

## **Tayside Sexual Health and Relationships Strategy**

### **Report on findings from community engagement and formal consultation**

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#### **INTRODUCTION**

This paper outlines the key findings from the public consultation on the draft Tayside Sexual Health and Relationships Strategy carried out between April and September 2005. The consultation involved three distinct aspects. The first element invited key stakeholders and the general public to submit responses to the draft Strategy. The second part of the consultation involved conducting discussion groups, with a cross section of the community including with some of the specific groups identified in the Strategy as experiencing the greatest barriers to good sexual health. The final component involved gaining the views of patients using the specialist sexual health services.

We wanted to get a wide cross-section of views on the proposals being made in the Strategy and particularly from young people, parents and 'hard to reach' groups. People expressed diverse opinions - issues raised included the availability of access to condoms, the role of parents and the appropriateness of sexual health and relationships education.

#### **MAIN FINDINGS**

- ❑ The overwhelming majority of people and organisations who took part in the consultation expressed support for the action proposed in the draft Strategy and recognised the impact of poor sexual health.
- ❑ Significant numbers indicated that sexual health and relationships education (SRE) is a vital element of acquiring knowledge and life skills for young people.
- ❑ A significant majority felt that schools play a major role in developing young people's access to sexual health information and services, but stated that changes to present practice are needed and that young people themselves do not always feel comfortable addressing sexual health issues within a school environment.
- ❑ The overwhelming majority of respondents agreed that parents have a role in SRE for their children, but highlighted a need for better information, education, guidance and support to do this well.
- ❑ Although there was considerable support for delivering local sexual health services, there was debate about the implications for confidentiality and young people stated a preference for broad-based services.
- ❑ There was strong support for increasing screening and treatment for Sexually Transmitted Infections (STIs) and many suggestions were received about how this should be delivered.

## **BACKGROUND**

The Scottish Executive launched its sexual health and relationships Strategy – ‘*Respect and Responsibility*’ - in January 2005.

The Tayside Sexual Health Strategy Group (SHSG) was set up in summer 2003 to lead the development of an integrated local Strategy. The SHSG brings together all the local agencies responsible for improving sexual health including clinicians, representatives from each of the Community Planning Partnerships and the independent and voluntary sectors.

The original recommendations in the draft Strategy were developed with a wide range of professionals involved in sexual health and informed by Community Planning Partners as well as extensive discussions with young people and by evidence-based practice.

The draft inter-agency Strategy was approved by the NHS Board for consultation in April 2005.

## **AIMS AND OBJECTIVES**

Sexual health is an issue that provokes strong and diverse opinions and goes to the heart of people’s personal moral beliefs and faith.

We wanted to gain a cross-section of views of the community in Tayside and especially those groups in the population that are marginalised or most ‘at risk’ of poor sexual health.

The findings from consultation will be used to build a common agenda and inform the Action Plan on what we need to do to improve sexual health and wellbeing.

## **METHODS**

The draft Strategy was distributed to a wide range of organisations and was also made available in electronic format on the NHS Tayside website. Community Planning Partners, voluntary sector organisations including those working with children and young people, faith communities, the Lesbian, Gay, Bisexual and Transgender (LGBT) community as well as health and other professionals involved in the field of sexual health were invited to respond. A list of the recipients is provided in Annex 1.

We met with Community Planning Partners in each of the three areas – Angus, Dundee and Perth & Kinross to provide an opportunity for more in depth discussion.

To complement the formal document and support wider community engagement we produced a leaflet that included a freepost response section. This was distributed widely in NHS and Local Authority outlets as well as community locations and at events such as ‘T in the Park’.

The results of a recent Dundee City Council survey of young people’s views stating that their preferred means of engaging in consultation were through interactive websites, email and text messaging were a major influence on how we invited young people to become involved. Information was posted on Young Scot and the local Dialogue Youth websites with an opportunity to express views through a chat forum.

People were also offered the opportunity to give us their views by using a dedicated email address or by text message.

Information on how to give views was publicised

through the leaflet, the website, local media and in the NHS Tayside in-house newsletter “Vital Signs”.

A questionnaire was distributed to patients in the Genito-urinary Medicine (GUM) and Family Planning services asking them for their views about the services and how they could be improved.

We held a series of facilitated discussion groups in each of the Community Planning areas including with some of the specific groups identified in the Strategy as being most at risk. A list of the discussion groups is attached in Annex 2.

In addition, the leaflet was posted on the Angus Council website and questions on sexual health were included in a questionnaire to members of the Angus Citizens Panel.

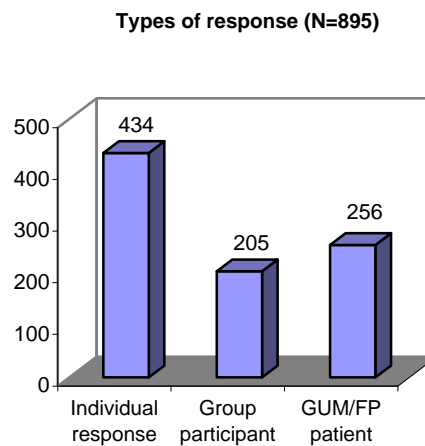
## RESPONSES

A total of 895 people participated in the consultation through the various methods available to them.

There were 434 individual responses including submissions by email and contributions to the electronic discussion forum on Young Scot.

Discussion groups took place in all three Community Planning areas. In all a total of 205 people took part. The participants came from a cross section of the community as well as specific target groups including ‘looked-after’ children; people with learning disabilities, young parents and people living in the most deprived communities. In addition, Pupil Councils in three Angus secondary schools also provided feedback.

A total of 256 patients completed questionnaires about the service provided in Family Planning and Genito-urinary Medicine (GUM).



The views of staff working in the specialist services were also sought as part of the GUM and Family Planning Review through a series of one-to-one interviews and in stakeholder events.

We also received responses from a range of statutory and interest groups including from the three Community Planning Partnerships and the Community Health Partnerships in Angus, Dundee and Perth & Kinross.

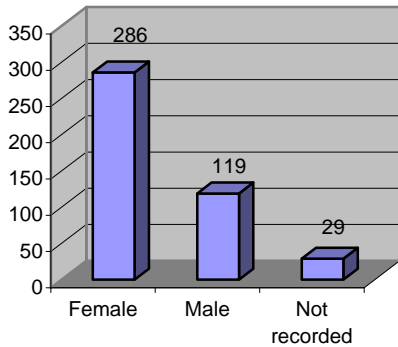
### Individual responses

The majority of the 434 individual respondents chose to give their views by freepost leaflet. The table below provides a breakdown of the preferred means of communication.

<b>Individual responses: Means of response</b>	
<b>Type</b>	<b>No.</b>
Freepost leaflet	425
Young Scot	4
Letter	3
Email	2
Text messaging	0

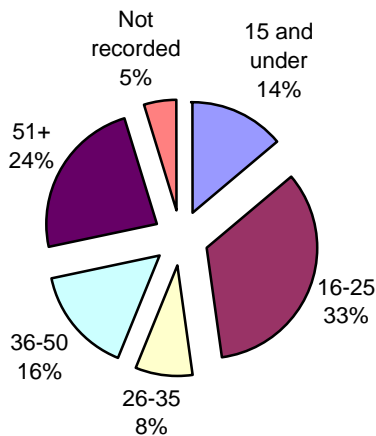
Of the 434 individual responses, 220 came from residents of Angus, 123 from Dundee City and 28 from Perth & Kinross. A further 63 were not recorded or were from other areas. The majority of respondents were women (66%).

**Gender of individual respondents**



The respondents were fairly evenly split between those aged 25 or under and the over 25s. Almost a quarter of people were aged over 50. The next chart shows the distribution of age groups.

**Age distribution of respondents**



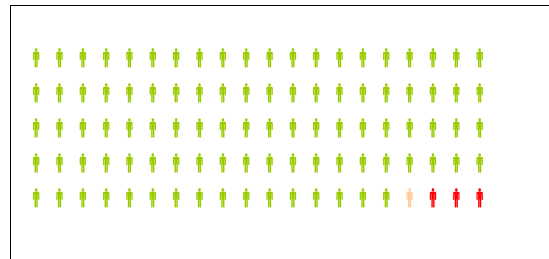
## RESULTS

Respondents expressed diverse and sometimes strong opinions. The responses provide a richness of information that will support and inform service planning and delivery.

The overwhelming majority of people who took part in the consultation recognised the impact of poor sexual health and expressed support for the action proposed in the draft Strategy. Only 15 individual respondents (3%) were wholly unsupportive of the draft Strategy and a further 5 respondents (1%) were critical of aspects of the Strategy but supportive of some elements, mainly the increase in screening and treatment of STIs. The chart below illustrates these proportions.

### Support of the Strategy per 100 respondents

♂ = wholly supportive  
 ♂ = partly supportive  
♂ = wholly unsupportive



The analysis of the responses from individuals and discussion groups is presented below by the major themes.

### Acquiring knowledge and skills to support informed choices

The topic mentioned most often was sex and relationships (SRE) education in schools. Almost 1 in 3 of the individual respondents and most of the groups felt that this was a vital component of acquiring knowledge and skills.

The value of SRE came over very strongly from young people themselves, although there were many suggestions to change the current practice and to strengthen the role of schools. One of the Pupil Councils suggested that *“the best way to promote sex when ready, would be to perhaps give out leaflets or educate pupils in what being ready really is. Perhaps give scenarios in classes which they could give comments on to make up their own opinions.”*

A young parent stated in response to a group’s support that there should be more sex education, that it *“depends what kind.”*

A few people believed that SRE encouraged early sexual activity

*“I think that sex education is being taught too young so people want to try it out”* (Female age 51+)

*“I totally disagree with the new sex education policy. It is too much too soon...”* (Female age 36-50)

However, many more felt that SRE should begin at an earlier age than happens now.

*“Begin sexual education earlier and consistent each year, not once a year at high school like I got and it was only 10 minutes”* (Gender and age not recorded)

*“Discuss developing relationships and self respect throughout the school years”* (Group of parents)

People also felt that SRE should be age appropriate and a comprehensive approach should be taken.

*“Comprehensive sex and relationships education from an early age (age appropriate) for everyone regardless of their background, religion etc....”*  
(Female age 26-35)

Information was considered a requirement by a considerable proportion of respondents and there were many suggestions about what information and education should cover. Areas that people thought were essential to include were:

### **Consequences and risks**

*“.....tell them of all the diseases they can catch”*  
(Female age 16-25)

*“Give more detailed information also give young people information of risks and things that happen in reality”* (Female age under 16)

*“Teaching about the consequences if you become pregnant at a young age. Say what can actually happen if you’re not ready.”* (Pupil Council)

### **Relationships and emotions**

*“The physical side of sex is well known (pregnancy) but not so much is taught about the emotion side, like being in a relationship with someone you love and trust”* (Female age 16-25)

*“Educating young people that a boy/girl relationship does not have to be a sexual one”*  
(Female age 51+)

*“Sit down and think to yourself, think about the person you are maybe liking or even in a serious relationship... think of trust and ask yourself am I ready? Your mind will tell you the right thing to do.”* (Pupil Council)

### **Confidence and self esteem**

*"Helping children to develop self esteem, confidence etc so that they can say no"* (Female age 36-50)

*"It's important to improve the confidence and self-esteem of children and young people to enable them to say 'no' to anything they don't want to do"* (Group of young parents)

### **Respect and self respect**

*"Discussion/communication from primary schools onwards about relationships and encouraging self respect and mutual respect"* (Female age 36-50)

Another respondent felt that it was important to talk about the meaning of a good relationship, *"which includes sex, respecting each other, but not to have sex until you love and respect each other"* (Female age 16-25)

### **Abstinence**

*"Education at school re all options and issues e.g. peer pressure, emotional consequences, abstinence, as well as STIs etc."* (Female age 36-50)

*"Need to send clear message to young people that it is OK not to be sexually active"* (Group of young people)

Responsibility was mentioned by several people, in the context of young people taking responsibility for their actions and more often in relation to parental responsibility in monitoring TV viewing and being aware of their children's behaviour.

It was also stated by several people that the needs of both genders should be considered.

Informal settings for SRE were suggested by many respondents, as was the use of different media to make information more accessible. This included suggestions of using:

- Posters
- Television
- Radio
- Videos
- Internet
- Computers
- Text messaging
- Helplines

*"Public health roadshows, displays in schools, articles on web, leaflets in schools, TV adverts & programmes"* (Female age 26-50)

*"Short films with people speaking about when they had sex too early and why they regret it"* (Female age 16-25)

*"Information pack sent out to Primary 7 pupils before they go to secondary school..... info about sex, STIs, relationships, discuss thoughts and feelings and where to get help"* (Group of parents)

*"..through TV shows instead of adverts as we normally leave the room when the adverts are on... other types of media should be used too"* (Group of young parents)

The need for access to services, including condoms, outreach services and support were highlighted. *"More health drop-ins, centres and more access to contraception"* (Male age 16-25)

*"Pubs and clubs should give out free condoms and sexual health information"* (Group of young people)

Respondents, especially young people also offered words of advice in their response to the question about acquiring skills and knowledge.

*"By asking the kid and not just telling them what is good and bad"* (Female age 16-25)

*"Be more informative, not telling them off about it, don't be like parents"* (Female age 16-25)

### **Influences on sexual behaviour**

Respondents commented on the influences on young people's sexual behaviour and gave suggestions as to how these might be tackled.

#### **The media**

*"There needs to be a change across society in regards to the attitudes towards sex. Media and the celebrity culture are giving the wrong messages to young people..."* (Male age 26-35)

*"Firstly the way sex is portrayed on TV. This gives a completely wrong idea. If the NHS is big enough to have some impact on TV progs i.e. no emphasis on building a relationship or what and how emotional feelings can enhance a relationship..."* (Female age 51+)

#### **Moral and religious values**

*"Religious instruction should be taught in primary schools as well as secondary to bring back value into people's lives and start them off on the right track."* (Male age 51+)

*"We are reaping the consequences of a secular humanistic liberal and godless society. If society will not change then the consequences will continue"* (Male Age 26-35)

### **Culture**

*"Promote a positive, open culture..."* (Female age 36-50)

*"Tackle the sex culture in school. Many people are bullied into having sex by their peers. This leads to STIs and such, you must tackle the problem at its roots in schools and in the media"* (Male age under 16)

*"Make the subject less taboo ..."* (Female age 16-25)

### **Alcohol and drugs**

*"Need to talk about drink because when you're drunk you just do it anyway"* (Female age 16-25)

*"Research needs to establish the links between drink, drugs and sexual activity....."* (Male age 51+)

### **The role of parents and carers**

A significant majority of respondents felt that parents should have a role in providing SRE for their children. Many of the respondents highlighted a lack of advice and support for parents and put forward a vast number of suggestions on what would help. There was considerable consensus, which fell into clear categories.

#### **Information on what children are being taught**

*"Parents/carers should be targeted with information about what their children are being told, why and when and given advice on how best to support their children"* (Male age 51+)

**Involvement of parents in school SRE**

*"Parents need to be more aware and become involved in their child's sex education..."* (Female age 51+)

*"Information more widely available for parents and carers from schools and parents evenings where information can be given and discussed."* (Pupil Council)

**Support for parents from school, from professionals and from peers**

*"Schools have to try to make themselves available to concerned parents and work with them"* (Male age 51+)

*"Start up support groups for parents/carers to give advice and support to enable parents to discuss matters with their children...."* (Female age 36-50)

*"A peer support approach – informal parent groups where parents can share experiences/offer guidance to each other..."* (Female age 26-35)

*"Peer led approaches supported by agencies with a rolling programme of workshops and training opportunities both formal and informal settings would be desirable"* (Group of parents)

**Information and education for parents**

*"Better information leaflets targeted at parents – so far never had one!"* (Female age 36-50)

*"Parents need education – classes for parents and keeping them informed"* (Gender not recorded age 36-50)

*"Provide the parents with the info"* (Female age under 16)

**Guidance for parents on how to talk to children about sexual health**

*"Give them an information book so that if a situation occurs, they will know how to handle it"* (Female 16-25)

*"Ensure parents/carers have up to date information and information on how to discuss such matters with their children"* (Female age 36-50)

*"Leaflets aimed at parents: questions and answers section with suggested responses for answering tricky questions"* (Group of parents/carers)

*"Written information(leaflets in many languages) to help parents talk to their children"* (Group of young people)

*"What to tell at what age?"* (Group of young parents)

**Advice to parents**

Some young people gave direct advice to parents in tackling the subject with their children, such as:  
*"Don't ask a lot of questions, let them come to you"* (Female under 16)

*"When children ask questions don't make excuses, just tell them the truth"* (Respondent age 16-25)

*"I would like them to know what's happening, but not to be up in your face about it."* (Pupil Council)

*"For them to listen instead of shouting"* (Female under 16)

*"Don't say 'I've been there' this switches young people off"* (Group of young people)

*"Don't have a strict no sex policy, it should be our choice."* (Pupil Council)

However, there were also suggestions that talking to children and young people at a younger age would make this easier.

*"They need to speak to us at a younger age – tell them how to talk to us"* (Group of young people)

*"More than half (the group) said their parents didn't speak to them about sex and 'stuff' as children, by the time they were teenagers they felt it was too late and they were both embarrassed and mortified at their parents broaching the subject"* (Group of young people)

A number of young people stated that they would not talk to their parents and would feel more comfortable talking to someone else.

*"Provide more information at school because children don't take it seriously when parents discuss it"* (Female age 16-25)

A small number of respondents suggested that SRE was a government or school responsibility.

One group issued a reminder that irresponsible behaviour is not unique to young people.

*"Why do young people always get the blame when adults do the same thing? i.e. act irresponsibly"* (Group of young people)

### **The role of schools**

There were several suggestions in relation to SRE in schools. The most common was that this should begin at an earlier age. There was considerable support for SRE in primary schools and that it should be age appropriate.

Acknowledging that teachers are not always comfortable with the subject, respondents felt that training and ensuring the competence of teachers in this area was important. Many people suggested that external professionals, such as nurses and youth workers should be involved in delivering SRE to young people within schools.

*"Training teachers more in handling pupils' questions without feeling awkward and vice versa"* (Female age 16-25)

*"To have a professional body to go to schools and talk to the young ones – remembering back, we thought it was funny to have a teacher talking to us"* (Female age 16-25)

*"They should educate us more at school and get people into school to talk to us ...."* (Group of young people)

*"Sexual health AND relationships to be taught in schools by professionals in this subject and not by teachers in that particular school"* (Female age 51+)

Peer education was suggested by many respondents and this included having young people share their experiences.

*"Peer education. Most people are scared to approach adults so maybe having someone younger that they can approach."* (Pupil Council)

*"Get people nearer or a few years older to educate them"* (Male age 16-25)

*"Have more talks at school, bring in young mums to do it"* (Female age 16-25)

However, schools were often considered to be appropriate places to give support to young people as well as education or information.

*“... a lot of children are having sex at earlier ages. I think it is to fit in with their friends. I think the school could help more and also having staff for them to talk to”* (Female age 16-25)

There were many suggestions that information should be made available through schools.

*“More information available in schools for informed choices...”* (Female age 16-25)

*“More information in schools from Primary 6 up”* (Female under 16)

#### **Availability and access to local sexual health services**

There was considerable support for availability and increased accessibility of services in communities. A wide range of venues for services were suggested including:

- Hospitals
- Health centres
- Chemist
- Schools
- College
- Clubs
- Youth groups
- Internet (for condoms)

However, group discussions with young people revealed that local communities may not be the best place for all services and some young people stated that they would much rather go to somewhere away from their own neighbourhood.

Although a small number of young people stated that they would access GPs or health centres for sexual health services, group discussions about this mainly concluded that there were issues including confidentiality, GPs knowing the family and knowing other staff and users of health centres which were seen as barriers to accessing these services.

There was wide support for the supply of condoms and Emergency Hormonal Contraception (EHC). It was felt that EHC should be free of charge. Other services suggested by respondents were all forms of contraception, STI screening and pregnancy testing. The point was also made by several people that condoms should be made available along with advice on how to use them.

*“Free condoms must have information and advice with them”* (Group of looked after children)

*“Free condoms are a positive and good idea but without education of how to use them they are as much value as a party balloon”* (Male age 51+)

The provision of free condoms brought objections from 12 individual respondents, and this was highlighted by some of those who were unsupportive of the Strategy. The Roman Catholic Church also raised significant objections (see page 13) to the provision of condoms within walking distance of secondary schools. However, many more people were supportive of the idea and this was illustrated at one of the group discussions.

*“..condoms within walking distance of secondary schools, everyone felt this was a good idea.....There was some discussion about the potential for disapproval of this proposal from some people in the community, but the group felt*

*that people needed to realise that if it doesn't change then the situation will only stay the same or get worse"* (Group of young parents)

A small number of people suggested that condoms should be available in schools and a few suggested that school services should include STI screening and emergency hormonal contraception.

However, some young people in the discussion groups said that they *"wouldn't trust the school to be confidential"* and would not feel comfortable talking to the school nurse.

There were comments about the lack of family planning clinics in local areas and some people highlighted that clinics which had been in existence before were no longer available.

Young people's clinics and drop-ins were requested from a number of people. Some thought that these should be broad-based; providing sexual health services as part of more general services. Many people stated that broad-based services like those offered by The Corner should be provided in local areas.

Counselling and support, advice and information were all suggested by many people as being important components of increased services and a few people thought that abortion counselling should also be included.

### **Increasing screening and treatment for the most common Sexually Transmitted Infections (STIs)**

There was a great deal of support for increasing screening and treatment for STIs. Almost 60% of individual respondents and all of the groups were explicitly supportive of this. Many more

respondents gave suggestions for venues and other proposals in relation to provision, such as:

- postal testing kits
- school screening
- college screening
- screening at health centres
- mobile unit
- wide range of venues
- rural areas
- drop-in clinics

A few respondents commented on the introduction of compulsory or regular screening. Opportunistic screening (health checks, smear tests) was also cited as something that should be considered.

There was a strong message that services should be well publicised and that it was important to make information available on STIs through TV and newspaper advertising and health promotion campaigns.

*"It's a good idea, perhaps handing out free packs to all young people describing symptoms, including a number they can call if they're worried"* (Female age 16-25)

*"...good info should help – many people know they have an STI – but the stigma of divulging this is embarrassing..."* (Male age 51+)

*"If we know the symptoms from class it will help"* (Female age under 16)

Confidentiality was an important element of an acceptable service and again, the disadvantage of having services in a local community was highlighted.

*"That's a good idea. If it's made confidential and easy to make an appointment"* (Female age 51+)

*"It should be anonymous and everything should be done by numbers it would save the person a lot of embarrassment"* (Male age 16-25)

*"People will not attend if they think someone may see them particularly in small communities"* (Female age 26-35)

*"Many people will still prefer services outwith their local area"* (Female age 51+)

### **Meeting the needs of those facing the greatest barriers to sexual health**

Some of the group discussions directly involved people who face barriers to good sexual health and they highlighted several areas in need of action.

Literacy levels were discussed by one group. *"Not everyone can read ... one leaflet can't cover everything"* (Group of looked after children)

A group of looked after children highlighted that limited contact with parents meant that they needed to access information from other sources. They also pointed out that information in school is limited and that internet access is monitored, compromising confidentiality.

There were many issues raised in relation to provision for young people living in rural areas and the challenges this presents for them. Travel to the nearest town was often necessary and this was difficult. A mobile service or a broad-based drop-in service in a local centre were suggested and there were many proposed times put forward.

One group of adult females with learning disabilities stated that they had not received any information on sex education until recently. It was felt by this group that education and specialist counselling should be more available.

It was felt by a group of parents of children with learning disabilities that their involvement in any discussions about SRE was vital and that messages need to be consistent. They highlighted the isolation they feel and difficulties associated with their children's emerging sexuality. They also pointed out that children with learning disabilities are not a homogeneous group and stressed the need for tailored individual support.

*"Different levels of disability mean that group work can very easily miss the mark due to individuals' varying levels of understanding"* (Group of parents)

It was felt that specific resources need to be identified or developed for young people with learning disabilities.

### **Views of organisations**

The statutory organisations were able to comment from a perspective of direct involvement in service provision.

Responses were submitted by all three Local Authorities, Angus, Dundee and Perth & Kinross Community Health Partnerships; the Perth & Kinross Association of Voluntary Services, NHS Lothian and by a number of individual health professionals or teams.

The Strategy was welcomed by the statutory organisations and recognised as a suitable

framework for multi-agency, multi-professional action to improve sexual health.

It was felt, however, that some areas would benefit from greater emphasis or inclusion. The common themes raised by statutory agencies were:

- ❑ Cultural change and how it could be tackled
- ❑ Requirement to address the needs of a wide range of ages. It was felt that the Strategy was very much biased towards young people, especially in the recommendations
- ❑ Need to be more specific about how to address the needs of vulnerable and hard to reach groups
- ❑ The need for additional resources for primary prevention, staff training and vulnerable groups
- ❑ Need to be more explicit about how engagement with and support for parents can be addressed
- ❑ Integrated Community Schools could play a more significant role

In general the Local Authorities felt that there was too great a bias towards investment in clinical services rather than in primary prevention.

Other issues raised by individual statutory organisations included:

- ❑ Broad-based service requirement was not sufficiently reflected in recommendations
- ❑ That there should be greater recognition of the role of Community Planning Partners, especially in implementing the recommendations

There were also issues raised about local GUM and family planning services, particularly in rural areas. Other organisations and projects responded with some similar comments, including:

- ❑ Local GUM services were required, especially in rural areas
- ❑ Investment in school health and the role of school nurses should be considered in relation to condoms and pregnancy testing
- ❑ Generic services were important in rural areas
- ❑ That SRE should be integrated across the school curricula

#### **Views of the Advisory Committees**

The Clinical Advisory structures supported the need for action and the importance that the Strategy gives to multi-disciplinary and joint working. There was strong support for developing a networked approach and a desire to be involved in the implementation of improvements in service delivery.

#### **Views of faith communities**

Although the faith communities in Tayside did not respond formally to the draft Strategy, the Roman Catholic Church and members of other Christian denominations did provide public comment.

The Churches raised a number of concerns that centred on the importance of:

- ❑ moral values in sexual health and relationships education;
- ❑ including abstinence as an option; and
- ❑ marriage.

In addition, the Roman Catholic Church challenged the Strategy citing that it was encouraging rather than discouraging irresponsible sexual behaviour. They also expressed particular opposition to:

- ❑ availability of free condoms, especially in close proximity to schools; and
- ❑ the use of Emergency Hormonal Contraception.

### **Views of patients using GUM and Family Planning Services**

A total of 287 user questionnaires were distributed to patients attending GUM and Family Planning Services across Tayside during May and June 2005. There was a 90% and 89% response rate respectively in GUM and Family Planning, giving a total of 256 respondents.

Over 90% of respondents were completely satisfied with the services they received at both GUM and Family Planning. A significant proportion (69%) of service users stated a preference for GUM to be a hospital-based service and 74% said confidentiality and anonymity were important. Patients felt that there should be clear information about the level of confidentiality offered by each service.

### **Views of specialist staff**

Staff supported the need for greater clinical leadership and more co-ordinated services, especially for developing community-based services.

Staff also expressed strong support to develop extended roles and competencies across both GUM and Family Planning.

## **FEEDBACK**

The views expressed during the consultation have been used to inform the final recommendations set out in the Tayside action plan. Copies of the report will be provided for practitioners working in sexual health to make sure that they can take the views into account in their own practice.

We also provided discussion group participants, agencies and the Patient Public Groups in each of the Community Planning areas with a copy of this report.

## **EFFECTIVENESS OF METHODOLOGY**

We carried out an evaluation of the different methods used to support the consultation as part of ongoing evaluation of Patient Focus Public Involvement (PFPI).

The more conventional method of response was by far the preferred choice for individuals, even among young people. The freepost questionnaires proved the most popular way for people to express their views. Only a small number of people chose to email comments and there was one short discussion forum through the Young Scot website.

No-one chose to use the text messaging facility. Text messaging has proved popular for other purposes, such as in response to competitions or polls where people are asked to vote or state a preference for options. However, for more complex or variable issues it may be less appropriate. In future, we should consider offering people a range of options e.g. strongly disagree to strongly agree, in response to a specific question. The inflexibility and cost may

have been additional factors that influenced people's decision not to use text messaging.

The inclusion of the Angus Citizen's Panel may account for the much higher level of responses in Angus. This type of approach may prove helpful in gaining a broad cross section of public opinion in the future, but would need to be limited in frequency to avoid 'over-burdening' panel members.

The patient questionnaire drew a very high response rate (89%). This is much higher than for most patient surveys. It is likely that the choice of distribution method i.e. by clinical staff who also explained the reasons for the questionnaire, would account for this higher participation level.

One parent felt strongly that it would have been more effective and would have resulted in broader participation if we had engaged with parents through the normal communication channels used by schools and Departments of Education.

It is likely that the subject matter of sexual health, a topic on which people hold strong views, was influential on the volume and richness of the responses we received. The use of methods such as the discussion groups and written responses allowed people to express their views more fully and for the analysis to reflect the complexity and range of opinion.

Many general, positive comments were received, including appreciation of having been consulted.

*"Great idea, hope this succeeds"* (Female age 51+)

*"Thank you for giving me the chance to express my thoughts"* (Female age 36-50)

*"Send more of these to more young people to get OUR views! Thank you"* (Male under 16)

**Circulation list**

The draft strategy document was circulated with an accompanying letter from the Chief Executive to a wide range of agencies, interest groups and communities. The recipients are listed below:

- Local Authority Chief Executives in Angus, Dundee City and Perth & Kinross
- Directors of Education in all three Local Authorities
- Directors of Social Work in all three Local Authorities
- Community Health Partnerships (CHPs) in Angus, Dundee and Perth & Kinross
- Community Planning Groups
- Head Teachers Association of Scotland
- Principals at the Universities of Dundee and Abertay
- The Principals of Angus, Dundee and Perth Colleges
- Students Associations
- Heads of Independent Schools
- The Scottish Executive
- Chief Medical Officer and the Chief Nurse for Scotland
- MSPs/MPs
- Council for Voluntary Services
- Voluntary sector and advocacy organisations involved in the field of sexual health or working with young people and vulnerable adults
- Carers organisations
- Young people's projects such as The Corner, the Web Project and No 1 for Youth
- Caledonia Youth
- Public Participation Groups (PPGs) in each area
- Faith communities, including the Church of Scotland, the Roman Catholic Church, the Scottish Episcopal Church and representatives of the Buddhist, Sikh, Muslim, Hindu communities in Tayside and the Dundee Interfaith community
- Humanist Society
- LGBT Youth
- Area Partnership Forum
- Area Clinical Forum
- Area Medical Committee
- GP Sub- Committee
- Area Pharmaceutical Committee
- All Tayside GP Practices
- Chief Executives of NHS Boards
- Members of the Sexual Health Strategy Group
- Chair of Child Health Strategy Group
- Prison Governors at Perth, Castle Huntly, Noranside and Cornton Vale

In addition, copies were also sent to members of the public and made available on the internet.

### Community discussion forums

Facilitated discussion groups took place in each of the Community Planning Partnerships as well as with some of the more 'hard to reach' groups. A list of the groups is set out below:

#### Angus

- Young carers group
- Youth justice groups
- Young people's smoking cessation group in Arbroath
- Youth Vehicle (access to hard to reach groups)
- Angus Youth Congress
- Pupil Councils in Arbroath, Kirriemuir and Monifeith
- Guthrie Hill homeless unit

The following groups also participated in group discussions, but members chose to return individual responses.

- Pitstop
- Angus College
- Kinnaird Street residential children's unit
- The Web Project
- Sure Start Parents Group
- Damacre Centre

#### Dundee

- Youth Voice (includes members of Youth Parliament)
- Stobswell Outloud Youth Group
- Young parents group
- Parents
- Healthy Living Initiative
- The Corner drop-in
- Sanjay Group (linked to international Women's Group)
- The Shore
- Peer education project
- Adult Learning groups
- Barnardo's Family Support Team
- Avrom House
- Partners in Advocacy – Citizen Advocacy for Adults with Learning Disabilities

### **Perth & Kinross**

- Young people's groups
- Young mums group
- Young Men's Health group
- Parents Groups
- Health topics group
- Adults with Learning Disabilities
- Two groups of adults in the Area Based Initiative areas (deprived communities)
- Looked after Young People
- Highland Perthshire Youth Initiative

### **Hard to reach groups**

- Caledonia Youth engaged opportunistically with young people in Secure Accommodation and with young people with Learning Disabilities
- Health Promotion staff also liaised with members of the Lesbian, Gay, Bisexual and Transgender (LGBT) Forum, LGBT Youth and with Gay Men's Health



**Russian**

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**Turkish- Turkce**

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**English**

This document can be made available in Urdu, Chinese, Hindi, Arabic, Russian, Polish, Czech, Turkish, large print, Braille or audiotape. Information in other languages and alternative formats can be made available on request.  
Contact NHS Tayside Communications Department on 01382 424138.