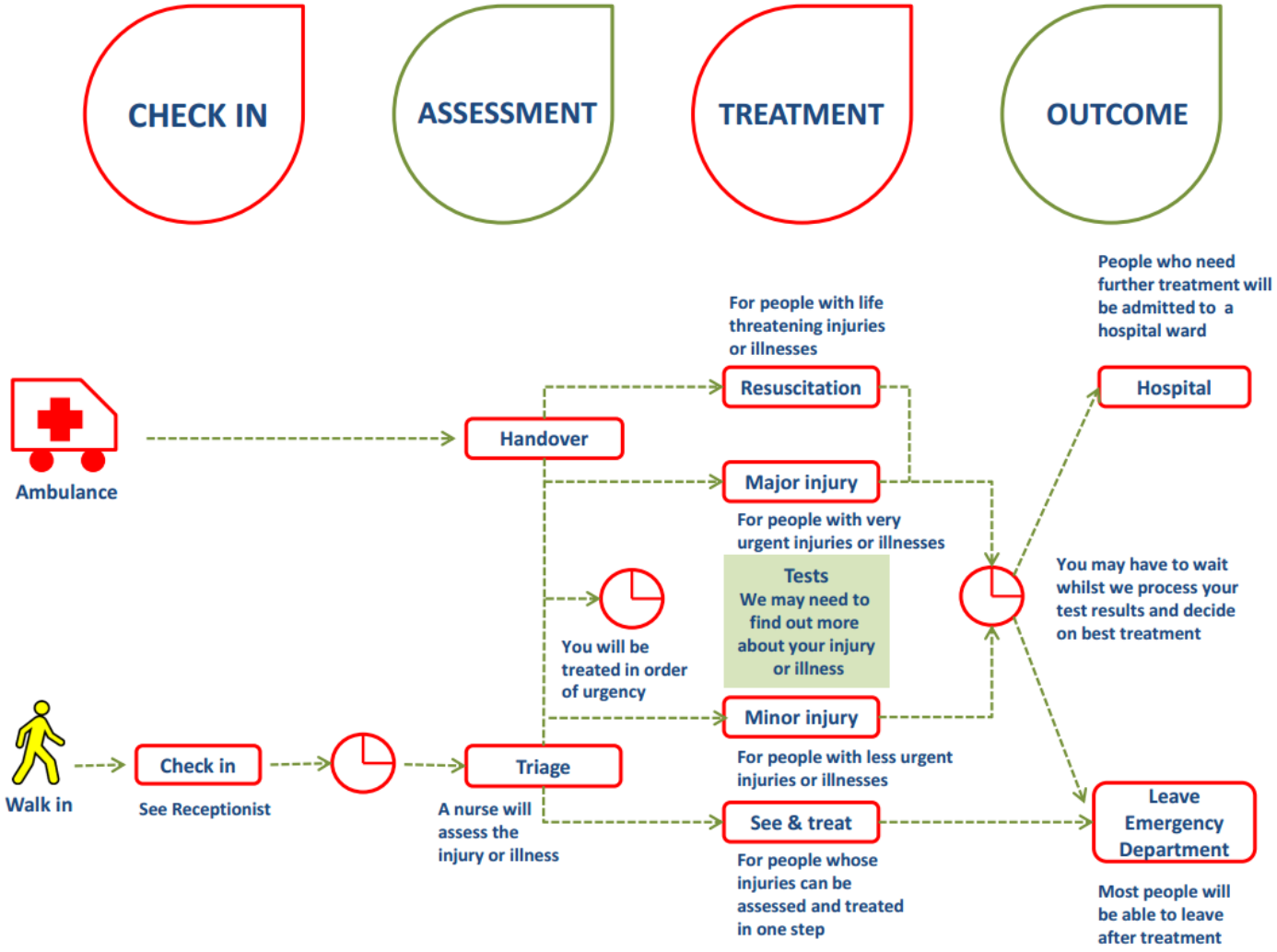
Appendix 6

GPs with a special interest in sexual health

GP Surname	Initials	Ordinary Place of work	Current special interest – sexual health (clinical)
Anand	T	Peel Medical Centre	Family planning
Blackman	C M	Palatine Group Practice	Implants
Chandra	S	Laxey & Village Walk Health Centres	Women's health
Clarke	H	Ramsey Group Practice	implants
Daniels	J K	Palatine Group Practice	Family Planning
Farrant	C M	Ballasalla Medical Centre	Genito Urinary Medicine, Family Planning
Heath	DM	Finch Hill Health Centre	Sexual & Women's Health/Medical Education/GP Trainer
Kelly	Y	Promenade Medical Centre	Women's health
Khan	S R K	Non-Principal	Gynae
Maska	M	Ramsey Group Practice	Family planning, IUDs,
McDermott	S	Ramsey Group Practice	Women's health
Snelling	J P	Peel Medical Centre	Vasectomies
Wignall	D	Southern Group Practice	Family planning
Wilson	K G	Laxey & Village Walk Health Centres	Family planning

Appendix 7

Emergency Department Patient Journey



(IOM Government, 2017:online)

Appendix 8

Service Content Table

Basic and Intermediate Care (Level 1 and 2)	**GUM**	**Family Planning**	**Pharmacy**
	Tick those which apply	Tick those which apply	Tick those which apply
Information on services provided by local voluntary sector sexual health providers including referrals and/or signposting	√	√	√
Full sexual history taking and risk assessment (all practitioners)	√	√	
Pregnancy testing	√	√	
Supply of male and female condoms and lubricant	√	√	
All methods of oral emergency contraception and the intrauterine device for emergency contraception		√	Only oral EHC is supplied
First prescription and continuing supply of combined hormonal contraception (combined and progestogen only) including oral, transdermal, transvaginal methods of delivery and a choice of products within each category where these exist	very occasionally	√	Not at present but pharmacist keen to do this (see models from England)
First prescription and continuing supply of injectable contraception	very occasionally	√	
IUD and IUD uncomplicated insertion, follow up and removal		√	
Diaphragm fitting and follow up		√	
Uncomplicated contraceptive implant insertion, follow up and removal		√	
Assessment and referral for difficult implant removal		√	
Natural family planning	√	√	
Cervical cytology	√	√	
Direct referral for antenatal care	√	√	
Direct referral for abortion care and to support self-referral		√	
Counselling and direct referral for male and female sterilisation		Counselling offered with referral to GP	
Domestic abuse screening and referral (all practitioners)	√	√	
Assessment and referral for psychosexual issues	√	√	
Assessment and referral for Brief Alcohol Interventions	√	√	
Referral for Female Genital Mutilation specialist advice and care	√	√	

STI testing and treatment of symptomatic but uncomplicated infections in men (except MSM) and women excluding: Men with dysuria and/or genital discharge Symptoms at extra-genital sites e.g. rectal or pharyngeal Pregnant women Genital ulceration other than uncomplicated genital herpes	√		
Chlamydia testing for sexually active under 25 year olds	√	√	Referrals offered. Willing to screen.
Case Management of uncomplicated Chlamydia	√	Referral	
HIV and syphilis testing and pre and post-test discussions (with referral pathways in place)	√		
Initiation of Post Exposure Prophylaxis with referral to Level 3 for on-going management	GUM are level 3		
Promotion and delivery of Hepatitis A and B vaccination, with a particular focus on key target groups	√		
Hepatitis C testing and discussion (with referral pathways in place)	√		
Uncomplicated contact tracing/partner notification (including chlamydia)	√		
Management of first episode uncomplicated vaginal discharge (low risk)	√	√	
Management of contacts of gonorrhoea and trichomonas vaginalis (excluding symptomatic men)	√		
Assessment & treatment of genital ulceration with appropriate referral pathways for those at high risk of syphilis/Lymphogranuloma Venereum	√		
Assessment and referral of sexual assault cases	√	√	
Holistic sexual health care for young people including child protection / safeguarding assessment	√	√	
Outreach services for STI prevention and contraception	Occasionally		
Problems with choice of contraceptive methods	Advise and signpost	√	Not at present, pharmacist keen to do this (see models from England)
Management of problems with hormonal contraceptives	Advise and signpost	√	
Urgent & routine referral pathways to/from related specialties (GP, urology, A&E, gynaecology) should be clearly defined. These may include general medicine/infectious diseases for inpatient HIV care	√	√	Referral to only
Urgent and routine referral pathways to and from social care	√	√	
Regular audit against national guidelines	√	√	

Complex (Level 3) Service Provision in addition to Levels 1 and 2	GUM	Family Planning	Pharmacy
	Tick those which apply	Tick those which apply	Tick those which apply
Management of complex contraceptive problems including UK Medical Eligibility Criteria		√	
Management of complicated/recurrent STIs (including tropical STIs) with or without symptoms	√		
Management of STIs in pregnant women	√		
Management of HIV partner notification	√		
Management of sexual health aspects of psychosexual dysfunction	Referred	Consultation with doctor, exam if needed and signposting/referral	
Management of organic sexual dysfunction	Consultant does some, others are referred	Consultation with doctor, exam and some prescriptions or referrals	
Coordination of outreach clinical services for high risk groups	Occasionally		
Interface with specialised HIV services	√		
Specialist contraception services e.g. IUD/IUS problem clinics, difficult implant removal etc. with appropriate diagnostic services (e.g. ultrasound) to support this		IUD/IUS problems and difficult implant removals and refer if appropriate for diagnostic services	
Provision and follow up of post-exposure prophylaxis after sexual exposure to HIV	√		
Coordination of contraceptive and STI care across a network including: Clinical leadership of contraceptive and STI management Co-ordination of clinical governance Co-ordination and oversight of training in SRH and GUM Co-ordination of pathways across clinical services Co-ordination of partner notification for STIs and HIV	√		

Self-Managed Care	GUM	Family Planning	Pharmacy
	Tick those which apply	Tick those which apply	Tick those which apply
Health information	√	√	No information provided
Generic information on pregnancy, STIs including and HIV prevention/safer sex advice	√	√	
Information on the full range of contraceptive methods and where these are available	√	√	
Primary prevention initiatives to improve overall sexual health to the community	√	√	
Male and female condoms and lubricant	√	√	
Chlamydia home sampling kits for under 25 year olds		self-swabs home & in clinic (given the choice as some patients prefer to do self-taken vaginal swabs)	
Pregnancy testing kits	√	√	

Appendix 9

Quality Outcome Indicators

Quality Outcomes Indicators	Threshold	Technical Guidance Reference	Method of Measurement	Consequence of Breach
Clinical Management				
Percentage of individuals accessing services who have sexual history and STI/HIV risk assessment undertaken	100%	BASHH Standard 1	Clinical Audit	Remedial Action Plan
Monitor percentage of first time service user (of clinical based services) offered and accepting an HIV test	For local determination	For local determination (to support PHOF 3.4)	GUMCAD	Remedial Action Plan
Percentage of routine STI laboratory reports of results (or preliminary reports) which are received by clinicians within seven working days of a specimen being taken	100%	BASHH Standard 4	Clinical Audit	Remedial Action Plan
Ratio of contacts per gonorrhoea index case, such that the attendance of these contacts at a Level 1, 2 or 3 service was documented as reported by the index case, or by a HCW, within four weeks of the date of the first PN discussion (within 12 weeks for HIV	At least 0.4 contacts per index case in large city clinics (London, Birmingham and Manchester), or at least 0.6 contacts in other clinics, and document within four weeks of the date of the first PN discussion	BASHH Statement on Partner Notification for STIs	Clinical Audit	Remedial Action Plan
Ratio of contacts of chlamydia index cases whose attendance at a Level 1, 2 or 3 service was document as reported by the index case, or by a HCW, within four weeks of the date of the first PN discussion	At least 0.6 contacts per index case for all clinics (in and outside London), and documented within four weeks of the date of the first PN discussion	BASHH Statement on Partner Notification for STIs NCSP Standard 4	Clinical Audit	Remedial Action Plan
The ratio of all contacts of chlamydia index case whose attendance at a Level 1, 2 or 3 sexual health service was documented as verified by a HCW, within four weeks of first PN discussion	At least 0.4 contacts per index case for all clinics (in and outside London) and documented within four weeks of date of first PN discussion	BASHH Statement on Partner Notification for STIs NCSP Standard 4	Clinical Audit	Remedial Action Plan

Documented evidence within clinical records that PN has been discussed with people living with HIV within 4 weeks of receiving a positive HIV diagnosis and within 1 week of identifying subsequent partners at risk	90%	BHIVA Standard 7	Clinical Audit	Remedial Action Plan
Documented PN outcomes or a progress update at 12 weeks after the start of the process	90%	BHIVA Standard 7	Clinical Audit	Remedial Action Plan
Monitor period of time from consultation to receipt of results by service user	For local determination (However suggested timeframe of 10 days based on NSCP threshold)	BASHH Standard 5	Clinical Audit	Remedial Action Plan
Percentage of women having access to and availability of the full range of contraceptive method (including choice within products)	100%	FSRH Standard 2	Clinical Audit	Remedial Action Plan
Monitor percentage of LARCs prescribed as a proportion of all contraceptives by age	For local determination	For local determination	For local determination	Remedial Action Plan
Percentage of women who have access to urgent contraceptive advice and services (including EHC) within xx hours of contacting the service	For local determination	For local determination	For local determination	Remedial Action Plan
Percentage of women who have access to LARC method of choice within x working days of contacting service	For local determination	For local determination	For local determination	Remedial Action Plan
Improving Productivity				
Percentage of staff delivering contraceptive and STI services who have successfully completed nationally accredited training, according to their scope of practice, and fulfilled relevant update requirements	100%	BASHH Standard 2	For local determination	Remedial Action Plan
Percentage of nurses dual trained to deliver contraceptive (including LARC methods) and GUM services	For local determination	For local determination	For local determination	Remedial Action Plan

Chlamydia Screening				
Work towards achieving a diagnostic rate of 2,300 / 100,000 for chlamydia screening	For local determination	PHOF measure (3.2)	CTAD Data	Remedial Action Plan
Percentage of all under 25 year olds screened for chlamydia	At least 75% of new attendances	Contributes towards PHOF measure (3.2)	For local determination (Drawing on CTAD where appropriate)	Remedial Action Plan
Percentage of all results notified to the young person within 10 working days (from test date)	At least 90%	NCSP Standard 4	For local determination	Remedial Action Plan
Percentage of positive patients who received treatment within six weeks of test dates	At least 95%	NCSP Standard 4	For local determination	Remedial Action Plan
Service User Experience				
Maintain / achieve You're Welcome accreditation	100%	National Expectation	For local determination	Remedial Action Plan
Evidence of at least one user experience survey annually	100%	For local determination	For local determination (However suggested best practice is on-going real time surveys)	Remedial Action Plan
Percentage of service user feedback on surveys that rates satisfaction as good or excellent	For local determination (However suggested threshold is 70%. Any lower may indicated poor service delivery)	For local determination	For local determination	Remedial Action Plan
Evident of improvements made to service as a result of user feedback	Demonstrate evidence of improvements and changes made to service delivery in response to feedback	BASHH Standard 9	For local determination	Remedial Action Plan
Number of service users making formal complaints about the service (verbal or written)	Provider to notify Commissioner in accordance with incidents Requiring Reporting Procedure Section – Appendix G	BASHH Standard 9	For local determination	Remedial Action Performance
Number of service users complimenting the service	For local determination	BASHH Standard 9	For local determination	Remedial Action Plan

Reducing Inequalities				
An Equality Impact Assessment (EIA) is undertaken and outcomes utilised to inform forward year planning	Completion of EIA	Locally Determined	For local determination	Remedial Action Plan
Provider to demonstrate that all functions and policies are equality impact assessed	Agreed programme to achieve compliance	Locally Determined	For local determination	Remedial Action Plan
Number of outreach sessions conducted in areas of high deprivation or aimed at vulnerable groups	For local determination	Locally Determined	For local determination	Remedial Action Plan
Access				
Percentage of clients accessing service to be seen within 48 hours of contacting the service	85%	Locally Determined	For local determination	Remedial Action Plan
Percentage of people offered an appointment, or walk-in, within 48 hours of contacting a provider	98%	BASHH Standard 1	For local determination	Remedial Action Plan
Percentage of users experiencing waiting times in clinics of >2 hours	For local determination (However suggested threshold is 30 minutes. Any longer may indicate poor service delivery)	For local determination	For local determination	Remedial Action Plan
Percentage of clients waiting longer than (to be agreed locally) from booking to appointment	For local determination	Locally Determined	For local determination	Remedial Action Plan
Increase in the number of men accessing services	For local determination	Locally Determined	For local determination	Remedial Action Plan
Care pathways with other organisations to include partner notification and/or linked services (e.g. alcohol, mental health etc.) are clearly defined	Pathways established	BASHH Standard 7	For local determination	Remedial Action Plan
Percentage of specialist SRH referrals from general practice seen within 18 weeks of referral	For local determination	Locally Determined	For local determination	Remedial Action Plan
Percentage of psychosexual clients seen within 18 weeks of referral	For local determination	Locally Determined	For local determination	Remedial Action Plan

(DOH, 2013b:21-27)

Appendix 10

Standards and Guidance for an ISHS

The DOH (2013b) highlights the following standards and guidance should underpin the ISHS:

- Service Standards for Sexual and Reproductive Healthcare (FSRH, 2013)
- British HIV Association Standards of Care for People Living with HIV (BHIVA, 2013)
- Clinical Guidance – Emergency Contraception (FSRH, 2012)
- UK National Guideline on Safer Sex Advice (BASHH & BHIVA, 2012)
- National Chlamydia Screening Programme Standards (6th Edition, 2012)
- BASHH Statement on Partner Notification for Sexually Transmissible Infections (BASHH, 2012)
- Hepatitis B and C: Ways to promote and offer testing to people at increased risk of infection. NICE Public Health Guidance 43 (NICE, 2012)
- Standards for psychological support for adults living with HIV (British Psychological Society, BHIVA & MEDFASH, 2011)
- UK Guideline for the use of Post-Exposure Prophylaxis for HIV following Sexual Exposure (BASHH, 2011)
- PH34 Increasing the uptake of HIV testing among men who have sex with men (NICE, 2011)
- PH33 Increasing the uptake of HIV testing among black Africans in England (NICE, 2011)
- The Care of Women Requesting Induced Abortion, Evidence-based Clinical Guideline Number 7 (RCOG, 2011)
- Standards for the Management of Sexually Transmitted Infections (BASHH & MEDFASH, 2010)
- UK National Guidelines for HIV Testing (BHIVA, 2008)
- Progress and Priorities - Working Together for High Quality Sexual Health (MEDFASH, 2008)
- PH3 One to one interventions to reduce the transmission of sexually transmitted infections (STIs) including HIV, and to reduce the rate of under 18 conceptions, especially among vulnerable and at risk groups (NICE, 2007)
- CG30 Long-acting reversible contraception (NICE, 2005)
- Recommended Standards for Sexual Health Services (MEDFASH, 2005)
- Research Governance Framework for Health and Social Care (DOH, 2005)
- Male and Female Sterilisation, Evidence-based Clinical Guideline Number 4 (RCOG, 2004)

Further standards and guidance that have emerged since 2013 include:

- Service Standards for Workload in Sexual and Reproductive Health (FSRH, 2017)
- Service Standards for Sexual and Reproductive Healthcare (FSRH, 2016)
- Standards for the management of STIs in outreach services (BASHH, 2016)
- Standards for the management of sexually transmitted infections (BASHH, 2014)
- Sexually transmitted infections: condom distribution schemes (NICE, 2017)
- HIV diagnoses, late diagnoses and numbers accessing treatment and care (PHE, 2016)
- Local Health and Care Planning: Menu of preventative interventions (PHE, 2016)
- Better care, a better future: a new vision for sexual and reproductive health care in the UK (FSRH, 2015)
- Health promotion for sexual and reproductive health and HIV: Strategic action plan, 2016 to 2019 (PHE, 2015)
- Commissioning Sexual Health services and interventions: Best practice guidance for local authorities (DOH, 2013)
- Making it work: A guide to whole system commissioning for sexual health, reproductive health and HIV (PHE, 2014)

Appendix 11

Focus Group Quotes

Works well in the current services

PHARMACY

Access

"Community pharmacy - provide 80-90% of EHC on-island"

"Good access - open late evening weekdays and weekends (out of hours service not necessarily needed)"

"Don't need to make an appointment"

"No barriers to free advice and reassurance"

Referrals / Pathways

"Good referral channels (clinical and safeguarding) - see people quickly"

"EHC - joined up service pharmacy"

"Pharmacy have good links with GPs - good communication and infrastructure already exists to enable growth of service"

"Pharmacy signposting and service recommendation"

Workforce

"Stable/available workforce"

"Good training programme for pharmacists and competency framework - good governance"

Awareness

"Signposting good - public know where to get help"

Cost

"Pharmacist consultations are cheaper than a GP to the DHSC"

"Pharmacy saves on GP and nurse consultations"

"Small budget to cover future training needs"

GUM SERVICE

Access

"Sometimes don't have a waiting list"

"Number of clinics – hours"

"Easy access - self referral"

"Everything available on one site"

"All medication on site and free of charge"

"Triage by telephone - respond appropriately to need"

"Access to a part time consultant (available by telephone when not physically present)"

"Small waiting list to see consultant"

"Microbiology on site - provisional results"

"Outreach when required - site visit or ward visit to give advice"

Services offered

"Offer personal service"

"Flexibility"

"Up to date patient advice"

"Bespoke service - quick to identify individual need"

"Holistic experience (help signpost)"

"Contact tracing"

Workforce

"Small team with low staff turnover"

"Good rapport with long term patients"

"Very good skills mix of staff (different levels of competencies)"

"Excellent support staff"

"Every person in team prepared to step in and cover each other's role"

"Substantive post - not reliant on bank staff"

"Regular weekly teaching"

Referral / Pathways

"GPs can contact for advice (and police/FPC/Practice Nurses/Patients)"

"Good safeguarding procedures and policies in place"

IT system

"Scheduled reminders by text"

FPC

Services offered

"Skills mix works well"

"All methods of contraception available at FPC"

"Patient information leaflets available"

Access

"FPC no waiting list for IUDs and implant"

"Central Douglas location"

Workforce

"E-learning for training - good on-island training"

IT system

"FPC text reminder service"

GP SERVICE

Services offered

"Cytology works well"

PATHOLOGY LAB

Services offered

"Versatile testing"

"24/48hr turnaround time for samples (it used to be a week!)"

Does not work as well in the current services

IN GENERAL

Access

"Not a one stop shop - fragmented service"

"Not a 'one stop shop' available"

"To have more daytime clinics - reaching out to youth"

"Better access needed - outside Douglas"

"Location (Hub & Spoke) - UK model"

"Clinic focused with lack of resource to go into the community"

Education

"Lack of value in school visits - more of a box ticking exercise"

"Have to be invited into schools"

"Sexual health education could be better"

"Lack of education of services in schools"

"Lack of time for the services to provide this service"

"Education of health care staff across the board - inappropriate checks"

Awareness

"Awareness - do people know where the FPC and GUM clinics are and what they do?"

"Are the service names appropriate? Do they need to be re-branded?"

"Some stigma with the existing names"

"Lack of awareness of who controls the information that is available to the public and ensure it is current and up to date?"

Leadership

"Willing workforce who feel under supported"

"Lack of commitment to change at every level - red tape / bureaucracy"

"Not able to just make decisions and get on with it"

"Lack of transparency in the past"

Services offered

"SH checkups - lack of skill and resource"

"Don't have access to medical records - have to rely on what the patient tells them"

PHARMACY

Services offered

"Not saving appointments if customer requires further care"

"Under-utilising skills"

"Pharmacy has to refer on if customer has further needs (for regular contraception)"

"Only emergency contraception available (pharmacy)"

"Pharmacist not able to offer chlamydia testing when it might be necessary"

"Not comparative with similar number areas in the UK over what pharmacy can provide"

"Pharmacists can't offer free pregnancy testing"

"Supply - lack of stock - non supplier delivery (on rare occassions - bad weather/bank hols etc)"

Education

"No prevention - missed opportunities"

"Some coming back for repetitive service rather than receiving complete care at the first opportunity"

Awareness

"Lack of understanding/knowledge on what the pharmacy can actually do"

"More public awareness needed"

GUM SERVICE

Staffing

"Sometimes clinics will have to be cancelled if lack of skills available"

"Doctors have locum status - a post 'disappeared' without explanation"

IT system

"IT system out of date and needs to be updated - not meeting basic standards"

"Have to manually text"

"Paper records - lack of storage - starting to become a H&S issue"

Access

"GUM - appointments system might put people off"

Venue

"GUM clinic layout doesn't work: *one shared toilet for 3 consultation rooms; *not enough private space; *limited (confidentiality) anonymity"

FPC

Workforce

"A lot to expect from Bank staff"

"No substantive contracts for staff"

"Works well now but wouldn't cope with increase in demand - people not dual trained"

"Some staff not willing to gain more skills"

Access

"Phone calls to clinic only when clinic open"

"Appointment times at FPC can overrun"

Referral / Pathways

"Inappropriate referrals to family planning from GP"

"Urgent scans are not dealt with urgently"

Services offered

"Not sure if there is a contact tracing"

Awareness

"Still have drop-ins - due to lack of information available"

IT system

"Paper records - lack of storage - starting to become a H&S issue"

GP SERVICE

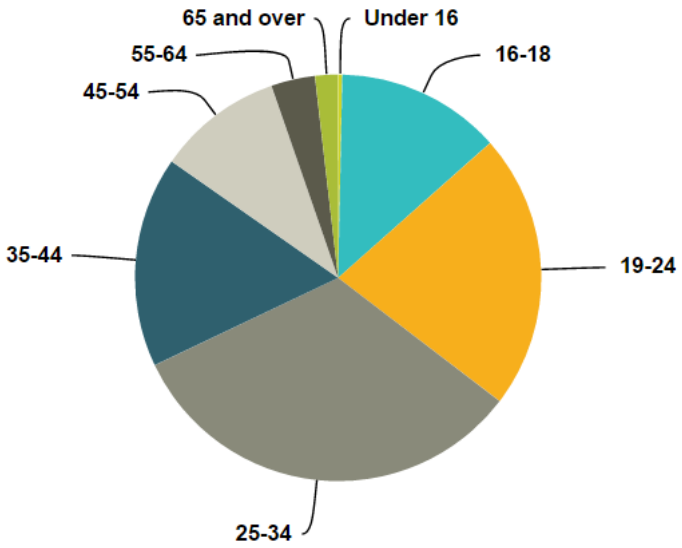
Services offered

"GPs busy - discrepancy in services offered"

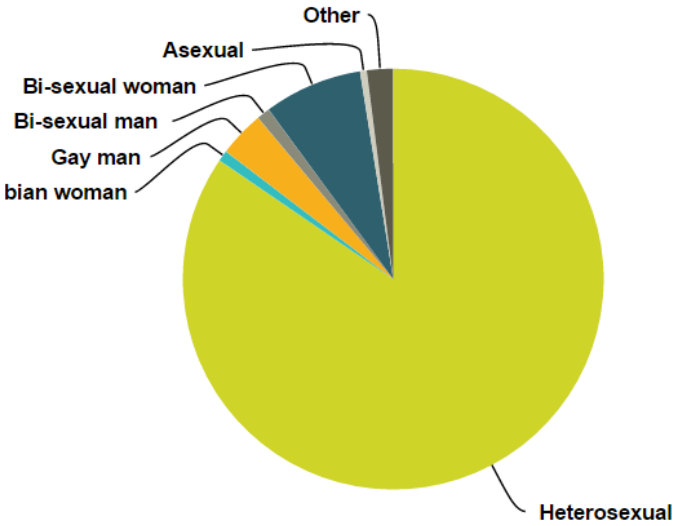
"Lack of resources in GPs"

Questionnaire Charts

Which age group do you belong to?
(180 skipped Q)



Sexuality (187 skipped Q)



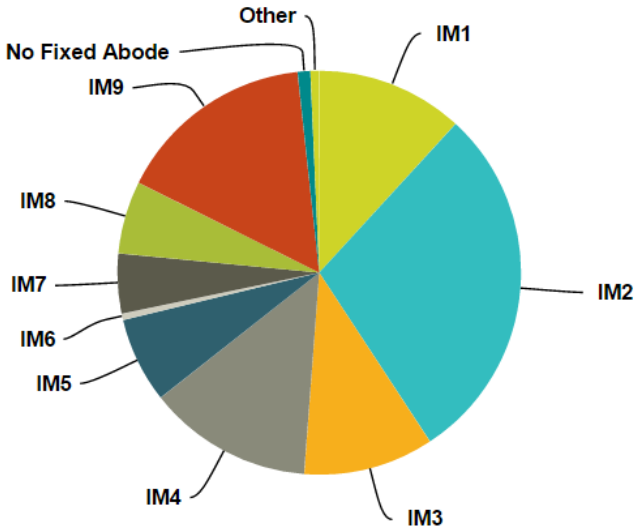
Other: Trisexual, Pansexual, MSM, Pegflowercasesexual

Gender status
(173 skipped Q)
76.35% Female
20.85% Male
1.48% Prefer not to say
0.66% Non-gender specific
0.66% Other: Gender reassigned, transgender, transsexual

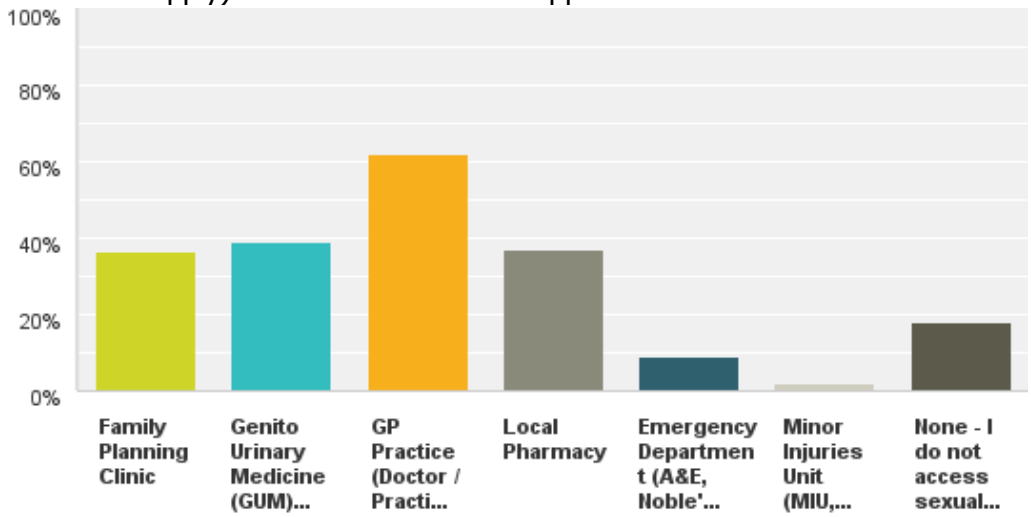
Employment status
(173 skipped Q)

Disability
(177 skipped Q)
47.76% Emotional / Mental Health
32.84% Physical
14.93% Learning
13.43% Other: epilepsy, Autistic, etc
11.94% Hearing impaired/deaf
4.48% Visually impaired/blind

Postcode (198 skipped Q)



Q2: Which of the following services do you / have you accessed for sexual health?
(please tick all that apply) Answered: 782 Skipped: 0

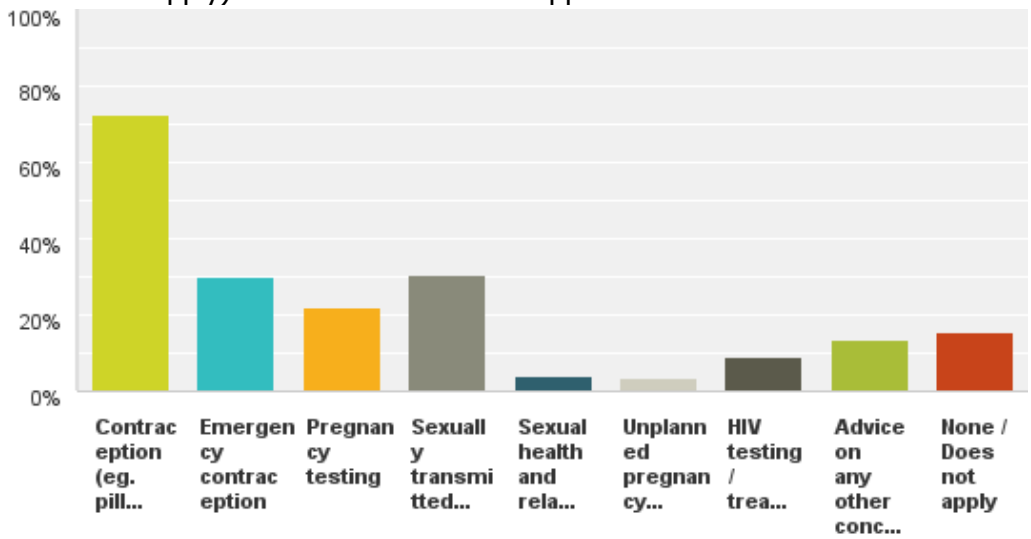


No-one skipped this Q

- Results fairly similar for IM1-4
- IM5 also similar with more attending ED
- IM6 shows very different results but this is only based on 3 responses
- IM7, 8 and NFA all showing lowest results for FPC
- IM7 and NFA showing lowest results for GUM
- Attendance at GPs and pharmacy fairly steady only lower for NFA – ignoring IM6

All categories highlight those who don't access any SHS – highest shown for NFA

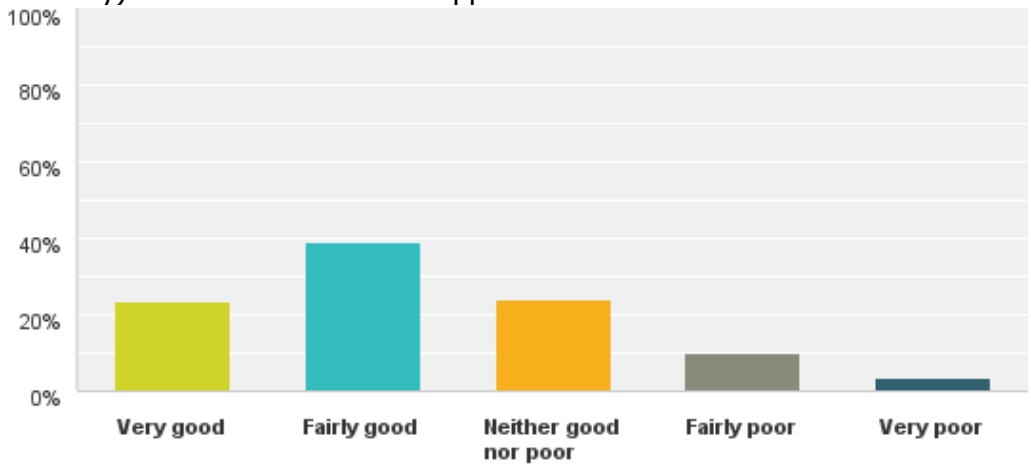
Q3: Which of the following sexual health services have you / do you use?
(please tick all that apply) Answered: 742 Skipped: 40



40 Skipped Q

- Contraception is predominant for all post codes
- Most categories are steady for all postcodes – again ignoring IM6
- Pregnancy testing and unplanned pregnancy advice is key for NFA

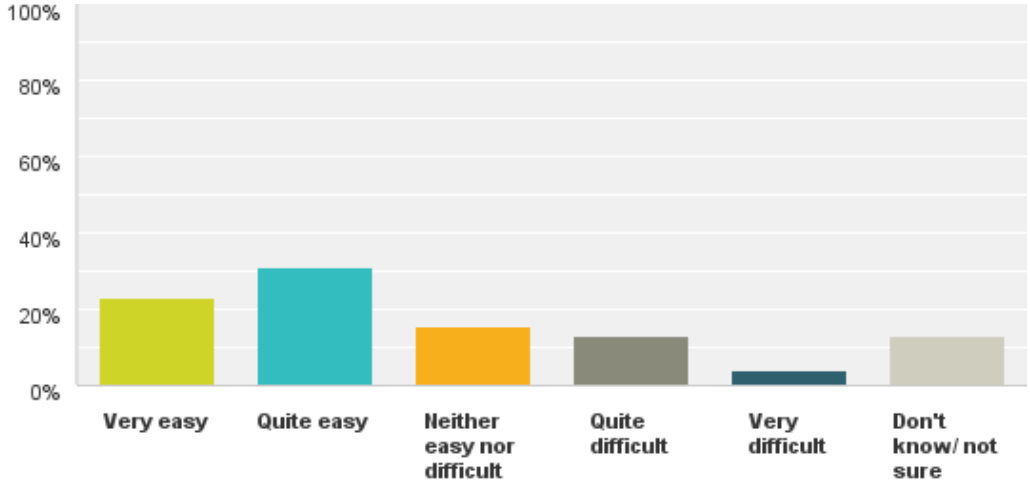
Q4: Overall, how would you describe sexual health services in the Isle of Man? (please tick one box only) Answered: 742 Skipped: 40



40 skipped Q

- NFA did not rate SHS as very good at all
- Fairly good most common response – fairly steady across the postcodes
- Neither good nor poor also fairly steady across the postcodes
- Not as many responses for fairly poor across the postcodes
- Very poor high for NFA
- 95 additional comments left – main themes include:
- Lack of information about services offered – *'There's a sexual health service?'*
- More needed for young people
- Lack of support for those with a disability – *'I feel there needs to be adaptations made to meet the needs of adults with learning disabilities'*
- Concerns regarding GP appointments – *'GP service is deteriorating on the IoM in terms of availability of appointments to access GP's and this is of significant concern in respect of sexual health'*

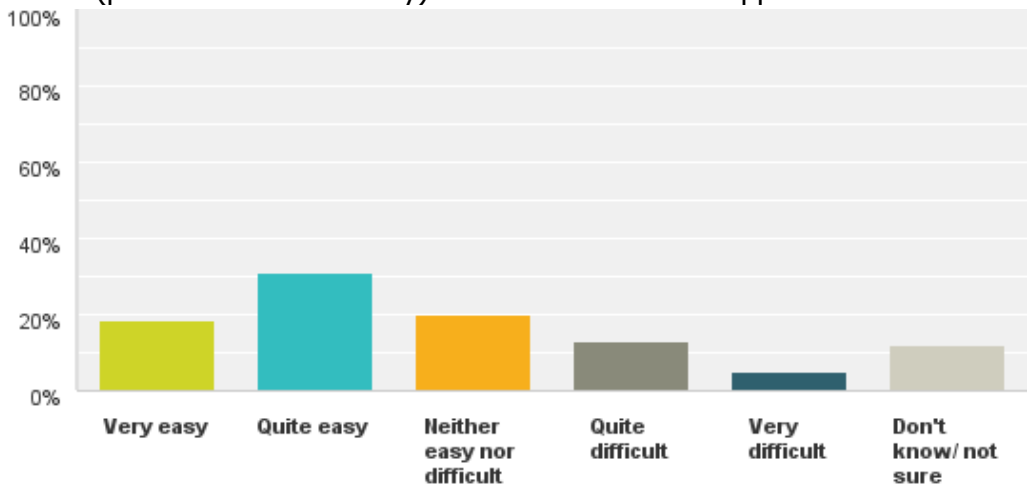
Q5: How easy or difficult is it to access sexual health services in the Isle of Man? (please tick one box only) Answered: 717 Skipped: 65



65 skipped Q

- IM6 shows very easy clearly – again this is based on 3 responses!
- Quite easy steady across the postcodes
- Others fluctuate across the postcodes
- All postcodes have a number of people who don't know / are not sure
- 81 comments left for this question - main themes include:
    - Services only in Douglas
    - Difficult if don't drive
    - Small island comments – stigma, confidentiality, anonymity
    - Limited opening times
    - Lack of drop-ins
    - Doctors appointments not available immediately
    - Easier to access when you know about SHS and how to access them

Q6: How easy or difficult is it to find information about sexual health services in the Isle of Man? (please tick one box only) Answered: 717 Skipped: 65

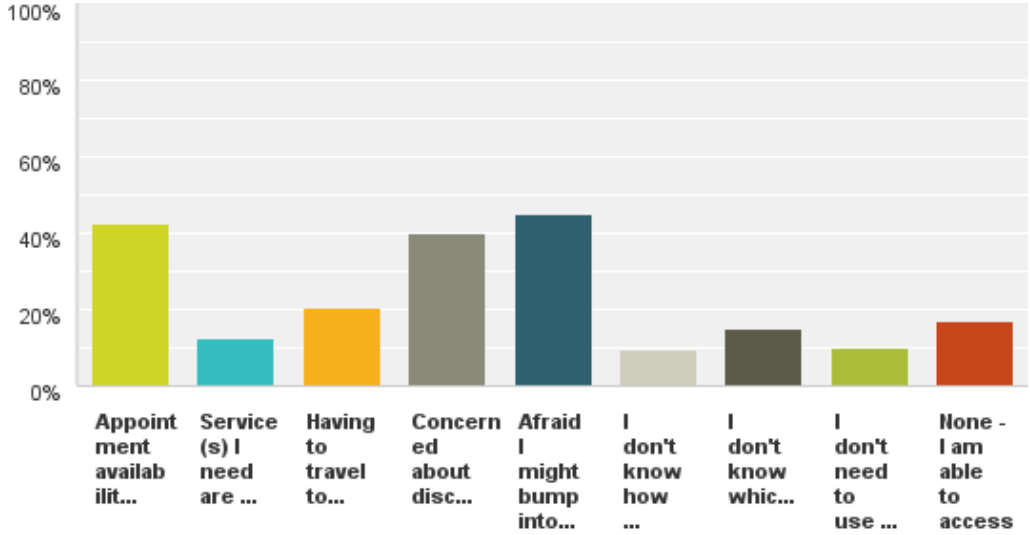


65 skipped Q

- All responses are fairly similar across the postcodes – ignoring IM6

- Again a number of responses for each postcode highlighting that they don't know / not sure

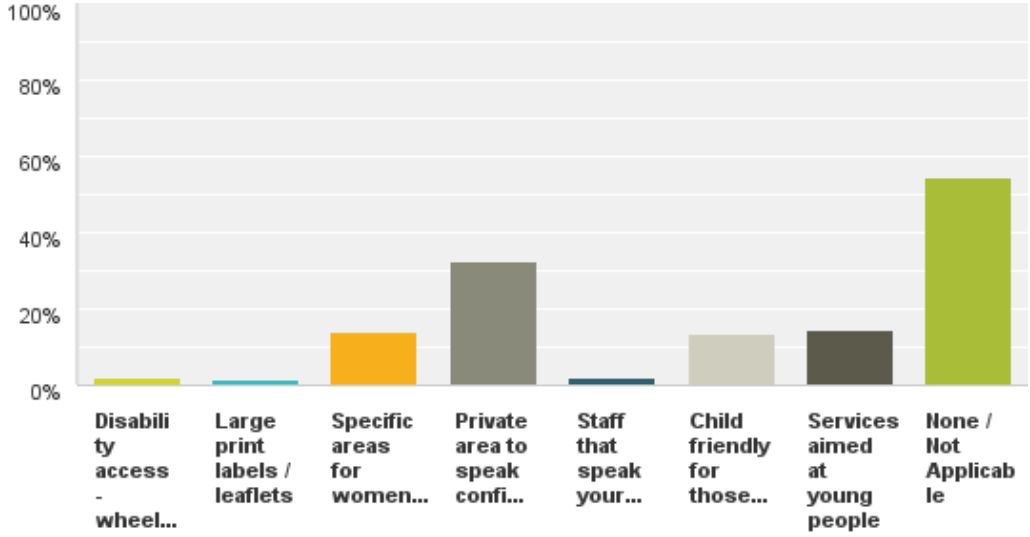
Q7: Are there any barriers to you accessing sexual health services in the Isle of Man? (please tick all that apply) Answered: 675 Skipped: 107



107 skipped Q

- Appointment availability / timely access and small island factors are the key barriers – all of which are steady across the postcodes
- A number of people highlight that they don't know how to access the services and that they don't know which services are offered for each of the postcodes

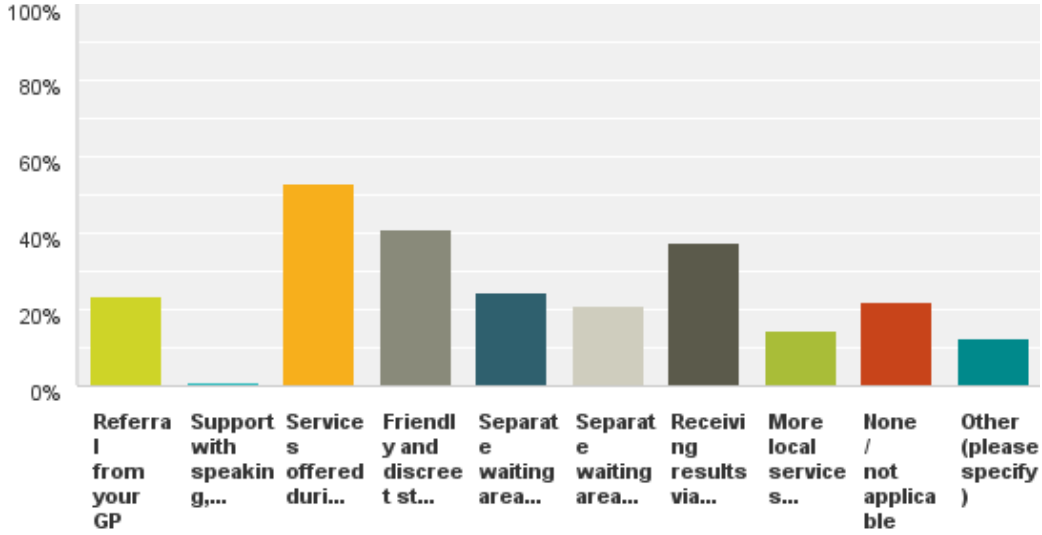
Q8: Please indicate if you have any of the following needs when accessing sexual health services (please tick all that apply) Answered: 675 Skipped: 107



107 skipped Q

- The main need highlighted is a private area to speak confidentially – steady across postcodes
- Having YP specific services, child friendly and specific areas for men and women were the other needs highlighted – also steady across the postcodes
- For NFA disability access, large print labels/leaflets and staff that speak your first language were also key areas with higher responses to postcodes

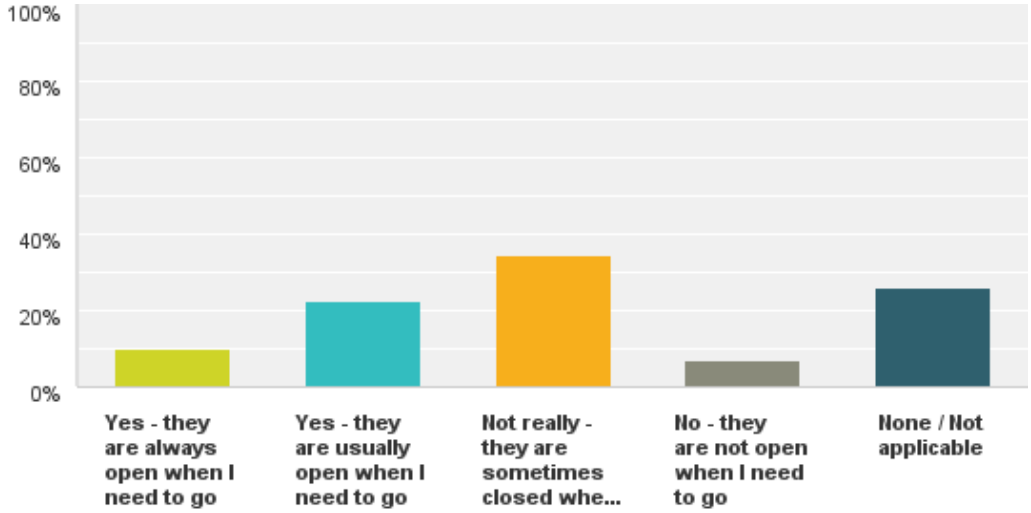
Q9: Would any of the following make the service more accessible to you? (please tick all that apply) Answered: 645 Skipped: 137



137 skipped Q

- Services offered during the evening and / or weekends was the most common response across most postcodes
- Followed by friendly and discreet staff at reception and receiving results via other methods – all steady across the postcodes
- Referral from your GP seems to be higher outside of Douglas
- Other – 80 respondents left comments – these need to be themed properly but general comments mainly around:
    - Services being offered island-wide
    - Flexible opening times
    - More drop-in clinics
    - Online booking system
    - Home testing kits
    - More information on services available – *one comment suggested 'More local pharmacies that offer emergency contraception'*
    - **Abortion – lots of comments!*

Q10: Are sexual health services in the Isle of Man available at times that suit you? (please tick one box only) Answered: 645 Skipped: 137



137 skipped Q

- Most common response is not really – they are sometimes closed when I need to go – steady across the postcodes
- For NFA it shows mixed results – Yes always open and No not open when need to go!
- Lots of comments – mainly about access to the services but also a high number of comments in regards to being unsure when the services can be accessed

Appendix 13

Sexual Health Survey Quotes

Integration

"It would be good to see some Co-ordination between services, working together"

"More joint working between GPs, Family Planning and GUM, additional training opportunities for Community Nursing staff interested in working in this area eg Health visitors / school Nurses"

"Having contraception and sexual health under one roof, and in more than one location"

"Working in partnership GUM and family planning - a one stop shop would be helpful"

"Poor integration with buses"

Access

"Difficult for those who cannot drive"

"Living out of Douglas and not driving makes it difficult to get to"

"Cinderella service in Douglas but not in the north"

"When I went to university getting an appointment is much easier than here and there are machines everywhere is you scan your student card you get a couple of free condoms, you can also go to any pharmacy and get a self test kit for some sti's . These things would make it much more convenient for young people as condoms expensive and a lot of young are embarrassed to go to a professional."

"Extended and varied operating hours"

"To make the services more widely available across the island"

"My nurse at the doctors used to do my implant but no longer does - was much better when I could go to my nurse and not have to wait weeks. There was no-one who could take out implant at my appointment so had to rearrange appointment at family clinic. Never had issues with my nurse before"

"Expand family planning / sexual health services throughout the island and of just for Douglas residents"

"GP service is deteriorating on the IoM in terms of availability of appointments to access GP's and this is of significant concern in respect of sexual health"

"Restricted times not conducive to people who work, multiple appointments needed to fit coil. Very frustrating service that needs to move with changing life patterns and be accessible to stop unwanted pregnancy."

"2-3 months to get an appointment for change of contraceptive implant. Very few GPs who offer this service so no alternative."

"More availability of services. Gps services are stretched to limits so more clinic should be available."

"Douglas centered fitted round needs of part time staff not clients. Pharmacists could be used more."

"They seem to be convenient to the staff rather than the public"

"No weekend or extra times around festivities. No early or late clinics."

"Limited opening times hard when juggling work and family"

"Clinics are only available at certain times and walk in clinics would be a good idea. I work with young people who often should be accessing these services and if we do manage to convince them to do so, by the time their appointment comes, they'll back out."

"Sometimes it just isn't worth the hassle to bother having sex as the contraception is too much of a pain to get sorted!"

"Unable to get appointment for such a long time I had to attend a UK clinic whilst on holiday for change of contraceptive implant"

Services

"Make more use of pharmacists"

"Allow pharmacists to prescribe contraceptives"

"WHERE is the psycho sexual counselling that should be provided??"

"Psycho sexual counselling is an absolute need yet the Isle of Man does not provide it or any provision to go across for it"

"Self-swab for basic issues such as chlamydia available within the community eg GP, pharmacy, college"

"It would be a lot better if you could request swabs in the post and mail them back to be tested"

"There should be sti tests via post like there is in the UK. This would help a lot of issues that living in a small community creates - embarrassment, shame, worry about seeing someone you know etc."

"After care needs improving. I suffered and still do mentally due to finding out my results. Just given tablets and sent on my way"

"Post-diagnostic support and treatment"

"Appointment schedules kept so no waiting"

"I do not have much knowledge of the services available on the IOM"

"A&E service was poor for administration of PEP"

"Clue in title sexual health. More counselling around illness, changes in body image, gender identity, relationship negotiation."

Stigma

"Let's take away the mystery and the shame and the stigma surrounding sexual health by normalizing it at a high school level and making everyone aware of the services on offer."

"It can be quite uncomfortable and embarrassing sitting in waiting rooms"

"To help break the stigma over sexual health and family planning... address it from high school age and make it an open place for all where you don't feel judged"

"As I've experienced going for the tests myself I found it a very scary situation and you are terrified about if you have anything and what people will think of you. If there was s possible way to try and avoid people feeling so ashamed that would be great."

"I think that more promotion of regular use of the gum clinic is needed. Young people should go regularly for checks, it should not be seen only as somewhere to go if you have a symptom or problem."

"Sexual health needs to be more publicly discussed and present in our society in order to break down barriers such as embraasment and false modesty"

"Going to the gum is what sexually responsible people do!"

"Having pharmacy staff trained to not make you feel irresponsible if you go for the morning after pill"

"I had some negative experiences with pharmacists when I sought the morning after pills on separate occasions where condoms failed. I was made to feel irresponsible and felt ashamed for taking action to prevent an unwanted pregnancy."

"Encourage public discussion - make it less of something to be ashamed of."

"Its like a walk of shame as everyone knows were you are heading then a good long wait in a full waiting room"

"I'm too scared to even go anywhere and get checked as I'm scared I'll get judged and I don't feel comfortable"

"Very embarrassing sat in a waiting room full of people and often running late, try to avoid going."

"Just having the maturity to know it doesn't matter if you see someone you know, it's better to be checked and ok than not"

"We all do it. We need to talk more openly about it!"

Anonymity

"Door in, door out system where there is no risk that you will meet anyone else!"

"Computerized check in so no need to be greeted by anyone or clear information on who you will see, where to go etc"

"No overlapping appointments"

"The nurses should call out your number in the waiting area - NOT YOUR NAME"

"They shouldn't be calling out names but should be giving you a number when you walk in and everyone can hear who is coming and going to reception"

"Shouting names out in waiting rooms rather than a number system is appalling"

"Private entrance to GUM at hospital"

"More difficult to access on a small island i.e. fear of seeing colleagues/ clients etc."

"Questionnaire to fill in but the form was attached to a clipboard that had numerous blank copies of the same form below it. As a result, when I was filling out my details they were transferred through to the sheet below"

Discretion

"More private areas for people who work with particularly vulnerable or challenging group so you don't walk in and sit by a service user or client"

"It needs to be made to feel as though it is not something to be ashamed of to look after your sexual health, whilst at the same time, the level of discretion ought to be paramount. Particularly important in such a small community."

"Admin staff ask too much personal information"

"I was initially concerned about confidentiality but the staff arranged for me to enter via the back door"

"I think it's really good that the G.U.M answers the phone with the number instead of announcing the department"

"I haven't had to use the services often, but every time the staff have been pleasant and professional. Please don't do anything to restrict people's access to discrete and confidential care for sexual health."

Education

"School children should be educated properly on contraception and sti's and should have easy access to FREE condoms"

"Better sex education. Teaching young people that it is a positive thing to get tested. Less fear of visiting sexual health clinics."

"Shocked that following sex ed at my daughters school that she didn't know any contraceptive methods except abstinence"

"There needs to be better education in schools about how individuals access the facilities for sexual health"

"Why were we not taught about more contraceptive methods at school? Or about non-heterosexual relationships?!"

Awareness

"There's a sexual health service?"

"If you know where to go"

"You have to know where to go and who to ask to find things"

"Accessing the service should be encouraged for everyone, especially young people, both as urgent care and as a regular sexual health MOT"

Inequalities

"More targeted support for specific groups. E.g. young people, MSM etc."

"I think that there needs to be a greater realisation that fertility for some women lasts longer than others and therefore a more open attitude that this group of women may continue to want/need contraception."

"Services aimed at older women.... more and more women are fertile for longer in their life and there is an "old fashioned" assumption that only young women need contraceptive advice."

"I feel there needs to be adaptations made to meet the needs of adults with learning disabilities"

"For a younger man, it is incredibly difficult with only 1 clinic in Douglas"

"Nothing for vulnerable groups homeless, learning or physical disability, communication or language problems"

"Staff need to be better educated and well-informed about less-mainstream sexual and relationship choices (like non-heteronormative sex, nontraditional relationships like polyamory). The odds are very high for a patient who isn't straight, married, and monogamous, to be shamed by staff for their choices and lifestyle."

Young people

"Go easier on young people. I'm in my 20s now but as a sexually active 16 year old I was spoken down to and made to feel guilty for having sex and even trying to check my sexual health. A judgment-free service is what's needed."

"Let's be serious; teenagers are starting to get curious and starting to experiment in high school, even if it's not with someone else and even if they don't go all the way"

Advertising

"More information readily available"

"As young adults aren't as informed as they could be about STIs I think it should be advertised more around the island about where to be tested"

"Invest in communication strategies and not leaflets…"

Advice

"No access for written information I/advice outside clinics"

Internet

"Online booking would be much easier and more subtle at work"

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This document can be provided in large print or in audio format on request

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