

Executive Summary



**The National Evaluation
of One Stop Shops
for Sexual Health.**



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Abbreviations

BASHH	British Association for Sexual Health and HIV
BME	Black and Minority Ethnic
CT	Chlamydia
DH	Department of Health
EC	Emergency Contraception
GP	General Practitioner
GUM	Genitourinary Medicine
HIV	Human Immunodeficiency Virus
IUD	Intrauterine Device
LARC	Long Acting Reversible Contraceptive
MREC	Multi-Research Ethics Committee
NHS	National Health Service
OSS	One Stop Shop
PCT	Primary Care Trust
PGDs	Patient Group Directives
PN	Partner Notification
QOF	Quality and Outcome Framework
R&D	Research & Development
STI	Sexually Transmitted Infection
STIF	Sexually Transmitted Infection Foundation
UCL	University College London

Contents

Executive Summary	6
Introduction	6
Conclusions from the Research	6
Implications for Policy and Practice	7
<i>Establishing the need for a one-stop shop</i>	7
<i>Strategy</i>	8
<i>Logistics</i>	8
<i>Training</i>	9
<i>Resources</i>	9
Evaluation Methods	10
<i>Service users</i>	10
<i>Staff and stakeholders</i>	10
<i>Community</i>	10
<i>Service</i>	10
Evaluation Findings	12
<i>Designated young people's model (Model A)</i>	12
<i>Mainstream services for all ages model (Model B)</i>	14
<i>General practice model (Model C)</i>	16
Economic Analysis	18
Views on OSSs and Integration	18

Figures

Figure 1: Area¹ and service characteristics of OSS and control sites by model type 11

Executive Summary

Introduction

- Although services for contraceptive provision and sexually transmitted infections (STIs) have developed along largely independent paths, the health issues are closely and commonly related.
- In 2001, the Government launched the National Sexual Health and HIV Strategy and one of its recommendations is the provision of more comprehensive and integrated sexual health services.
- The ‘one-stop shop’ (OSS) in its broadest sense refers to the provision of sexual health services on a single site. There is no clear consensus on whether one provider should manage care (and who that provider should be) or whether different specialists should be housed in the same building.
- In 2003, the Department of Health (DH) commissioned an evaluation of three models of OSS: **Young People’s Services (Model A)**, **Mainstream Services of All Ages (Model B)** and **General Practice (Model C)**.
- The aims of the evaluation were 1) to assess the effectiveness, acceptability, accessibility and efficiency of OSS models of sexual health provision in comparison to more traditional models of sexual health provision, and 2) to assess the impact these models have on the local community. It was not an aim of this work to make direct comparisons between different OSS models as each of the models were in areas with very different demographic profiles.
- In this document we identify the implications for policy and practice in light of the evaluation findings, and provide a summary of the evaluation methods, the results for each model and the views on OSSs and integration.

Conclusions from the Research

- The evaluation provides an in-depth study of different models and approaches to OSSs for sexual health provision and integration at both site level and across the community. It should be viewed as a study of ‘real life’ and evolving sexual health services rather than as an evaluation of different interventions.
- The complex evaluation design ensured that we were able to examine the impact of these models from different perspectives, i.e. the user, the community, staff and other stakeholders, the service and cost. However, there are limitations to the evaluation that need to be considered when interpreting its findings. For example, the extent to which OSS and control sites were ‘pure’ in their approach was often blurred.
- It was difficult to assess effectiveness of the evaluated OSSs at a community level (e.g. what impact they have on STI rates in a local area), but at a site level there were some differences in how care was managed. For example, there was some

evidence that people attending the mainstream OSS for STI-related reasons were more likely to be offered contraceptive advice or supplies. The designated young people's OSS was more likely than the control sites within this model to see young people with multiple partners and those who had had a previous STI. This site was also successful in attracting young men.

- Staff working within sites providing sexual health services support the concept of OSSs. However having an integrated mindset was viewed as just as important, if not more important, than the establishment of OSSs. In the main OSSs are acceptable to many users, provided they facilitate access for different users (e.g. separate young people's services and gender-specific clinics). Some individuals and target groups, such as gay men, maintain a strong preference for stand-alone specialist (i.e. designated young people's, community contraceptive or GUM) services.
- At present general practice is the major provider of sexual health care, but the range of provision is often limited and variable, for example the limited availability of implants. The findings from the general practice OSS show that it is possible to provide a more comprehensive sexual health service in this setting.
- Convenience was the most frequently cited reason for choice of service for sexual health-related needs.
- Access to specialist sexual health services is inadequate with a current mismatch between supply and demand. Unless this is addressed, only re-organisation of services will adequately improve access to care. In the long-term, improving organisational structure, and the collaboration and integration between services will help to improve access to sexual health care, but in the short-term, primary care and acute trusts need to address ways of increasing quick access to services.
- Although sexual health should increasingly become a priority at a local level through inclusion in Local Development Plans, there are still challenges to reach targets and implement change. This may hinder the move towards a more integrated approach to sexual health service provision.

Implications for Policy and Practice

The following sections describe the main findings. This section highlights the implications of the evaluation for those planning, commissioning or organising services.

Establishing the need for a one-stop shop

- Local needs assessments should be conducted to establish whether or not a OSS would improve how sexual health services are delivered, and if so, where would be the most appropriate setting.
- The impact a OSS will have at a local level on current and potential users of sexual health services, and the staff working within these and other services must be examined before a decision is made on how best to proceed. Attention also needs to be paid to whether OSS sexual health provision would increase or reduce capacity. We found whilst observing consultations in each of the evaluated sites

that consultations in the OSS sites were longer in comparison to those in the control sites. For example, in the designated young people's OSS service the small number of observed consultations were 50% longer than those in the control sites. Therefore increasing the amount of sexual health care provided within one session could limit the numbers of people seen within a service. However, if referrals elsewhere are reduced overall capacity may not be limited.

- Encouraging an integrated mindset across different service providers is more feasible in the short-term and may be more important than focusing on '*bricks and mortar*'.

The following considerations that need to be addressed when setting up a OSS were identified over the course of our evaluation. Many of these points are applicable to integration of sexual health services across the community and do not just refer to the establishment and running of OSSs.

Strategy

- National policy can help provide a central steer regarding the need to prioritise sexual health. This includes providing the necessary incentives to services to encourage a more integrated approach.
- Common aims need to be established at a local authority level and within individual services, e.g. addressing both under 18 pregnancy and STIs together rather than separately.
- A sexual health lead responsible for integrating sexual health care at a local level must be identified.
- Primary Care Trust (PCT) support is a pre-requisite for good integration, including the establishment of OSSs.

Logistics

- Transparency in the provision and delivery of sexual health services (including general practice) is needed. For example, sites could be categorised as National Sexual Health & HIV Strategy Level 1, 2 and 3.
- A 'hub and spoke' approach to the delivery of sexual health care can provide a framework for good links and communication between the different service providers. The central mainstream 'hub' could provide the management and co-ordination to the other specialist services and partners ('spokes'). Clear referral pathways would need to be identified to and from the hub.
- The establishment of a OSS should not be at the expense of local satellite services or choice of different providers - a reduction of services may reduce access to the most vulnerable and least vociferous groups.
- Most people use general practice for sexual health care. Although there was general consensus that more comprehensive sexual health care can be provided within general practice (certainly to Level 2 standard), this should be done with support from the specialist services.

- The outreach program connected to the OSS general practice was successful in getting people from the community into general practice for sexual health care. Taking sexual histories at registration to general practice helped normalise sexual health within this setting.
- Information needs to be collected and reported in case notes in a standardised way across providers to ensure efficient care.
- Anonymised common core datasets across services (including both specialist sites and general practice) are needed to monitor patterns of service use and sexual health outcomes.

Training

- Training, including work placements, is needed to ensure core knowledge of sexual health (i.e. HIV, contraception and GUM) amongst those working in sexual health services.
- There are particular problems with nurse sexual health training at present. Foundation sexual health training for nurses, with the option to specialise in areas such as HIV, young people and STIs, or fitting of implants and coils, need further exploration.
- More nurses, particularly in services that are nurse-led, should be trained to manage whole episodes of care, including prescribing/supplying treatment for STIs and contraceptive methods. Patient Group Directives (PGDs) need to be used or developed where they do not exist and suitable candidates for nurse independent prescribing courses identified.
- Training, support and incentives are required to enhance the competence and range of services provided within general practice, particularly around sexual history taking and risk assessment. Increasing attendance on Sexually Transmitted Infection Foundation (STIF) courses should be encouraged.
- Training of non-health sector staff (e.g. youth workers) on providing sexual health advice and increasing their knowledge of local sexual health services is required.

Resources

- In primary care, increased priority needs to be given to sexual health. For example, provision of sexual health care in general practice is hindered by lack of financial incentives in the Quality and Outcome Framework (QOF).
- Payment by results may be counterproductive to developing more integrated specialist sexual health services, as there are presently no tariffs for contraception. When both contraception and STIs are addressed within one consultation only one payment can be claimed.
- Sustainable resources need to be made available to services to develop integrated and OSS services. This includes adequate set up costs, identification of appropriate sites and for training.

- Commissioning needs to take place across the range of sexual health services. Greater clarity is required with regard what services are being provided and where.

Evaluation Methods

- A OSS site for each model was selected by the DH to take part in the evaluation. These were each compared by the research team to two control sites in geographically and demographically similar areas (e.g. deprivation scores within similar ranges) and with corresponding service level characteristics (e.g. opening times). A summary of the area and service level characteristics of the participating sites is provided in Figure 1.
- A complex evaluation using quantitative and qualitative methodologies was conducted and covered four broad themes, which included user, staff and other stakeholders, community, and service perspectives. The following methods were used:

Service users

- Questionnaire survey of people attending the evaluated designated young peoples' or mainstream services
- Questionnaire survey of people who had used general practice for sexual health needs, identified via population survey (see below)
- Semi-structured interviews of service users

Staff and stakeholders

- Staff questionnaire survey
- Semi-structured interviews with staff, and local and national stakeholders

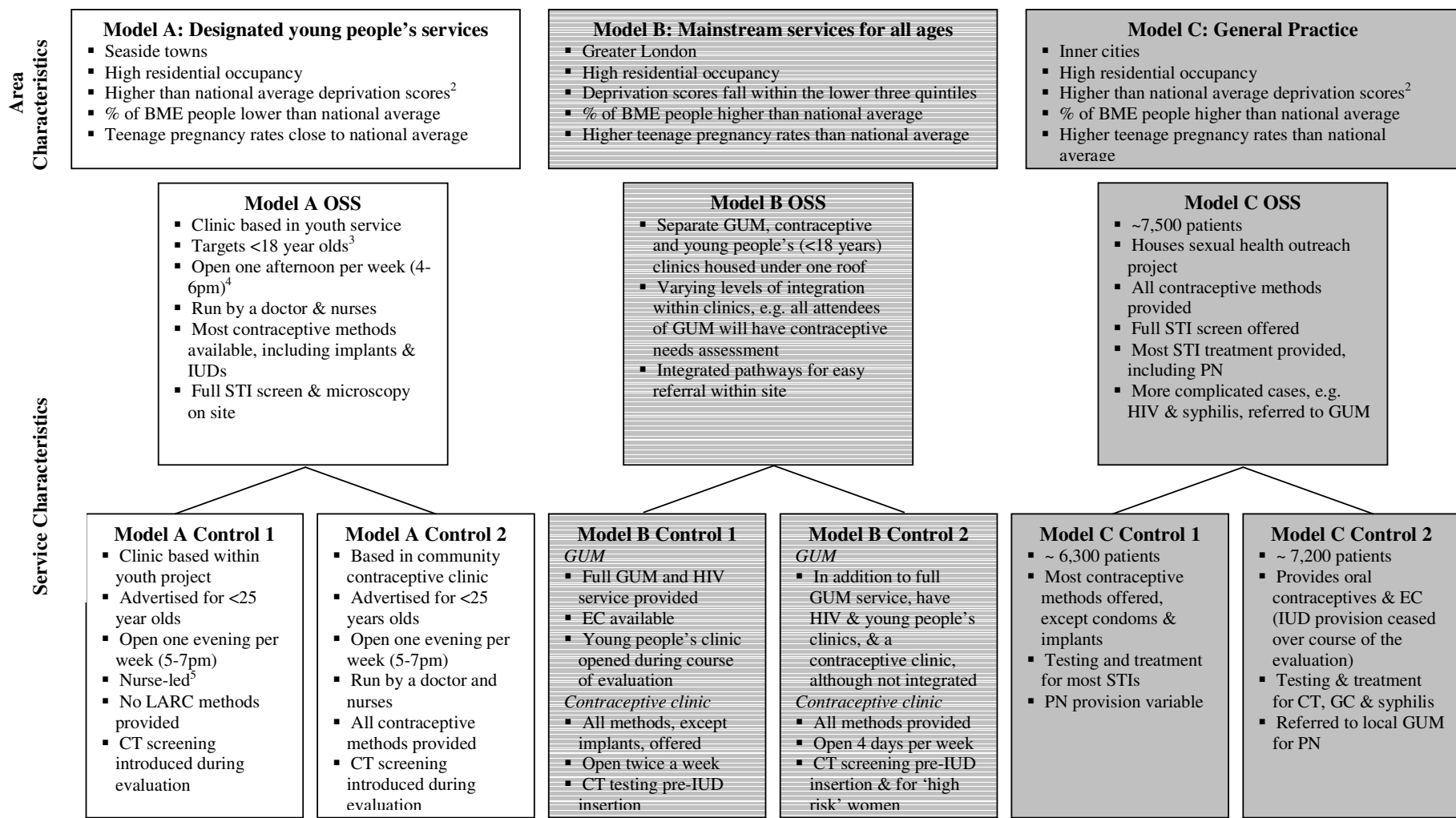
Community

- Population survey (respondents identified through general practice registers)
- Examination of routine demographic and sexual health outcome data
- Community interviews and focus groups with gay men, young men and people from Black & Minority Ethnic groups

Service

- Collection of service level data
 - Case note audit
 - Observation of consultations
- An integrated economic analysis was conducted at area level to examine the impact of running a OSS. This combined data from the population survey about levels of use of different services (including the OSS) and information from the services themselves, reference sources and the user surveys to estimate costs of consultations and treatments/investigations.

Figure 1: Area¹ and service characteristics of OSS and control sites by model type



Notes: ¹Area defined by top-tier local authority boundaries ²Index of Multiple Deprivation from the Office of the Deputy Prime Minister ³Age limit reduced to target most vulnerable just prior to the evaluation. ⁴Increased to two days per week over the course of the evaluation. ⁵Doctor no longer present over course of the evaluation.

Abbreviations: BME=Black and Minority Ethnic, CT=Chlamydia, EC=emergency contraception, GC=gonorrhoea, GUM=Genitourinary Medicine, IUD=intrauterine device, LARC=long acting reversible contraception, PN=partner notification, STIs=sexually transmitted infection

Evaluation Findings

Designated young people's model (Model A)

Profile

- All of the Model A young people's sites are based in residential areas in seaside towns. They are all open access and open for a couple of hours in the early evening for one or two days a week.
- The services have evolved in different ways. The OSS site is based within a youth service and offers a fully integrated sexual health clinic, which is run by dual trained staff. One of the control services is based within a youth project and is linked to a mainstream integrated sexual health service. The other is a community contraceptive clinic for under 25s.

Where young people go

- The population survey found that the most commonly cited service provider by young men and women aged 16-24 years in terms of actual and preferred use for most of the identified sexual health needs was general practice. The exceptions were for condoms and pregnancy testing where retail services were the most frequently cited. We found little difference between the proportions of young women living in the OSS and control areas who reported accessing services for different sexual health needs. However, young men were significantly more likely to report using the OSS site than the control sites for condoms and STI testing.
- 'High risk' young people (i.e. those with two or more partners) were more likely to say they used or would use one of the designated young people's (Model A) sites to access condoms or to have an STI test.
- Knowledge of local sexual health services and what they provided was often poor, particularly amongst the young men. In rural and suburban areas, access to specialist clinics was a problem for young people.

Users of the designated young people's sites

- Service level data (2004) showed young men contributed to fairly small proportions of the total clinic attendance figures. The proportion of women under 18 years was much higher in the OSS than the two control sites. Overall attendance was highest in the control community contraceptive clinic. Young women requiring prescriptions for the pill accounted for most of the attendances in all sites. Nearly all of the implants and intra-uterine methods were inserted in the control community contraceptive site. In the OSS, 20% of young women who were screened for chlamydial infection were positive and 11% of young men. No HIV infection was identified and one case of gonorrhoea.
- In contrast to the population survey, the user survey found that designated young people's services were the preferred service for most young people accessing these sites. Factors such as accessibility, a community setting, informal atmosphere and confidence in the staff were reasons cited by young people as the reasons for their preference of these services. Convenience-related factors (e.g. no appointment necessary) were the reasons users were most likely to give for choice of service. Over a third of OSS users stated they had selected this service because it offers both tests for STIs and contraception.

- None of the OSS users stated they would prefer to use a mainstream contraceptive and genitourinary medicine (GUM) clinic. All young people were more likely to report they would use general practice for contraceptive or pregnancy-related reasons in comparison to STI-related needs. The most common reason young people attended the OSS service was to find out if they had an STI. Within the control services it was to pick up condoms.
- The users of the OSS, when compared to users of the control services, reported more sexual partners and were more likely to have had a previous STI. The users of the control services were more likely to report marriage or cohabitation and children. Around a quarter of all young people responding to the user survey were under 16 years.

Management of care

- In the user survey young people reported little difference between the OSS and control services in how their care was managed. The exception was that a higher proportion of the OSS female users were diagnosed and/or received treatment for an STI in comparison to control site female users (17% versus 1%, respectively).
- The user survey found no significant difference in the referral rates of OSSs and the control sites. However, the case note audit showed that those diagnosed with chlamydial infection in the control sites would be referred to GUM for treatment and partner notification. Young people with chlamydial infection attending the OSS site were managed in-house.
- The observations of consultations provided a clearer picture about the complexities of some of the consultations with young people and how sexual health has to be seen in context, e.g. problems with alcohol and drug use. Much attention was paid to child protection issues in the OSS service, e.g. whether sex was consensual and talking with parents. The few observations with young men in control services found these consultations tended to focus on condom demonstrations and distribution.
- User satisfaction in all three sites was high, although interviews with young men found that there was sometimes frustration that there was little available for them in the control services.

Staff

- The OSS service was the only site to have some dual trained staff (i.e. in both GUM and family planning).
- Many staff were employed on a sessional basis. This meant that training opportunities and support were at times limited.
- All of the health service staff were female, although the two clinics within youth services usually had a male youth worker on site.

Mainstream services for all ages model (Model B)

Profile

- The mainstream Model B site areas are all based In London.
- The OSS runs separate clinics for GUM, contraception and young people that are all housed under the same roof. In broad terms the contraceptive and GUM clinics are integrated at a minimum of level 1 of the National Sexual Health and HIV Strategy. An appointment system is in place, although some clinics are open access, e.g. the young people's sessions.
- Both the control GUM clinics are based in hospital grounds, while the two community contraceptive clinics were based in health centres. The GUM and contraceptive sites were linked in terms of referrals. One of the GUM control sites does have a contraceptive clinic, but GUM is not integrated into this clinic. Both the GUM clinics have separate clinics for young people and for people with HIV.

Where people go

- In the mainstream evaluation area, the population survey found that for “consumerist” sexual health needs, such as condoms, pregnancy tests, and to some degree, emergency contraception, retail sites were most frequently cited as the actual or preferred service. For all other sexual health needs, general practice was the most frequently cited service provider.
- Women living in the OSS area were more likely to report actual and preferred use of the mainstream OSS when compared to those accessing the standalone GUM and community contraceptive clinics in the control areas for condoms, emergency contraception, abortion advice and pregnancy tests. Those in the OSS area were less likely to use, or say they would use, general practice for all these services, with the exception of pregnancy testing.
- During the qualitative work knowledge of local sexual health services was found to be poor amongst many. However, the gay men participating in focus groups were well informed and they felt that community outreach played an important role in sign posting people to relevant services.
- Interviews with service users and within the community suggested people would use different services for different sexual health needs. For example, some women were happy to use general practice for contraceptive needs, but would want a specialist service for STI-related needs. Gay men expressed an overwhelming preference for specialist GUM services. Some interviewees, particularly those of South Asian origin and older women, expressed concerns about using a service that was associated with GUM.
- However, the user survey showed that amongst both women and men accessing the OSS site, this site was the option most likely to be preferred for all the identified sexual health needs. There was more variation in preference amongst those using control sites.

Users of the mainstream sexual health sites

- Service level data suggested that the age profile of OSS users was younger than that of all other sites. These data also showed that the provision of oral contraceptive supplies accounted for most female attendance, and amongst men it was STI screening. The proportions of men testing positive to chlamydia and gonorrhoea were higher than the proportions of women in all sites.
- Male and female OSS user survey respondents were more likely than control respondents to be younger, single and without children. Women using the OSS were more likely to report an STI diagnosis in the last year, while male OSS users were less likely. Female OSS users were less likely to be from a BME group in comparison to control users.
- Female users of OSS were more likely than the control users to report the site they were accessing as their preference for all the identified sexual health needs (i.e. information on safer sex, HIV testing, STI testing, condoms, emergency contraception, other contraception and abortion advice). Male users of the OSS were more likely than male users of the controls to report the site they were using as their preference for information about safer sex and condoms, but no difference between the OSS and control sites was observed for STI and HIV testing.
- Convenience-related factors were the reasons for service selection cited by both users of OSS and control sites, women using the OSS site were more likely than women using the control sites to give convenience-related factors for choice, while for men it was the other way round. However, many concerns were voiced about the poor access into sexual health services, particularly into GUM (for both OSS and control sites).

Management of care

- Both men and women attending the OSS site for an STI-related reason were more likely to report they were offered or given contraceptive advice and/or supplies, and for women emergency contraception, than the control users. OSS users attending for a contraceptive-related reason were more likely to report they had been offered or received STI advice, testing, treatment or a diagnosis. However, when the analysis was just confined to those who received treatment or a diagnosis there was no difference between the OSS and control users.
- The case note review and consultant observations found there was more integration in the GUM clinics, irrespective of whether or not they were within the OSS or control sites, compared to the community contraceptive clinics.
- User satisfaction was high at all sites. Most complaints were round the difficulty in getting an appointment.

Staff

- Staff working in the OSS site were more likely to report previous experience in other sexual health specialties. There were more dual-qualified staff in the OSS and stand-alone GUM sites in comparison with the community contraceptive sites. Training opportunities were minimal in some areas, this being particularly difficult for sessional staff.

- Nurses enjoyed running the nurse-led services, but problems arose when they were unable to prescribe treatment or provide contraceptive methods.
- Consultants were taking on more management and planning of services.

General practice model (Model C)

Profile

- The Model C sites are all in cities and are group-training practices.
- The OSS practice offers all contraceptive methods and STI screening and treatment. At registration the practice nurses take a sexual history and risk assessment. In addition, a sexual health outreach programme is linked with the practice. The control practices offer a less comprehensive range of contraceptive methods and STI tests.

Where people go

- As observed with the other models, the population survey respondents cited general practice as their actual or preferred source of sexual health. More people reported use or preferred use of the OSS practice for all the identified sexual health needs than the control practices. In addition, those in the OSS area were less likely to cite a specialist mainstream service or a retail service as their actual or preferred choice for most sexual health needs under consideration.
- Reasons for preference of general practice included continuity of care, knowledge of medical history, ease of access, and ability to get a female doctor. In the OSS area, the outreach project targeting young people was given as a reason for preferring or using the OSS general practice. However, there were many barriers to general practice highlighted in the qualitative work in the community with young men, gay men and people from some BME communities, for example concerns of the lack of confidentiality.

Users of the general practice sites

- The user survey found there were no differences between OSS and control practice users in relation to reported sexual behavioural characteristics, but OSS users were more likely to be single and without children.
- General practice was also cited as the preferred service amongst all Model C user survey respondents. The OSS practice was significantly more likely to be cited by users than the control practices for each of the different sexual health needs.
- Convenience related factors were the reasons users of all of the evaluated practices gave for choosing these services. Although, amongst the women, OSS users were significantly more likely than control users to report that the quality of the advice and treatment, and the fact that they could get both contraception and tests for STIs as reasons for selection.
- The most common reason for the visit in all Model C sites was for a repeat contraceptive prescription. Some of the users interviewed explained they were

happy to attend general practice for contraceptive-related needs, but would go elsewhere for STI-related needs, although the user survey found there was little difference in the proportions of users citing preferred use of the evaluated general practices for contraceptive and STI-related needs.

Management of care

- Service level data showed that in terms of contraceptive provision, the workload across the sites was fairly similar, with the exception that no subdermal implants were inserted in the control practices. The numbers diagnosed with chlamydial infection were higher in the OSS practice.
- The user survey found that women attending the OSS practice for an STI-related reason were significantly more likely to be offered an HIV test and condoms in comparison to control practice users. Those attending the OSS for a contraceptive-related reason were significantly more likely to be offered condoms. No other significant differences were observed between the reason for visit and the outcome in terms of management in the different sites.
- No significant difference was observed between the OSS and controls in terms of overall referral, but control users were significantly more likely to be referred to community contraceptive clinics in comparison to OSS users.
- The case note review found that women attending the OSS for a contraceptive-related reason were more likely to have a record of a sexual history being taken than women attending the control practices for the same reason. Amongst those diagnosed with chlamydial infection or attending with genital symptoms there was little difference. There was more variability in the treatment of chlamydial infection in the control sites and treatment was not always in line with British Association for Sexual Health & HIV (BASSH) guidelines.
- The observations of consultations (particularly in the controls sites) showed that patients often do not present to their general practice with a “sexual health” problem, but with symptoms, such as pain and discharge.
- Users of both the OSS and control practices were usually satisfied with the care they had received.

Staff

- Staff at all three practices were more likely to be qualified or have attended a course in contraception rather than GUM.
- Most staff felt that they were able to take on sexual health in general practice, although there was less confidence in some areas like partner notification.

Economic Analysis

- It is important to reiterate that the economic analysis did not focus on the cost of the OSS itself, but on the cost of having a OSS within the local health economy of an area, as the additional cost of an OSS may or may not be offset by changes in use of other local services.
- The economic analysis should be interpreted with caution. First, because it relied on data from the population survey which had a low response rate leading to the possibility of bias and a lack of precision in estimates due to small numbers of respondents. Second, because some of the data about costs (e.g. of buildings and staff) were provided by the services themselves, and are of uncertain reliability. Third, because despite our attempts to match OSS and control areas, there may be important differences in the populations or other NHS services in different areas unconnected with the existence of an OSS. These variations between areas may mask any effects of the OSS.
- With these provisos, the data suggest the following tentative conclusions:
 - The influence of the designated young people's OSS on expenditure on sexual health care in an area was small, because this service was a minor provider of services within the community. Differences in cost at an area level are probably related to factors other than the existence of the OSS.
 - However, the mainstream OSS accounted for around a quarter of all NHS sexual health expenditure within the local area of the OSS. NHS expenditure in total in the OSS area was higher than that in the control areas, mainly because the OSS appeared to be acting as an *additional* resource, without any compensatory reduction in the costs of providing other local services. (This extra expenditure may or may not be justified, depending on whether or not it leads to extra health benefits. It is not possible to answer this question from this evaluation.)
 - By contrast, for the area served by the general practice OSS, expenditure was lower than in the control areas. This is because use of the GP OSS appeared to *substitute* for the use of other services, with fewer consultations at GU clinics and contraceptive clinics in the area served by the GP OSS.

Views on OSSs and Integration

- The benefits of OSSs from a user perspective cited during the qualitative work included convenience, public health benefits (e.g. reduction of both unplanned pregnancy and STIs), reduction of stigma, more confidentiality around the reason for attendance, capturing people who are unaware of their need for other services, better for young people, and improved access for men. Additional benefits for a general practice OSS included being local, easier to get an appointment in comparison to mainstream services, good relationship with GP, reason for visit not obvious, and people being unaware of the need for mainstream services.
- Disadvantages of OSSs for users included reduction of consumer choice (particularly amongst some groups such as gay men and older women), longer waiting times, less confidentiality, increased stigma, the fact that contraception

was seen as something for 'healthy' people while STIs were an 'illness', dilution of specialisms, greater centralisation, insufficient time during consultations and loss of acceptance of gay issues. Specific disadvantages relating to general practice OSSs included only being open during office hours, confidentiality concerns and having to explain the reason for one's visit.

- From a staff perspective, the advantages of specialist (i.e. designated young people's and mainstream) OSSs included greater job satisfaction, improved opportunities for education, less professional isolation, greater flexibility, convenience, greater autonomy, less duplication and reduction of costs. The cited benefits of OSSs in general practice were that sexual health would be managed in-house and there would not be concerns that those referred to mainstream services would not turn up, and many felt provision in general practice would help free up the specialist services that are currently in crisis.
- Disadvantages of OSSs for staff included infrastructure unable to cope with increased demands, less staff 'loyalty', dilution of services, clashes between different managers, and cost. A disadvantage mentioned regarding general practice OSSs was that mainstream services may see general practice as a threat.
- Staff and stakeholders felt that there needed to be flexibility in how services were developed. Some felt that for young people it was important that one person provided all the care, so that trust could be established and messages reinforced.
- There was general support for mainstream OSSs. However, this approach was not viewed as being mutually exclusive from integration at a community level. Staff felt that the target group for mainstream OSSs should be those who are less likely to use general practice for sexual health or those who require more specialist care. Users felt that there should be maintenance of specialities in a OSS and clinics should be single gender.