

Sexual Health Needs Assessments (SHNA) A 'How To Guide'



Commissioned Jointly by the Department of Health's National Support Teams for Sexual Health and Teenage Pregnancy

Overview of Design Options

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Design Options are experts in the UK in sexual and reproductive health, adolescent health, service design, monitoring & evaluation, policy & practice and user consultation. Within the broader health field we also have expertise in practice based commissioning and practice based provision.

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1. Introduction

1. Investment in sexual health services can deliver healthcare savings through preventing unplanned pregnancies and reducing the transmission of Sexually Transmitted Infections (STIs) including HIV. There is evidence that investment in sexual health interventions is good value for money (within the cost-effectiveness range accepted by the NHS) and in many cases cost-saving (see Appendix 1: Summary of the Economics of Sexual Health).

2. Primary Care Trusts (PCTs) are responsible for ensuring sexual health services meet local population needs and reduce health inequalities. To this end, appropriate service commissioning and service provision is inextricably linked to local sexual health needs assessments (SHNAs).

3. This guide is designed to assist lead officers responsible for coordinating, executing and delivering an SHNA. It is hoped this guide will be of interest to those who are responsible for the planning, commissioning and delivery of sexual health services and for reducing health inequalities.

4. Throughout this guide the term sexual health is used. Sexual health is a complex area of healthcare that extends beyond the provision of genito urinary medicine or contraception services operating in isolation.

5. Sexual health is a cross-cutting issue and liaison and discussion with colleagues across other sectors of healthcare and related services is therefore essential.

6. This joined up or partnership approach can ensure local services meet local population needs in an efficient and effective manner. An SHNA provides an essential start-point and a valuable opportunity to work towards integrating sexual health services.

7. Remember that when planning any needs assessment it is important that this is done within the context of planning and budgeting cycles within the NHS Local Development Plan processes and within the Local Authority Annual Planning cycles and strategies.



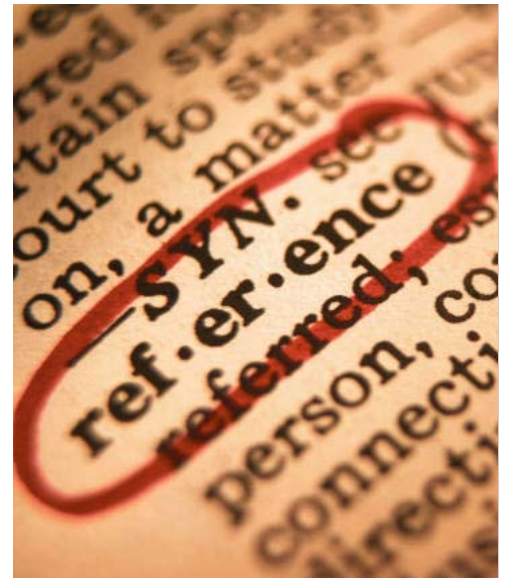
2.

A How to Guide

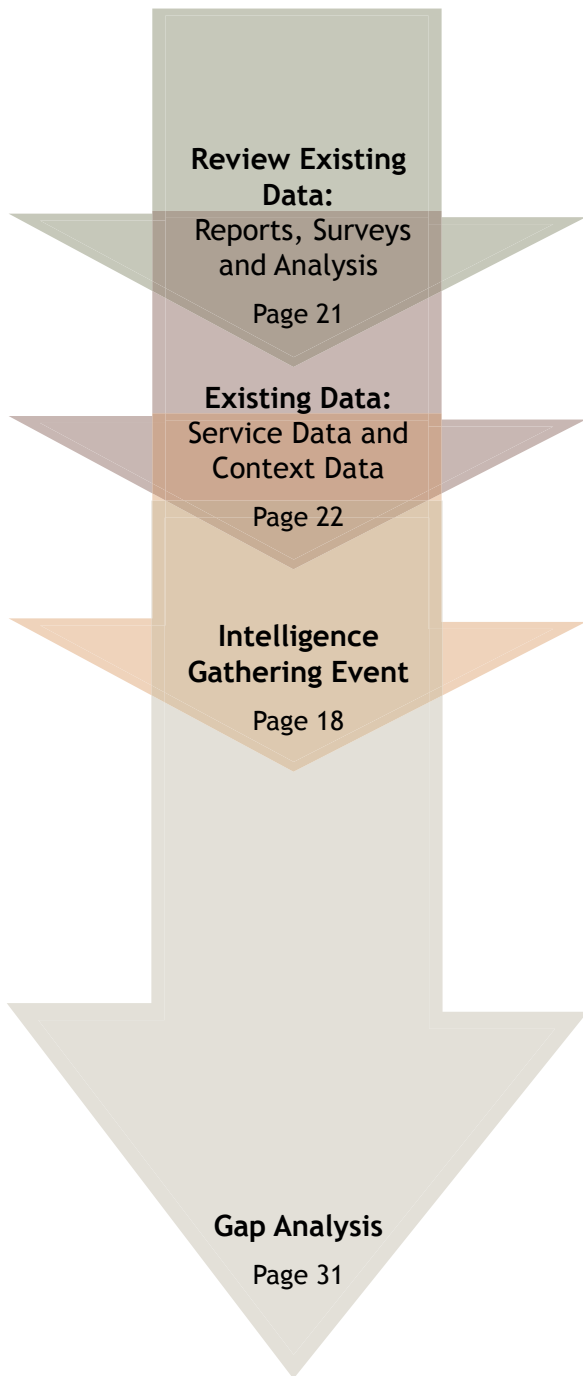
An SHNA is the first stage in a process of change. The information and intelligence you capture during an SHNA will provide the evidence for decision makers to inform them of the type and content of change needed to reduce health inequalities and to help meet current sexual health performance targets.

This Guide:

- Provides a brief overview and rationale for why an SHNA is necessary for good service delivery;
- Explains how to conduct a rapid SHNA and describes the key steps and tasks needed to conduct a more comprehensive SHNA (see figure 1 - page 6);
- Discusses existing data sources, which we have organised in broad streams, and suggests ways of gathering new data;
- Provides a useful reference section - signposting data sources and further information;
- Introduces you to some tried and tested methods to engage your stakeholders (such as Expert Panels);
- Provides a number of pointers to help you question the data and information you collect;
- Provides some useful tips and reminders to act as reference points as you work your way through your SHNA process.



Rapid SHNA



Comprehensive SHNA

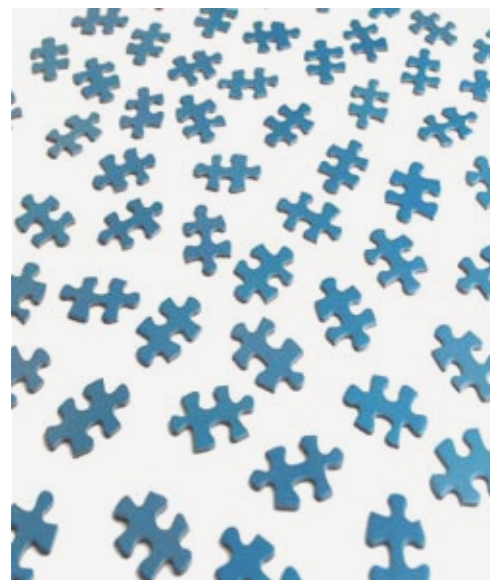


What Next?

3.

Why do an SHNA?

- 1. To better meet need and demand.** To gather the information you need to re-focus your local sexual health strategy and, in combination with a service re-design programme, change your services to better meet need and demand.
- 2. To focus on integration.** An SHNA reviews needs and maps services in an integrated fashion including related services and services delivered by other providers - the basis for integrated planning of service delivery.
- 3. To understand the local picture.** The SHNA process provides a baseline of need and current service content and configuration against which you can evaluate and measure the progress of any changes you implement.
- 4. To identify barriers to access and opportunities for overcoming them.** The determinants of needs and use among diverse populations are complex. An SHNA ensures you know your local population and their needs and can then facilitate better access to information and services among your population.
- 5. To help allocate scarce resources to best meet need.** Information collected during an SHNA will help service providers focus resources effectively and efficiently and inform prioritisation when there are conflicting demands. In the absence of a needs assessment there is a danger that services in historical locations that bear no resemblance to current patterns of need might be bolstered.
- 6. To engage your stakeholders.** Responsive services should ensure the ongoing involvement of staff, users and relevant community stakeholders. Carrying out a quality SHNA will stimulate involvement and ownership amongst your stakeholders.



4.

How long will an SHNA take?

1. In this guide we refer to two approaches to an SHNA: a **rapid SHNA** and a **comprehensive SHNA**. The distinction is not rigid but in summary the latter may take up to three to four months and generates *new* or primary data and information. A comprehensive SHNA requires far more in-depth investigation of the behaviours, preferences and barriers to access of the local population and involves a high degree of input from staff and practitioners.

2. A rapid SHNA does not generate primary data and concentrates on collating information that *already* exists and applying intelligence to it via a gap analysis. An effective rapid SHNA, which still provides sufficient information and intelligence for decision makers to improve the existing service content and configuration to better meet local need, could be completed within two-three weeks.

3. In this guide we describe the necessary core components of such a rapid SHNA and how you can undertake one without compromising quality. A rapid SHNA should however be looked at as a short term fix and not a substitute for a more thorough exercise. We also provide an overview of the methods to use for a more comprehensive SHNA.

Influences on Timescales

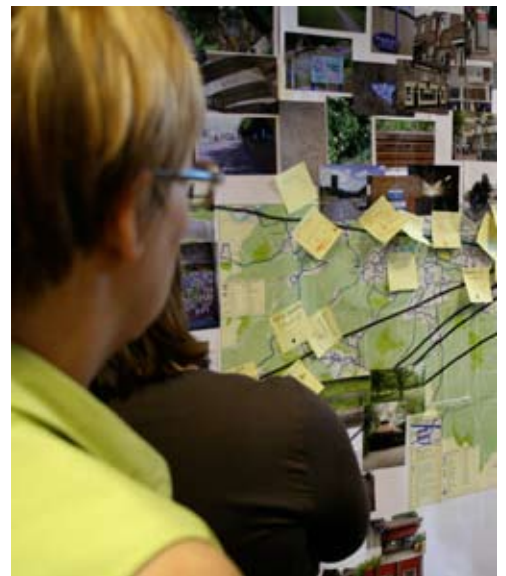
4. Key factors such as the skills of the person leading the exercise, the state of data and data sharing arrangements, the strength of your partnerships, organisational communications and the availability of key people can greatly influence the time needed. Any one of these factors can help or hinder the time your assessment will actually take.

5. If you have a well informed Public Health Observatory (PHO), Local Authority (LA) research unit or a strong public health analyst, the gathering of existing service and other data will be more straightforward. If the data sit with different people and have never been collated this stage will take longer.



6. Likewise, if you have a managed sexual health network already or a relevant alternative, identifying key informants and gathering their intelligence will also be a smoother and quicker process. In the absence of this and being realistic you need to incorporate time for locating data and key people.

7. Once you have your informants and your data and information the analysis and application of intelligence to this information can be undertaken relatively quickly. You can add a great deal of substance to your SHNA with a day spent with the right people and the right data if your time is limited. The preparation and gathering of the right information and identifying the right people are critical. **Don't scrimp on this.**



5.

How often do you need to conduct an SHNA?

1. What you would like to do and what you have the resources and time to do are often very different. Once you have conducted a comprehensive SHNA, elements will need to be reviewed on an on-going basis dependent on local circumstances.
2. Ideally you would undertake a comprehensive SHNA at least once every five years.
3. A rapid needs assessment would normally be undertaken between your comprehensive needs assessment or in response to significant policy, clinical or organisational changes or a funding opportunity.

Ongoing Monitoring and Evaluation

4. In the years between any SHNA it is important to have in place mechanisms for ongoing monitoring and evaluation of your services and user needs.
5. In some services such as contraception and genito urinary medicine (GUM), a range of data is already routinely collected (KT31, KC60 data) as these services have a statutory requirement to collect and report data centrally.
6. Routinely collecting and managing these data effectively will greatly assist in the data gathering stages of the SHNA whether rapid or comprehensive.



6.

An Overview: What are the core components of an SHNA?

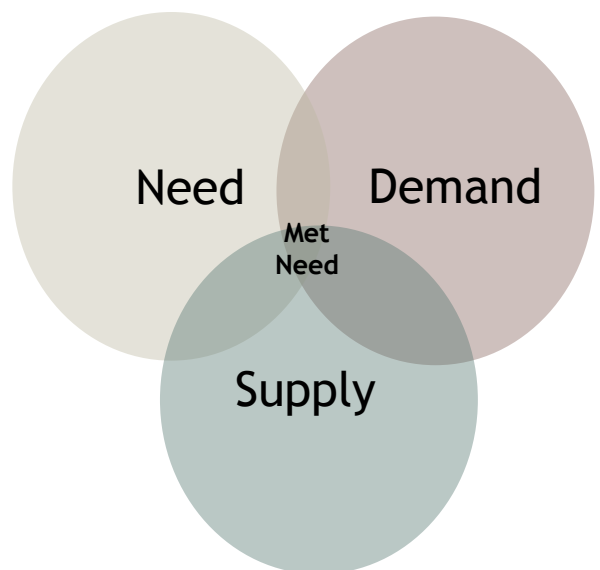
1. Irrespective of a rapid or comprehensive SHNA the core elements are to map need, examine demand, map service provision and then assess the gaps between these factors. This is illustrated in the diagram on the right (see also Appendix 3).

The latter element - the gap analysis - may highlight one of several outcomes. These are:

- Need but no demand
- Need but no supply
- Unmet demand
- Demand but insufficient supply †, ‡
- Demand but no supply
- Demand but no need
- Supply but not need
- Supply but no demand

2. The following section outlines these four steps and what each of them consists of so use this to plan out what data you need to collect and remind yourself how these data fits into the broader picture of identifying and meeting needs. This overview is useful if you are undertaking a rapid SHNA.

3. In Appendix 2 we have included a comprehensive list of data sources and a range of additional questions and issues to explore. This will further help you deliver a more comprehensive SHNA and serve as a reference point to help you navigate where you are in the process.



† Defined as insufficient capacity of existing provision, or inaccessible provision due to service configuration e.g. young people's clinics at midday on school days. ‡ Additionally, insufficient supply may lead to use of alternative services e.g. geographically misplaced young peoples services necessitating use of mainstream services or level 1 sexual health services being 'first point of contact' when higher-level specialised services required.

Mapping Need

4. An SHNA is ultimately about understanding the sexual health needs of your population and establishing whether the content and configuration (i.e. the supply) of your existing services adequately meet this need sufficiently to create demand that can be met. To map need you must find out information about the general population and about the size and location of your high risk groups.

- A key starting point is mapping groups at higher risk of negative sexual health outcomes such as STIs, unintended pregnancy or abortion

5. You also need to examine your service data and ask:

- Are you meeting existing performance targets?
- What is the level and change in rates of infection by type of infection?
- Have you any infection outbreaks among particular groups?
- What is happening to your local teenage conception, unwanted pregnancy and abortion rates across the area?

See section on data gathering - page 20

See page 29 and Appendix 2 for suggestions how to map need in non-users or potential users of sexual health services.

*These groups are at high risk for different reasons and have different types of health needs. See resource list to find out more about the relative risks for the above groups

HIGH RISK GROUPS*

Do you know who they are and where they are?*

Young men
Different BME groups
Gypsies and Travellers
Deprived estates and neighbourhoods
Looked after children
Care leavers
Teenage parents
Young Offenders
Prison population
Asylum seekers
Men who have sex with men

Resident Populations

Due to the open access nature of sexual health services, a number to which your resident population are accessing services in neighbouring PCTs. Liaise with those service commissioners and providers to ascertain the degree of your resident population accessing services "out of area"

Mapping Demand

6. Demand relates to those people who are willing to use services. There may be demand and use of services (i.e. service uptake) but there may also be a situation where there is demand but no supply (or insufficient supply) or demand but no need or both.

7. To map demand you need to identify all types of demand. This would include service uptake including general practice (GP), specialist community contraceptive services, abortion services, GUM services, condom distribution schemes, outreach sexual health services and emergency contraception schemes.

8. Ask if and how uptake varies by population and by service (type and location)? It would also include demand where potential users are willing to use a service but no service exists (or they are unable to get an appointment due to phone lines only being open at certain times). Identify situations where service uptake is high but the percentage of low risk attendees, as a proportion of total users, is also high.

9. You will have a range of service data that you collect from and about the people who use your services, some of which will be shared at national level with the Department of Health, the Health Protection Agency and at a local level with Teenage Pregnancy Partnership Boards. These data, when analysed, will help you establish service up-take and how closely your existing user profile matches the level of need you have identified.

10. There are ways you can assess demand where supply does not exist (or insufficient supply) by for example opening your service provider phone lines for e.g. 12 hours a day and over weekends for a period of time, and comparing demand over this period with that of a period during normal phone opening times. Other ways of estimating demand for which there is not the supply will rely on methods which help increase understanding about the experiences of particular types of users e.g. using your Expert Panel (as discussed on page 17).

Mapping Services (Supply)

11. The next parallel but critical task in an SHNA is to map services and related activities in your area.

- Where are they located?
- What do they provide and when do they provide it?
- Who delivers these services?
- You also need to look at the profile of those using your existing services.



12. Some services are likely to undertake activities that do not involve the provision of commodities or direct health services but are supporting activities such as sex and relationship education (SRE), health promotion or sign-posting services. It is important to map these services which are likely to be provided by a range of agencies including the community and voluntary sector.

13. You will need to work closely with all such groups to build a comprehensive picture of what is currently available and what activities are currently provided across your area.

14. An SHNA is also about identifying where your services are in relation to each other, to transport infrastructures and in relation to key population groups.

15. Work with a Geographic Information Systems (GIS) Analyst or at the very least use a large scale map to physically locate services to support this mapping exercise.

See section on service mapping - page 25

Analysing the Gaps

16. The final task is a gap analysis. Pull your information about need, supply and demand together and identify obvious gaps or mismatches in provision such as geographical gaps, over-supply, insufficient supply or mismatch against need in terms of service content and delivery mechanisms.

- You need to examine to what extent existing users reflect your higher risk groups compared with your lower risk population.
- If your groups at higher risk are not accessing existing services adequately - the next question is why?
- Do you have the right services for the need locally?

17. Look at what is being provided and ask whether it is configured in the best way to meet the needs your mapping exercise has identified. Are changes to service provision needed? Is there appropriate demand that is not met? i.e. are there groups willing to use services but, for whatever reason, are unable or unwilling to use services already available?



7.

Getting it Right: The detailed components of a good SHNA

1. While the steps for both a rapid and comprehensive SHNA are essentially the same, in this section we provide more detailed methods that will help you to deliver a robust and useful SHNA.
2. A comprehensive SHNA involves more focused activities to capture information directly from the general population and high risk groups about their needs, preferences, experiences and lifestyles.
3. Conducting an SHNA of the local population is not just an administrative number crunching exercise, it is about change and the SHNA should lead to a better shared understanding of the local population and their sexual health needs along with the gaps between these needs and your existing services.
4. The evidence and impetus created through a well conducted SHNA should provide you with the political and organisational will and local engagement to enable you to implement effective service redesign.

Leadership and Governance

5. Many aspects of executing a needs assessment are operationally straight forward but this does not mean that the execution and management should be left to individuals with no decision-making powers. It is therefore critical to demonstrate early 'buy-in' from Chief Executives and relevant Directors to demonstrate support that will help facilitate the SHNA process.

Authority

Getting the level of authority right at the start of the process is important. SHNAs can get delayed awaiting information. Ensure the most senior relevant person with responsibility for the SHNA signs requests for data and invitations to join Expert Panels to limit these delays.

Circulate Briefings

Circulate briefings signed by Chief Executives and Directors of any of your key partners to demonstrate the level of senior organisational buy-in. Use staff newsletters, email lists and team meetings to raise awareness. Briefings will be for information but also encourages support and cooperation during the SHNA process

What Resources do you Need?

6. Resource requirements will vary depending on a rapid or comprehensive SHNA. For a rapid assessment you will need the dedicated support of a lead research officer or public health analyst for up to a four week period. They will require administrative support internally and "in kind" support from partners over this period.

7. If internal resource is being used a **Project-Lead** and **Assistant** should be appointed for the duration of the SHNA. Their tasks will include coordinating the process and to facilitate groups, prepare data requests, analyse data and prepare reports and recommendations.

8. Alternatively you may commission this work from an independent group. They will need an organisational link person to gain access to the relevant people and resources. For a comprehensive SHNA the resource needs will be greater and will reflect the methods you choose for this exercise.

9. If you do commission the SHNA from an external agent you will still need a named organisational lead with sufficient organisational knowledge and seniority to facilitate introductions. This internal lead should not be expected to bolt this onto their day job and will need to be allocated sufficient time to support this process effectively.

Establish an SHNA Project Group

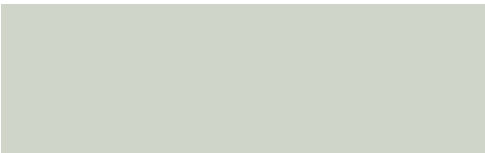
10. Sexual health is a complex issue and an SHNA **Project Group** should be established with senior strategic and operational representatives from key partner organisations to provide leadership and facilitate the management and delivery of the project.

Diary Review

Identify and map key strategic meetings over the near future at which the signatories to the briefing will attend. Arrange inclusion as an agenda item announcing the forthcoming SHNA process and its aims.

Media Review

Speak to the communications managers at relevant partner organisations, including community groups, to identify publicity opportunities for the SHNA and encourage involvement.



11. Suggested Project Group members, terms of reference and first meeting aims are shown below:

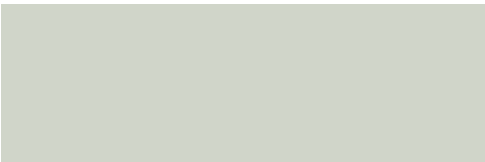
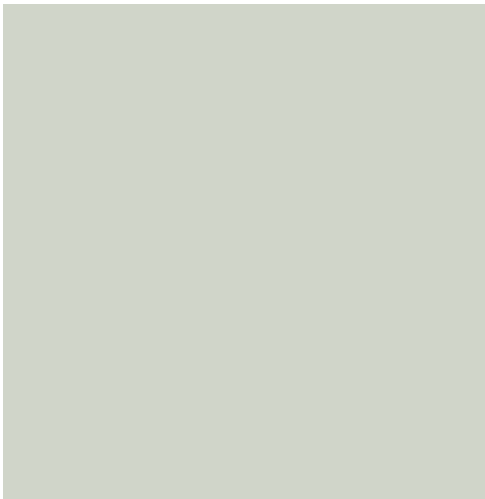
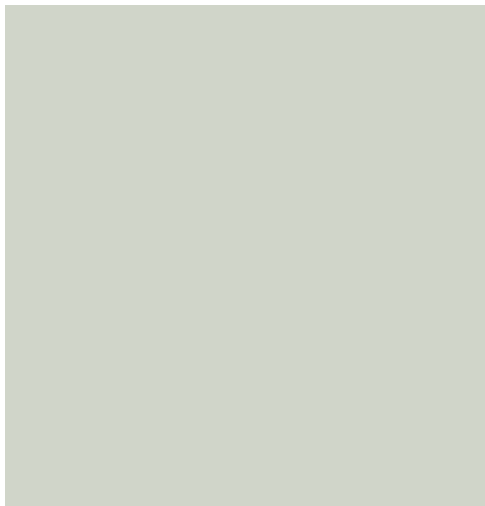
Members of the Project Group	Terms of Reference for Project Group	First Meeting Aims
<ul style="list-style-type: none"> • SHNA Project Lead and Assistant • Director (Assistant) of Public Health • PCT Commissioners - for all aspects of Sexual Health / Children / Joint Commissioners • PCT Sexual Health Lead • Director (Assistant) of Children Services • Teenage Pregnancy Coordinator. • Adult Social Services 	<p>Support the SHNA Lead by:</p> <ul style="list-style-type: none"> • Providing organisational and departmental access to key individuals and data and information • Leveraging partner resources • Co-opting members onto an expert panel • Ensuring momentum and profile for the exercise is sufficient 	<ul style="list-style-type: none"> • Presentation by Project Lead on aims, objectives and process • Clarify individual roles and skills • Assign task to group members • Establish short-term aims • Establish agreed internal communication protocol • Agree timelines and targets • Identify stakeholders to be invited to participate in the SHNA expert panel

12. Some of the members of the Project Group will also provide inputs throughout the SHNA as members of an Expert Panel (a group of key informants critical to service and user mapping - see page 17).

13. The Project Group need not meet often but will need to act as a virtual group throughout the process. During a rapid needs assessment they may only meet once but should be involved virtually throughout the process.

14. Invite individuals able to assist the Project Lead in terms of requests for advice and support. Individuals who can help unblock bottlenecks and delays in information sharing are essential.

15. During a comprehensive SHNA this group will effectively be the steering group providing support, direction and leadership for the exercise and may need to meet up to three times over the timeframe of the project.



Establish an SHNA Expert Panel

16. An early action for the Project Lead is to undertake a stakeholder analysis with the Project Group to identify an Expert Panel of key informants who understand the local sexual health picture (or parts of it) from both a supply, demand and need perspective.

17. These individuals will be invited to form part of a local sexual health **Expert Panel** to contribute to and support the SHNA. If you already have a managed sexual health network you may decide to co-opt this group for this purpose.

18. Representatives to consider for inclusion on an Expert Panel include acute NHS providers, GUM, specialist community contraceptive providers, teenage pregnancy coordinators, chlamydia screening coordinators, general practitioners, pharmacy, independent abortion providers, local authority (LA) colleagues such as Head of Youth Services, Social Care Lead, Healthy Schools Coordinator and LA teams e.g. drug and alcohol outreach, voluntary and youth groups.

19. Choose individuals with strong networks and local knowledge of existing service provision and local populations. Institutional and community memory of how services currently work and why they are organised in that way is invaluable. Identify 'gatekeepers' to specific groups of interest e.g. Black and Minority Ethnic (BME), Lesbian, Gay, Bisexual and Transgender (LGBT), Looked After Children, refugees, Gypsies and Travellers.

20. Don't be afraid of including specialists or narrow interests groups on the panel as their role is not, in the first instance, to have an overarching or strategic view of the issues, rather their focus will bring vital elements of the jigsaw puzzle to the bigger picture.

21. In a rapid SHNA it is unlikely that you will have the time to convene a full Expert Panel. Instead organise an intelligence gathering event to which you would invite the same type of people but this will be a quick and effective way to gather intelligence from these key individuals without them committing the time that would have been needed for a comprehensive SHNA. Use this day to undertake a condensed version of the exercise we discuss in this section.



Why Have an Expert Panel?

Working together

Bringing together people who are able to represent different perspectives and understanding of the needs of the local area and building the networks and relationships that will be critical when trying to develop solutions.

Ownership

Shared responsibility for solution finding and decision-making about how to best meet the needs of the population once the SHNA has been completed.

Ambassadors

Producing organisational ambassadors who can help leverage access to key networks. Keeping this group together beyond the initial SHNA will be critical when implementing changes resulting from the SHNA findings.

Managed sexual health network

If you do not have a managed sexual health network already your Expert Panel could provide an embryonic network upon which you can build in the future.

Critical knowledge and local intelligence

About non-statutory provision and opportunities for additional provision. Identify at risk groups not currently being sufficiently catered for and awareness of local idiosyncrasies with key groups and barriers and preferences.

Make Use of Technology

We're all busy. In a comprehensive SHNA the Expert Panel only needs to meet at the start of the project to assist in 'mapping' and again when initial data analysis is complete, as they will be able to help tell the story behind the data. So use them in a virtual capacity where you can.

For the rapid SHNA try and use participants after the event as a virtual Expert Panel as their networks and local intelligence will be critical.

Remember some members of the Expert Panel will not be office based so ensure effective mechanisms and realistic time frames for their contribution and share progress with them throughout the SHNA.

8.

Data Gathering

1. Data are not just numbers. Data in the context of an SHNA can also be information e.g. the location of a clinic or views of service users. However without intelligence (making sense of the data), its use will be limited.
2. The data gathering activities described below are parallel activities and data from all the streams discussed can be collected with the help of the Project Group or the Expert Panel. The Project Lead should coordinate these activities.
3. The Expert Panel is also a source of data and this is discussed under the data stream section. This panel is also one of the key tools you will have to apply intelligence (making sense) to the data.
4. See Appendix 2 for themes, data sources and questions to help you plan your data gathering exercise. In a rapid SHNA establish early on which data you will be concentrating on and where your effort needs to be targeted. Remember that even for a rapid assessment you need to gather information about needs, demand and services as detailed in the overview section of this guide.

Remember

Data collection can be time consuming and resource intensive. Make sure you allow plenty of time for this aspect of the project.

Gather Data You Need

Always ask yourself WHY do I need these data? WHAT will they tell me? If you are not sure ask your Expert Panel for their perspective and look at the range of questions provided in Appendix 3 to help you check this.

Data Stream One

Existing Data: Reports, Surveys and Analysis (refer to Appendix 2)

5. Preparation is everything. It is important to do your groundwork. Spend some time locating studies that have been conducted in your area over the last 5 years that contain information that will be important for the SHNA.
6. Use your Expert Panel and Project Group to identify studies and provide contacts for data analysts and/or research teams in your partner organisations including local universities, as staff may have undertaken fieldwork for professional and external qualifications.
7. Gain access to recent service reviews, performance monitoring exercises, patient panel consultation and so forth before planning further data gathering.
8. National and Local Surveys can provide important contextual information about your locality at a given time. There are a number of surveys that are likely to have been carried out in your region. Talk to colleagues within public health, the Local Authority research department and other partnerships to locate reports and findings.

Remember

- Allow time and resources for existing information to be sourced, read, collated and summarised and relevant areas incorporated into the SHNA.
- Find out what is already known as information often lies unused. Do not duplicate work that already exists as this is a waste of time and resources.
- Talk to partner organisations to identify completed work on e.g. young people and sexual behaviours or the characteristics of local minority groups. Existing work can inform how additional data are gathered during the SHNA.
- Be flexible in your approach - a housing needs assessment on a specific group may well contain relevant information about health needs and preferences and provide insights into barriers to access.

	E	F	G	H
b. By phoning from an ordinary phone			1	From home
c. By phoning from a pay phone			1	Elsewhere, if
d. By texting the service to request a call back			3	Private
e. By using the website to request a call back				
f. By asking GP/practice nurse/social worker to call on your behalf			1	They know
When would you most like the phonenumber to be open? (choose 1)				
a. 24 hours			7	24 hours 24
b. From 8 am to 8 pm			4	Good time
c. From 9 am to 5 pm				
When would you expect/prefer the phonenumber to be open? (choose 1)				
a. 7 days a week			8	Not having
b. Monday - Friday			3	Best time
When would you be most likely to call the phonenumber? (choose 1)				
a. In the morning				
b. In the afternoon			4	After school
c. In the evening			5	After school
d. At the weekend			2	Have time
What would you want to use the phonenumber for? (choose all that apply)				
a. To find out information about contraception			4	None of the
b. To make an appointment about contraception			3	

Existing Data: Service Data and Context Data

9. There are two core types of data under this stream: **service data** and **contextual data**. These data will help you understand existing sexual health service need and use and demand (who is currently using your services and what for). From this you can develop a picture of incidence and prevalence rates for specific infections and increase your understanding about the characteristics of your population all of which will help you predict likely need.

10. **Service data** refers to data that you have originally collected directly about people who have or are using your services. Think of this as your primary source of demand data. These data are normally collected at the point of provision such as STI (KC60) data that are collated systematically for surveillance monitoring and reporting nationally via the Health Protection Agency (HPA).

11. Other service data includes contraception (KT31) data, abortion statistics and teenage conception data. These also tell you about trends and distribution within your area. Where data are not reported to your public health analysts you will need to go to the original source (see Appendix 2).

12. Where possible analyse your data by gender, age, ethnicity and sexuality. If you have a high proportion of data which have post codes you should use these to map differences in patterns of use and profile of users across the area.

Analysing Service Data

13. Ideally you need support from an analyst with GIS skills. If you are not already examining the distribution of users, you will need to do this. Most data collected about users have a postcode identifier, mapping the location of these users against infection hotspots and teenage pregnancy hotspots and the location of your services is an important exercise.

14. Where services do not collect information about individual users they should have some method of measuring volume of demand (e.g. number of people through the door, number of condoms distributed). These numbers can be mapped against the service using a GIS, mapping system or simply a map of your area. This will help you see visually whether, for example, two similar services in different parts of your area have similar levels and patterns of activity.

15. If these data have to be collected from new from individual services this type of analysis may take a good few weeks. If you are undertaking a rapid SHNA then collect total numbers, use a large map of your area and start to add information about location of services and numbers of users - and build your own layered picture of activity and demand across your area. If you do not have GIS analyst support you will need to highlight the need for stronger data analyst input and access to GIS technical expertise in the future.

DH Common Data Set for Sexual Health

In the future it is intended that this will provide a single standard structure for collecting data on sexual health within the NHS in all settings providing sexual health services including primary care.

16. If you are undertaking a comprehensive SHNA you should map these data and the location of sexual health service activity and services using GIS technology. Build a picture of service configuration, content and demand. This mapping is critical for the gap analysis exercise.

17. An important step in establishing potential need is to understand the make-up and distribution of your wider population. To do this you will need to turn to the second type of data - contextual data.

Contextual Data

18. Contextual data relates to the profile of your general population and communities.

19. You will need these data to tell you about the size and make-up and location of the full pool of your potential service users. Many existing sources of data exist and these are listed in Appendix 2.

20. Contextual data such as socio-demographic, economic and epidemiological data will help provide information about your local population and from this their likely needs. These data will enable you to profile the characteristics of your population including location of significant areas of poverty and higher risk groups e.g. refugees, Gypsies and Travellers and high student populations and where they all live.

21. It is more than likely that a profile of your area has already been completed within your local authority or regional PHO so check at an early stage to see what already exists.

22. This contextual information will provide a solid foundation to help you to begin to understand whether your services are meeting the needs of your population. This exercise does not need to be too onerous as these data sources are limited in what they can tell you and may well be out of date. For example be careful not to rely too heavily on the ethnic mix data from Census 2001 as this is now quite out of date. The ONS neighbourhood statistics site is a very good source of local data.

Get Names of Key Individuals

Find out who collects data locally and where from. Speak to these people directly and build a relationship with them. Find out if your local authority or PCT has a database of research and consultation and get access to this.

Stay Up to Date

Once you have identified where and how to collect data on local teenage pregnancies from maternity services and TOP providers, continue to collect this on a quarterly basis. This will provide an up-to-date picture of local trends that will enable you to direct and then measure the impact of local interventions.

23. Your service data and contextual data will provide useful profiles of demand in relation to your local population. They will help tell a story but alone are not sufficient as its limitations include:

- It may not tell you many relevant facts about your users e.g. sexuality, residential and relationship / marital status;
- It does not tell you about who is *not* accessing your services or where else residents may be accessing services (**remember the open-access nature of sexual health services**). You may have a significant high risk minority at disproportionately higher risk of infection but who, for a range of reasons, do not access services or are not being reached by any of your existing health promotion or social marketing approaches.

24. To complete your profile you need to gather information from those directly involved in managing and delivering services across your area, neighbourhood areas and from users, non-users and their representatives. There are a number of techniques you can use to gather this information which are discussed in Data Stream Two below.



Data Stream Two

Stakeholder Analysis and Service Mapping

25. Approaches in data stream two will tell you more about the full range of existing sexual health related services in your area. They will tell you more about local need and help you understand the barriers to access that exist for different groups.

26. Two approaches for capturing this information and intelligence are recommended: the Expert Panel or, for a rapid SHNA, a one-day event with experts and *key informants*.

Expert Panel: Service Mapping Exercise.

27. Use your Expert Panel to undertake a service mapping exercise as follows.

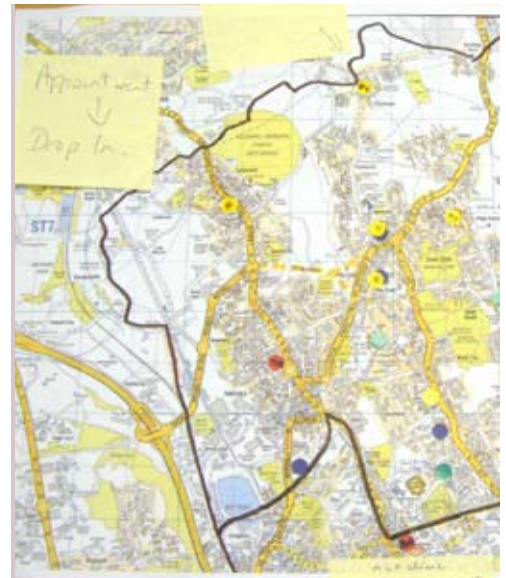
- Provide a map of the geographical area.
- Plot and record their knowledge about the locations of and content of existing sexual health services (GUM, specialist community contraception, abortion) and related service provision e.g. youth service, drugs and alcohol outreach, domestic violence support groups, sexual assault referral centres, condom distribution schemes; pharmacy emergency contraception schemes, drop-in centres for teenage mothers).
- Some services may not appear to have any direct link with sexual health services but they do. They could be access points for potential users and could be considered as future satellite providers as part of integrated services.

28. This mapping will help you to establish a baseline of services and ensure that the Expert Panel and Project Group (to whom you will be reporting back to following this exercise) all have a shared understanding of what is currently available across your area.

29. Remember that this is often the first time all those working in the field will have a comprehensive overview of local provision across multiple providers.

Expert Panel: Mapping Local Needs

30. Following the service mapping exercise the next step is for the Expert Panel to share their experience and understanding of the needs of existing and potential users. Analysis of existing data from formal national and local sources such as Census data and the local child protection register will identify some obvious population groups at risk e.g. a large student population or a high number of looked after children.



Key Informants

35. In addition to the information that you have captured using the above exercises, you will need to talk to a wide range of people who have detailed knowledge from a number of perspectives. These people are your key informants and they include providers of services as well as community representatives.

36. Be aware that some may have vested interests and different perspectives but these all need to be considered when assessing need and prioritising resources.

37. Key informants include policy makers, service commissioners, providers, front line operational staff and user representatives or communities of interest. Use your Expert Panel and Project Group to identify a list of potential key informants, including themselves.

38. In a rapid SHNA you need to restrict the numbers of key informants to no more than 10 but in a comprehensive SHNA you need to talk in-depth to a much wider range of commissioners, practitioners and community representatives across all key agencies.

39. Semi-structured interviews (face-to-face, telephone) and short email questionnaires are the basic techniques for gathering information from key informants. Remember that members of the Expert Panel and Project Group may also be key informants. This will allow them to share relevant information on a one-to-one basis that may be too sensitive to share in a group setting.

Workshops:

Use a mixture of facilitation methods to get the most from your experts. Be sure to send them an agenda and a brief description of broad aims and what you hope they will contribute. Give them time to prepare and speak to colleagues or community members.

Reminders

Send a reminder a day or so beforehand, putting the key information in the text and not in attachments.

Allow a period of time after the meeting for the Expert Panel members to share further thoughts and information with you.

Data Stream Three

Users and Potential Users

40. Data collected from service users does not reflect the perceptions of *potential* users.

41. In a rapid SHNA assessment you will not have time or resources to undertake any direct engagement with users or potential users. Instead use existing data and key informants who have knowledge about specific user groups to help understand local needs.

42. While a good deal of information about preferences and experiences can be gathered from the key informants, a comprehensive SHNA should gather information *directly* from sexual health service users and potential users. A number of imaginative techniques can be used to gather this information.

- Focus groups
- Suggestion boxes (in a range of locations not just at clinics)
- One to one interviews
- Exit interviews
- Online surveys
- Feedback boards
- Facilitated service design workshops
- Other providers with good access to groups you are trying to access should be approached to participate / issue questionnaires on specific aspects of service improvements.

44. Choice of technique is dependant upon resources and technology and the most appropriate method for the target populations. Check whether your organisation or your local authority has a consultation department who may be able to undertake some of this work with you or on your behalf or review specifications if you are commissioning an independent group to support this element of the SHNA.

45. Local Youth Services should be able to offer advice on ways to consult and involve young people.

46. Using an independent research group can facilitate a more open engagement with users and potential users as individuals often feel more comfortable reporting their needs, preferences and experiences to independent researchers rather than those providing or commissioning the services themselves.



Ask Key Informants About

Content and quality of local services - what works well and not so well? What would improve services?

Local Needs - of the groups they represent (e.g. MSM, YP, refugees)

Barriers to Access - as above (cultural, language etc)

Resource and Capacity - staff and provider (workforce and training)

Policy implications (local and national)

Effectiveness:

47. Clear information on effectiveness is often absent in service planning. However, "It cannot be argued that ineffective services are needed. Therefore where effectiveness is in doubt a first step is a gathering of effectiveness information"¹.

48. Discuss how services are doing against national guidance, standards, clinical practice and clinical effectiveness guidelines produced by professional bodies and the National Institute for Health and Clinical Excellence (NICE).

49. Be mindful of the recently published Healthcare Commission document 'Performing better? A focus on sexual health services in England'. This provides guidance on what constitutes good practice in sexual health service delivery.

50. Clinicians and managers should know how compliant existing services are against standards and guidance and if not, this needs to be included as a finding in your gap analysis.

These documents provide a number of outcomes that services could be audited against as part of the SHNA and as an ongoing measurement of effectiveness. In addition 'Gold Standard' models of care, including best practice from other areas, should be used to inform future service planning see (Appendix 4).



¹ Stevens, A. Raftery, J. Mant, J. An Introduction to HCNA. The epidemiological approach to health care needs assessment. Available from: <http://hcna.radcliffe-oxford.com/introframe.htm>

9.

Gap Analysis

1. The SHNA Project Lead and Assistant are responsible for pulling together the various data strands and for circulating the findings to the Project Group and Expert Panel (and key informants if appropriate) for information and verification.

2. These findings are the basis for the gap analysis. This is the evidence to inform choices and decisions about how to improve the local population's sexual health through service change and redesign.

3. In your gap analysis you should review your findings from an equity perspective. Are your services configured to meet the needs of those at greatest risk and those who face the greatest barriers to access?

4. Formally present the results of the SHNA and gap analysis to the Project Group, Expert Panel and attendees of any rapid SHNA events. Gain consensus on the major gaps in need and identify how these may inform future strategy and service change.

5. This analysis can highlight:

- Where need is not met
- Where there is a mismatch of services
- Where there are insufficient services
- Where effort is being duplicated
- Where there are opportunities to support service reconfiguration.

In Appendix 3 there is list of questions that will help you make sense of your data for your gap analysis.



10.

What Next?

1. You now need to enter into a process of decision making using your SHNA to inform the development of recommendations and to provide evidence to support the allocation of resources and help scope the components of service redesign.

2. At the beginning of this guide we talked about the importance of leadership in the SHNA process. The findings of the SHNA now need to be enacted. Board approval is necessary for any modernisation work e.g. endorsing recommendations to integrate services and agreeing formal projects to undertake this integration.

3. Ensure Boards are informed and engaged. They need to be confident that your SHNA was thorough and reliable. This will mean they are more likely to support and approve recommendations.

4. The main reason SHNAs (and all assessments) fail is a lack of integration into planning and commissioning cycles. Ensure project timelines fit budget and decision making cycles so any recommendations that are made on the basis of the SHNA can be acted upon.



Appendix 1.

The economics of sexual health: Why invest in sexual health services?

Investment in sexual health services can deliver healthcare savings through preventing unplanned pregnancies and reducing the transmission of Sexually Transmitted Infections (STIs) including HIV.

- The average cost of contraceptive failure in 2005/06 is around £1500 including costs of ectopic pregnancy, maternity (live births), abortion and miscarriage.
- Contraception services probably save the NHS over £2.5 billion a year.
- HIV imposes a significant burden on healthcare resources at around £580 million a year. As well as high costs of treatment and care, HIV is associated with serious morbidity, significant mortality and a high number of potential years of life lost. Preventing the onward infection of one case of HIV could save around £0.5 million in health care costs and individual health gains.
- The direct costs of treating other STIs cost the health service approximately £165 million a year. Including the cost of treating sequelae would increase this. Chlamydia, for example, often produces no symptoms, but if left untreated it can lead to pelvic inflammatory disease, infertility and ectopic pregnancy, which impose high costs to the healthcare system and the individual.

There is evidence that investment in sexual health interventions is good value for money (within the cost-effectiveness range accepted by the NHS) and in many cases cost-saving. This includes:

- Sexual health promotion and disease prevention especially interventions targeting high-risk groups. For example, widespread condom provision, outreach safe sex training for high risk groups, school education programmes and needle exchange services.
- Many screening programmes. Screening strategies targeting high-risk populations such as pregnant women for HIV, and young women for chlamydia - leading to early treatment, averting costs of complications (such as infertility), and onward transmission.
- High quality and rapid access STI services. Untreated infections lead to onward transmission and further increase demand on GUM services. Prompt treatment of STIs, and effective partner notification are key elements of cost-effective prevention interventions.
- Wide choice of contraceptive services and abortion services provided with minimal delay. For every £1 spent on contraception services, £11 is saved. The NHS could save money through improving contraception services by ensuring access to the full range of methods which reflect women's preferences including more cost-effective longer-acting reversible methods.

The full report of the Economics of Sexual Health is available for the Department of Health (England):

<http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Sexualhealth/index.htm>

Appendix 2.

Data Matrix

Sexual Health Needs Assessments | Data Matrix

Data Stream One: Service data

Ref	Data Type	Potential Data Source	What to query	Cross reference with
1	Existing data, reports and analysis	<ul style="list-style-type: none"> Local needs assessments, reports, dissertations Regional Health Observatory Reports Teenage Pregnancy Unit self-assessment framework Contraception Services Baseline Review 2004/05 submission <p>http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_074727</p> <ul style="list-style-type: none"> Local Strategic Partnership Strategy Children and Young Persons Trust - Needs assessment and Strategy 	<ul style="list-style-type: none"> Within these reports you will find a good deal of the information you will need so make sure you review these and other locally relevant needs assessments and strategies to ensure you are gathering what is already known and do not duplicate effort 	<ul style="list-style-type: none"> Is sexual health strategically embedded in relevant strategies? Do the strategies reflect need or historical patterns of service delivery? Strategies will need to be reviewed in light of the findings of the SHNA
2	Sexually Transmitted Infection (STI) data, including HIV	<ul style="list-style-type: none"> KC60 GUM data and Health Protection Agency <p>http://www.hpa.org.uk/infections/topics_az/hiv_and_sti/stidefault.htm</p> <ul style="list-style-type: none"> SOPHID (HIV) data: http://www.hpa.org.uk/infections/topics_az/hiv_and_sti/hiv/sophid/sophid_main.htm Local pathology department data (via Microbiology / GUM) Local chlamydia screening data (via screening coordinators) 	<ul style="list-style-type: none"> Local epidemiology of STIs / positivity rates Geographical spread / hotspots STIs by age STIs by sexuality (local clinic attendance data) New to follow-up ratios 	<ul style="list-style-type: none"> Age / sex profile across PCT GUM access / waiting times data Notifications of infectious diseases
3	GUM waiting times data	<ul style="list-style-type: none"> GUM Waiting Times Audit: Health Protection Agency <p>http://www.hpa.org.uk/infections/topics_az/hiv_and_sti/epidemiology/wtimes.htm</p> <ul style="list-style-type: none"> Local GUM clinic / colleagues 	<ul style="list-style-type: none"> GUM waiting times: patients offered / seen within 48 hours 	<ul style="list-style-type: none"> Levels of deprivation across PCT Service provision data Equity in access (waiting times by profile of user)

Sexual Health Needs Assessments | Data Matrix

Data Stream One: Service data

Ref	Data Type	Potential Data Source	What to query	Cross reference with
4	Contraception KT31 data	<ul style="list-style-type: none"> Local community contraceptive clinics data PCT data on condom distribution / Emergency Hormonal Contraception Schemes National reports (N.B first attendance data only) http://www.ic.nhs.uk/statistics-and-data-collections/health-and-lifestyles/contraception	<ul style="list-style-type: none"> Local contraceptive service usage Methods by age National data is first attendance only - local data may be available Local prescribing of contraceptive methods New to follow-up ratios 	<ul style="list-style-type: none"> Age / sex profile across PCT Abortion statistics Prescribing data
5	Abortion Statistics	<ul style="list-style-type: none"> Local service provider data National report - Abortion Statistics England and Wales http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsStatistics/DH_075697	<ul style="list-style-type: none"> Abortion by gestation Abortion by methods Abortion by age Repeat abortion rates and second conceptions Local 'hotspots' 	<ul style="list-style-type: none"> Age / sex profile across PCT Contraception data Teenage conception data Births / conception data
6	Teenage conceptions	<ul style="list-style-type: none"> Teenage conception data http://www.dfes.gov.uk/teenagepregnancy/dsp_content.cfm?pageid=245 <ul style="list-style-type: none"> Local Teenage Pregnancy Coordinator 	<ul style="list-style-type: none"> Hotspots Trends 	<ul style="list-style-type: none"> Deprivation Births / conception data KT31 data Service content and configuration

Sexual Health Needs Assessments | Data Matrix

Data Stream One: Service data

Ref	Data Type	Potential Data Source	What to query	Cross reference with
7	Local Maternity Statistics	<ul style="list-style-type: none"> Data analyst responsible for maternity data at hospital trust. 	<ul style="list-style-type: none"> Local maternity data is a rich source of data. Information about pregnant teenagers and teenage mothers collected by maternity services should include ethnicity or place of birth of mother; whether in a union; residential status; parity and should note other characteristics of the health and social situation of the young woman relevant to improving understanding need. These data can be shared as long as anonymised. 	<ul style="list-style-type: none"> How does distribution of births geographically compare with distribution of abortions and key STI infections? How does age profile of births compare with age profile of STI (among females).
8	Notification of Infectious diseases (NOIDs)	<ul style="list-style-type: none"> NOIDs http://www.hpa.org.uk/infections/topics_az/noids/menu.htm 	<ul style="list-style-type: none"> In particular hepatitis A, B and C Are there local / population group hotspots? 	<ul style="list-style-type: none"> Where are services compared with hotspots? Have there been any local targeting of messages or services to population of geographic hotspots? Do location of hotspots fit with providers and health promotion teams understanding of key areas of risk and strategies?
9	Prescribing Data	<ul style="list-style-type: none"> PCT colleagues; ePACT data 	<ul style="list-style-type: none"> Distribution of prescribing of contraceptive methods 	<ul style="list-style-type: none"> Method mix is important to look at and if you can get data by age to compare use by method between age groups. Can you measure distribution of free condoms via e.g. C-card scheme by provider and location?

Sexual Health Needs Assessments | Data Matrix

Data Stream One: Context data

Ref	Data Type	Potential Data Source	What to query	Cross reference with
10	Population Demographics	<ul style="list-style-type: none"> Census 2001 http://www.statistics.gov.uk/census/default.asp ONS neighbourhood statistics http://neighbourhood.statistics.gov.uk/dissemination/ 	<ul style="list-style-type: none"> Age, gender, ethnicity profile across PCT Marital / residential status Long-term limiting illness Concentration of students Marker of sexually active population (>age15) Marker of fertile female population (age 15-49) 	<ul style="list-style-type: none"> STI / KC60 data KT31 data Teenage conception data
11	Deprivation	<ul style="list-style-type: none"> Indices of Multiple Deprivation: http://www.communities.gov.uk/index.asp?id=1128440 DH: http://www.communityhealthprofiles.info/ 	<ul style="list-style-type: none"> Deprivation hotspots Housing deprivation Income deprivation Educational deprivation 	<ul style="list-style-type: none"> Teenage conception data
12	Local Authority Data	<ul style="list-style-type: none"> ONS neighbourhood statistics http://neighbourhood.statistics.gov.uk/dissemination/ NEET Data (Not in Education, Employment or Training) via Connexions Pupil Level Annual School Census (PLASC) Data Local Authority register of Looked After Children Local accommodation needs assessment of Gypsies and Travellers Housing data Referral to drug and alcohol services Asylum seekers - local authority housing department and local community and voluntary sector Local HM Prison Health Care colleagues Youth Offending Team 	<ul style="list-style-type: none"> Know your 'at risk groups' (please see page 14) Local Authority Health Profiles show the health of people in local authorities across England Levels of school absence / exclusion PLASC Numbers and spread of Looked after Children (local register) Teenage conception data 	<ul style="list-style-type: none"> Age / sex profile across PCT STI / KC60 data KT31 data Composition of services and how they fit with existing sexual health services How well aligned are strategies and action plans for e.g. drug and alcohol referral services; youth offending services; NEET strategies with sexual health services?

Monitoring Data

Do services collect monitoring data on ethnicity (including Gypsies and Travellers), disability and sexuality? To fully understand your user profile and differences in need you should implement a full monitoring on registration and any other relevant services review surveys. These data are important for both SHNAs and for service level monitoring.

Sexual Health Needs Assessments | Data Matrix

Data Stream Two: Stakeholder and Service Mapping

Ref	Data Type	Potential Data Source	What to query	Cross reference with
13 (cont on next page)	Service Mapping: Content and Configuration	<ul style="list-style-type: none"> Existing Service Specifications / Service Level Agreements Partnership arrangements and related services Local sexual health service commissioners and providers Locally Enhanced SH service specifications Sexual Health Network Key Informants Expert Panel Community Representatives Patient (user) Representatives Patient (user) experience surveys Complaints and plaudits Staff and performance audits and reviews 	<p>Service Data: Where are your services and who delivers the following:</p> <ul style="list-style-type: none"> Health Centres Contraception, sexual health and GUM clinics Well Man/ Well Woman Emergency contraception schemes Condom distribution schemes Youth Centres GPs (+ with female GPs) Pharmacies Extended Schools Children Centres Homelessness support points Community Centres Abortion providers Needle exchange Sure Start Neighbourhood Offices Health Living Centres Housing Offices YMCA/YWCA Rape Crisis/Domestic Violence outreach or services Sex worker outreach or drop in schemes Domiciliary Services 	<ul style="list-style-type: none"> GUM waiting times data Teenage Pregnancy data Links between services and referral pathways Partnership working or seconded/shared staff Types of facilities services are delivered from

Sexual Health Needs Assessments | Data Matrix

Data Stream Two: Stakeholder and Service Mapping

Ref	Data Type	Potential Data Source	What to query	Cross reference with
13 (cont)			<p>Virtual Services:</p> <ul style="list-style-type: none"> • Health promotion sites • Other sign posting sites (actual or potential) • Phone lines • Internet sites <p>Operational Considerations:</p> <ul style="list-style-type: none"> • Content of services (map to visualise distribution and coverage). Is there duplication, gaps or over / under delivery? • Distance between GUM / contraception / abortion providers. How accessible are your services by public and private transport? • Opening times; appointment mixes; access times • Workforce issues (e.g. staffing numbers and training e.g. one full time consultant in sexual and reproductive health care for every 125 000 population). • What proportions of your staff are dual trained? Does existing services content optimise use of staff and space? What training opportunities exist? • Leadership - are there champions for sexual health who have disproportionate influence/or not enough in leading this area? • Which agents are delivering which services? • How well integrated are services / partnerships? Are referral pathways explicit? • Are there opportunities to reconfigure services and improve joined up working to improve user access? • Can commissioning arrangements change to improve integration and access? 	

Sexual Health Needs Assessments | Data Matrix

Data Stream Two: Stakeholder and Service Mapping

Ref	Data Type	Potential Data Source	What to query	Cross reference with
14	Barriers to access and understanding need	<ul style="list-style-type: none"> • Expert Panel • Key informants • Survey and existing assessment data: <ul style="list-style-type: none"> - Health Related Behaviour Questionnaire (for young people - PCT/LA / Children's Trust - National survey of sexual attitudes and lifestyles - Sigma Survey (Vital Statistics 2006 - The UK Gay Men's Sex Survey) - Housing needs assessment 	<ul style="list-style-type: none"> • Using key informants and information collected via related surveys you will be able to begin to build a picture about the barriers to access faced by different groups; operational; socio-cultural and logistic. Why do certain people and groups not use services? Why and when do they use them? How do they perceive the quality and accessibility of services? 	<ul style="list-style-type: none"> • Patterns of use • Distribution and content of services • Operational arrangements e.g. opening times, proximity to public transport, location in relation to different groups • Communication strategy - how effectively does it address diversity of need
15	Cost effectiveness	<ul style="list-style-type: none"> • PCT budget (capital costs; staff costs; commodities) • Commissioned services - contract costs (e.g. pharmacy contracts for EHC or third party suppliers of e.g. abortion services) • Total number of users/first attendances/commodities distributed • Staff (time, cost and level) breakdown 	<ul style="list-style-type: none"> • It would not be possible to do more than very high level analysis in a rapid SHNA. • In a comprehensive SHNA try and identify as much detail relating to cost of the service. For example the total cost allocated to sexual health services and calculate the total number of contacts; first attendances; diagnostic tests; diagnosis in relation to overall budget (this will only be indicative and will be useful to measure annually to compare performance). • Where possible, estimate cost per first attendance or per user (or whatever element you are interested in) as a proportion of the total budget. This will help identify which services are more efficient. 	<ul style="list-style-type: none"> • NB. In order to reduce inequalities in health balance cost effectiveness with access. Central clinics will be more cost effective as throughput will be higher. Be clear about your parameters.

Sexual Health Needs Assessments | Data Matrix

Data Stream Two: Stakeholder and Service Mapping

Ref	Data Type	Potential Data Source	What to query	Cross reference with
16	Performance against standards and targets	<ul style="list-style-type: none">• Any local audit of services• Service specifications against national standards• Key informants• Healthcare Commission Performance Targets• National Support Team or MedFASH visits	<ul style="list-style-type: none">• An SHNA is not an audit of service performance against standards. However, it is important to identify where gaps in knowledge or service content and configuration exist to inform decision making and prioritisation.	<ul style="list-style-type: none">• Gold standard models of care including best practice from other areas should be used to inform future planning.

Sexual Health Needs Assessments | Data Matrix

Data Stream Three: User and Potential Users

Ref	Data Type	Potential Data Source	What to query	Cross reference with
17	Need, preferences and experiences and barriers to access for different population groups, in particular higher risk groups	<ul style="list-style-type: none"> • Self completion questionnaires (in community locations and/or distributed via community groups or link workers) • Random street survey • Customer service questionnaires • Exit interviews • Facilitated Workshops • Focus Groups • One to one interviews with both users and potential users • Other service design techniques e.g. cultural probes; persona development (see Design Options website for examples of personas they have used) http://designoptions.org.uk/index.php?option=com_gallery2&Itemid=144&g2_itemId=114&g2_GALLERYSID=4f05da5fdf407f9b352735b2fcf2cd84	<ul style="list-style-type: none"> • Knowledge and awareness of risk • Better understanding of risk taking behaviours and their determinants • Experience of services • Experience of care seeking process • Determinants of non use • Perceived barriers to access • Logistic and operational barriers to access (e.g. opening hours; distance; appointment system) • Socio-cultural barriers to access • Stigma - how it influences health seeking behaviour • Map actual experiences of different users to identify blockages and barriers • What works well from user perspectives? • What does not work so well from user perspectives? 	<ul style="list-style-type: none"> • Intelligence collected via key informants and expert panel • Patterns of demand • Service configuration and service mapping (verify are barriers to access really operational or is communication strategy not fit for purpose) • Does intelligence about reasons for non use reflect what you have found about likely need and actual demand?

Appendix 3.

What to find out during your needs assessment?

NEED: refers to people who may be, or perceive themselves to be, at risk of negative sexual health outcomes such as sexually transmitted infection or an unintended pregnancy.

UNMET NEED: refers to those with sexual health needs that are not accessing services or changing their behaviour to reduce risk.

DEMAND: refers to those individuals who are willing to use a service. This includes existing service up-take but also those whom have a demand but whose demand is not met by existing services (unmet demand, see below). You should ask: how does the profile of those whose demand is met compare with those whose demand is not met? Why is that demand not met? How does demand compare with need? This includes those who are using services to a greater extent than their need might suggest they need to. Does the supply of services match demand and if not why not? Do you supply services that users are not willing to use (insufficient service supply?). We call this unmet demand.

UN-MET DEMAND: this group have a demand but it is not met by existing services i.e. people who want to access services or are aware of associated risks, but cannot for whatever reason access appropriate services e.g. due to physical access; opening hours; not knowing where to turn for information or services or cannot access information in a format suitable to their needs. Sex workers for example are generally aware of the risks involved in their lifestyle but the chaotic lifestyle of drug using sex workers or the limited freedom and language difficulties of 'imported' sex workers can prevent them accessing fixed appointments, if not services at all. Gypsies and Travellers and the homeless are another group who find accessing health services particularly difficult even when in desperate need.

SERVICES: refers to the services available. Be mindful of the When-Where and by Whom are they provided? Identify the balance between primary care; acute; independent; voluntary, community and specialist service providers. How do users perceive the quality of services, identified via service reviews; feedback responses; complaints and plaudit and service questionnaires? How do potential users perceive the quality and accessibility of services? How effective is your cross agency working?

GAP ANALYSIS: refers to the gap between demand, supply and need. Are you collecting the right information to help inform the analysis? Where is need not being met (and why)? Are existing services inaccessible to certain groups or simply not available at all or on certain times of the week (insufficient supply)? Are your population able to access the full range of sexual health services or do you need to change the content of services? Are services integrated and working with partners in a coordinated manner to best meet need? If not, are they responsive and able (willing) to change? Are your population aware of risks and the means of avoiding them? Do you consult with users effectively to know this information? Do you have an effective communications strategy both internally and externally?

Appendix 4.

Supporting Documents and Useful Web Sites

Department of Health (England) - Sexual health:

This link provides access to all Government documents related to the National Strategy for Sexual Health and HIV; including: General Sexual health; High Impact Changes for GUM 48 hour Access; MedFASH Standards; The Independent Advisory Group on Sexual Health and HIV and the full report of Health Economics of Sexual Health in Appendix 1.

<http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Sexualhealth/index.htm>

Department for Education and Skills (DfES) - National Teenage Pregnancy Unit:

Available here are copies of a range of Guidance and Publications, including those issued by the Teenage Pregnancy Unit; copies of research reports including those commissioned by the Teenage Pregnancy Unit; and the latest data on conception rates. Examples of promising practice are also available through work undertaken by the Health Development Agency to identify projects showing indications of success.

http://www.dfes.gov.uk/teenagepregnancy/dsp_content.cfm?pageid=32

The National Institute for Health and Clinical Excellence:

NICE is an independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health. In particular review the following:

Long-acting Reversible Contraceptives (LARCs)

<http://guidance.nice.org.uk/page.aspx?o=lac>

Preventing sexually transmitted infections and reducing under 18 conceptions

<http://www.nice.org.uk/guidance/PHI3>

The Healthcare Commission

'Performing better? A focus on sexual health services in England'. This provides guidance on what constitutes good practice in sexual health service delivery.

www.healthcarecommission.org.uk/_db/_documents/Sexual_health_full_report.pdf

Professional Organisations - Clinical Effectiveness Guidelines / Standards:

British Association for Sexual Health and HIV

<http://www.bashh.org/>

The Faculty of Family Planning and Reproductive Health Care

<http://www.ffprhc.org.uk/>



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