A Fieldwork Evaluation of NICE Guidance on Sexual Health Interventions

Penny A. Cook

Kevin Corbett

Jennifer Downing

Michele Crossley

Mark A. Bellis

Centre for Public Health
Castle House
North Street
Liverpool John Moores University
Liverpool L3 2AY
Tel: 0151 231
Fax: 0151 231 4515
Email: p.a.cook@ljmu.ac.uk

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GLOSSARY OF ACRONYMS

CPH	Centre for Public Health (Liverpool John Moores University)
CPHE	Centre for Public Health Excellence (National Institute for Health and Clinical Excellence)
DH	Department of Health
EC	Emergency contraception
GP	General Practice(s) and/or General Practitioner(s)
GUM	Genitourinary medicine
HIV	Human immunodeficiency virus
LARC	Long acting reversible contraception
LJMU	Liverpool John Moores University
NHS	National Health Service
NICE	National Institute for Health and Clinical Excellence
NWPHO	North West Public Health Observatory
PCT	Primary Care Trust
PN	Partner notification
SHA	Strategic Health Authority
STI	Sexually transmitted infection

EXECUTIVE SUMMARY

Introduction
On the request of the Department of Health, the National Institute of Health and Clinical Excellence (NICE) has developed draft guidance on sexual health interventions. The guidance consists of six recommendation based on an assessment of interventions aiming to reduce the transmission of Chlamydia and other sexually transmitted infections (STIs)(including HIV); and reduce the rate of under-18 conceptions, and promote screening, especially among vulnerable/at risk groups. The Centre for Public Health at Liverpool John Moores University was commissioned by NICE to undertake a Delphi-style questionnaire survey of specialist/generic sexual health professionals across the North West and the London Strategic Health Authorities. These health service commissioners and service personnel in the two regions were purposively selected for inclusion in this survey because these regions have some of the UK's most challenging public health problems. The survey identified views on the relevance/usefulness of NICE's sexual health intervention guidance.

Methodology
This survey developed and evaluated a novel rapid online Delphi-style (consensus) methodology for testing public health intervention guidance across two UK health regions. The Delphi technique is an established research method that aids identification and synthesis of views and opinions from a target population via cycles of surveying. In this particular survey only two rounds were undertaken. Respondents' contributions were kept confidential in both rounds. The target population was randomly drawn from the sectors and agencies involved in developing and delivering sexual health programmes. Samples were drawn from each region separately using specific role categories and for differing deprivation of the population served. The online questionnaire used 4-point Likert scales to identify participants' views on the effectiveness/utility of the guidance, current practice, professionals/settings used and referrals made. At round two participants viewed a summary of the previous participants' answers (i.e. the percentage strongly agreeing, agreeing, disagreeing and strongly disagreeing) together with a summary of all open comments. They then could revise their opinion or not.

First round frequency distributions were calculated to identify patterns of agreement (and disagreement) within the feedback. The percentage frequency distributions for each item generated were included to enable respondents to take majority/minority viewpoints into consideration whilst replying. Feedback received from the first round was synthesised into specific themes in order to create a manageable set of anonymous feedback for participants. Once first round results had been fed back to participants, data were analysed using backwards-stepwise logistic regression to predict agreement with the statements from the participants' characteristics. Characteristics were which region they were from (North West or London), whether or not they were in a role specific to sexual health and the deprivation level of the population they served. Results from the second round were summarised as frequencies of agreement with the recommendations, compared to the frequency in the first round, and summarised the number of people who changed their opinion. Because relatively few people changed their opinion, further statistical analysis was not carried out. Responses to the open response items in each round were analysed using a system of inductive thematic categorisation. This systematic process enabled categorisation/identification of the emerging themes and in-depth familiarisation of the research team with the breadth of the qualitative data. It further enabled integration of the qualitative and quantitative data to illustrate aspects of the findings and produce an integrated analysis.

Findings
*Recommendation one: '*High risk groups'

> "Health professionals in general practice, community health, voluntary sector and genito-urinary medicine (GUM) services should identify individuals at high risk of STIs, using the client's sexual history. They should provide or arrange sexual health counselling with an appropriately trained practitioner. Opportunities for risk assessment may arise during contraception, pregnancy testing and abortion consultations, when offering an STI test, during routine care and when a new patient registers. High risk groups include anyone with – or being tested for – an STI/HIV,

> men who have unsafe sex with men, substance misusers, sexually active young people and anyone with multiple sex partners." (NICE Sexual Health Guidance 2006)

Ninety seven percent thought this would help reduce rates of STIs, 91% found it relevant to practice, 88% said it would be useful in service delivery and 86% thought the wording was appropriate. More thought is required about how the recommendation can be made more relevant to service delivery. Greater definition is needed about the terms like 'counselling', 'high risk', 'provide' and 'appropriate trained practitioner'. A majority working in sexual health settings said they were already undertaking the recommendation, as did 72% in other settings. It was reported that education (for example in general practice), better integration of services, and not restricting the recommendation to health settings could facilitate the recommendation. Barriers hindering the recommendation were lack of resources (staffing/financial) and the criminalisation of STI transmission (silencing patient disclosure of risky behaviour due to possible legal implications/ramifications). Further consideration is needed of what themes to include within sexual history taking to effectively assess 'high risk'.

Recommendation two: 'High risk groups'

> "Health professionals trained in sexual health counselling – and who work in general practice, community health, voluntary sector or GUM services – should provide counselling for individuals at high risk of STIs. The counselling should comprise one to one structured sessions. The number of sessions will depend on individual need, but each should last 15-20 minutes." (NICE Sexual Health Guidance 2006)

Eighty three percent agreed that implementing this recommendation would improve sexual health. Although a majority, this was the lowest agreement of all the recommendations. Those delivering exclusively sexual health services were more likely to find the recommendation relevant, which may have consumer implications as regards user attitudes about signposting into the more appropriate NHS services to present to; although this may entail further workload implications and ramifications. The main problem seen with the recommendation is in the use of the term 'counselling' and the specification of the duration of counselling. It was seen to limit those who can 'do' counselling to specialists. Prescribing counselling time causes a decrease in the capacity of those clinics unless an integrated credible service exists (e.g. cognitive behavioural therapy); clients who want a rapid service are discouraged; and the wording excludes potentially capable health professionals losing an opportunity to influence possibly a much larger number of people at risk of poor sexual health. Scepticism also was reported with regard to whether counselling actually 'works'. Because of some of these perceived problems, a significant minority (23%) thought that the recommendation was worded inappropriately.

*Recommendation three: '*Partner notification'

> "Health professionals in general practice, community health, the voluntary sector and GUM should provide help to patients with an STI to get their partners tested and treated. This support should be tailored to meet the individual's needs. They should provide both the patient and their partners with disease-specific information, including advice about retesting. Health professionals may need to refer patients to a specialist with responsibility for helping to contact, test and treat partners of people with an STI (partner notification). The specialist may be a sexual health adviser, general practitioner (GP) or practice nurse providing enhanced sexual health services, Chlamydia screening coordinator or GUM clinician. Partner notification may be undertaken by the health professional or by the patient. It may include provision of a home sampling kit, prescription and/or medication for the partner." (NICE Sexual Health Guidance 2006)

A majority agreed that if health professionals provided help to patients with an STI to get their partners tested and treated, then this would have an impact on the rates of STIs. One in five participants from general backgrounds (double the percentage of those in specialist roles) thought this recommendation was not applicable to their service delivery. Most sexual health practitioners were reportedly already providing this service through several models. Difficulties associated with reduced patient anonymity were perceived, particularly for GPs. Factors enabling implementation of the recommendation were perceived as workforce competency and attitude training, treating STIs in community contraception clinics and providing GP time and funding for unregistered patients. One crucial concern is that criminalisation of STI transmission may fatally complicate the implementation

of this recommendation. Practitioners were more likely to state that they were currently providing information to the partners of those with STIs, and medication for partners was provided by 62% of all respondents. Strong concerns were expressed about home test kits, the provision of medication for a partner without knowledge of their medical history or without medical assessment in person and the specific legal footing of such practice, as well as the missed opportunity to screen for other STIs. Suggestions for re-wording of the recommendation included changing 'disease specific' to 'infection specific' and include 'family planning'.

*Recommendation four: '*Partner notification'

> "Primary care trust (PCT) commissioners should ensure that sexual health services are in place to meet local needs. Services should include arrangements for the notification, testing, and treatment and follow up of the partners of people who have an STI (partner notification). The responsibilities of both non-specialist (primary and community) and specialist (GP enhanced services, Chlamydia screening programme and GUM) sexual health services should be defined. Staff should be appropriately trained and there should be an audit and monitoring framework in place." (NICE Sexual Health Guidance 2006)

A majority thought that primary care trust commissioners should ensure that sexual health services actually meet local needs and 99% said that if services include arrangements for partner STI notification, testing, treatment and follow up this would help reduce STI rates. Issues stressed include adequacy of funding, more empowered commissioning with service level agreements and having incentives, training and monitoring for GP involvement (e.g. with HIV patients) and user guidelines and audit for partner notification, as well as a higher profile for asymptomatic community screening. Whilst the majority stated that arrangements for partner notification already informed current practice and met local needs, only 58% felt that this was suitably audited. While the recommendation states that individual responsibilities of both specialist/non-specialist services should be defined, only one third thought that this was true for GUM services, and a quarter similarly for Chlamydia screening services. Eleven percent thought that the role of non-specialist primary and community services was defined and only 10% felt this was true of specialist GP services. In terms of staff training, the vast majority of participants thought that staff had competencies fit for purpose and most felt this was audited. Some thought 'commissioned community contraception services' should be included under 'specialist sexual health services' yet others thought the latter were not specialist in STI testing, treatment and partner notification. Re-wording should reflect the logical sequence of testing, treatment, then notification and follow-up. A first round concern about combining STI testing in family planning clinics could put people off attending due to the stigma of STIs was argued down in the second round.

Recommendation five: 'Vulnerable young people'

> "GPs, nurses and other clinicians should, where appropriate, provide vulnerable young people aged 18 years and under with one to one sexual health advice. This should include a discussion – and the provision of information – about the prevention of STIs and contraception methods, including long-acting reversible contraception (LARC) (in line with NICE clinical guideline no. 30). It should also cover other reproductive issues and concerns. Young women should be advised how to get and use emergency contraception (EC). If necessary, they should be given advance EC. The consultation should take place in primary care, family planning, antenatal/postnatal services, GUM, drug and alcohol misuse and youth clinics, schools and outreach centres. Vulnerable young people may include those from disadvantaged backgrounds, those who are in – or leaving – care and those who have low educational attainment." (NICE Sexual Health Guidance 2006)

Most participants (97%) agreed that if health professionals were to provide vulnerable young people with one to one sexual health advice, including prevention of STIs and pregnancy, this would result in improved sexual health. The importance of early sex education was stressed. Respondents described successful models for providing this advice to vulnerable young people (multi-agency working, priority training and referral links). Most were already providing advice on contraception (including LARC and emergency contraception). For providing the latter, community contraceptive services with convenient opening hours (Saturdays/evenings) were seen as an effective and

efficient. Young people's services should be provided in general practice and less formal or traditional settings with several access points. 'Family planning' should be re-titled 'community contraception service'. Some felt that recommendation should be reworded replacing 'vulnerable' with 'all under 18 years', although widening the definition may make the recommendation unworkable. Targeting vulnerable young people through specific settings (e.g. youth offending schemes) was seen as feasible but the current wide definition made this unrealistic. The wording of the recommendation needs to provide detail on advising young people on the benefits of STI screening, and how and where to get tested.

Recommendation six: 'Vulnerable young people'

> "Midwives, health visitors and nurses who provide antenatal, postnatal and child development services should regularly visit vulnerable women, aged 18 or under, who are pregnant or who are already mothers. They should discuss – and provide information about – preventing sexually transmitted infections (STIs) and contraception methods (including long-acting reversible contraception (LARC) in line with NICE clinical guideline no. 30, and emergency contraception). They should provide health promotion advice (in line with NICE clinical guideline no. 37) and discuss the young women's opportunities for returning to education, training and employment. Where appropriate, they should refer them to the relevant agencies. Vulnerable young women may include those from disadvantaged backgrounds, those who are in – or leaving – care and those who have low educational attainment." (NICE Sexual Health Guidance 2006)

Most (98%) of participants agreed that home visits by midwives, nurses and health visitors that included discussion about STI prevention/contraception would help improve the sexual health of these vulnerable young people. Success of this recommendation was seen to require adequate social support and follow up for teenage mothers, effective care pathways, involvement of appropriately skilled midwives, health visitors and nurses, and use of multi-agency approaches (e.g. with Connexions, drug agencies etc.). Participants questioned the appropriateness of their providing advice about education/training and the relevance of advising young mothers to return to work. Many (85%) were already advising about LARC, EC and STIs but only 65% advised about returning to education, training or employment.

Research recommendations

> - What are the key characteristics of an effective one to one counselling session to reduce STIs in different high risk groups?
> - What is the relative effectiveness of one to one interventions delivered by different health professionals and in different settings?
> - What is the relative effectiveness of one to one interventions to reduce STIs and unintended teenage pregnancies compared to group interventions?
> - What is the most effective way of identifying high risk groups to target using one to one interventions?
> - In the UK, what are the most effective methods of contacting, testing and treating partners of patients who have an STI, particularly in groups whose partners may be hard to contact? (Examples of such groups include men who have sex with men or anybody who has multiple partners and/or frequently changes partners.)
> - What are the most effective ways of communicating information about sexual health and STIs to young people and the wider public? In particular, how can such information effectively address the stigma and discrimination surrounding sexual health and STIs?
> - What utility scores should be applied to individuals with STIs and women who conceive under 18 to generate QUALYs for use in cost-effectiveness analysis?" (NICE Sexual Health Guidance 2006)

Ninety seven percent of respondents said NICE's sexual health research priorities would help identify interventions to improve sexual health (by promoting positive behavioural change). Some thought the evidence already existed or that research funding is currently difficult. Other than a lack of resources, barriers to implementation were lack of organisational leadership/capacity and poor technical infrastructure. Profiling users' needs, being part of an academic unit, motivation/support, and being currently involved in research were identified as facilitating research. Those working in the most deprived areas were more likely to think that the recommendation would help them support

research. Additional suggestions for the research recommendation including identifying what would work to reduce repeat unintended pregnancies or terminations.

Conclusion and further considerations

This research consulted commissioners/practitioners delivering sexual health services at a local level that play a key role in improving sexual health, a majority of whom believed that the recommendations would improve sexual health and that many elements were already being carried out. The novel online, rapid Delphi-style consensus method was highly successful in gauging opinion from a variety of people who would not necessarily be available/willing to attend a conventional focus group. The rapid analysis/feedback of qualitative data (in addition to the percentage agreement statistics) was valued by respondents and increased their feelings of participation in the research process. This novel method should be considered for further use in assessing public health views. Several issues were identified by participants as requiring further consideration:

Recommendation one

- Themes constituting the most effective assessment of 'high risk' so these can be recommended as components of sexual history taking.

Recommendation two

- How the ability of health professionals *per se* (irrespective of specialist/generic sexual health role) to undertake appropriate sexual health advice-giving/counselling is perceived by clients/health consumers.
- Scepticism regarding the credibility of the evidence base by professionally informed respondents.
- Reference to counselling should be made *only* in its strictest sense (and therefore be out of the remit of most GPs/healthcare professionals), *or* should be less prescriptive about minimum session time; defining counselling more carefully, or (preferably) using less loaded terms, like for example 'advice giving'.

Recommendation three

- Increasing the positive perceptions of those working in less specialist sexual health roles about how the recommendation could be applied.
- Overcoming perceptions of the difficulty of partner notification in specific settings (e.g. in general practice) through provision of information on suitable models of service delivery.
- How criminalisation of STI transmission may fatally complicate recommendation implementation.
- Clarification of the current legal position of current/future practices in terms of treating partners, in relation to all of the Royal Colleges and with respect to the likelihood of litigation/prosecution and professional misconduct reporting.
- Re-wording the recommendation changing 'disease specific' to 'infection specific' and include 'family planning'.

Recommendation four

- Commissioning a variety of forms of GP incentives to undertake a range of sexual health work.
- Helping commissioners define in practical terms the responsibilities of specialist/non-specialist services.
- Perceptions of practitioners about the mutual/potential relationships between commissioned 'GUM' and 'family planning' and/or 'reproductive health' services.
- Re-wording the recommendation to reflect the logical sequence of testing, treatment, then notification and follow-up.

Recommendation five

- Adding more detail to the recommendation about STI interventions.
- Defining what a 'vulnerable young person' should mean.

Recommendation six

- Understanding the apparent mis-match between the evidence base in terms of the known benefits of returning to work and/or education and the actual perceptions of informed respondents.

Research recommendations

- Identification of what would ‘work’ to reduce repeat unintended pregnancies or terminations.

SECTION 1 – INTRODUCTION AND RATIONALE

On the request of the Department of Health, the National Institute of Health and Clinical Excellence (NICE) has developed guidance on the most effective ways that professionals both within and outside the NHS in England can improve sexual health (NICE 2006). Specifically the guidance focuses on one to one interventions to prevent STIs and under 18 conceptions, with the aims of:

- Reducing the transmission of Chlamydia (including screening) and other sexually transmitted infections (STIs) (including HIV);
- Reducing the rate of under-18 conceptions, especially among vulnerable/at risk groups.

Following the production of the draft guidance, NICE invited comments from stakeholders and commissioned fieldwork to test the effectiveness and utility of the guidance in the view of specialist and generic sexual health professionals. This study by the Centre for Public Health (CPH) at Liverpool John Moores University forms part of the fieldwork, as well as evaluating a novel rapid online Delphi-style (consensus) methodology.

Context

In 2004, the Department of Health produced its plan to improve the health of the population *Choosing health: making health choices easier*. In this key national policy document, sexual health was named as one of six key priorities. In 2005 DH published the action plan *Delivering choosing health* which set key targets around STIs, including rolling out Chlamydia screening and access to genitourinary medicine (GUM) clinics within 48 hours.

Since taking on the remit for examining public health evidence, NICE has updated the review of reviews carried out by the Health Development Agency on STI prevention (Ellis and Grey 2004) and HIV prevention (Ellis *et al.* 2003) to ensure that the most recent review-level evidence is available for planning services and improving the sexual health of the population (Downing *et al.* 2006a, 2006b). NICE has described the pathway to set one-to-one interventions in sexual health in the context of a broader sexual health strategy and policy (NICE 2006). NICE has also described the specific interventions included within the guidance concerned with STI prevention and partner notification (NICE 2006). The framework shows that one-to-one interventions operate within the broader context of national and local strategies and programmes relating to sexual health. The pathway and specific interventions are the context for the fieldwork research. The draft guidance presents the evidence that support the draft recommendations. This is also consistent with the recent review-level evidence that finds support for one-to-one counselling as an effective way of reducing risk behaviour and good evidence that partner notification reduces rates of STIs and HIV (Downing *et al*. 2006a, 2006b).

Local PCTs and local authorities working in partnerships are expected to develop and implement local strategies and programmes that respond to the distinct local sexual health needs of their communities, and also contribute to achieving national targets. The specific interventions in the guidance focus on STI prevention, partner notification and prevention of under-18 conceptions, and it is these aspects on which the fieldwork research focuses. One-to-one interventions contribute to sexual health promotion and also other components of sexual health programmes. Many factors influence the utility and effective implementation of the guidance, such as local leadership, resources and education/training. Health professionals working in the field are therefore ideally placed to comment on and help develop the guidance.

The recommendations

In October 2006, NICE released the Public health intervention draft guidance on 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 (Public Health Intervention Guidance no.3, NICE 2006). These are reproduced below, and these were the recommendations that formed the basis of the fieldwork reported here.

Recommendation one - high risk groups

Health professionals in general practice, community health, voluntary sector and genito-urinary medicine (GUM) services should identify individuals at high risk of STIs, using the client's sexual history. They should provide or arrange sexual health counselling with an appropriately trained practitioner. Opportunities for risk assessment may arise during contraception, pregnancy testing

and abortion consultations, when offering an STI test, during routine care and when a new patient registers. High risk groups include anyone with – or being tested for – an STI/HIV, men who have unsafe sex with men, substance misusers, sexually active young people and anyone with multiple sex partners.

Recommendation two – high risk groups
Health professionals trained in sexual health counselling – and who work in general practice, community health, voluntary sector or GUM services – should provide counselling for individuals at high risk of STIs. The counselling should comprise one to one structured sessions. The number of sessions will depend on individual need, but each should last 15-20 minutes.

Recommendation three – partner notification
Health professionals in general practice, community health, the voluntary sector and GUM should provide help to patients with an STI to get their partners tested and treated. This support should be tailored to meet the individual's needs. They should provide both the patient and their partners with disease-specific information, including advice about retesting. Health professionals may need to refer patients to a specialist with responsibility for helping to contact, test and treat partners of people with an STI (partner notification). The specialist may be a sexual health adviser, general practitioner (GP) or practice nurse providing enhanced sexual health services, Chlamydia screening coordinator or GUM clinician. Partner notification may be undertaken by the health professional or by the patient. It may include provision of a home sampling kit, prescription and/or medication for the partner.

Recommendation four – partner notification
Primary care trust (PCT) commissioners should ensure that sexual health services are in place to meet local needs. Services should include arrangements for the notification, testing, treatment and follow up of the partners of people who have an STI (partner notification). The responsibilities of both non-specialist (primary and community) and specialist (GP enhanced services, chlamydia screening programme and GUM) sexual health services should be defined. Staff should be appropriately trained and there should be an audit and monitoring framework in place.

Recommendation five – vulnerable young people
GPs, nurses and other clinicians should, where appropriate, provide vulnerable young people aged 18 years and under with one to one sexual health advice. This should include a discussion – and the provision of information – about the prevention of STIs and contraception methods, including long-acting reversible contraception (LARC) (in line with NICE clinical guideline no. 30). It should also cover other reproductive issues and concerns. Young women should be advised how to get and use emergency contraception (EC). If necessary, they should be given advance EC. The consultation should take place in primary care, family planning, antenatal/postnatal services, GUM, drug and alcohol misuse and youth clinics, schools and outreach centres. Vulnerable young people may include those from disadvantaged backgrounds, those who are in – or leaving – care and those who have low educational attainment.

Recommendation six – vulnerable young people
Midwives, health visitors and nurses who provide antenatal, postnatal and child development services should regularly visit vulnerable women, aged 18 or under, who are pregnant or who are already mothers. They should discuss – and provide information about – preventing sexually transmitted infections (STIs) and contraception methods (including long-acting reversible contraception (LARC) in line with NICE clinical guideline no. 30, and emergency contraception). They should provide health promotion advice (in line with NICE clinical guideline no. 37) and discuss the young women's opportunities for returning to education, training and employment. Where appropriate, they should refer them to the relevant agencies. Vulnerable young women may include those from disadvantaged backgrounds, those who are in – or leaving – care and those who have low educational attainment.

Research recommendations
NICE (2006a) also recommended that the following research questions be addressed:

1. What are the key characteristics of an effective one to one counselling session to reduce STIs in different high risk groups?

2. What is the relative effectiveness of one to one interventions delivered by different health professionals and in different settings?
3. What is the relative effectiveness of one to one interventions to reduce STIs and unintended teenage pregnancies compared to group interventions?
4. What is the most effective way of identifying high risk groups to target using one to one interventions?
5. In the UK, what are the most effective methods of contacting, testing and treating partners of patients who have an STI, particularly in groups whose partners may be hard to contact? (Examples of such groups include men who have sex with men or anybody who has multiple partners and/or frequently changes partners.)
6. What are the most effective ways of communicating information about sexual health and STIs to young people and the wider public? In particular, how can such information effectively address the stigma and discrimination surrounding sexual health and STIs?
7. What utility scores should be applied to individuals with STIs and women who conceive under 18 to generate QUALYs for use in cost-effectiveness analysis?

SECTION 2 – AIMS AND OBJECTIVES

The study aims to answer the following research questions:

i) What are the views of practitioners on the relevance and usefulness of the intervention guidance to their current practice?
ii) What factors could either help or hinder the effective implementation and delivery of the intervention guidance as part of current practice?

The aim was to identify effectiveness/utility of the draft sexual health intervention guidance among local commissioners and services who are responsible for the strategic and operational service delivery on the ground. An additional aim was to develop and evaluate a rapid Delphi-style (consensus) methodology for use in testing public health intervention guidance.

SECTION 3 – DESIGN AND METHODS

The local commissioners and services in two regions, the North West and London, were selected for inclusion in a Delphi-style questionnaire survey. The two regions were chosen as being those within which there are some of the UK's most challenging public health problems. London suffers under a disproportionate burden of STIs (21% of the total volume of STIs) and HIV (over 50% of cases: Health Protection Agency 2005a) and while the North West has 13% of the total volume of STIs (Health Protection Agency 2005a) and seen particularly rapid rises in HIV (an 82% increase between 2001 and 2004, compared to London's 37% increase: Health Protection Agency 2005b). A significant proportion of the North West's HIV positive population are asylum seekers or other migrants (Cook *et al.* 2006). On a variety of measures, the North West is repeatedly shown to display significant inequalities in wealth and health (Wood *et al.* 2006), and those with HIV living in the most deprived areas have been shown to have poorer health (Cook *et al.* 2004). London and the North West have also experienced large rises in syphilis (Health Protection Agency 2005a, Cook *et al.* 2001, Bellis *et al*. 2002). Both regions have a higher than average rate of conceptions in those aged under 18 years, but while the North West has seem some success at reducing the rate (by 10% since 1998), London has seen only a 0.5% reduction since 1998. The two regions are comparable in terms of population size, with London's population standing at 7.3million and North West's at 6.8 million.

Given the heterogeneous nature of the sample (see below) a non-experimental design was needed to identify and synthesize a potentially disparate range of opinions and viewpoints across commissioners and service-based practitioners. The Delphi technique is an economic, valid and well-established research method that aids identification and synthesis of disparate views and/or opinions from any target population via cycles of surveying. North American proponents of this method have described the Delphi technique as "a method for structuring a group communication process so that the process is effective in allowing a group of individuals, as a whole, to deal with a complex problem" (Linstone & Turoff 1975, p3). In addition the Delphi technique (Linstone & Turoff 1975) has become an effective and highly efficient health research method (de Meyrick 2003) that has been used for enabling the generation and validation of new public health knowledge across a range of disparate opinions and/or viewpoints (e.g. Magid *et al.* 1996, Tideman *et al.* 2006, Wang *et al*. 2005, Watson 2004). However, this method has only had limited use in the assessment of practitioner views on the effectiveness of sexual health interventions (e.g. Chambers *et al.* 2002). The advantages of the Delphi technique are summarised in Box 1.

Box 1 – advantages of the Delphi technique

- Surveying commissioner and service practitioner 'experts' (respondents) to obtain data on relevance/utility of guidance for target population (and latter's perception of effectiveness/utility for patients/clients);
- Respondents do not need to meet in face-to-face discussion;
- Use of sequential structured questionnaires;
- Systematic emergence of a concurrence of a judgment/opinion;
- The guarantee of anonymity of respondents' responses;
- The use of frequency distributions to identify patterns of agreement/disagreement;
- The use of rounds, between which a summary of the responses of the previous round are anonymously communicated to, an evaluated by, all respondents;
- This report develops new knowledge on, and national research capacity for, using the Delphi method to research views/opinions of commissioners/practitioners about effectiveness and utility of evidence-based sexual health interventions.

Ethical considerations

Respondents of the Delphi survey were informed that their contributions are confidential, and assured that study researchers will not reveal or deliberately expose the organisational location and/or personal/professional identities of any respondents. They were also informed that responses were to be synthesised into anonymous feedback and then shared with all respondents. After initial contact with a participant, an email gave information on the function of the study, its aims and objectives, as well as the contact details of the Principal Investigator and the research team. This information was repeated on the first page of the online questionnaire. Participants were also informed that they could withdraw from the study at any point. Study participants had to

acknowledge that they had read the participant information section before they could move on to fill out the questionnaire. They were reminded at the beginning of the subsequent round that their responses would be summarised and presented anonymously in a final report to NICE.

Sampling
The target population was drawn from the sectors and agencies involved in developing sexual health programmes and their delivery. The implementation and delivery of the one-to-one interventions within at least three specific settings (below) provided the research focus for the fieldwork, and enabled engagement with commissioners and practitioners:

- School and youth settings e.g. young people's clinics; computer-based information & interaction e.g. text-messaging.
- Community outreach work with particular groups e.g. homeless people, travellers and commercial sex workers.
- Clinical settings e.g. primary care (GPs, walk-in); contraceptive services; hospitals.

Sampling was undertaken across the health, education, social services; and independent, voluntary and community sectors. The following role categories were defined:

- PCT commissioners, NHS Trust managers, local authority managers, teachers;
- Clinicians and nurses concerned with STIs, HIV, GUM, as well as relevant midwives;
- GPs, practice nurses and community nurses, health promoters and community/voluntary workers including those working with particular vulnerable groups such as homeless people, or drugs and alcohol services, youth offenders and people on probation.

The above role categories and the local range of NHS and other organizations were used to develop a stratified sampling frame from which local authority areas and roles were selected at random. This helped to reduce bias and ensure validity of the findings. Professional groups, commissioners groups, teenage pregnancy leads and sexual health leads were approached to help identify participants. None of the participants approached stated that they had no access to e-mail and internet, therefore no questionnaires were posted out. The organisational location of potential respondents was checked and electronic-mail (e-mail) access verified. Information e-mails about the study invited participation in the study. Respondents had five working days to complete each round of the questionnaire. Technical assistance was available for those experiencing problems. (These were uncommon and usually due to local settings and firewalls affecting user access to the website.) Reminder emails were sent the day before closure, and on the day of closure non-respondents were contacted by telephone. In total, 110 out of the 118 people who agreed to take part completed at least the first recommendation, with 94 completing all seven sections in the first round. In the second round, 105 of the 110 who had started the first round completed the survey for the second time, with all of the 94 who finished the first round also completing the second round. Reasons for not completing the second round included technical problems with accessing the site, being on annual leave during the short period of time the questionnaire was available and time constraints.

Table 3.1 gives the number of participants, stratified by region, deprivation level of the population served and role. Although we recruited individuals to fulfil particular roles, many professionals had either current or previous experience of several roles. Not all the participants classified their role on the questionnaire as the one we had used as the basis for recruiting them. In these cases, we have allocated them to the category in which we originally recruited them, having confirmed that they did indeed have the relevant experience. However, throughout the analysis it must be recognised that many of the professionals taking part answered questions from the perspective of their breadth of different experience and knowledge of their local services. We also stratified recruitment by the deprivation level of the populations served, in order to get a balanced view from those working with the most disadvantaged communities, as well as those in potentially less challenging areas. However, seven of our participants, although recruited to cover a particular deprivation category, revealed that they in fact covered more than one area. Such individuals were therefore classified as 'multiple' on table 3.1.

Data collection
For the Delphi survey, data were collected through an online questionnaire that accumulated the data in a database for analysis (Appendix 1). The questionnaire was developed to capture

respondents' views and/or opinions on the effectiveness and utility of the guidance to reduce the transmission of STIs (including HIV) and the rate of under-18 conceptions, especially among vulnerable and at risk groups. The questionnaire first captured details on the respondents to confirm their role, the setting they worked in and the geographical area they covered. Then, each recommendation was reproduced, and a series of closed item questions used a 4-point Likert scale for rating the effectiveness and the utility of the recommendations. The use of a 4-point scale encouraged respondents to take an opinion one way or another, without a middle ground option. For each recommendation, closed questions sought an opinion on whether the recommendation would work, whether it was relevant to practice, whether it would be useful in delivering services, and whether the recommendation was worded appropriately. Further closed questions elicited information on current practice: whether the recommendation was currently being carried out, which professionals and settings were used, and what referrals were made. All the closed questions were mandatory, and the internet-based form would not allow respondents to proceed unless all fields had been completed. Respondents had opportunity to complete further open questions seeking the reason for agreement or disagreement with the recommendations, more details on how they were currently carrying out the recommendations and how it had been achieved, and also provided an opportunity to identify barriers and facilitating factors that would allow the recommendations to be put in place. Respondents were also asked to give comments on the wording of the questionnaire. Appendix 2 gives an example of one page of the questionnaire to illustrate the layout and design. The questionnaire was subject to review by experts in research methods and local practitioners for face validity.

There were two rounds undertaken for this Delphi survey. Round one proceeded as above. In round two, the website and questionnaire were modified to reflect the results of round one (see Appendix 3 for an example of the second round layout). Each recommendation had four questions repeated in round two: whether the recommendation would work, whether it was relevant to practice, whether it would be useful in delivering services, and whether the recommendation was worded appropriately. Participants viewed a summary of the previous participants' answers (i.e. the percentage strongly agreeing, agreeing, disagreeing and strongly disagreeing) and could also view their own previous answers. They then had the option to revise their opinion. It is not always clear in the literature whether previous studies allow the participants to view their original answers, or whether they relied on participants keeping notes, or on their recall of their answers. One of the advantages of the electronic online database was that respondents knew exactly what their first round responses had been, could put this in relation to the anonymised group response, and use both to reconsider their opinion. This would have been more difficult to accomplish with a paper-based survey (since each participant would have needed a unique feedback sheet). Use of the online technology was therefore used to enhance the validity of the method.

Data processing and quantitative analysis

Data collected by the online structured questionnaire were retrieved electronically. This was a major advantage over a paper-based system as it allowed us to rapidly analyse and feedback first round results. For the first round feedback, frequency distributions were calculated to identify patterns of agreement (and disagreement). The percentage frequency distributions for each item were included to enable respondents to take majority/minority viewpoints into consideration whilst replying. Qualitative feedback was synthesised into specific themes in order to create a manageable set of anonymous feedback for participants.

Once first round results had been fed back to participants, data were analysed using backwards stepwise logistic regression to predict agreement with the statements (will the recommendation help improve sexual health? Is the recommendation relevant? Is the recommendation useful?) from the participants' characteristics. Characteristics were which region they were from (North West or London), whether or not they were in a role specific to sexual health (e.g. GUM nurse) or more general (e.g. school nurse) and the deprivation level of the population they served (deprived, average or affluent). Those serving more than one area with different deprivation categories were omitted from this analysis.

Results from the second round were summarised as frequencies of agreement with the recommendations, compared the frequency in the first round, and summarised the number of people who changed their opinion. Because relatively few people changed their opinion, further statistical analysis was not carried out.

Table 3.1 Number of participants in each role, region and deprivation category

	London				North West				Entire sample				
Role	**Affluent**	**Average**	**Deprived**	**Multiple**	**Affluent**	**Average**	**Deprived**	**Multiple**	**Affluent**	**Average**	**Deprived**	**Multiple**	**Total**
Family planning physician	2	2	1		1	1	4		3	3	5		**11**
Family planning nurse	2	1	2		1		3	2	3	1	5	2	**11**
GUM physician	1	2	4			1	1	1	1	3	5	1	**10**
GUM nurse		3	2		1	1			1	4	2		**7**
GUM health advisor	1	1	2		1	2	2		2	3	4		**9**
GP[1]			1		1	1	1		1	1	2		**4**
Practice nurse[1]	2				1				3				**3**
Health visitor	1				1	1			2	1			**3**
Midwife			1		2	1	2		2	1	3		**6**
Walk-in centre staff	1	2	1				1		1	2	2		**5**
Youth offending service[1]	1								1				**1**
Services for vulnerable groups[2]	2		1			1	1		2	1	2		**5**
Drugs and alcohol worker		1	2			1				2	2		**4**
Teenage pregnancy lead[3]						2				2			**2**
Young people's sexual health services		1	1			1	2			2	3		**5**
School nursing	3	1			1		1	1	4	1	1	1	**7**
Compulsory education services[1]							1				1		**1**
Chlamydia screening coordinator[3]						1	1			1	1		**2**
Manager, sexual health services[3]			2	1	1			1	1		2	2	**5**
Commissioner	1	1	2		1	1	2		2	2	4		**8**
Other												1	**1**
Total(4)	**17**	**15**	**22**	**1**	**12**	**15**	**22**	**5**	**29**	**30**	**44**	**7**	**110**

1 recruitment low despite intensive effort to contact suitable participants
2 homeless people, commercial sex workers, travellers
3 role not specifically recruited
4 includes one person with a national role

Qualitative analysis

All responses to the open response items in each round were analysed using a system of inductive thematic categorisation similar to the detailed qualitative analytic processes described by Glaser and Strauss (1967), reported by Burnard (1991) and pragmatically adapted by Corbett and Bent (2005). This qualitative analysis involved six stages. Firstly, a qualitative researcher read all open item responses thoroughly and made notes about the general thematic within the responses. An example of these notes include:

- ”An important category seems to be service configuration”
- “A major theme emerging is adequate funding”

This enabled the researcher to become immersed in the ‘frame of reference’ (Rogers 1951) of the respondent. Validity at this stage was further enhanced by the NHS experience and academic/professional training of the researcher (KC) brought to bear during this initial reading of the data. All open items were read through again. Particular headings or categories were noted in order to reflect the particular focus in the content of the responses and to exclude any ‘unusable fillers’ (Field and Morse 1985), that is, issues unrelated to the topic of focus. These headings/categories, or ‘open codes’ (after Berg 1989), reflected almost all of the thematic content of the data. This allowed all open item responses to be allocated to a particular category/heading within a table of categories for each open response item. An example of this coding is given in table 3.2.

Table 3.2 Example of coding of open item responses

Open item responses	Open coding
“*Recruitment of staff. Concerns about contraceptive services becoming a GUM outreach service with less time for contraceptive advice and shift to a much younger clientele”*	‘Recruitment’
“Lack of time and training in non GU settings”	‘Resources’
“Time, we have a high ethnic and cultural mix. Language may be a barrier.”	
“Lack of awareness of correct referral for patient. Time. Leaving individuals to do their referral themselves”	

Next, the list of categories for each open response item was surveyed by the researcher and grouped together under higher order categories. The aim was to collapse the number of categories as much as possible into a broader set of categories. For example, the following categories were collapsed into ‘sexual history-taking’:

- Sexual history-taking focusing on lifestyle
- Sexual history-taking focusing on STI rates
- Sexual history-taking focusing on partner change

The new list of categories with sub-themes was read through and repetitious and/or similar categories were merged in order to produce a more concise set of categories. Four other experienced researchers repeated the above processes in each stage, checking and challenging the first researchers’ steps/outputs with the aim of enhancing the validity of the categorization process and minimizing any of the initial researcher’s biases. Given the time frame for the study it was not possible to undertake a validity check on the emerging categories with each of the study’s respondents. Finally, each set of categories per open response item were then re-read by the initial researcher in relation to all of the responses received in order to that the categories reflected the thematic content of the responses. When qualitative data is used in the results section to illustrate emergent themes within our integrated analysis, the particular source articulating this data is cited in

terms of their role category e.g. GUM physician, nurse etc., together with the particular round from which the data was volunteered by that participant e.g. first round or second round.

In conclusion, thematic categories were developed from the open responses by the research team via an inductive process of repetitive reading of these open responses. This systematic process enabled categorisation/identification of the emerging themes and in-depth familiarisation of the research team with the breadth of the qualitative data. It further enabled integration of the qualitative and quantitative data to illustrate aspects of the findings and produce an integrated analysis.

SECTION 4 – RESULTS

Round one

Recommendation one

The vast majority (95%) of respondents agreed that recommendation one, the identification of high risk groups and provision of sexual health counselling, would help to reduce STIs (table 4.1). This was reflected in the qualitative comments, which were overwhelmingly positive. For example:

> "This will enable services to be a one-stop shop. Patient satisfaction [will be increased] due to saving time accessing only one service. High standards of care [will result from] from specially trained staff, which would lead to job satisfaction, and high staff moral. All the issues raised affect a person's sexual health. Addressing one aspect leads to another" (GUM nurse, round one).

The above was seen to be the case because the recommendation was seen to help:

> "..identify people with asymptomatic infections, will go towards normalising talking about sex in other settings, provides opportunity for health education" (GUM nurse, round one).

> "..looking at appropriate referral pathways for those who may require more input around risk" (GUM nurse, round one).

There were no statistically significant differences in agreement that the recommendation would help reduce STI rates between participants from London compared to the North West, between professionals who were primarily involved in sexual health compared to those in general services or depending on whether participants covered deprived, average or affluent populations (backwards logistic regression to predict agreement from region, speciality and deprivation, $P>0.05$). While 8% of sexual health specialists rated the relevance of the recommendation as not applicable to their practice, only 3% of generalists did so (table 4.2). Overall 87% agreed that the recommendation was relevant to practice (table 4.2) and the same proportion thought it useful for delivering their service (table 4.3), however agreement was less strong for usefulness in delivery than relevance to practice (65% vs 76% strongly agreeing). There were no statistically significant differences in agreement as to the usefulness or relevance of the recommendation between participants from London compared to the North West, between professionals who were primarily involved in sexual health compared to those in general services or depending on whether participants covered deprived, average or affluent populations (backwards logistic regression to predict agreement from region, speciality and deprivation, $P>0.05$).

Of the professionals for whom the recommendation was applicable, 94% of sexual health professionals and 72% of general healthcare professionals felt they were already delivering the recommendation (table 4.4). This was reflected in some of the qualitative comments, for example:

> "I feel this statement has been known and promoted since the National Strategy for Sexual Health and HIV, 2001. It is not a new concept and happens in the sexual health services in this area. It is currently being promoted in Primary Care Services as part of developing Level 1 / Level 2 services in sexual health in the community" (Chlamydia screening programme coordinator, round one).

Nearly three quarters (73%) of those not working in a GUM setting made referrals to GUM for counselling (table 4.5) and for GUM-type services not locally provided, like full STI screens, for example:

> "I would like our service to offer a full STI screen. Currently we do not offer Syphilis and Hepatitis B and C tests due to cost issues. I feel if we could offer these test in one visit we could feel more certain that clients have had a full screen. We currently refer client to GUM for these tests, but not all clients attend GUM." (Lead nurse, sexual health and reproductive services, round one).

Table 4.1. Opinions on whether the recommendations would improve sexual health (number and percentage), by role and region

	Region	Role	Strongly agree	Slightly agree	Slightly disagree	Strongly disagree	Total
Rec 1	London	General	14 (82.4)	1 (5.9)	1 (5.9)	1 (5.9)	17
		SH	27 (71.1)	11 (28.9)			38
	North West	General	13 (68.4)	6 (31.6)			19
		SH	21 (60)	10 (28.6)	4 (11.4)		35
	All	General	27 (75)	7 (19.4)	1 (2.8)	1 (2.8)	36
		SH	49 (66.2)	21 (28.4)	4 (5.4)		74
Total			76 (69.1)	28 (25.5)	5 (4.5)	1 (0.9)	110
Rec 2	London	General	8 (53.3)	5 (33.3)	2 (13.3)		15
		SH	14 (37.8)	14 (37.8)	7 (18.9)	2 (5.4)	37
	North West	General	12 (70.6)	4 (23.5)	1 (5.9)		17
		SH	14 (42.4)	13 (39.4)	5 (15.2)	1 (3)	33
	All	General	20 (62.5)	9 (28.1)	3 (9.4)		32
		SH	29 (40.8)	27 (38)	12 (16.9)	3 (4.2)	71
Total			49 (47.6)	36 (35)	15 (14.6)	3 (2.9)	103
Rec 3	London	General	14 (93.3)	1 (6.7)			15
		SH	27 (77.1)	7 (20)	1 (2.9)		35
	North West	General	12 (70.6)	5 (29.4)			17
		SH	19 (59.4)	12 (37.5)	1 (3.1)		32
	All	General	26 (81.3)	6 (18.8)			32
		SH	47 (69.1)	19 (27.9)	2 (2.9)		68
Total			73 (73)	25 (25)	2 (2)		100
Rec 4	London	General	15 (100)				15
		SH	29 (82.9)	5 (14.3)		1 (2.9)	35
	North West	General	16 (94.1)	1 (5.9)			17
		SH	26 (83.9)	5 (16.1)			31
	All	General	31 (96.9)	1 (3.1)			32
		SH	56 (83.6)	10 (14.9)		1 (1.5)	67
Total			87 (87.9)	11 (11.1)		1 (1)	99
Rec 5	London	General	13 (86.7)	1 (6.7)	1 (6.7)		15
		SH	26 (74.3)	9 (25.7)			35
	North West	General	15 (88.2)	2 (11.8)			17
		SH	27 (87.1)	3 (9.7)	1 (3.2)		31
	All	General	28 (87.5)	3 (9.4)	1 (3.1)		32
		SH	53 (79.1)	12 (17.9)	2 (3)		67
Total			81 (81.8)	15 (15.2)	3 (3)		99
Rec 6	London	General	13 (86.7)	2 (13.3)			15
		SH	27 (81.8)	6 (18.2)			33
	North West	General	15 (88.2)	2 (11.8)			17
		SH	21 (70)	7 (23.3)	2 (6.7)		30
	All	General	28 (87.5)	4 (12.5)			32
		SH	48 (75)	14 (21.9)	2 (3.1)		64
Total			76 (79.2)	18 (18.8)	2 (2.1)		96
Rec 7	London	General	15 (100)				15
		SH	23 (69.7)	8 (24.2)	1 (3)	1 (3)	33
	North West	General	14 (82.4)	3 (17.6)			17
		SH	16 (55.2)	12 (41.4)	1 (3.4)		29
	All	General	29 (90.6)	3 (9.4)			32
		SH	39 (62.9)	20 (32.3)	2 (3.2)	1 (1.6)	62
Total			68 (72.3)	23 (24.5)	2 (2.1)	1 (1.1)	94

Table 4.2 Opinions on whether the recommendations are relevant to practice (number and percentage), by role and region

	Region	Role	Strongly agree	Slightly agree	Slightly disagree	Strongly disagree	Not applicable	Total
Rec 1	London	General	13 (76.5)	2 (11.8)		2 (11.8)		17
		SH	30 (78.9)	4 (10.5)		1 (2.6)	3 (7.9)	38
	North West	General	14 (73.7)	4 (21.1)			1 (5.3)	19
		SH	26 (74.3)	2 (5.7)	2 (5.7)	2 (5.7)	3 (8.6)	35
	All	General	27 (75)	6 (16.7)		2 (5.6)	1 (2.8)	36
		SH	56 (75.7)	7 (9.5)	2 (2.7)	3 (4.1)	6 (8.1)	74
Total	Total		83 (75.5)	13 (11.8)	2 (1.8)	5 (4.5)	7 (6.4)	110
Rec 2	London	General	5 (33.3)	3 (20)	4 (26.7)		3 (20)	15
		SH	23 (62.2)	10 (27)	1 (2.7)	1 (2.7)	2 (5.4)	37
	North West	General	9 (52.9)	3 (17.6)	1 (5.9)	1 (5.9)	3 (17.6)	17
		SH	17 (51.5)	8 (24.2)	3 (9.1)	1 (3)	4 (12.1)	33
	All	General	14 (43.8)	6 (18.8)	5 (15.6)	1 (3.1)	6 (18.8)	32
		SH	40 (56.3)	19 (26.8)	4 (5.6)	2 (2.8)	6 (8.5)	71
Total			54 (52.4)	25 (24.3)	9 (8.7)	3 (2.9)	12 (11.7)	103
Rec 3	London	General	6 (40)	5 (33.3)			4 (26.7)	15
		SH	29 (82.9)	4 (11.4)			2 (5.7)	35
	North West	General	8 (47.1)	4 (23.5)	2 (11.8)		3 (17.6)	17
		SH	21 (65.6)	5 (15.6)	1 (3.1)		5 (15.6)	32
	All	General	14 (43.8)	9 (28.1)	2 (6.3)		7 (21.9)	32
		SH	50 (73.5)	10 (14.7)	1 (1.5)		7 (10.3)	68
Total			64 (64)	19 (19)	3 (3)		14 (14)	100
Rec 4	London	General	13 (86.7)	1 (6.7)			1 (6.7)	15
		SH	29 (82.9)	4 (11.4)			2 (5.7)	35
	North West	General	15 (88.2)	2 (11.8)				17
		SH	27 (87.1)	2 (6.5)			2 (6.5)	31
	All	General	28 (87.5)	3 (9.4)			1 (3.1)	32
		SH	56 (83.6)	7 (10.4)			4 (6)	67
Total			84 (84.8)	10 (10.1)			5 (5.1)	99
Rec 5	London	General	14 (93.3)				1 (6.7)	15
		SH	32 (91.4)	2 (5.7)			1 (2.9)	35
	North West	General	14 (82.4)	3 (17.6)				17
		SH	25 (80.6)	1 (3.2)	1 (3.2)		4 (12.9)	31
	All	General	28 (87.5)	3 (9.4)			1 (3.1)	32
		SH	58 (86.6)	3 (4.5)	1 (1.5)		5 (7.5)	67
Total			86 (86.9)	6 (6.1)	1 (1)		6 (6.1)	99
Rec 6	London	General	6 (40)			2 (13.3)	7 (46.7)	15
		SH	11 (33.3)	4 (12.1)		2 (6.1)	16 (48.5)	33
	North West	General	9 (52.9)	2 (11.8)	1 (5.9)		5 (29.4)	17
		SH	9 (30)	8 (26.7)	3 (10)	1 (3.3)	9 (30)	30
	All	General	15 (46.9)	2 (6.3)	1 (3.1)	2 (6.3)	12 (37.5)	32
		SH	20 (31.3)	12 (18.8)	3 (4.7)	3 (4.7)	26 (40.6)	64
Total			35 (36.5)	14 (14.6)	4 (4.2)	5 (5.2)	38 (39.6)	96
Rec 7	London	General	9 (60)	4 (26.7)			2 (13.3)	15
		SH	24 (72.7)	4 (12.1)			5 (15.2)	33
	North West	General	11 (64.7)	5 (29.4)			1 (5.9)	17
		SH	17 (58.6)	9 (31)	1 (3.4)	1 (3.4)	1 (3.4)	29
	All	General	20 (62.5)	9 (28.1)			3 (9.4)	32
		SH	41 (66.1)	13 (21)	1 (1.6)	1 (1.6)	6 (9.7)	62
Total			61 (64.9)	22 (23.4)	1 (1.1)	1 (1.1)	9 (9.6)	94

Table 4.3 Opinions on whether the recommendations are useful service delivery (number and percentage), by role and region

	Region	Role	Strongly agree	Slightly agree	Slightly disagree	Strongly disagree	Not applicable	Total
Rec 1	London	General	12 (70.6)	3 (17.6)	1 (5.9)		1 (5.9)	17
		SH	25 (65.8)	8 (21.1)	2 (5.3)	1 (2.6)	2 (5.3)	38
	North West	General	12 (63.2)	5 (26.3)	1 (5.3)		1 (5.3)	19
		SH	22 (62.9)	9 (25.7)	2 (5.7)		2 (5.7)	35
	All	General	24 (66.7)	8 (22.2)	2 (5.6)		2 (5.6)	36
		SH	47 (63.5)	17 (23)	4 (5.4)	1 (1.4)	5 (6.8)	74
Total	Total		71 (64.5)	25 (22.7)	6 (5.5)	1 (0.9)	7 (6.4)	110
Rec 2	London	General	4 (26.7)	4 (26.7)	3 (20)	1 (6.7)	3 (20)	15
		SH	17 (45.9)	8 (21.6)	5 (13.5)	4 (10.8)	3 (8.1)	37
	North West	General	8 (47.1)	4 (23.5)		2 (11.8)	3 (17.6)	17
		SH	14 (42.4)	10 (30.3)	3 (9.1)	2 (6.1)	4 (12.1)	33
	All	General	12 (37.5)	8 (25)	3 (9.4)	3 (9.4)	6 (18.8)	32
		SH	31 (43.7)	18 (25.4)	8 (11.3)	6 (8.5)	8 (11.3)	71
Total			43 (41.7)	26 (25.2)	11 (10.7)	9 (8.7)	14 (13.6)	103
Rec 3	London	General	5 (33.3)	6 (40)			4 (26.7)	15
		SH	27 (77.1)	4 (11.4)	2 (5.7)	1 (2.9)	1 (2.9)	35
	North West	General	10 (58.8)	4 (23.5)			3 (17.6)	17
		SH	15 (46.9)	9 (28.1)	2 (6.3)	1 (3.1)	5 (15.6)	32
	All	General	15 (46.9)	10 (31.3)			7 (21.9)	32
		SH	42 (61.8)	13 (19.1)	4 (5.9)	2 (2.9)	7 (10.3)	68
Total			57 (57)	23 (23)	4 (4)	2 (2)	14 (14)	100
Rec 4	London	General	13 (86.7)				2 (13.3)	15
		SH	28 (80)	4 (11.4)		1 (2.9)	2 (5.7)	35
	North West	General	15 (88.2)	2 (11.8)				17
		SH	26 (83.9)	2 (6.5)			3 (9.7)	31
	All	General	28 (87.5)	2 (6.3)			2 (6.3)	32
		SH	55 (82.1)	6 (9)		1 (1.5)	5 (7.5)	67
Total			83 (83.8)	8 (8.1)		1 (1)	7 (7.1)	99
Rec 5	London	General	11 (73.3)	3 (20)			1 (6.7)	15
		SH	27 (77.1)	5 (14.3)			3 (8.6)	35
	North West	General	14 (82.4)	3 (17.6)				17
		SH	23 (74.2)	3 (9.7)	1 (3.2)		4 (12.9)	31
	All	General	25 (78.1)	6 (18.8)			1 (3.1)	32
		SH	51 (76.1)	8 (11.9)	1 (1.5)		7 (10.4)	67
Total			76 (76.8)	14 (14.1)	1 (1)		8 (8.1)	99
Rec 6	London	General	7 (46.7)			1 (6.7)	7 (46.7)	15
		SH	9 (27.3)	6 (18.2)	1 (3)	1 (3)	16 (48.5)	33
	North West	General	9 (52.9)	2 (11.8)	1 (5.9)		5 (29.4)	17
		SH	7 (23.3)	7 (23.3)	1 (3.3)	1 (3.3)	14 (46.7)	30
	All	General	16 (50)	2 (6.3)	1 (3.1)	1 (3.1)	12 (37.5)	32
		SH	16 (25)	13 (20.3)	2 (3.1)	2 (3.1)	31 (48.4)	64
Total			32 (33.3)	15 (15.6)	3 (3.1)	3 (3.1)	43 (44.8)	96
Rec 7	London	General	4 (26.7)	5 (33.3)	2 (13.3)	1 (6.7)	3 (20)	15
		SH	15 (45.5)	10 (30.3)	1 (3)	2 (6.1)	5 (15.2)	33
	North West	General	9 (52.9)	4 (23.5)		2 (11.8)	2 (11.8)	17
		SH	10 (34.5)	11 (37.9)	3 (10.3)	2 (6.9)	3 (10.3)	29
	All	General	13 (40.6)	9 (28.1)	2 (6.3)	3 (9.4)	5 (15.6)	32
		SH	25 (40.3)	21 (33.9)	4 (6.5)	4 (6.5)	8 (12.9)	62
Total			38 (40.4)	30 (31.9)	6 (6.4)	7 (7.4)	13 (13.8)	94

Table 4.4 Participants' current delivery of the recommendations (number and percentage), by role and region (continued overleaf)

	Region	Role	Yes	No	Not yet	Not applicable	Total
Rec 1	London	General	12 (70.6)	4 (23.5)		1 (5.9)	17
		SH	33 (86.8)	3 (7.9)		2 (5.3)	38
	North West	General	11 (57.9)	5 (26.3)		3 (15.8)	19
		SH	29 (82.9)	1 (2.9)		5 (14.3)	35
	All	General	23 (63.9)	9 (25)		4 (11.1)	36
		SH	62 (83.8)	4 (5.4)		8 (10.8)	74
Total			85 (77.3)	13 (11.8)		12 (10.9)	110
Rec 2	London	General	5 (33.3)	4 (26.7)		6 (40)	15
		SH	29 (78.4)	6 (16.2)		2 (5.4)	37
	North West	General	7 (41.2)	6 (35.3)		4 (23.5)	17
		SH	18 (54.5)	9 (27.3)		6 (18.2)	33
	All	General	12 (37.5)	10 (31.3)		10 (31.3)	32
		SH	48 (67.6)	15 (21.1)		8 (11.3)	71
Total			60 (58.3)	25 (24.3)		18 (17.5)	103
Rec 3 (partner testing)	London	General	2 (13.3)	7 (46.7)		6 (40)	15
		SH	30 (85.7)	4 (11.4)		1 (2.9)	35
	North West	General	5 (29.4)	5 (29.4)		7 (41.2)	17
		SH	26 (81.3)	1 (3.1)		5 (15.6)	32
	All	General	7 (21.9)	12 (37.5)		13 (40.6)	32
		SH	56 (82.4)	5 (7.4)		7 (10.3)	68
Total			63 (63)	17 (17)		20 (20)	100
Rec 3 (STI info for partner)	London	General	9 (60)			6 (40)	15
		SH	34 (97.1)			1 (2.9)	35
	North West	General	12 (70.6)	1 (5.9)		4 (23.5)	17
		SH	28 (87.5)			4 (12.5)	32
	All	General	21 (65.6)	1 (3.1)		10 (31.3)	32
		SH	63 (92.6)			5 (7.4)	68
Total			84 (84)	1 (1)		15 (15)	100
Rec 4 (ensure PN)	London	General	2 (13.3)	3 (20)		10 (66.7)	15
		SH	27 (77.1)	3 (8.6)		5 (14.3)	35
	North West	General	2 (11.8)	3 (17.6)		12 (70.6)	17
		SH	22 (71)	3 (9.7)		6 (19.4)	31
	All	General	4 (12.5)	6 (18.8)		22 (68.8)	32
		SH	49 (73.1)	6 (9)		12 (17.9)	67
Total			53 (53.5)	12 (12.1)		34 (34.3)	99
Rec 4 (audit PN)	London	General	1 (6.7)	4 (26.7)		10 (66.7)	15
		SH	18 (51.4)	12 (34.3)		5 (14.3)	35
	North West	General	1 (5.9)	4 (23.5)		12 (70.6)	17
		SH	18 (58.1)	8 (25.8)		5 (16.1)	31
	All	General	2 (6.3)	8 (25)		22 (68.8)	32
		SH	36 (53.7)	20 (29.9)		11 (16.4)	67
Total			38 (38.4)	28 (28.3)		33 (33.3)	99
Rec 4 (staff comp)	London	General	7 (46.7)			8 (53.3)	15
		SH	31 (88.6)	1 (2.9)		3 (8.6)	35
	North West	General	8 (47.1)	1 (5.9)		8 (47.1)	17
		SH	28 (90.3)	1 (3.2)		2 (6.5)	31
	All	General	15 (46.9)	1 (3.1)		16 (50)	32
		SH	59 (88.1)	2 (3)		6 (9)	67
Total			74 (74.7)	3 (3)		22 (22.2)	99

Table 4.4 (continued) Participants' current delivery of the recommendations, by role and region

	Region	Role	Yes	No	Not yet	Not applicable	Total
Rec 4 (audit comp)	London	General	6 (40)	1 (6.7)		8 (53.3)	15
		SH	25 (71.4)	3 (8.6)		7 (20)	35
	North West	General	5 (29.4)	2 (11.8)		10 (58.8)	17
		SH	22 (71)	6 (19.4)		3 (9.7)	31
	All	General	11 (34.4)	3 (9.4)		18 (56.3)	32
		SH	47 (70.1)	9 (13.4)		11 (16.4)	67
Total			58 (58.6)	12 (12.1)		29 (29.3)	99
Rec 5 (advice)	London	General	9 (60)		3 (20)	3 (20)	15
		SH	33 (94.3)		1 (2.9)	1 (2.9)	35
	North West	General	11 (64.7)	1 (5.9)	2 (11.8)	3 (17.6)	17
		SH	28 (90.3)			3 (9.7)	31
	All	General	20 (62.5)	1 (3.1)	5 (15.6)	6 (18.8)	32
		SH	61 (91)		1 (1.5)	5 (7.5)	67
Total			81 (81.8)	1 (1)	6 (6.1)	11 (11.1)	99
Rec 5 (contra inc. LARC)	London	General	11 (73.3)		1 (6.7)	3 (20)	15
		SH	33 (94.3)		1 (2.9)	1 (2.9)	35
	North West	General	11 (64.7)	1 (5.9)	1 (5.9)	4 (23.5)	17
		SH	26 (83.9)		1 (3.2)	4 (12.9)	31
	All	General	22 (68.8)	1 (3.1)	2 (6.3)	7 (21.9)	32
		SH	59 (88.1)		2 (3)	6 (9)	67
Total			81 (81.8)	1 (1)	4 (4)	13 (13.1)	99
Rec 5 (EC Advice)	London	General	12 (80)	1 (6.7)	1 (6.7)	1 (6.7)	15
		SH	34 (97.1)			1 (2.9)	35
	North West	General	14 (82.4)	1 (5.9)	1 (5.9)	1 (5.9)	17
		SH	25 (80.6)	1 (3.2)	2 (6.5)	3 (9.7)	31
	All	General	26 (81.3)	2 (6.3)	2 (6.3)	2 (6.3)	32
		SH	60 (89.6)	1 (1.5)	2 (3)	4 (6)	67
Total			86 (86.9)	3 (3)	4 (4)	6 (6.1)	99
Rec 5 (provide advance EC)	London	General	4 (26.7)	1 (6.7)	6 (40)	4 (26.7)	15
		SH	17 (48.6)	11 (31.4)	6 (17.1)	1 (2.9)	35
	North West	General	4 (23.5)	3 (17.6)	3 (17.6)	7 (41.2)	17
		SH	11 (35.5)	7 (22.6)	9 (29)	4 (12.9)	31
	All	General	8 (25)	4 (12.5)	9 (28.1)	11 (34.4)	32
		SH	28 (41.8)	18 (26.9)	15 (22.4)	6 (9)	67
Total			36 (36.4)	22 (22.2)	24 (24.2)	17 (17.2)	99
Rec 6 (home visits)	London	General	4 (26.7)	3 (20)		8 (53.3)	15
		SH	3 (9.1)	8 (24.2)		22 (66.7)	33
	North West	General	10 (58.8)	1 (5.9)		6 (35.3)	17
		SH	3 (10)	11 (36.7)		16 (53.3)	30
	All	General	14 (43.8)	4 (12.5)		14 (43.8)	32
		SH	6 (9.4)	19 (29.7)		39 (60.9)	64
Total			20 (20.8)	23 (24)		53 (55.2)	96
Rec 6 refer	London	General	12 (80)	1 (6.7)		2 (13.3)	15
		SH	20 (60.6)	4 (12.1)		9 (27.3)	33
	North West	General	15 (88.2)			2 (11.8)	17
		SH	20 (66.7)	1 (3.3)		9 (30)	30
	All	General	27 (84.4)	1 (3.1)		4 (12.5)	32
		SH	40 (62.5)	5 (7.8)		19 (29.7)	64
Total			67 (69.8)	6 (6.3)		23 (24)	96

Table 4.4 (continued) Participants' current delivery of the recommendations, by role and region

	Region	Role	Yes	No	Not yet	Not applicable	Total
Rec 7	London	General	2 (13.3)	7 (46.7)		6 (40)	15
		SH	10 (30.3)	19 (57.6)		4 (12.1)	33
	North West	General	3 (17.6)	9 (52.9)		5 (29.4)	17
		SH	6 (20.7)	14 (48.3)		9 (31)	29
	All	General	5 (15.6)	16 (50)		11 (34.4)	32
		SH	16 (25.8)	33 (53.2)		13 (21)	62
Total			21 (22.3)	49 (52.1)		24 (25.5)	94

Table 4.5 Recommendation 1: referrals to sexual health practitioners (number and percentage)

	Referral to							
Respondent's role	GUM	GP	Young people's clinic	Voluntary agency	School nurse	Other	None/Not applicable	Total*
Family planning physician	7 (63.6)		1 (9.1)			3 (27.3)		11
Family planning nurse	11 (100)	1 (9.1)	4 (36.4)			4 (36.4)		11
GUM physician	4 (40)					4 (40)	1 (10)	10
GUM nurse	1 (14.3)	1 (14.3)	1 (14.3)	1 (14.3)	1 (14.3)	4 (57.1)	2 (28.6)	7
GUM health advisor	5 (55.6)	1 (11.1)	2 (22.2)	1 (11.1)	1 (11.1)	1 (11.1)	2 (22.2)	9
GP	2 (50)	1 (25)				1 (25)		4
Practice nurse	3 (100)	1 (33.3)				1 (33.3)		3
Health visitor	1 (33.3)	1 (33.3)	2 (66.7)				1 (33.3)	3
Midwife	6 (100)		3 (50)					6
Walk-in centre staff	5 (100)		1 (20)					5
Youth offending service			1 (100)					1
Services for vulnerable groups	5 (100)	1 (20)	3 (60)	1 (20)		1 (20)		5
Drugs and alcohol worker	2 (50)	1 (25)	1 (25)				1 (25)	4
Teenage pregnancy lead	1 (50)						1 (50)	2
Young people's sexual health services	4 (80)	1 (20)	2 (40)	2 (40)	1 (20)	1 (20)	1 (20)	5
School nursing	7 (100)	2 (28.6)	4 (57.1)		1 (14.3)			7
Compulsory education services							1 (100)	1
Chlamydia screening coordinator	1 (50)		1 (50)				1 (50)	2
Manager, sexual health services	2 (40)		1 (20)	1 (20)		1 (20)	2 (40)	5
Commissioner	4 (50)		2 (25)	3 (37.5)		1 (12.5)	3 (37.5)	8
Other							1 (100)	1
Total	71 (64.5)	11 (10)	29 (26.4)	9 (8.2)	4 (3.6)	22 (20)	17 (15.5)	110

> "[what would help are] Improved access to GUM services along with the choice to refer to services outside GUM with appropriate trained practitioners" (Family planning physician, round one).

Around half of physicians and health advisors working in GUM also stated that they referred to GUM, presumably to another health professional within their clinic. Over a quarter (26%) of professionals additionally or alternatively made referrals to young people's clinics, and a few made referrals to GPs (10%), voluntary agencies (8%) and school nurses (4%).

When asked about the appropriateness of the wording, 56% strongly agreed and 28% slightly agreed that the wording was appropriate (table 4.6), with suggestions for wording including greater definition of the following terms: 'counselling', 'high risk', 'provide' and 'appropriate trained practitioner'.

Analysis of qualitative comments also showed that different combinations of sexual practices and/or risk assessment protocols are used by services to identify 'high risk'. These were all based on taking a sexual history plus identification of the following factors: infection rates; lifestyle; partner change, history of multiple STIs/partners/unsafe sex; other high risk/condom use/blood transfusion; education/interpersonal skill/confidentiality; drug-taking; setting/route of referral and assessment of risk according to presentation. Presentation of clients to differing parts of the NHS was perceived to impact on their STI assessment/treatment, for example.

> "Depends on where the patient is identified and what community or demographic group they belong. Sexual health counselling and group work is available for gay men but not BME groups group" (Commissioner of sexual health services, round one).

Factors enabling implementation of the recommendation were said to include better staff education/training (e.g. in general practice) and integration of family planning/STI services. For example:

> "We need to do [STI] testing and assessments in outreach posts such as youth groups etc. and involve community organisations where targets groups can be accessed and testing etc. done opportunistically. Don't base it all in health settings" (Commissioner of sexual health services, round one).

> "Community contraceptive services are ideally situated locally in the community to provide the whole spectrum of level 1 STI services and are very cost-effective (but are currently not funded or commissioned for this activity)" (Family planning physician, round one).

In addition inclusion of all services inside a network was seen as advantageous. For example:

> "INTEGRATED SERVICES!! Being able to provide contraception in GUM, being able to offer 'screening' in contraceptive clinics (including routine HIV testing)" (Family planning nurse, round one, respondent's emphasis)

> "Networking and closer work with other organisations/local groups. A realisation that young people will not access statutory services and other means are necessary. In Sexual Health Clinics we have very strict confidentiality rules, which may not apply in GP and community settings" (GUM health advisor, round one).

Barriers to implementation of Recommendation One were said to include resources (staffing/financial), commissioning and the impact of current policy/legislation e.g. criminalisation of HIV transmission. For example:

> "Criminalisation of transmission will probably mean the ceasing of all this type of work. No individual is going to talk freely about risky behaviour when they are potentially providing evidence which can be used against them, and practitioners will need to be providing virtual police cautions before entering into such discussions in order that the individual can make an informed choice about whether they wish to disclose information or not. Equally, practitioners

Table 4.6. Opinions on whether the wording of the recommendations is appropriate (number and percentage), by role and region

	Region	Role	Strongly agree	Slightly agree	Slightly disagree	Strongly disagree	Total
Rec 1	London	General	9 (52.9)	6 (35.3)	2 (11.8)		17
		SH	19 (50)	11 (28.9)	5 (13.2)	3 (7.9)	38
	North West	General	15 (78.9)	4 (21.1)			19
		SH	18 (51.4)	10 (28.6)	7 (20)		35
	All	General	24 (66.7)	10 (27.8)	2 (5.6)		36
		SH	38 (51.4)	21 (28.4)	12 (16.2)	3 (4.1)	74
Total			62 (56.4)	31 (28.2)	14 (12.7)	3 (2.7)	110
Rec 2	London	General	9 (60)	1 (6.7)	3 (20)	2 (13.3)	15
		SH	16 (43.2)	11 (29.7)	5 (13.5)	5 (13.5)	37
	North West	General	11 (64.7)	5 (29.4)		1 (5.9)	17
		SH	11 (33.3)	11 (33.3)	9 (27.3)	2 (6.1)	33
	All	General	20 (62.5)	6 (18.8)	3 (9.4)	3 (9.4)	32
		SH	27 (38)	23 (32.4)	14 (19.7)	7 (9.9)	71
Total			47 (45.6)	29 (28.2)	17 (16.5)	10 (9.7)	103
Rec 3	London	General	13 (86.7)	1 (6.7)	1 (6.7)		15
		SH	20 (57.1)	9 (25.7)	2 (5.7)	4 (11.4)	35
	North West	General	12 (70.6)	5 (29.4)			17
		SH	16 (50)	8 (25)	7 (21.9)	1 (3.1)	32
	All	General	25 (78.1)	6 (18.8)	1 (3.1)		32
		SH	36 (52.9)	18 (26.5)	9 (13.2)	5 (7.4)	68
Total			61 (61)	24 (24)	10 (10)	5 (5)	100
Rec 4	London	General	13 (86.7)	2 (13.3)			15
		SH	21 (60)	8 (22.9)	4 (11.4)	2 (5.7)	35
	North West	General	15 (88.2)	1 (5.9)		1 (5.9)	17
		SH	24 (77.4)	3 (9.7)	2 (6.5)	2 (6.5)	31
	All	General	28 (87.5)	3 (9.4)		1 (3.1)	32
		SH	45 (67.2)	12 (17.9)	6 (9)	4 (6)	67
Total			73 (73.7)	15 (15.2)	6 (6.1)	5 (5.1)	99
Rec 5	London	General	14 (93.3)		1 (6.7)		15
		SH	22 (62.9)	8 (22.9)	4 (11.4)	1 (2.9)	35
	North West	General	15 (88.2)	2 (11.8)			17
		SH	20 (64.5)	8 (25.8)	3 (9.7)		31
	All	General	29 (90.6)	2 (6.3)	1 (3.1)		32
		SH	42 (62.7)	16 (23.9)	8 (11.9)	1 (1.5)	67
Total			71 (71.7)	18 (18.2)	9 (9.1)	1 (1)	99
Rec 6	London	General	11 (73.3)	4 (26.7)			15
		SH	22 (66.7)	10 (30.3)	1 (3)		33
	North West	General	13 (76.5)	1 (5.9)	2 (11.8)	1 (5.9)	17
		SH	20 (66.7)	8 (26.7)	2 (6.7)		30
	All	General	24 (75)	5 (15.6)	2 (6.3)	1 (3.1)	32
		SH	42 (65.6)	19 (29.7)	3 (4.7)		64
Total			66 (68.8)	24 (25)	5 (5.2)	1 (1)	96
Rec 7	London	General	12 (80)	2 (13.3)	1 (6.7)		15
		SH	24 (72.7)	8 (24.2)	1 (3)		33
	North West	General	14 (82.4)	3 (17.6)			17
		SH	13 (44.8)	13 (44.8)	2 (6.9)	1 (3.4)	29
	All	General	26 (81.3)	5 (15.6)	1 (3.1)		32
		SH	37 (59.7)	21 (33.9)	3 (4.8)	1 (1.6)	62
Total			63 (67)	26 (27.7)	4 (4.3)	1 (1.1)	94

> will be placed in a position of either having to inadequately record their discussions or risk their files being produced for the prosecution." (Local authority HIV social care commissioner, round one).

Recommendation two

The majority (83%) agreed that implementing recommendation two, that health professionals trained in sexual health counselling should provide one to one counselling, would help to reduce the rate of STIs (table 4.1). Although a majority, this was the lowest agreement of all the recommendations. One problem of the recommendation was identified as a:

> "Conflict between providing very intensive services for selected clients at very high risk and very accessible services for large numbers of clients at less risk." (Family planning physician, round one).

There were no statistically significant differences in agreement about the effectiveness between participants from London compared to the North West, between professionals who were primarily involved in sexual health compared to those in general services or depending on whether participants covered deprived, average or affluent populations (backwards logistic regression to predict agreement from region, speciality and deprivation, P>0.05). In total, 77% thought it relevant to their practice, and sexual health specialists were more likely to find it relevant (adjusted OR=4.01, 95% CI=1.31-12.23, p=0.015, backwards logistic regression also incorporating deprivation – p>0.05 – and region – p>0.05). Of those who thought the recommendation applicable, 78% agreed it would be useful in delivering services. There were no significant differences in agreement between regions, between the deprivation levels of the populations served or between specialists and generalist professions (backwards stepwise logistic regression, p>0.05).

When asked about current practice, 18% found the question not applicable (11% of sexual health specialists and 31% of those delivering general health or education services: table 4.4). Of those for whom it was applicable, most (71%) stated they were already carrying out the recommendation through integration of counselling into core services or through use of existing specialist roles. For example:

> "All doctors and nurses working in General Practice, GUM clinics, Reproductive and Sexual Health services should be capable of identifying high risk sexual behaviour and providing sexual health counselling as part of routine consultations. Health Care Assistants and Community Pharmacists can also be trained to provide opportunistic sexual health counselling. By using words such as 'structured' sessions and being prescriptive about the minimum amount of time that should be spent with each client we are creating a myth that sexual health counselling is a highly specialised field that requires a specific category of health professionals to deliver the service. The reality is that there is a huge unmet demand in the society to reduce the incidence of STI's and unplanned pregnancy, which can only be tackled if we de-stigmatise the way we provide sexual health services." (Consultant in reproductive and sexual health, round one).

The most common settings for delivering one to one counselling were young people's clinics (58%) and GUM clinics (50%), with school nurses (21%) and voluntary agencies also being mentioned by several people (16%: table 4.7). The professionals used to deliver counselling sessions were GUM nurses (49%), doctors (38%), and health advisors (16%), as well as nurses in general practice (19%: table 4.8) and a variety of other professionals and settings (community contraceptive services, youth offending teams, through outreach, drugs and alcohol services, termination of pregnancy services, children leaving care services and learning disability teams).

When asked whether the recommendation was worded appropriately, 26% agreed (table 4.6), with some commenting that the recommendation was too prescriptive about counselling time and that little evidence existed showing behaviour change after counselling. For example:

> "Counselling and a consultation are different. A counselling service would need a specialist to perform if to be done properly and would need time. If the statement refers to counselling skills as part of a normal consultation then the allocated time mentioned is what is generally used

now. Structured counselling sessions are 1hr with a 15-minute introductory session maybe. Feel the wording of this may need to be made clearer as well as the expectation of this recommendation." (GUM health advisor, round one).

"Weak evidence of effectiveness of this level of counselling in reducing STIs and producing sustained behaviour change. Most patients unlikely to return for separate counselling session and trying to fit a 20 minute session into a GUM consultation would be impossible even if we had the staff to do this." (GUM physician, round one).

The number of counselling sessions vary greatly in frequency (from 1 to 20 per client) and duration (depending on client need) as do the range of ways of facilitating/enabling attendance of some high-risk groups. For example, trained professional health promoters are employed from within MSM and BME communities and who therefore know their own communities.

Table 4.7 Recommendation 2: Settings used to provide one to one counselling (number and percentage)

	Setting						
Role	GUM	Young people's clinic	Voluntary agency	School nurse	Other	Not applicable	Total
Family planning physician	3 (30)	6 (60)	2 (20)	1 (10)	5 (50)		10
Family planning nurse	4 (40)	8 (80)	1 (10)	2 (20)	5 (50)	1 (10)	10
GUM physician	7 (70)	6 (60)	1 (10)	1 (10)	2 (20)		10
GUM nurse	3 (42.9)	2 (28.6)	1 (14.3)	1 (14.3)	1 (14.3)	3 (42.9)	7
GUM health advisor	9 (100)	7 (77.8)		2 (22.2)			9
GP	2 (66.7)					1 (33.3)	3
Practice nurse	2 (66.7)			1 (33.3)	1 (33.3)		3
Health visitor		2 (66.7)					3
Midwife	4 (80)	2 (40)	1 (20)				5
Walk-in centre staff	3 (60)	2 (40)	1 (20)	1 (20)		1 (20)	5
Youth offending service		1 (100)	1 (100)	1 (100)	1 (100)		1
Services for vulnerable groups	2 (40)	3 (60)	3 (60)	1 (20)			5
Drugs and alcohol worker		1 (33.3)			1 (33.3)	1 (33.3)	3
Teenage pregnancy lead		2 (100)			2 (100)		2
Young people's sexual health services	4 (80)	5 (100)		1 (20)	2 (40)		5
School nursing		5 (83.3)		5 (83.3)			6
Compulsory education services						1 (100)	1
Chlamydia screening coordinator	1 (50)	1 (50)				1 (50)	2
Manager, sexual health services	3 (60)	3 (60)		1 (20)	2 (40)		5
Commissioner	4 (57.1)	4 (57.1)	5 (71.4)	4 (57.1)		2 (28.6)	7
Other							1
Total	51 (49.5)	60 (58.3)	16 (15.5)	22 (21.4)	22 (21.4)	11 (10.7)	103

*Excluding double counting: participants could tick more than one option

Table 4.8 Recommendation 2: professionals used to provide one to one counselling (number and percentage)

	Professional						
Role	GP nurse	GUM doctor	GUM nurse	GUM health advisor	Other	Not applicable	Total*
Family planning physician	1 (10)	1 (10)	2 (20)	2 (20)	6 (60)		10
Family planning nurse	1 (10)	3 (30)	3 (30)	1 (10)	4 (40)	1 (10)	10
GUM physician	2 (20)	7 (70)	7 (70)	3 (30)	2 (20)		10
GUM nurse	1 (14.3)	2 (28.6)	3 (42.9)	1 (14.3)	1 (14.3)	3 (42.9)	7
GUM health advisor	2 (22.2)	5 (55.6)	7 (77.8)	3 (33.3)	1 (11.1)		9
GP		1 (33.3)	1 (33.3)	1 (33.3)	1 (33.3)	1 (33.3)	3
Practice nurse	3 (100)	3 (100)	2 (66.7)				3
Health visitor	1 (33.3)	1 (33.3)	1 (33.3)		1 (33.3)		3
Midwife	1 (20)	4 (80)	4 (80)		2 (40)		5
Walk-in centre staff	1 (20)	1 (20)	3 (60)	2 (40)		1 (20)	5
Youth offending service		1 (100)	1 (100)		1 (100)		1
Services for vulnerable groups	2 (40)	2 (40)	3 (60)		1 (20)		5
Drugs and alcohol worker	1 (33.3)	1 (33.3)	1 (33.3)			1 (33.3)	3
Teenage pregnancy lead					2 (100)		2
Young people's sexual health services	1 (20)	2 (40)	3 (60)		2 (40)		5
School nursing		1 (16.7)	2 (33.3)		1 (16.7)		6
Compulsory education services					1 (100)		1
Chlamydia screening coordinator		1 (50)	1 (50)			1 (50)	2
Manager, sexual health services	1 (20)	2 (40)	4 (80)	2 (40)	1 (20)		5
Commissioner	2 (28.6)	1 (14.3)	2 (28.6)	1 (14.3)	1 (14.3)	3 (42.9)	7
Other							1
Total	20 (19.4)	39 (37.9)	50 (48.5)	16 (15.5)	28 (27.2)	11 (10.7)	103

*Excluding double counting: participants could tick more than one option

Current counselling provision involves a range of service delivery methods including user friendly/non-judgemental/flexible to walk-in/open access approaches. Factors enabling implementation of the recommendation are said to be: more time with clients, better skill mix, guidelines and referral networks. For example:

> "Time, staff trained to appropriate level, capacity, effective referral pathways if not able to offer on site." (GUM health advisor, round one).

> "Good links with GUM." (Family planning physician, round one).

> "Targeting areas of high risk in local communities by joint working with public health and other agencies such as Education" (School nurse, round one).

Inhibiting factors said to be: user attitudes/behaviours, poor staff training and lack of clinic resources. For example:

> "Patients - they wouldn't want to come back for a counselling session unless they had actually asked for support. The impact on the function of the clinic produced by 20 min appointments for

> patients with counsellor would discourage patients from attending and antagonise young people who want to be in and out" (GUM physician, round one).

Suggestions for reworking the recommendation include redefining 'counselling', more flexibility about counselling time, commissioning peer-support services and for contraceptive services to provide a Level One STI service. For example:

> "The term counselling is difficult in relation to general practice consultations, and could be off putting as it has implications of a level of expertise usually associated with SRH trained nurses/ Drs or health advisors. If we are to really impact on populations at high risk the generalist need to become involved - it would be helpful if the guidelines demystified talking about sex and GPs and Practice nurses provide advice, information, health promotion advice rather than counselling in their consultations - there may well be no difference, but terms are important." (GP, round one).

Recommendation three

The vast majority (98%) of respondents agreed that recommendation three, that health professionals should provide help to patients with an STI to get their partner tested and treated, would help to reduce STIs (table 4.1). This view was reflected in the qualitative comments, for example:

> "NICE recommendation [three] would support the incorporation of partner notification within service level agreements" (Clinical director, round one).

Most comments reported the recommendation as helpful for reducing STIs and is relevant/useful to practice through, for example:

> "..setting a clear pathway and standard. However we currently test for Chlamydia and Gonorrhoea but refer positives to GUM. We do now have one combined sexual health nurse who can do partner notification but that is only in one area of the district." (Family planning nurse, round one).

There were no statistically significant differences in agreement between participants from London compared to the North West, between professionals who were primarily involved in sexual health compared to those in general services or depending on whether participants covered deprived, average or affluent populations (backwards logistic regression to predict agreement from region, speciality and deprivation, $P>0.05$). One in ten of those working in sexual health services and one in five participants from general backgrounds felt the recommendation was not applicable to delivering their service. Of those who felt it applicable, the vast majority thought the recommendation relevant (93%, table 4.2) and useful (97%, table 4.3). There were no significant differences between professional groups, regions and deprivation of populations served in terms of perceptions of relevance and usefulness (backwards logistic regressions, $p>0.05$).

When asked about current practice, of the 80% who thought the question applicable (90% of specialists and 59% of generalists: table 4.4), 37% of those in general and 92% of those working in sexual health services were providing help to get partners tested and treated. Partner notification is currently delivered through integration with screening programmes, use of community-based health advisors, trained GPs/practice nurses and via patients undertaking contract tracing. However, difficulties associated with reduced patient anonymity are perceived, for example:

> "It is very difficult for GPs to balance patient confidentiality with partner notification, as our patients will remain under our care for all aspects of their general health both physical and psychological. The GUM service is more anonymous and patients prefer this." (GP, round one).

Different models of partner notification were reported like the provider informing partners without disclosing the identity of the index patient, which was seen as potentially useful in community settings. Factors enabling implementation of the recommendation are workforce competency/attitude training, treating STIs in community contraception clinics and providing GP time/funding for unregistered patients. For example:

> "The first sentence of the recommendation should include family planning clinicians as well because a considerable degree of STI work is now being undertaken in community contraceptive services under the umbrella of integrated clinics. The sentence of specialist should include a family planning clinician and a family planning trained nurse. Both these health professionals will be vital to the success of partner notification in the community family planning/STI clinics. (Family planning physician, round one).

More people felt that the provision of information was applicable to their role (69% of generalists and 93% of specialists). Of these, all but one participant (who worked in a general role) was already providing such information. Support provided for partners included medication (provided by 62% of respondents), prescriptions (36%), home testing kits (7%) as well as contraception (73%: table 4.9). Concerns were raised over home test kits, fragmented services and prescribing and/or dispensing medication for unregistered partners/non-attendees (i.e. prescribing for people who are not medically assessed in person by any clinician). For example:

> "I agree that partner treatment is crucial to reduce the re-infection and onward transmission of STIs. However home sampling kits have been shown to have a very poor return rate and also providing medication for a partner without seeing him/her is fraught with danger medico legally" (Family planning physician, round one).

Table 4.9 Recommendation 3: services provided for partners of those with STIs (number and percentage)

Role	Home sampling kits	Medication	Prescription	Contraception	Other	Not applicable	Total*
Family planning physician	2 (20)	5 (50)	3 (30)	8 (80)	1 (10)		10
Family planning nurse	1 (11.1)	6 (66.7)	4 (44.4)	9 (100)			9
GUM physician		8 (80)	5 (50)	9 (90)			10
GUM nurse		6 (85.7)	3 (42.9)	6 (85.7)	2 (28.6)		7
GUM health advisor		7 (87.5)	7 (87.5)	5 (62.5)			8
GP		3 (100)	2 (66.7)	3 (100)	1 (33.3)		3
Practice nurse	1 (33.3)	3 (100)	2 (66.7)	2 (66.7)			3
Health visitor				3 (100)			3
Midwife		1 (20)	1 (20)	4 (80)		1 (20)	5
Walk-in centre staff	1 (20)	3 (60)		4 (80)			5
Youth offending service						1 (100)	1
Services for vulnerable groups		1 (25)	1 (25)	2 (50)		2 (50)	4
Drugs and alcohol worker					1 (33.3)	2 (66.7)	3
Teenage pregnancy lead		1 (50)		1 (50)		1 (50)	2
Young people's sexual health services	1 (20)	5 (100)	3 (60)	5 (100)			5
School nursing	1 (16.7)	3 (50)		5 (83.3)		1 (16.7)	6
Compulsory education services						1 (100)	1
Chlamydia screening coordinator		2 (100)	1 (50)	1 (50)			2
Manager, sexual health services		5 (100)	3 (60)	3 (60)			5
Commissioner		2 (28.6)	1 (14.3)	2 (28.6)		4 (57.1)	7
Other				1 (100)			1
Total	7 (7)	61 (61)	36 (36)	73 (73)	5 (5)	13 (13)	100

*Excluding double counting: participants could tick more than one option

> "…The practice of supplying medication or a prescription would need to thorough evaluation before it could become a recommendation. It seems that it could help and is not supported by professional bodies or the law in the UK. A health professional needs to ensure that they have assessed and checked that it would be okay for them to commence the medication. Moreover, it could lead to non-attendance for a full GUM screen and a missed opportunity to pick up other infections if partners attend…" (Family planning physician, round one).

> "I have concerns that this might provide a fragmented service with the risk of some clients falling through the net. I feel that there should be some local service whose main remit is to provide for partner notification, and overseeing the service" (Family planning physician, round one).

> "I have slight concern about issuing prescription/medication to partners due to unknown drug/allergy history of partners. Also missing an opportunity to screen for all STIs if client doesn't attend service." (STI lead nurse for sexual health and reproductive services, round one).

Those working in GUM clinics (84%), young people's sexual health services (100%) and general practice (100%) were most likely to provide medication for partners.

The majority of participants agreed (61%) or slightly agreed (24%) that the wording of the recommendation was appropriate (table 4.6). Suggestions for re-wording of the recommendation included changing 'disease specific' to 'infection specific'. One crucial concern is that criminalization of STI transmission may fatally complicate the implementation of this recommendation:

> "Ability to identify sexual practices, and risky behaviour, and the ability to encourage partner notification and especially our role in partner notification is probably fatally damaged by the issues around criminalisation. Which client is going to discuss their risky behaviour with us if they know the facts raised in the discussion can be used as prosecution evidence? And who is going to tell us the identities of their partners and allow us to contact them, when these individuals can now prosecute you! Basically we would be asking people to provide evidence which will form the prosecution against them, and then give us a list of people who we can pass the information on to so they can launch a prosecution. The second area of concern relates to where all these non-judgemental, non moralising, knowledgeable and skilled staff are coming from." (Local Authority HIV social care commissioner, round one).

Recommendation four

All but one person agreed that the implementation of recommendation four (that commissioners ensure there are arrangements for notification, testing, treatment and follow up of partners) would reduce the rate of STIs. Qualitative comments were similarly positive about the recommendation but stressed adequacy of funding, more empowered commissioning with service level agreements and incentives/training/motivation/monitoring for GP involvement (e.g. with HIV patients) and user guidelines/audit for partner notification and higher profile for asymptomatic community screening. For example:

> "A combined approach is needed, not just relying on GUM services to deal with STIs therefore effective commissioning is essential in providing the right levels of care in the wider community" (GUM physician, round one).

> "This is a great recommendation, but I don't understand how PCTs can achieve this. Laying aside the notification issues related to prosecution previously discussed, PCTs don't seem to be in a position to ENSURE this happens at all. Locally, we would love to see GP services developed but GPs are not interested (even without considering the quality they may offer). It is still commonplace for people with HIV to be refused any care with GP practices, and virtually unknown for a GP to actively participate in any HIV element of an individual's care. Refusal is clearly a breach of the DDA and their own regulations, but it still happens, and there doesn't seem to be anything PCTs can do about it. Until the basics are right it seems pointless to move on." (Local Authority HIV social care commissioner, round one).

> "I think this recommendation could be stronger and highlight where services should be delivered in terms of appropriateness - asymptomatic screening in the community rather than GUM." (Commissioner, sexual health services, round one).

Some comments reported concern about the move of STI services to community settings and with family planning clinics becoming STI-focused and some female users not taking up the service due to perceptions over the social stigma associated with STIs.

Most (95%) of participants thought the question on the relevance of the recommendation applicable, and all these individuals stated it was relevant to their service. Only one person felt that the recommendation was not useful in delivering their service. Due to this high level of agreement, it was not possible apply quantitative analysis to the differences in agreement between groups.

When asked about current practice (table 4.5), 82% of those who found the question applicable stated that arrangements for partner notification formed part of sexual health services and met local needs. However, only 58% felt that an audit framework was in place to monitor this. Nearly a third felt that the responsibilities of GUM services were defined (table 4.10), and a quarter stated this was so for Chlamydia screening services. In contrast, only 11% felt that the role of non-specialist primary and community services was defined, and only 10% felt this was true of specialist GP services. An additional 8% felt that the individual responsibilities were not defined at all (table 4.10). In terms of staff training, the vast majority (96%) of participants thought that staff had competencies fit for purpose and 83% felt this was audited.

Table 4.10 Recommendation 4: views on whether individual responsibilities are defined (number and percentage)

Participant's role	GUM	Chlamydia screening	Non-sp primary & comm	Sp. GP	Ind resp not defined	Not Applicable	Total*
Family planning physician	2 (20)	2 (20)			1 (10)	2 (20)	10
Family planning nurse	1 (11.1)	3 (33.3)	1 (11.1)		1 (11.1)	3 (33.3)	9
GUM physician	7 (70)	3 (30)	3 (30)	1 (10)		2 (20)	10
GUM nurse	4 (57.1)	2 (28.6)	1 (14.3)	1 (14.3)	1 (14.3)	1 (14.3)	7
GUM health advisor	3 (42.9)	1 (14.3)		1 (14.3)	1 (14.3)	1 (14.3)	7
GP	1 (33.3)	1 (33.3)		1 (33.3)		2 (66.7)	3
Practice nurse		2 (66.7)				1 (33.3)	3
Health visitor		1 (33.3)				1 (33.3)	3
Midwife	2 (40)					3 (60)	5
Walk-in centre staff						5 (100)	5
Youth offending service						1 (100)	1
Services for vulnerable groups	2 (50)					2 (50)	4
Drugs and alcohol worker						1 (33.3)	3
Teenage pregnancy lead	1 (50)					1 (50)	2
Young people's sexual health services	3 (60)	2 (40)	2 (40)	2 (40)			5
School nursing		1 (16.7)			1 (16.7)	3 (50)	6
Compulsory education services						1 (100)	1
Chlamydia screening coordinator	1 (50)	2 (100)		1 (50)			2
Manager, sexual health services		1 (20)	1 (20)		1 (20)	2 (40)	5
Commissioner	4 (57.1)	4 (57.1)	3 (42.9)	3 (42.9)	2 (28.6)	1 (14.3)	7
Other						1 (100)	1
Total	31 (31.3)	25 (25.3)	11 (11.1)	10 (10.1)	8 (8.1)	34 (34.3)	99

*Excluding double counting: participants could tick more than one option. Sp.GP=Specialist GP; Non-sp primary & comm=non-specialist primary and community services; Ind resp not defined=individual responisibilities not defined.

Eleven percent of participants felt the wording of the recommendation was not appropriate (table 4.6), and re-wording suggestions included omitting 'notification' first (as the logical sequence is testing, treatment, then notification and follow-up) and including 'commissioned community contraception services' under 'specialist sexual health services'.

Recommendation five

Most participants (97%) agreed that providing one to one sexual health advice for vulnerable young people would improve their sexual health (table 4.1). Only one person found it not relevant (table 4.2) and one person found it not useful (table 4.3). However, open comments stressed the importance of early sex education and the need for user-friendly services specifically for young people. For example:

> "I agree that it is good, but the young person has taken the risk before they got to the clinic. I am concerned that this is seen as the be all and end all! Reducing negative outcomes from risk taking is about attitude, education and aspiration" (Teenage pregnancy lead, round one).

Six percent regarded the relevance question as not applicable, and 8% regarded the usefulness question as not applicable (rising to 10% of those specialising in sexual health). Due to the high level of agreement amongst those finding the questions applicable, there were no statistically significant differences between groups (regions, professionals or deprivation, $p>0.05$).

When asked whether one to one advice was currently offered in their service, 82% said yes, 1% said no and 6% said no but that it could be put in place (table 4.4). Eleven percent stated the question was not applicable (including 19% of those not specialising in sexual health and 8% of those who did). This one to one sexual health advice to young people is provided using different service models. For example:

> "Core part of our service provision and all options including LARC are discussed with all clients" (Family planning nurse, round one).

> "We opened a dedicated young peoples drop-in service which is situated in the town centre. The project is a multi-agency service offering advice and information on a range of issues including sexual health. Youth workers, doctors, nurses and counsellors offer a range of services including all stated in the recommendation .The service has been recognised nationally as a model of good practice and we are currently developing the model to include outreach clinics in areas of high teenage pregnancy [locally]. We offer priority for training as "family planning" nurses to those nurses who work with vulnerable groups e.g. school nurses, health visitors working in areas of deprivation, health worker for the homeless, health worker for the YOT, health worker for Looked After Children, in order to have the expertise to offer up to date advice and information and provide or refer on to appropriate services as required." (Family planning nurse, round one).

Of those working in general services who did not currently offer one to one advice, most said that they could put it in place. One-to-one advice reportedly is delivered via mechanisms such as patient group directions (PGDs); dedicated young people's services with youth workers for advice/signposting to contraception/STI services/EC suppliers; by school nurses trained in contraception advice ("fertility control"); by integration into core services and by specialist teenage pregnancy midwives.

Most participants currently offered advice on contraception, including LARC (81%), although 13% of participants found this question not applicable to their service (table 4.4). Offering advice on emergency contraception was more common (86%) and few people thought the question did not apply to their service (6%: table 4.4). Comments also indicated precisely how EC and LARC should be more locally accessible for younger people. For example:

> "Good local access for emergency contraception, which is widely publicised, should be commissioned locally including care pathways where a practitioner is unable to fit copper IUDs for this purpose. This should also apply to LARC methods which should be commissioned to cover all providers not just GPs. The community contraceptive services provide emergency contraception (hormonal and IUDs) as well s the full contraceptive and STI consultation. This is

comprehensive, effective and cost-effective compared to acute services (A&E, maternity services) and GP services (not open evenings, weekends and not preferred by young people). The service is accessible (open evenings and Saturdays with walk in sessions and outreach clinics)" (Family planning physician, round one).

However, there was also concern reported about providing advance EC and monitoring LARC take up/removal. For example:

"This could be possible if vulnerable groups with high risk factors were clearly defined e.g. young offenders but the net is drawn too widely above to be realistically affordable… LARC uptake needs monitoring along with LARC removals" (NHS commissioner, sexual health services, round one).

Table 4.11 Recommendation 5: settings for offering advice to vulnerable young people (number and percentage)

Role	GUM	YP	FP	D&A	Sch	AN/ PN	Out R	PC	Total*
Family planning physician	2 (20)	6 (60)	10 (100)	1 (10)	5 (50)	1 (10)			10
Family planning nurse	4 (44.4)	4 (44.4)	8 (88.9)	1 (11.1)	2 (22.2)		1 (11.1)	2 (22.2)	9
GUM physician	9 (90)	3 (30)	4 (40)	1 (10)			1 (10)	2 (20)	10
GUM nurse	6 (85.7)	3 (42.9)	4 (57.1)		2 (28.6)		2 (28.6)	4 (57.1)	7
GUM health advisor	7 (100)	2 (28.6)	4 (57.1)		3 (42.9)		1 (14.3)	2 (28.6)	7
GP	1 (33.3)							3 (100)	3
Practice nurse	2 (66.7)	1 (33.3)	2 (66.7)				1 (33.3)	3 (100)	3
Health visitor		1 (33.3)				1 (33.3)		1 (33.3)	3
Midwife	2 (40)	1 (20)	2 (40)	1 (20)		5 (100)		1 (20)	5
Walk-in centre staff	1 (20)							3 (60)	5
Youth offending service		1 (100)							1
Services for vulnerable groups	1 (25)		1 (25)	1 (25)	1 (25)		1 (25)	2 (50)	4
Drugs and alcohol worker				1 (33.3)					3
Teenage pregnancy lead		2 (100)	2 (100)		1 (50)	1 (50)	1 (50)	1 (50)	2
Young people's sexual health services	4 (80)	3 (60)	4 (80)		2 (40)		2 (40)	2 (40)	5
School nursing		4 (66.7)	6 (100)		6 (100)	2 (33.3)	2 (33.3)	2 (33.3)	6
Compulsory education services									1
Chlamydia screening coordinator	1 (50)		2 (100)						2
Manager, sexual health services	3 (60)	1 (20)	3 (60)					1 (20)	5
Commissioner	2 (28.6)	3 (42.9)	3 (42.9)	1 (14.3)	2 (28.6)	1 (14.3)		1 (14.3)	7
Other									1
Total	45 (45.5)	35 (35.4)	55 (55.6)	7 (7.1)	24 (24.2)	11 (11.1)	12 (12.1)	30 (30.3)	99

*Excluding double counting: participants could tick more than one option. YP=young people's sexual health clinic; FP=family planning clinic; D&A=drugs and alcohol services; Sch=School nurse; AN/PN=antenatal/postnatal services; Out R=outreach; PC=primary care.

Family planning clinics, GUM clinics and young people's sexual health clinics were the most common settings that this advice was given (cited by 56%, 46% and 35% of respondents respectively: table 4.11). Advice was also given in primary care settings (30%), school (24%), outreach (12%), during antenatal or postnatal care (11%) and in drugs and alcohol clinics (7%).

Comments also suggested that young people's services should be provided in general practice/less formal or traditional settings and that 'family planning' be re-titled 'community contraception service'. For example:

> "Sexual health needs to be addressed in non-traditional areas including schools and colleges especially if you are considering health promotion" (GUM health advisor, round one).
>
> "Opportunities to expand current provision will only serve to encourage individuals to access appropriately giving more choice locally" (Walk-in centre nurse, round one).
>
> "Very important to provide a wide variety of access points to meet needs of young people, and also to make them accessible where young people go (or have to go)." (Youth offending service, round one).

Other settings mentioned included termination of pregnancy services, services for street workers, walk in centres and youth offending teams, as well as telephone counselling services.

Participants were also asked whether they already provided advanced emergency contraception if necessary. A quarter of those in general services and 42% of those in specialist sexual health services did so (table 4.4). A further 24% of respondents felt they could put this in place. However, there was some disagreement with the principle of offering advanced emergency contraception:

> "Do not agree with advance EC. Think that this should be easily available e.g. through community pharmacies without charge. [The] aim is to get young people to take responsibility for their own sexual health." (NHS commissioner, sexual health services, round one).

Ten percent of the respondents did not think the wording of the recommendation was appropriate (table 4.6). Re-wording suggestions included replacing 'vulnerable' with 'all under 18-years'.

Recommendation six

The vast majority (98%) agreed that regular visits to vulnerable young women who were pregnant or already mothers to provide information about STIs and contraception would help improve their sexual health (table 4.1). Qualitative comments stressed the validity of the recommendation depended on adequate social support/follow up for teenage mothers, effective care pathways, the involvement of appropriately trained/skilled midwives/health visitors/nurses, appropriately trained/skilled due to their access to the client group for purposes of EC, LARC and STI (e.g. Chlamydia) information/advice; and use of a multi-agency approach (e.g. with Connexions, drug agencies etc). For example:

> "Having recently established a referral pathway from the teenage pregnancy midwife to myself and home visits now take place at 36 weeks of pregnancy+ to discuss contraception and offer screening for chlamydia, with follow up after the birth I have seen the benefits of this service - a lot of young people have been provided with LARC who previously were unaware or not well informed about these methods" (Young people's sexual health clinic, round one).
>
> "Agree, but should be a multi agency approach not purely health as issues arising will not be purely health. For example a Connexions teenage pregnancy advisor or a drugs counsellor could visit in conjunction with a midwife or Health Visitor." (Youth offending service, round one).
>
> "Vulnerable mothers may not have time to attend clinic especially if they have little support, Also: increase self-esteem via work may influence future sexual behaviour? Health visitors etc. have the contact and have the opportunity to develop good rapports that help people often to discuss sex and contraception." (HIV specialist nurse, round one).

Concerns were expressed about the preparation needed by the various professional groups in touch with vulnerable young women. For example:

> "Not sure what level of training midwives, nurses, health visitors have had to be able to offer advice and guidance on education, training and employment" (NHS commissioner, sexual health services, round one).

> "Not certain to what extent the health professionals mentioned could provide advice on employment and training and how appropriate it is for them to do so." (Family planning physician, round one).

The recommendation was relevant to 51% of respondents. Those providing antenatal and postnatal care (midwives and health visitors) were included in the general professionals category, and these were more likely to strongly agree with the relevance of the recommendation (47% vs 31% of those specialising in sexual health: table 4.2). The recommendation was perceived as being useful in delivering services by 49% of participants (table 4.3).

Of those indicating the recommendation was relevant, 47% were already providing regular home visits to pregnant women and young mothers (table 4.4). This included all three of the health visitors and four out of the five midwives. Of those who had stated that they were providing home visits, most gave advice on contraception and general health promotion advice (90% each), as well as LARC, emergency contraception and STIs (85% each). Fewer (although still a majority) gave advice on returning to education, training or employment (65%: table 4.12). Midwives (41%) and health visitors (53%) were the only health professionals mentioned as providing these home visits (table 4.13). The majority of participants (92%) who thought the question applicable referred clients to other agencies for advice and support where relevant (table 4.4).

Table 4.12 Recommendation 6: topics that are currently included in advice to vulnerable young people (number and percentage; includes only participants who stated they currently delivered this recommendation)

Role	Contra	STIs	LARC	EC	Health Prom	Ed/ Train/ Emp	Total *
Family planning physician	1 (100)	1 (100)	1 (100)	1 (100)	1 (100)		1
GUM nurse	1 (100)	1 (100)	1 (100)	1 (100)	1 (100)		1
GUM health advisor	1 (100)	1 (100)	1 (100)	1 (100)	1 (100)	1 (100)	1
GP	1 (100)	1 (100)	1 (100)	1 (100)			1
Practice nurse	1 (100)	1 (100)	1 (100)		1 (100)	1 (100)	1
Health visitor	2 (66.7)	1 (33.3)	2 (66.7)	3 (100)	3 (100)	2 (66.7)	3
Midwife	4 (100)	4 (100)	3 (75)	3 (75)	4 (100)	3 (75)	4
Youth offending service						1 (100)	1
Services for vulnerable groups	2 (100)	2 (100)	2 (100)	2 (100)	2 (100)	2 (100)	2
Young people's sexual health services	1 (100)	1 (100)	1 (100)	1 (100)	1 (100)		1
School nursing	3 (100)	3 (100)	3 (100)	3 (100)	3 (100)	2 (66.7)	3
Commissioner	1 (100)	1 (100)	1 (100)	1 (100)	1 (100)	1 (100)	1
Total	18 (90)	17 (85)	17 (85)	17 (85)	18 (90)	13 (65)	20

*Excluding double counting: participants could tick more than one option

Table 4.13 Recommendation 6: professionals used for home visits to vulnerable young people (number and percentage)

Role	Midwife	Health visitor	Not applicable	Total*
Family planning physician		1 (11.1)	6 (66.7)	9
Family planning nurse	1 (12.5)	1 (12.5)	6 (75)	8
GUM physician			10 (100)	10
GUM nurse			7 (100)	7
GUM health advisor	1 (16.7)		5 (83.3)	6
GP	1 (33.3)	1 (33.3)	1 (33.3)	3
Practice nurse	1 (33.3)	1 (33.3)	2 (66.7)	3
Health visitor	1 (33.3)	3 (100)		3
Midwife	5 (100)	2 (40)		5
Walk-in centre staff			5 (100)	5
Youth offending service	1 (100)	1 (100)		1
Services for vulnerable groups	1 (25)	2 (50)	2 (50)	4
Drugs and alcohol worker			2 (66.7)	3
Teenage pregnancy lead			1 (50)	2
Young people's sexual health services			2 (40)	5
School nursing	1 (16.7)	4 (66.7)	1 (16.7)	6
Compulsory education services			1 (100)	1
Chlamydia screening coordinator			2 (100)	2
Manager, sexual health services			5 (100)	5
Commissioner		1 (14.3)	5 (71.4)	7
Other			1 (100)	1
Total	13 (13.5)	17 (17.7)	64 (66.7)	96

*Excluding double counting: participants could tick more than one option

Most people felt the wording of the recommendation was appropriate (94%: table 4.6). However, some concerns were reported with occupational aspects of the recommendation, for example:

> "I think that the section of the recommendation dealing with return to work is not relevant in this piece of work. It appears to be promoting a government imperative, as return to work is not relevant necessarily to sexual health. I am not opposed to health professionals providing this sort of help and guidance but directions [about] this should not be included in this recommendation" (School nurse, round one).

Research recommendation

Ninety seven percent of respondents believed that the research priorities identified in the NICE guidance would help identify interventions that would improve sexual health (table 4.1). Qualitative comments reported similarly but stressed the need to assess the impact on behaviour change. For example:

> "We need to continually assess the most effective and cost-effective methods of both communicating and delivering sexual health services which are evidence-based" (Family planning physician, round one).

There were too few people disagreeing to allow for statistical comparisons between regions, professional groups or deprivation levels of the areas served. However, qualitative comments indicated that those disagreeing claimed that this evidence already exists or that research funding is difficult in the current NHS financial climate. For example:

> "I think that all the evidence is already out there as to how to provide good successful programmes that benefit the identified at risk groups. What we need is the support to carry out

> these services and not be hampered by yet more research or dictated as to what we can and cannot do - obviously where relevant to the service" (GUM nurse, round one).
>
> "In a time of financial crisis across PCTs and staff are working to maximum capacity with poor staffing numbers. New initiatives / research is not at this time a priority" (Lead practice nurse, round one).

Qualitative comments reported factors negatively impacting on the implementation of the recommendation were: human/funding resources, organisational leadership/capacity and technical infrastructure. Likewise factors reportedly impacting positively on implementing the recommendation were: profiling users' needs, being part of academic unit, motivation and support, being currently involved in research and resources.

In terms of their practice, 88% of participants agreed it was relevant (table 4.2), and there was no significant differences between groups (regions, professions or deprivation, backwards logistic regression, $p>0.05$). However, there was an effect of deprivation of population served in terms of whether the recommendation would enable them to carry out or support the research: those serving the most deprived areas were more likely than those in the most affluent areas to state that the recommendations would help them support research (adj OR=5.29, 95%CI=1.62-17.30, $p=0.006$, region and speciality were not significant, $p>0.05$). In total, 72% of participants felt the recommendation would help them to support or carry out such research (table 4.3).

Most people thought the wording of the recommendation was appropriate (95%: table 4.6), although critical comments did not relate to the wording as such but to the existing evidence, the complexity of recommendations and the resources/support for implementation. For example:

> "I agree with some of the statement but it needs to be broken down a lot more. I don't think resources should be taken from front line areas to fund it. I also feel that a different message about having sex needs to be a priority." (GUM nurse, round one).
>
> "In the era of payment by results there is little likelihood of getting funding or resources for such research."(GUM physician, round one).
>
> "I think that all the evidence is already out there as to how to provide good successful programmes that benefit the identified at risk groups. What we need is the support to carry out these services and not be hampered by yet more research or dictated as to what we can and cannot do - obviously where relevant to the service." (GUM nurse, round one).

Round two

Recommendation one

The high level of agreement with the recommendations identified in round one was also reflected in round two. Each recommendation had four questions that had been scored in round one and were repeated in round two: whether the recommendation would work, whether it was relevant to practice and whether it would be useful in delivering services. Participants viewed their previous answers and had the option to revise their opinion. In all cases the net movement of people between agreement categories was either positive (from disagreement or ticking not applicable to agreement), or zero (table 4.14). Qualitative comments indicative of change revealed the limited movement towards agreement, for example:

> "The above comments would alter some answers **more positively**" (GUM health advisor, round two, emphasis added).
>
> "I would change my answers [on the relevance and usefulness] **to agree**. My previous answer was based on what we already do in GUM clinics so I felt there was no need to change but for other services I agree that identification of high risk sexual behaviour & onward referral to an 'appropriately' trained practitioner.." (GUM physician, round two, emphasis added).

Agreement that the first recommendation would help to reduce STIs, already high at 95%, increased to 97%. Four people changed their opinion on the relevance of the recommendation to their practice;

the largest net change of opinion out of all the questions, moving agreement up from 88% to 91% (table 4.14). Agreement on the usefulness for delivering services and on the appropriateness of the wording increased slightly to 88% and 86% respectively.

Qualitative comments also showed that respondents were concerned about funding equity (e.g. financial incentives for general practice), rationalising their previous round one choices and the use/definition of terms in the recommendation, like 'counselling', 'high risk young people' and 'integrated services' (Family Planning/STI).

Table 4.14. Percentage agreement with the usefulness and relevance of the guidance in each round, by role and region

		Percentage agreeing		Net change (no. individuals)*	Total number
		Round 1	Round 2		
Recommendation 1	Will work	95	97	2	105
	Is relevant	88	91	4	105
	Is useful	87	88	1	105
	Is worded appropriately	85	86	1	105
Recommendation 2	Will work	82	84	2	100
	Is relevant	76	78	2	100
	Is useful	66	69	3	100
	Is worded appropriately	74	77	3	100
Recommendation 3	Will work	98	99	1	100
	Is relevant	83	85	2	100
	Is useful	80	83	3	100
	Is worded appropriately	86	87	1	100
Recommendation 4	Will work	99	99	0	99
	Is relevant	95	96	1	99
	Is useful	92	93	1	99
	Is worded appropriately	89	89	0	99
Recommendation 5	Will work	97	97	0	99
	Is relevant	93	94	1	99
	Is useful	91	91	0	99
	Is worded appropriately	90	90	0	99
Recommendation 6	Will work	98	98	0	96
	Is relevant	51	54	3	96
	Is useful	49	51	2	96
	Is worded appropriately	94	94	0	96
Research recommendations	Will be useful	97	98	1	94
	Are relevant	88	90	2	94
	Will support research	72	72	0	94
	Are worded appropriately	95	96	1	94

*All positive values, denoting more people changing from disagree or not applicable to agree in the second round

Recommendation two

Recommendation two also saw slightly more agreement on all the questions, representing two or three people changing their opinions. Agreement on whether the recommendation would work (84%), whether it was relevant (78%), useful (69%) and agreement with the wording (77%) were all higher on round two. Qualitative comments similarly reflected these themes, for example, limited change towards agreement:

> "The difficulty I am having is that the organisation I work for does have a helpline and does give emotional support to people on a one to one signposting as necessary. Also helpline advisers

> have all had to undertake the telephone helpline brief counselling course. If this definition fits in with counselling then it is applicable to the service and my answers would steer **more towards slightly agree to agree**." (Project manager for a national sexual health charity, round two, emphasis added).

Further concerns were reported about the use of several terms, for example:

> "My choice .. was based on my concerns about the use of the word **counselling** .. Counselling can mean different things to different people and may not always be the best way to address issues…" (NHS commissioner, sexual health services, round two, emphasis added).

> "In the wording **community health** should make explicit family planning. Redefining counselling and appropriately trained practitioner important" (Family planning physician, round two, emphasis added).

> "For this recommendation to be relevant to general practice, the use of a word **other than counselling**, and the **timings** should be considered." (GP, round two, emphasis added).

In addition, questions about the evidence base for counselling used less categorical to more categorically worded statements, for example:

> "I **wonder if there is actually any evidence** that counselling will result in behaviour change" (Family planning physician, round two, emphasis added).

> "..there is **little evidence** that counselling effects behaviour change and while there may be a role within sexual health services many services are currently too overstretched to provide this level of intensive one to one counselling. Placing a time of 20 minutes is far too prescriptive." (Family planning physician, round two, emphasis added).

> "I am of the view that the only way to reduce STIs is to make sexual health services more accessible, both in terms of ease of appointments, less stigmatised, and faster turn around times for results etc**. I am not convinced** that counselling changes behaviour" (GP, round two, emphasis added).

> "In a many settings skills, resources & time do not permit intensive one to one counselling. Such counselling **has not been proven** to be effective. In our GUM clinic we used multi-skilled nurses to do initial counselling & refer on 'difficult or needy' clients to a clinical psychologist who can use CBT [cognitive behaviour therapy] techniques to try and effect a behaviour change…" (GUM physician, round two, emphasis added).

Comments arguing that the recommendation has being achieved in practice could reflect rationales for further population-wide interventions, for example:

> "This is already done – by the professional treating the patient – not by a counsellor. There are measures **that could be taken** that would have a **greater impact on the sexual health of the nation** – **e.g. increase the tax on alcohol as the minister suggested last week**. Also much **more publicity about condom use** – and the government needs to lean on programme makers to carry stories with a positive sexual health message instead of just glorifying sex all the time – in the US programme makers get a tax concession if they do stories with appropriate public health messages – e.g. if "ER" carries a story about a drug user getting hepatitis from sharing needles." (NHS commissioner, sexual health services, round two, emphasis added).

Recommendation three

Recommendation three had a high level of agreement at round one (98%). On round two, one person changed opinion to agree, leaving only one person (1%) disagreeing with the recommendation. Agreement with the relevance (85%), usefulness (83%) and appropriateness of the wording (87%) all increased slightly in round two (table 4.14). Qualitative comments resonated with the previous round one concerns regarding use of the term 'community contraception services' (instead of 'family planning') and those surrounding partner notification, for example:

> "I still wish treatment **not to be separated from partner notification** either **geographically or in time**" (GUM physician, round two, emphasis added)

> "I don't feel happy with the statement because I don't think that contacts should be sent treatment **without having a history taken**" (Respondent, round two, emphases added)

> "..the whole issue of **partner tracing and criminalisation** will become a **bigger issue and barrier** due to HIV transmission linked convictions" (GUM nurse, round two, emphases added).

Recommendation four

Recommendation four was the recommendation with the highest level of agreement, with everyone agreeing in round one that it would help reduce STIs (and no change on round two), and agreement with the relevance and usefulness increasing slightly (to 96% and 93%: table 4.14). Agreement with the wording was unchanged at 89%. Qualitative comments reported a little concern with the 'catch-all' use of the term sexual health services and that use of 'community contraception services' was more appropriate, again, noting these services' limitations, for example:

> "..wording for commissioned services should remain as it is – community contraception services are NOT specialist in testing, treatment and partner notification for STIs" (GUM nurse, round two).

The concerns raised in round one over any stigma associated with STI services being conflated with 'traditional' family planning services were addressed through positive solutions, for example:

> "Concerns over STI services in community settings with family planning should reduce stigma as clients can be attending for a multitude of reasons" (Family planning nurse, round two).

> "The concern for STI testing in family planning clinics appears unfounded as women often request both contraception and testing for STIs at the same visit." (Family planning physician, round two).

> "Clinics should be multi purpose to avoid stigma." (GUM nurse, round two).

Recommendation five

Recommendation five saw little change in scores, with agreement that the recommendation could improve the sexual health of vulnerable young people standing at 97% at the end of round two. Ninety four percent agreed with the relevance, 91% agreed with the usefulness and 90% agreed with the wording at the end of round two. Qualitative comments were concerned with additional information in support of respondents' round one choice and with redefining terms, for example:

> "I note that – whereas the statement details pregnancy prevention interventions – in relation to STI risk it only talks about primary prevention and omits in the suggested discussion giving information on risk assessment, benefits of screening and the intervention of STI testing. Young people should be advised how and where to get tested not only how to access contraception" (GUM physician, round two).

> "Use of 'fertility control' is outdated - suggest use 'contraception' instead" (Family planning physician, round two).

> "Young people's sexual health services need to include both comprehensive contraception & STI screening including serology not just pee in pot!" (GUM physician, round two).

Recommendation six

Participants agreed overwhelmingly that recommendation six would improve the sexual health of vulnerable young mothers (98% in both rounds). However, as in the first round, many people scored the relevance to practice and usefulness to service as not applicable since the recommendation relates to antenatal and postnatal services. Despite this, agreement did increase from 52% to 54% for relevance and from 49% to 51% for usefulness. The majority agreed with the wording (94%), and

this was unchanged from the first round. There were no open comments in round two for recommendation six.

Research recommendations

There was strong agreement with the research recommendations, and this was little changed from the first round, with 98% (up from 97%) citing them as useful, 90% (up from 88%) citing them as relevant to them and 72% (unchanged) saying they would help to support them to carry out or support research. The wording was deemed appropriate by the vast majority (96%), although qualitative comment reiterated concerns about the evidence base, for example:

> "Outcome measures of change in behaviour are **needed** for validity of such research. Additionally research should also look at repeat unintended pregnancies and abortions and what can be done to reduce these." (Family planning physician, round two, emphasis added)

Feedback on the questionnaire and methodology

We invited participants to feedback on their experience of taking part in the survey. This was done using open questions. In the first round, a few comments reported difficulty with the format/terminology in the questionnaire and the time needed to complete the questionnaire. For example:

> "[needed] longer time to fill in the form. Due to staffing levels and clinic times, time is very short and sporadic. I don't feel I have given it my best effort due to the lack of time available." (GUM health advisor, round one).

Some comments reported that the recommendations are too broad and unrealistic in trying to apply to all sexual health services or found difficulty answering questions from the viewpoint of service commissioning. For example:

> "Some questions not universally applicable e.g. Commissioning Questions - not directly applicable to Provider service - more opportunity for free text especially if service doesn't fit into prescribed boxes" (Family planning physician, round one).

Other comments reported non-agreement with all of the recommended outcomes but saw the value in the approach whilst others wanted more of a profile for the family planning/contraceptive services as many vulnerable and sexually active young people are seen in these services that may not be catered for in general practice. For example:

> "Did not always agree with outcomes but saw the value in the approach." (Family planning physician, round one).

> "Please do not forget the Family Planning Contraceptives services where a lot of vulnerable sexually active Young People are seen. These services are neglected. GPs in our areas give the patients packets of contraceptive pills and tell them to attend FP clinic for instruction on how to take them." (Family planning nurse, round one).

In the second round, the majority of open comments were positive about the application of the Delphi methodology, the particular layout of the feedback by the research team and the manner whereby each individual respondent could anonymously read the particular comments of the whole group at each round. For example:

> "Easy to participate and useful to see collated feedback. Thank you." (GUM nurse, round two).

> "Was interesting to have feedback on what others thought" (GP-employed nurse, round one).

> "A clear and thought provoking survey" (Youth offending service, round two).

> "I found the process thought provoking and found this second part of the process useful in that it gave rise to alternative viewpoints. The layout of the statements is much better as the whole statement can be read without having to move it on the computer screen" (School nurse, round two).

> "Excellent opportunity to gain feedback of the views of the group as a whole which is so often missing from questionnaires" (Family planning physician, round one).

> "From the practical point of view it is good to be able to come back to the survey as and when one has a spare 1/2-hour. This, with the generous time scale for completion, must improve response rates I would have thought." (Clinical director, round one).

There were some concerns evident about the resources needed for implementing the recommendations and about the time taken to complete the web based questionnaire. For example:

> "It's useful for the timelines were difficult for people in pressurised jobs. Concerned that the recs, which were generally supported, will come out as guidelines with no resources attached" (Commissioner, sexual health services, round two).

> "It takes more than the time specified to complete the survey." (Consultant in Reproductive and Sexual Health , round two).

> "I found the time scales quite difficult due to work commitments. The questionnaire took me longer to complete than I was advised it would." (Chlamydia screening coordinator, round two).

In addition, there was evidence from round two comments that this particular methodology may have stimulated a need for further dialogue on the recommendations, which unfortunately was beyond survey's remit. For example:

> "I found that the summary of qualitative feedback did not necessarily change my previous answers/ opinions but I would have preferred the opportunity to discuss some of the points in more detail and did not feel that the survey offered the opportunity to do that.
> Hope all goes well and thank you for offering me the opportunity to be involved." (Family planning nurse, round two).

SECTION 5 – DISCUSSION

Participants in this survey were drawn from a variety of settings, and the majority had regular face-to-face contact with clients. These individuals will have a key role in delivering any recommendations to improve sexual health. The overwhelming majority of these participants believed that the recommendations would improve sexual health, and, indeed, in many cases, they considered that elements of the recommendations were already being carried out. The commitment and passion of these participants, many of whom are working in the sexual health field, was revealed by the extensive comments and detailed answers to the optional open questions. In general, we could identify little difference in opinion between the professionals from the two regions, or between those serving relatively deprived areas compared to relatively affluent areas, or between those working in services exclusively dedicated to sexual health (e.g. GUM and family planning staff) and those in more less specialised roles in terms of sexual health (e.g. health visitors, school nurses and midwives). However, several issues were raised that require further consideration in the development of sexual health intervention guidance.

Recommendation one

The first recommendation states that health professionals should identify individuals at high risk of STIs and provide or arrange counselling. The vast majority (97%) agreed that this would help reduce rates of STIs, 91% found it relevant to their practice, 88% said it would be useful in delivering their service and 86% thought the wording appropriate. Consideration is needed about how the recommendation can be made more relevant to delivery, given agreement was less strong for usefulness in delivery than relevance to practice (65% vs 76% strongly agreeing). Suggestions for wording included greater definition of the following terms: ‘counselling’, ‘high risk’, ‘provide’ and ‘appropriate trained practitioner’. Most of those working in sexual health settings reported they were already carrying out the recommendation, as did 72% of those in other settings. Factors that could enable the recommendation to be carried out were perceived as better education (for example in general practice), better integration of services, and not restricting the recommendation to health settings. Barriers that might hinder the recommendation being put in place were perceived as a lack of resources (staffing and financial) and the potential that the move towards criminalising STI transmission will mean that individuals will not want to disclose risky behaviour as there are perceived to be potential legal implications/ramifications prospectively given such disclosures. Due to the diversity in comments about what constitutes assessment of ‘high risk’, further consideration should be given to determining what themes constitute the most effective assessment of ‘high risk’ in terms of mandating these components for inclusion in sexual history taking.

Recommendation two

Recommendation two states that health professionals trained in sexual health counselling should provide counselling for high risk individuals. Although the majority (84% by the end of round two) agreed that implementing this recommendation would improve sexual health, this was the lowest overall agreement found for any of the recommendations tested in this survey. Consideration should be given to this finding in terms of the concerns expressed and detailed below about what defines ‘counselling’, resources and the sceptical perceptions over of the nature of the evidence base, all of which may have impacted on perceptions of the efficacy of the recommendation.

It was pointed out that providing very intensive services for selected clients might jeopardise the provision of accessible services for all. Those delivering exclusively sexual health services were more likely to find the recommendation relevant. Further consideration may need to be given to this perception of relevance, in relation to any consumer expectations concerning the overall ability of a health professional *per se* to undertake appropriate advice-giving/counselling. There may also be consumer implications as regards user attitudes about signposting into the more appropriate NHS services to present to; although this may entail further workload implications and ramifications.

Most of those who thought the recommendation relevant to them were already integrating counselling into core services or using existing specialised roles. The participants identified a wide variety of settings where such counselling currently takes place, including in schools and youth offending settings, as well as the more traditional GUM setting.

The main problem with the recommendation as it stands is that the use of the term ‘counselling’ and the specification of the duration, the combination of which have several effects: firstly, it appears to limit who can do the counselling to specialists; secondly, since these specialists are often based in

sexual health services, and fitting a 20 minute session causes a decrease in the capacity of the clinic unless there is a specific and integrated counselling service undertaking those interventions with a very credible evidence base e.g. cognitive behavioural therapy-type interventions; fourthly, clients who want a rapid service are discouraged; and finally, the wording then excludes other health professionals, who may well be capable, given training, thereby losing an opportunity to influence a potentially much larger number of people at risk of poor sexual health.

Despite the fact that the recommendation is based on evidence and documented in the NICE report, there was also a degree of scepticism as to whether there was any credible evidence that counselling actually 'works', and this scepticism was even more pronounced in the second round of the questionnaire. Consideration ought to be given to these perceptions of scepticism regarding the credibility of the evidence base, especially given the professionally informed nature of the respondents. Because of some of these perceived problems, a significant minority (23%) thought that the recommendation was worded inappropriately. This recommendation either should to refer to counselling in its strictest sense (and therefore be out of the remit of most GPs and other professionals), or should be less prescriptive about minimum session time and should define counselling more carefully, or (preferably) use a less loaded term other than counselling, like for example 'advice giving'.

Recommendation three

All bar one person responding to the survey agreed that if health professionals provided help to patients with an STI to get their partners tested and treated, then this would have an impact on the rates of STIs. Given that one in five participants from general backgrounds (double the percentage of those in specialist roles) thought this recommendation was not applicable to service delivery, further consideration may need to be given to increasing the positive perceptions of those working in less specialist sexual health roles about how the recommendation could be applied.

Most sexual health practitioners were already providing this service. Partner notification is currently delivered through integration with screening programmes, use of community-based health advisors, trained GPs/practice nurses and via patients undertaking contract tracing. However, difficulties associated with reduced patient anonymity were perceived, particularly for GPs. Further consideration should be given to overcoming perceptions of the difficulty of partner notification in specific settings (e.g. in GP) through provision of information on suitable models of service delivery. A limited number of partner notification models were reported, such as the provider informing partners without disclosing the identity of the index patient, which was seen as potentially useful in community settings. Factors enabling implementation of the recommendation were perceived as workforce competency and attitude training, treating STIs in community contraception clinics and providing GP time and funding for unregistered patients.

One crucial concern is that criminalisation of STI transmission may fatally complicate the implementation of this recommendation. Further consideration should be given to this issue, which appeared to embody significant adverse consequences for this recommendation.

Practitioners were more likely to state that they were currently providing information to the partners of those with STIs (84%), and medication for partners was provided by 61% of all respondents. However, there were strong concerns about home test kits, the provision of medication for a partner without knowledge of their medical history or without medical assessment in person and the specific legal footing of such practice, as well as the missed opportunity to screen for other STIs. Further consideration should be given to clarifying the current legal position of such current and future practices; and where the respective Royal Colleges are positioned in relation to these practices for all types of prescribing practitioners (doctors, nurses and pharmacists) as well as information on the likelihood of litigation/prosecution and professional reporting in cases of perceived adverse effects.

Suggestions for re-wording of the recommendation included changing 'disease specific' to 'infection specific' and include 'family planning'.

Recommendation four

It was overwhelmingly agreed that recommendation four, that primary care trust commissioners should ensure that sexual health services are in place to meet local needs, that services should include arrangements for the notification, testing, treatment and follow up of partners of people with

STIs, would help reduce STI rates (99% of participants). Participants stressed adequacy of funding, more empowered commissioning with service level agreements and having incentives, training and monitoring for GP involvement (e.g. with HIV patients) and user guidelines and audit for partner notification, as well as a higher profile for asymptomatic community screening. Further consideration should be given to commissioning for a variety of forms of GP incentivisation to undertake a range of sexual health work. Whilst the majority stated that arrangements for partner notification already formed part of sexual health services and met local needs, only 58% felt that an audit framework was in place to monitor this. The recommendation also states that the individual responsibilities of both specialist and non-specialist services should be defined, and this is the area where there was the biggest gap between any of the recommendations and current practice: over two thirds felt that this was not the case for GUM services, and three quarters thought this was not the case for Chlamydia screening services. Even fewer (11%) felt that the role of non-specialist primary and community services was defined, and only 10% felt this was true of specialist GP services. Further consideration may be required about ways for commissioners to help define in practice terms the responsibilities of specialist and non-specialist services.

In terms of staff training, the vast majority of participants thought that staff had competencies fit for purpose and most felt this was audited. Although some thought that NICE should consider including 'commissioned community contraception services' under 'specialist sexual health services', others thought that community contraception services were not specialist in STI testing, treatment and partner notification. Further consideration should be given to practitioners' perceptions over the mutual and potential relationships between commissioned 'GUM' and 'family planning' and/or 'reproductive health' services. The recommendation should be re-worded to reflect the logical sequence of testing, treatment, then notification and follow-up.

A concern brought up in the first round that combining STI testing in family planning clinics could put people off attending due to the stigma of STIs was dismissed by several people in the second round. The majority opinion was that combining the two helped to reduce stigma because clients could be attending for a number of reasons, and frequently requested both contraception and testing in the same visit.

Recommendation five

The vast majority (97%) agreed that if health professionals were to provide vulnerable young people with one to one sexual health advice, including prevention of STIs and pregnancy, this would result in improved sexual health. However, the importance of early sex education was stressed, which is fully congruent with the credible evidence base indicating positive health and social outcomes from sex and relationship education begun prior to the onset of sexual activity (Downing *et al.* 2006a). Respondents described successful models for providing this advice to vulnerable young people, including multi-agency working, priority training and referral links. Most respondents already provided advice on contraception (including LARC and emergency contraception) and it was suggested that using community contraceptive services with convenient opening hours (Saturdays and evenings) was an effective and cost-effective way of providing this. Young people's services should be provided in general practice and less formal or traditional settings, and there should be several access points. 'Family planning' should be re-titled 'community contraception service'. Health commissioners should give further consideration to these latter suggestions for re-titling of services.

Suggestions for changing the wording included replacing 'vulnerable' with 'all under 18 years' although others feared that widening the definition would make the recommendation unworkable. For example some thought that while would be feasible to target vulnerable young people through specific settings, for example youth offending schemes, in the current definition 'the net is drawn too widely above to be realistically affordable'. Further consideration is needed on how wide the definition of a 'vulnerable young person' should be.

It was pointed out that the wording of the recommendation mentions STIs and pregnancy prevention, and then goes on to detail pregnancy prevention interventions (LARC and emergency contraception) without providing similar detail on STIs (for example advising young people on the benefits of screening, and how and where to get tested). Further consideration should be given to adding more detail for STI interventions.

Recommendation six

Recommendation six provides guidelines for vulnerable young women who are, or are going to be, mothers. The vast majority of the participants (98%) agreed that home visits by midwives, nurses and health visitors that included discussion about STI prevention and contraception would help improve the sexual health of these vulnerable young people. However, success of the recommendation will depend on adequate social support and follow up for teenage mothers, effective care pathways, the involvement of appropriately skilled midwives, health visitors and nurses, and use of a multi-agency approach (e.g. with Connexions, drug agencies).

It is well recognised that factors such as education are strongly linked to pregnancy in those aged under 18 years, and that some of the most powerful interventions to prevent such pregnancies aim to raise the aspirations of young people (Social Exclusion Unit, 1999). However, it was clear that health professionals questioned the appropriateness of their providing advice about education and training, and particularly questioned the relevance of advising young mothers to return to work. Comments suggested that some respondents saw the latter advice-giving as a more political-type of intervention, something possibly stemming from the government's employment policies, and much less directly related to the promotion of sexual health. In line with this, when asked about current practice, although most advised about LARC, emergency contraception and STIs (85%), only 65% advised about returning to education, training or employment. Further due consideration should be given to this apparent mis-match between the evidence base and the perceptions of informed respondents, prior to any change in the recommendation to promote the referral of young mothers to other practitioners for discussion of education/employment opportunities.

Research recommendations

Ninety seven percent of respondents believed that the research priorities identified in the NICE guidance would help identify interventions that would improve sexual health (by promoting positive behavioural change), although some argued that the evidence already existed or that research funding is difficult in the current NHS financial climate. Other than a lack of resources, barriers to implementing the research recommendations were lack of organisational leadership and capacity, and poor technical infrastructure. Profiling users' needs, being part of academic unit, motivation and support, and being currently involved in research were all identified as facilitating research. Those working in them most deprived areas were more likely to think that the recommendation would help them support research. Additional suggestions for the research recommendation including identifying what would work to reduce repeat unintended pregnancies or terminations.

Strengths, limitations and recommendations from the methodology

This study has demonstrated and harnessed the high degree of motivation by health care professionals to volunteer views and ideas, and in general was viewed positively by respondents. Participants particularly appreciated the second round of the questionnaire, since allowing them to view previous responses and summaries of comments gave the study the flavour of participatory action research. The study therefore resembled a focus group where each participant could intimately articulate to the researchers their own perceptions/viewpoints, whilst simultaneously remaining anonymous to the wider group and also very geographically dispersed. This research process was further enabled through a member of our research team (Kevin Corbett) who had both participatory action research and NHS sexual health expertise.

Our resultant methodological form of *'intimacy/anonymity at a distance'* was probably the closest that can be achieved without having face-to-face meetings, in a traditional workshop-style format. This particular method had the distinct advantage of being anonymous, and allowing participants sufficient 'voice' who may not be so outspoken in face-to-face settings due to various factors like management hierarchies and perceptions of superiority which often confound communications within interprofessional contexts. It also enabled the Delphi process to remain focused and not to become embroiled with potentially inconsequential, insignificant and time-intensive discussions, which can often occur in face-to-face encounters.

Conducting the survey as a questionnaire rather than as a workshop increased the potential pool of participants and meant that we could be systematic in our recruitment. Roles and areas were selected randomly, and then we sought to recruit a suitable individual. We were not always able to get a list of people from which to select randomly, but nethertheless we feel that this systematic

approach reduced bias in recruitment. Disappointingly, despite intensive effort, recruitment in certain key roles was low, notably GPs and practice nurses.

During the lead in time to the project we invested a lot of effort into identifying and building relationships with our participants. We also used relationships between NHS participants to aid this process, for example a London-based consultant in reproductive sexual health posted details our contact details on a service website and fed back to the research team the contact details of other potential respondents to help build contacts for the sampling frame, and this occurred with several contacts. These relationships with participants, valid e-mail address and contacts were all established in advance so that when the survey took place, almost all those recruited managed to complete it. The use of e-mail and internet technology greatly facilitated the delivery of the survey, and this was seen as an appropriate way of communicating with individuals (see the appendices for illustration of the design of the questionnaire). During the recruitment phase (which involved intensive telephoning as well as e-mails), not one person requested a paper copy of the questionnaire. In retrospect, given the timescales for the survey (final recommendations received 4th October 2006, fieldwork period from 9th October to 6th November 2006), a paper-based technique would have failed to reach sufficient participants in time and also would have prevented prompt follow-up of non-responders, as well as being overly long to analyse. The significant advantages of the online questionnaire were that:

- It was more rapid to design (it is easier to lay out questions since a screen is larger than standard paper)
- Drop down menus took up less space, and therefore the size of the questionnaire was smaller and not as off-putting
- Some questions were be set as mandatory, thus avoiding the problem of non completion
- E-mail notification alerted us when participants had completed
- Data were accumulated in a database, which, because it was appropriately designed, was already in the ideal format for analysis – no data entry required. This was an advantage at all stages, but particularly because it enabled rapid feedback for round two
- Participants could save incomplete versions of the questionnaire for completion later. This was more likely to fit in to a busy schedule.

The short timescale allowed for the survey was a significant challenge, which was overcome in several ways:

- Advanced recruitment, establishment of e-mail contact and assuring the participants' availability throughout the survey period
- Web designers with appropriate experience of online database technologies on hand to rapidly create each version of the questionnaire (for example, only four days from receipt of final wording of recommendations to launch of the website; including researcher effort in designing questions as well as the technical aspects)
- Automatic notification of completion of questionnaires and maintaining an up to date tracking list of participants allowing e-mail reminders, and phone calls where necessary
- At the end of the first round, intensive researcher effort was needed to analyse the qualitative comments, the quantity of which had not been anticipated, in order to rapidly incorporate findings into the second round.

Some participants did complain that the questionnaire took longer than they had been told or anticipated. We had estimated 25 minutes on the basis of reading the questionnaire and responding to the mandatory (tick box) questions. We had not appreciated the extent to which our participants would contribute additional comments, opinions and suggestions. Although having only five days to complete each round was a barrier to some, the survey was more inclusive than relying on people being able to attend workshops.

If more time had been available it may have been feasible to develop the qualitative thematic in the second round so that people could vote on each particular suggestion e.g. statements like *'Integrating STI testing with family planning will put off some people attending because of the stigma associated with STIs'* would have been presented so that respondents could have fed back 'strongly agree', 'agree' etc. as appropriate.

One of the aims of this project was to identify whether a rapid two-round modified Delphi technique would be useful in achieving consensus on public health recommendations. However, because there was in general very good agreement with the recommendations on the first round, there was only a fairly limited opportunity for people to change mind towards consensus. In addition, it is interesting to consider how the precise manner whereby each second round participant could personally gain on-line access to their own first round responses, enabled their second round responses; because by being so reminded they did not have to rely on memory, or even pull out hardcopy printouts. Our discussions with the organisers of other Delphi surveys of healthcare professionals appear to indicate that the latter factor is indeed an enhancement that improved our study's methodological validity (e.g. Finger *et al.* 2006). Although the finding of very good agreement with the recommendations they stand is a very positive finding for the purposes of developing the sexual health intervention guidance, from a methodological point of view, it would have been interesting to see to what extent consensus could be achieved in two rounds on a more contentious topic. An example of such an area could be the issues surrounding criminalisation of STI transmission raised by some participants in this study.

In summary, we recommend that this methodology be considered in future as a valid alternative to the traditional workshop-style approach when gaining the views of sexual health and/or other healthcare professionals. Its major advantage is the breadth of potential participants that become available for recruitment, rather than the restricted subset of professionals that are willing or able to give a day to travel to/from a particular venue (usually at some distance from their occupational site) in order to take part in a workshop; which in itself produces potential bias in any survey. While the mandatory closed voting-style questions were very useful for summarising views, it could lead to criticism of the reductive closed question approach. However, because of the willingness and application shown by participants in spending considerable time inputting (often lengthy) comments, and our ability to rapidly synthesise/ feedback the qualitative data, our questionnaire retained in a 21st century context the typically inclusive and anonymous hallmarks that have been historically associated with the Delphi technique (e.g. Dalkey 1969).

SECTION 6 – CONCLUSIONS AND FURTHER CONSIDERATIONS

This research sought to consult individuals commissioning and delivering sexual health services at a local level. These individuals will have a key role in delivering any recommendations to improve sexual health. Participants in this survey were drawn from a variety of settings, and the majority had regular face-to-face contact with clients. The overwhelming majority of these participants believed that the recommendations would improve sexual health, and reported that many elements of the recommendations were already being carried out. The dedication of our participants was revealed by the extensive comments and detailed answers to the optional open questions, and these raised several issues that require further consideration in the development of sexual health intervention guidance. These are identified below for further consideration during the development of the final guidance. Additionally, we found that the survey methodology used, an online rapid Delphi-style consensus method, was highly successful in gauging opinion from a variety of people who may not necessarily have been available or willing to attend the more conventional focus group style of fieldwork. The rapid analysis and feedback of qualitative data (in addition to the percentage agreement statistics) was valued by the respondents, and increased their feeling of participation in the process.

Recommendation one

- Given the diversity in comments about what constitutes assessment of 'high risk', further consideration should be given to determining what themes constitute the most effective assessment of 'high risk' in terms of mandating these components for inclusion in sexual history taking.

Recommendation two

- Further consideration may need to be given to the fact that there was a low perception of relevance by those not in sexual health-specific roles, in relation to any consumer expectations concerning the overall ability of a health professional *per se* to undertake appropriate advice-giving/counselling
- Consideration ought to be given to scepticism regarding the credibility of the evidence base, especially given the professionally informed nature of the respondents.
- This recommendation either should to refer to counselling in its strictest sense (and therefore be out of the remit of most GPs and other professionals), or should be less prescriptive about minimum session time and should define counselling more carefully, or (preferably) use a less loaded term other than counselling, like for example 'advice giving'.

Recommendation three

- Given that one in five participants from general backgrounds (double the percentage of those in specialist roles) thought this recommendation not applicable to service delivery, further consideration may need to be given to increasing the positive perceptions of those working in less specialist sexual health roles about how the recommendation could be applied.
- Further consideration should be given to overcoming perceptions of the difficulty of partner notification in specific settings (e.g. in general practice) through provision of information on suitable models of service delivery.
- One crucial concern is that criminalisation of STI transmission may fatally complicate the implementation of this recommendation. Further consideration should be given to this issue, which appeared to embody potentially fatal prospective consequences for this recommendation.
- Further consideration should be given to clarifying the current legal position of current and future practices in terms of treating partners; and where the respective Royal Colleges are positioned in relation to these practices for all types of prescribing practitioners (doctors, nurses and pharmacists) as well as information on the likelihood of litigation or prosecution and professional reporting in cases of perceived adverse effects.
- Suggestions for re-wording of the recommendation included changing 'disease specific' to 'infection specific' and include 'family planning'.

Recommendation four

- Further consideration should be given to commissioning for a variety of forms of GP incentives to undertake a range of sexual health work.

- Further consideration may be required about ways for commissioners to help define in practice terms the responsibilities of specialist and non-specialist services.
- Further consideration should be given to practitioners' perceptions over the mutual and potential relationships between commissioned 'GUM' and 'family planning' and/or 'reproductive health' services.
- The recommendation should be re-worded to reflect the logical sequence of testing, treatment, then notification and follow-up.

Recommendation five

- Further consideration should be given to adding more detail for STI interventions.
- Further consideration is needed on how wide the definition of a 'vulnerable young person' should be.

Recommendation six

- Further due consideration should be given to the apparent mis-match between the evidence base and the perceptions of informed respondents, prior to any change in the recommendation to promote the referral of young mothers to other practitioners for discussion of education/employment opportunities.

Research recommendations

- Additional suggestions for the research recommendation including identifying what would work to reduce repeat unintended pregnancies or terminations.

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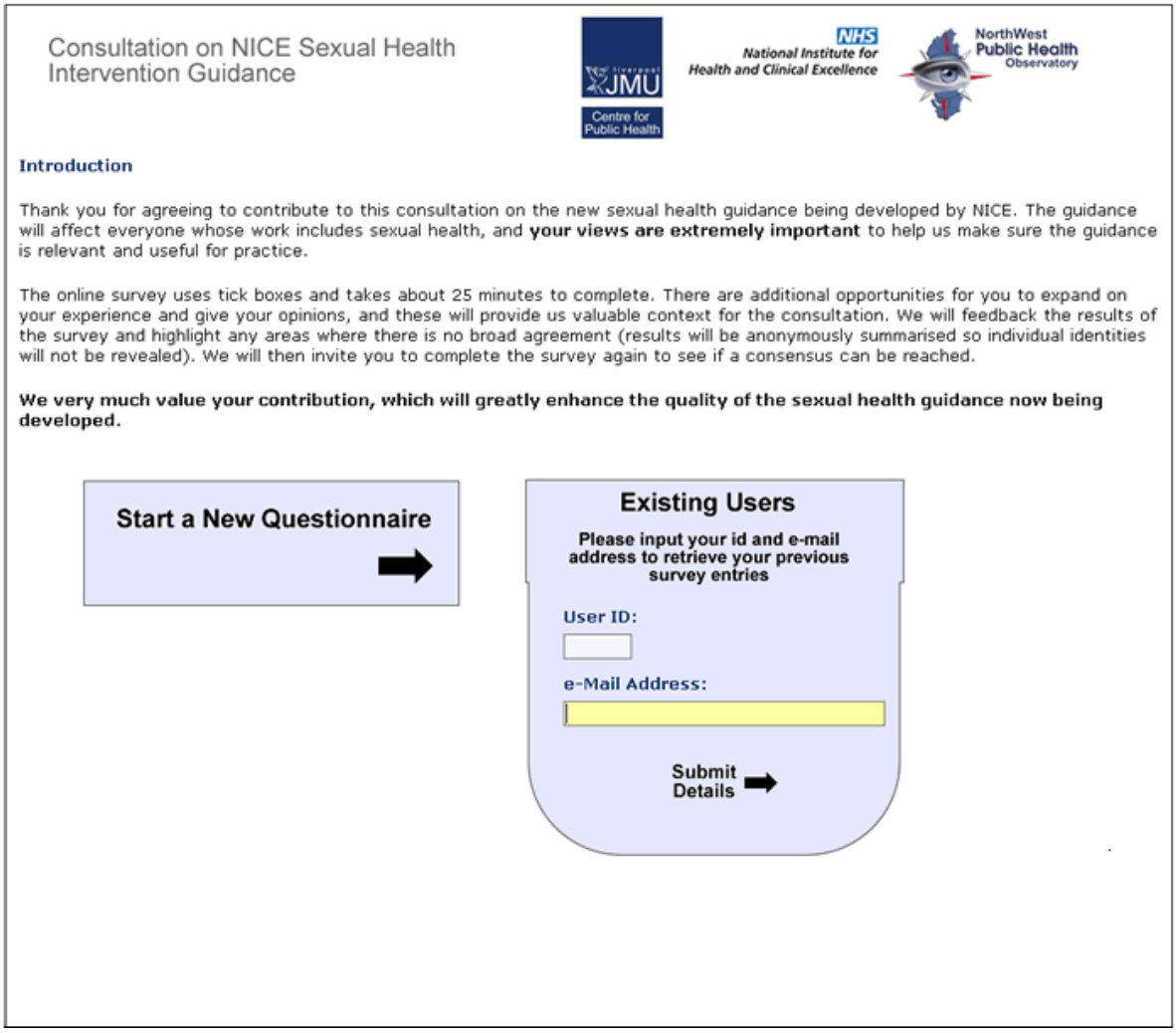
APPENDIX 1 – INTRODUCTION TO FIRST ROUND QUESTIONNAIRE



Consultation on NICE Sexual Health Intervention Guidance

LJMU Centre for Public Health

NHS National Institute for Health and Clinical Excellence

NorthWest Public Health Observatory

Introduction

Thank you for agreeing to contribute to this consultation on the new sexual health guidance being developed by NICE. The guidance will affect everyone whose work includes sexual health, and **your views are extremely important** to help us make sure the guidance is relevant and useful for practice.

The online survey uses tick boxes and takes about 25 minutes to complete. There are additional opportunities for you to expand on your experience and give your opinions, and these will provide us valuable context for the consultation. We will feedback the results of the survey and highlight any areas where there is no broad agreement (results will be anonymously summarised so individual identities will not be revealed). We will then invite you to complete the survey again to see if a consensus can be reached.

We very much value your contribution, which will greatly enhance the quality of the sexual health guidance now being developed.

Start a New Questionnaire ➡

Existing Users

Please input your id and e-mail address to retrieve your previous survey entries

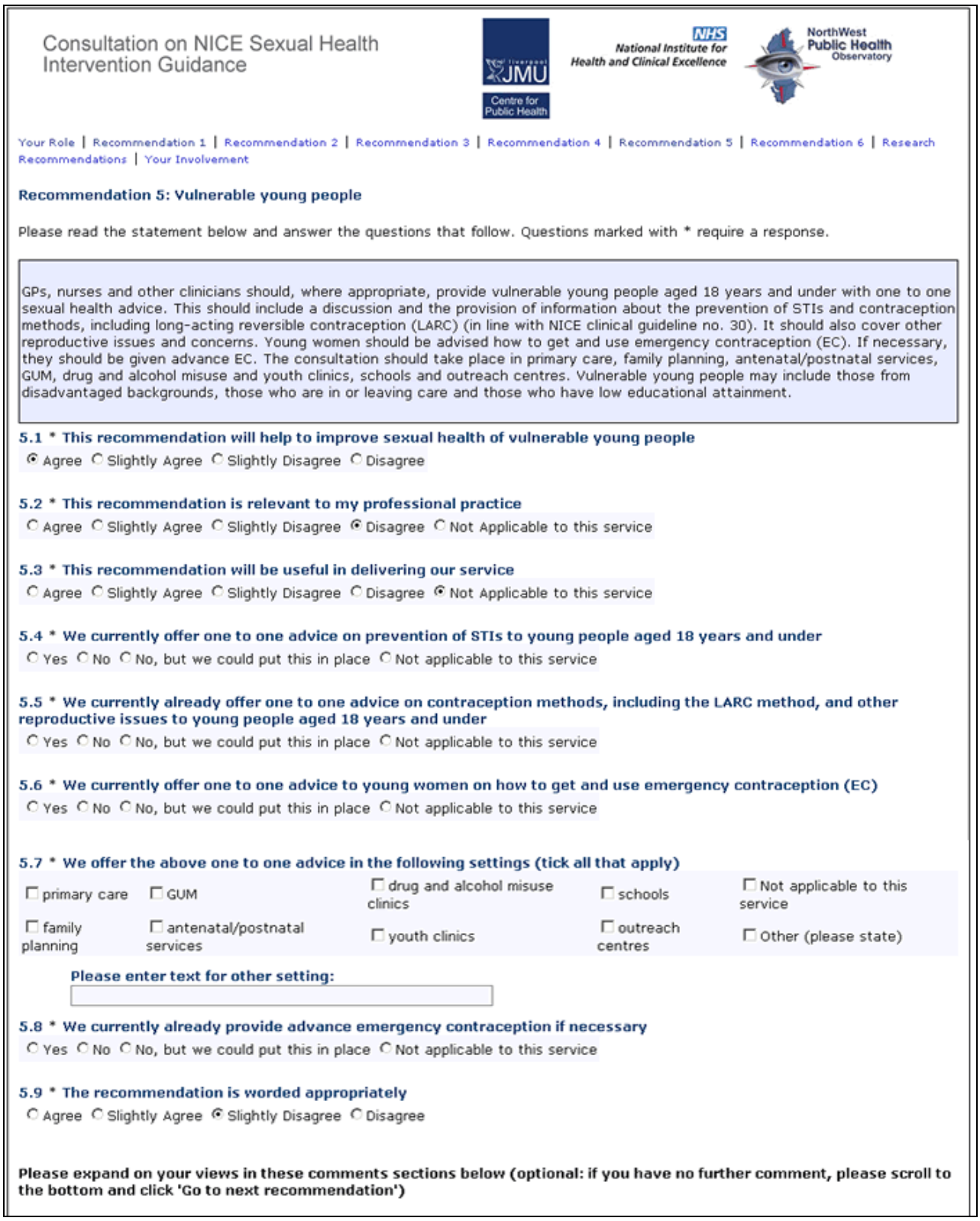
User ID:

e-Mail Address:

Submit Details ➡

APPENDIX 2 – EXAMPLE OF FIRST ROUND LAYOUT AND QUESTIONS

Quantitative (closed) questions – mandatory



Consultation on NICE Sexual Health Intervention Guidance

Your Role | Recommendation 1 | Recommendation 2 | Recommendation 3 | Recommendation 4 | Recommendation 5 | Recommendation 6 | Research Recommendations | Your Involvement

Recommendation 5: Vulnerable young people

Please read the statement below and answer the questions that follow. Questions marked with * require a response.

GPs, nurses and other clinicians should, where appropriate, provide vulnerable young people aged 18 years and under with one to one sexual health advice. This should include a discussion and the provision of information about the prevention of STIs and contraception methods, including long-acting reversible contraception (LARC) (in line with NICE clinical guideline no. 30). It should also cover other reproductive issues and concerns. Young women should be advised how to get and use emergency contraception (EC). If necessary, they should be given advance EC. The consultation should take place in primary care, family planning, antenatal/postnatal services, GUM, drug and alcohol misuse and youth clinics, schools and outreach centres. Vulnerable young people may include those from disadvantaged backgrounds, those who are in or leaving care and those who have low educational attainment.

5.1 * This recommendation will help to improve sexual health of vulnerable young people

(•) Agree ( ) Slightly Agree ( ) Slightly Disagree ( ) Disagree

5.2 * This recommendation is relevant to my professional practice

( ) Agree ( ) Slightly Agree ( ) Slightly Disagree (•) Disagree ( ) Not Applicable to this service

5.3 * This recommendation will be useful in delivering our service

( ) Agree ( ) Slightly Agree ( ) Slightly Disagree ( ) Disagree (•) Not Applicable to this service

5.4 * We currently offer one to one advice on prevention of STIs to young people aged 18 years and under

( ) Yes ( ) No ( ) No, but we could put this in place ( ) Not applicable to this service

5.5 * We currently already offer one to one advice on contraception methods, including the LARC method, and other reproductive issues to young people aged 18 years and under

( ) Yes ( ) No ( ) No, but we could put this in place ( ) Not applicable to this service

5.6 * We currently offer one to one advice to young women on how to get and use emergency contraception (EC)

( ) Yes ( ) No ( ) No, but we could put this in place ( ) Not applicable to this service

5.7 * We offer the above one to one advice in the following settings (tick all that apply)

☐ primary care	☐ GUM	☐ drug and alcohol misuse clinics	☐ schools	☐ Not applicable to this service
☐ family planning	☐ antenatal/postnatal services	☐ youth clinics	☐ outreach centres	☐ Other (please state)

Please enter text for other setting:

5.8 * We currently already provide advance emergency contraception if necessary

( ) Yes ( ) No ( ) No, but we could put this in place ( ) Not applicable to this service

5.9 * The recommendation is worded appropriately

( ) Agree ( ) Slightly Agree (•) Slightly Disagree ( ) Disagree

Please expand on your views in these comments sections below (optional: if you have no further comment, please scroll to the bottom and click 'Go to next recommendation')

Qualitative questions (open, optional)

GPs, nurses and other clinicians should, where appropriate, provide vulnerable young people aged 18 years and under with one to one sexual health advice. This should include a discussion and the provision of information about the prevention of STIs and contraception methods, including long-acting reversible contraception (LARC) (in line with NICE clinical guideline no. 30). It should also cover other reproductive issues and concerns. Young women should be advised how to get and use emergency contraception (EC). If necessary, they should be given advance EC. The consultation should take place in primary care, family planning, antenatal/postnatal services, GUM, drug and alcohol misuse and youth clinics, schools and outreach centres. Vulnerable young people may include those from disadvantaged backgrounds, those who are in or leaving care and those who have low educational attainment.

5.10 The recommendation will improve sexual health in vulnerable young people and is relevant/useful. If you agreed with these statements, please can you state why?

jlkj lkj lkj lkjlkj lkj lkj lk jl

5.11 If you disagreed, please can you state why?

5.12 If you currently provide one to one sexual health advice:

a. how have you been able to achieve this?

b. If LARC (long acting reversible contraceptive) is not discussed, why not?

5.13 If you currently target advice for vulnerable young people, how do you identify these people?

5.14 If you currently already provide advance emergency contraception to vulnerable young women

a. how have you been able to achieve this?

b. How do you identify vulnerable young women?

5.15 Assuming appropriate resources, what other factors would enable you to put this recommendation in place?

5.16 Assuming appropriate resources, what other barriers might make it difficult to put this recommendation in place?

5.17 Have you any comments or suggestions on the wording of the recommendation?

5.18 Have you any other comments or suggestions?

Save and Exit Go to next recommendation

APPENDIX 3 – EXAMPLE OF SECOND ROUND LAYOUT AND QUESTIONS

Quantitative questions and feedback

Participants could view their previous answers alongside the group response and change their response if desired.

Consultation on NICE Sexual Health Intervention Guidance

JMU Centre for Public Health

NHS National Institute for Health and Clinical Excellence

NorthWest Public Health Observatory

Recommendation 1 | Recommendation 2 | Recommendation 3 | Recommendation 4 | Recommendation 5 | Recommendation 6 | Research Recommendations | Your Involvement

Recommendation 5: Vulnerable young people

Please read the statement below and answer the questions that follow. Questions marked with * require a response.

GPs, nurses and other clinicians should, where appropriate, provide vulnerable young people aged 18 years and under with one to one sexual health advice. This should include a discussion – and the provision of information – about the prevention of STIs and contraception methods, including long-acting reversible contraception (LARC) (in line with NICE clinical guideline no. 30). It should also cover other reproductive issues and concerns. Young women should be advised how to get and use emergency contraception (EC). If necessary, they should be given advance EC. The consultation should take place in primary care, family planning, antenatal/postnatal services, GUM, drug and alcohol misuse and youth clinics, schools and outreach centres. Vulnerable young people may include those from disadvantaged backgrounds, those who are in – or leaving – care and those who have low educational attainment.

Summary of quantitative feedback

5.1 * This recommendation will help to improve sexual health of vulnerable young people (In the first round, 82% agreed and 15% slightly agreed; only 3% slightly disagreed)

◉ Agree ○ Slightly Agree ○ Slightly Disagree ○ Disagree

5.2 * This recommendation is relevant to my professional practice (In the first round, the overwhelming majority agreed – 92% – or slightly agreed – 7%; only 1% slightly disagreed)

○ Agree ○ Slightly Agree ○ Slightly Disagree ◉ Disagree ○ Not Applicable to this service

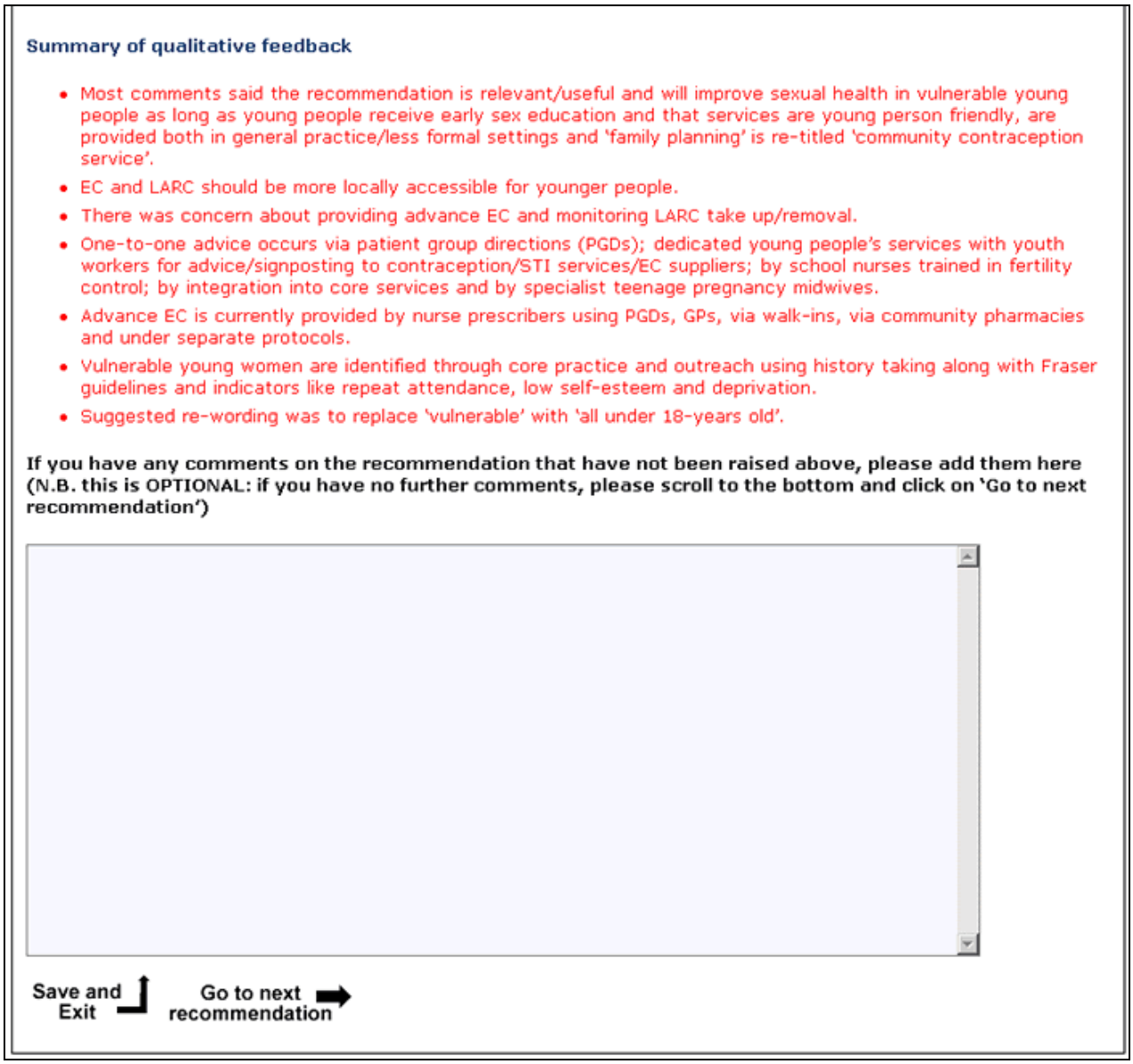
5.3 * This recommendation will be useful in delivering our service (In the first round, the overwhelming majority – 83% – agreed or slightly agreed – 16%; only 1% slightly disagreed)

○ Agree ○ Slightly Agree ○ Slightly Disagree ○ Disagree ◉ Not Applicable to this service

5.9 * The recommendation is worded appropriately (In the first round, 72% agreed and 18% slightly agreed; only 9% slightly disagreed and 1% disagreed)

○ Agree ○ Slightly Agree ◉ Slightly Disagree ○ Disagree

Qualitative feedback



Summary of qualitative feedback

- Most comments said the recommendation is relevant/useful and will improve sexual health in vulnerable young people as long as young people receive early sex education and that services are young person friendly, are provided both in general practice/less formal settings and 'family planning' is re-titled 'community contraception service'.
- EC and LARC should be more locally accessible for younger people.
- There was concern about providing advance EC and monitoring LARC take up/removal.
- One-to-one advice occurs via patient group directions (PGDs); dedicated young people's services with youth workers for advice/signposting to contraception/STI services/EC suppliers; by school nurses trained in fertility control; by integration into core services and by specialist teenage pregnancy midwives.
- Advance EC is currently provided by nurse prescribers using PGDs, GPs, via walk-ins, via community pharmacies and under separate protocols.
- Vulnerable young women are identified through core practice and outreach using history taking along with Fraser guidelines and indicators like repeat attendance, low self-esteem and deprivation.
- Suggested re-wording was to replace 'vulnerable' with 'all under 18-years old'.

If you have any comments on the recommendation that have not been raised above, please add them here (N.B. this is OPTIONAL: if you have no further comments, please scroll to the bottom and click on 'Go to next recommendation')

Save and Exit

Go to next recommendation