ShowCase

Design and Sexual Health (DaSH)

Topic: Sexual health

Organisation: Gateshead PCT

Location: Gateshead (North East)

Dates: From 2006; Ongoing implementation

Budget: £500,000 (capital funding); £500,000 (Choosing Health funding)

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Overview

The DaSH (Design and Sexual Health) programme was an innovative partnership between Design Options and Gateshead PCT to design a new, integrated genito-urinary medicine and sexual health service for Gateshead.

Without its own service, residents of Gateshead had to travel to Newcastle or South Shields to be tested and treated for sexually-transmitted infections. Recognising the problem, the Department of Health provided funding to develop a new service in Gateshead.

Design Options looked at the barriers to using sexual health services, the customer journey and possible ways to improve the customer experience, to create a user-centered service. Many of the recommendations were incorporated into the new service, which opened in July 2008.

Results from its first full year of operation (April 2009 to March 2010) included:

- 3,963 total attendances
- Of these, 55 per cent were new to the service or had a new reason to attend
- 100 per cent were offered an appointment within 48 hours (meeting the government target)
- 99.3 per cent were seen by a professional within 48 hours
- 65 per cent of users attended as a result of a friend's recommendation

1. BEHAVIOUR

- Increase participation in sexual health screening and use of contraception

2. CUSTOMER ORIENTATION

- Literature review
- Visual mapping of the Gateshead area
- Provider meetings and workshops
- Random sample street survey of 500 Gateshead residents
- Questionnaire and vox pops at health and community centres
- Clinic visits
- Cultural probes
- Service user workshops with community groups
- Care journey mapping
- Stakeholder mapping and interviews
- Persona and scenario creation

3. THEORY

- **NICE** (National Institute for Health and Clinical Excellence) guidelines on 'one-to-one interventions with vulnerable and at risk groups'

- **Health Belief Model (Rosenstock 1974):** Individuals carry out health-related behaviours based on perceived susceptibility, perceived severity, perceived benefits and perceived barriers

4. INSIGHT

- Stigma and embarrassment surrounding sexual health prevent people accessing services and seeking advice
- Inconvenience of existing services prevents frequent use
- GP not a popular choice for sexual health-related issues
- Individuals unclear about symptoms of sexually transmitted infections (STIs)
- Poor condom use
- Lack of knowledge about how common STIs are, how easily they can be transmitted and how easily they can be treated

5. EXCHANGE

- **Proposed benefits:** Improved sexual health; Freedom from worry; Timely treatment
- **Barriers:** Service is awkward to get to; Fear of the unknown; Belief that 'I'm not ill, so why should I go?'; Clinical environment is off-putting; Stigma of visiting the 'clap clinic'; Confidentiality fears
- **Solutions:** Service relocation; extended opening hours; Reduced wait time; Improved confidentiality; Welcoming environment; Improved user flow through the clinic; Holistic service combining sexual health, contraception and counselling

6. COMPETITION

- Existing GUM service in Newcastle, attracting users from Gateshead
- Transport links made getting to the Newcastle service easy
- Existing community contraception services in Gateshead

Work was carried out with the above to coordinate services rather than have them compete

7. SEGMENTATION

- Priority (high risk) users of sexual health services, including young people, men who have sex with men, looked after children, and sex workers

8. METHODS MIX

Significant changes made to:

- Core service structure, with extended opening hours
- Service promotion and awareness raising, with tailored branding and publicity campaigns
- Service gateways
- Clinic location, with satellite services
- User flow through the clinic
- Clinic environment