Understanding the development needs of the primary care and community health workforces with regard to sexual health in NHSScotland to enable the successful implementation of ‘The Sexual Health and Blood Borne Virus Framework 2011-2015’: a scoping study

Report for NHS Education for Scotland

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Executive Summary

Background: The Sexual Health and Blood Borne Virus Framework (Scottish Government, 2011) was published in July 2011 providing a single overarching strategy to bring together and address four linked policy areas: sexual health and wellbeing, including teenage pregnancy, HIV, Hepatitis C and Hepatitis B.

The need for the delivery of sexual health services to be a multi-agency, multi-disciplinary responsibility is highlighted throughout the Framework, as is the importance of having adequately trained staff in both health and non-health roles. The primary care workforce are often responsible for delivering a large proportion of frontline sexual health services, often by staff who have little specialist education and training in sexual health. Understanding the training and development needs of this workforce is therefore important in ensuring effective delivery of service, and implementing The Sexual Health and Blood Borne Virus Framework.

Aim: The main aim of the scoping study was to understand the development needs of the primary care and community health workforces with regard to sexual health in NHS Scotland to enable the successful implementation of ‘The Sexual Health and Blood Borne Virus Framework 2011-2015’. For the purposes of this study, the primary care workforce considered included the following groups: general practitioners, general practice nurses, public health nurses (health visitors and school nurses), community midwives, receptionists and administrative staff, health care assistants and healthcare support workers.

Method: A two-stage approach was adopted to understand the current state of training and development of the primary care and community health workforce. The first stage was a desk based review of existing work on training and development for the workforce, followed by a ‘listening exercise’ with key stakeholders with a strategic or operational interest in delivering sexual health training, by means of an online questionnaire and semi-structured telephone interviews. A total of 83 practitioners responded to the questionnaire, and 12 interviews were conducted.

Findings: Establishing the development needs of the primary care workforce is difficult with no overarching organisational structure in place to support or implement a cohesive training strategy. Sexual health training was identified to be one of many competing priorities for primary care practitioners, with specific training priorities identified:

- STI testing in the community
- Contraception availability including LARC
- Identifying and working with vulnerable groups
- Basic, generic level of understanding of sexual health including confidentiality,
taking sexual health history and signposting.

Current training provision and access to training varied widely between Boards and for different practitioner groups. While a structured programme of training existed for some practitioners, a need for training courses to be consistent, standardised and accredited was identified, as well as being more widely advertised. Ensuring the available training meets the needs of each practitioner group is essential, supporting the idea of conducting well-coordinated locally based training needs analyses.

The study sought to identify the gaps in current training provision. The main gaps identified through the scoping study included:

- Specific training for practitioner groups, with the needs of practice nurses being more frequently highlighted,
- Identifying opportunities to discuss sexual health with patients,
- Diversity awareness,
- Emergency contraception and LARC,
- Gender based violence and identification of vulnerable individuals,
- Communication and interpersonal skills,
- Basic training for reception and admin staff
- Understanding multiple needs of patients, particularly young people.

Time was most frequently cited as being the main challenge to accessing sexual health training – even when the funding was available to attend, there were still barriers in terms of time, locum cover and other priorities. Other barriers included access and availability of information, availability of staff to provide training, working patterns of primary care staff, and timing and location of training and lack of backfill or locum assistance. Limited funding for non-statutory training was highlighted as a problem, particularly within GP practices.

Suggestions for improving the planning and delivery of training included delivering training locally at a suitable time of day, such as twilight sessions; having a standardised programme of training coordinated nationally for different levels of need and expertise or similarly having a generic baseline level of sexual health training to ensure all primary care staff reach a recognised level of competence.

Conclusions and recommendations: Whilst there is work currently underway to address the training and development needs of the primary care workforce, gaps in training for individual practitioner groups and geographical differences need to be considered in order to meet the requirements of the Framework. There is scope for the good practice approaches to be built upon and adopted more widely. Additional support at a national level, and Board level, would help to ensure the workforce is adequately trained to deliver sexual health services and meet the requirements at a local level.
The key recommendations for NES arising from this scoping study are summarised as follows:

- Development of a strategic national focus on training in sexual health to provide consistency between and within Health Boards. This national approach to training should allow flexibility in implementation at a local level.

- Provide additional support at a national, Board and local level to overcome the barriers in accessing training by primary care and community health workforce, including support for providers in making training available in different formats as appropriate.

- Increase awareness of the training that is already available, to identify appropriate opportunities relevant to daily practice. A single point of reference that signposts practitioners to relevant training opportunities would be useful.

- Development of a national online core learning resource that is accessible by all primary care and community based practitioners who need to deliver sexual health services. This should provide a basic level of knowledge and education, to ensure consistency between practitioner groups and also geographically across Scotland. This would also be of value to the Health Improvement workforce, and other partner agencies involved in delivering sexual health services.

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1. Introduction

1.1. Sexual Health and Blood Borne Virus Framework

In the past the state of sexual health in Scotland has been deemed to be poor, with rising levels of sexually transmitted diseases and high levels of unintended teenage pregnancy (Scottish Government, 2007). In 2005, the Scottish Executive published the Respect and Responsibility Strategy and Action Plan for Improving Sexual Health (Scottish Executive, 2005), which stated that sexual health services should be provided by “skilled, confident and suitably equipped staff”. As part of the action plan to achieve this, the Scottish Executive Health Department agreed to work with the National Sexual Health Advisory Committee to ensure that appropriate training programmes were in place to support/enable the development of the required skills to the workforce, to enable them to respond to the sexual health agenda. Likewise, each NHS Board was required to appoint a lead clinician, who, amongst other things, was responsible for ensuring that the training needs of staff were known and understood, and that staff had the opportunity to develop core skills needed to perform effectively.

Since then, the strategy for improving sexual health has been encompassed into the Sexual Health and Blood Borne Virus Framework (Scottish Government, 2011). This was published in July 2011 providing a single overarching strategy to bring together and address four linked policy areas that had previously been addressed separately: sexual health and wellbeing, including teenage pregnancy, HIV, Hepatitis C and Hepatitis B. The Framework is outcome focused, rather than on inputs and processes. There are five main Framework outcomes:

1. Fewer newly acquired blood borne virus and sexually transmitted infections; fewer unintended pregnancies – improvement in public health caused by preventable infections and poor sexual health through a strong health improvement, prevention and education initiative amongst professionals and the public.

2. A reduction in the health inequalities gap in sexual health and blood borne viruses – the greatest impact is currently on most vulnerable in society; this sets out an improvement target to ensure nobody is inappropriately disadvantaged in prevention, treatment and care.

3. People affected by blood borne viruses lead longer, healthier lives – better longer term health to be achieved through more and better targeted testing, early diagnosis and effective treatment. The framework aims to improve practice through better partnership
working, including closer links with sexual health and drug & alcohol misuse partners to support those living with blood borne viruses.

4. **Sexual relationships are free from coercion and harm** – A positive approach to sexual health and relationships to be achieved through a holistic approach to sexual wellbeing, including issues such as gender based violence, homophobia and racism. The framework aims to improve knowledge and awareness; promote of positive sexual health and raise awareness amongst public and professionals.

5. **A society where attitudes of individuals, public and professionals and the media towards sexual health and blood borne viruses are positive, non-stigmatising and supportive** – the framework aims to change the culture and promote positive attitudes towards sex, sexual health, sexual relationships and blood borne viruses through better communication and improved knowledge.

Each of the policy areas that sit within the framework specifies the importance of having regular training, education and continuous professional development for the health and non-health related workforce. A multi-agency approach to achieving the outcomes is promoted throughout the framework, including training and development of staff. For NHS Boards, the standard for sexual health services applies, with standard statement 9 (NHS Quality Improvement Scotland, 2008) stating that “All staff who deliver sexual health services are adequately and appropriately trained.” A similar standard is in place for delivery of HIV care (Healthcare Improvement Scotland 2011a).

Within this Framework, NES have the responsibility of providing strategic support for delivering training, education and continuous professional development to the workforce dealing with sexual health and blood borne viruses. Work is already underway to look at workforce development for those working on Blood Borne Viruses, such as the outline of requirements of the Hepatitis C workforce development that was produced by NES in 2010, along with a workbook for staff to assess, monitor and develop their competency in delivery Hepatitis C services (NHS Education for Scotland, 2010a and 2010b). The need for a similar approach for understanding and delivering the training needs of the sexual health related workforce has now been identified, and is the focus of this scoping study.
1.2. Sexual Health and Wellbeing

Within the Framework, the sexual health focus is broad, and aims to build on the achievements of the *Respect and Responsibility Strategy and Action Plan*, which has seen improved integrated sexual health services and greater help and advice for young people, along with improved communication and health promotion, and greater leadership and coordination at national and local level. The new Framework aims to continue supporting the principles and aims of *Respect and Responsibility*, set out as follows:

- to improve the quality, range, consistency, accessibility and cohesion of sexual health services from primary care to GUM services, in line with the principles of providing services that are safe, local and appropriate;
- to support everyone in Scotland, including those who face discrimination due to their life circumstances or their gender, race or ethnicity, religion or faith, sexual orientation, disability or age, to acquire and maintain the knowledge, skills and values necessary for good sexual health and wellbeing; and
- to positively influence the cultural and social factors that impact on sexual health.

In addition to continuing the work under *Respect and Responsibility*, the Framework intends to identify key areas for further action to improve sexual health and wellbeing in Scotland, informed by up to date evidence.

Multi-agency partnership is seen to be central to the delivery of the Framework, and in achieving the outcomes. Board level sexual health strategy groups, set up to implement and monitor local sexual health strategies, have multi-agency membership, including local authorities, drug and alcohol partnerships and third sector organisations, with joint accountability for many of the sexual health indicators. Throughout the Framework the need for sexual health services to be a multi-agency, multi-disciplinary responsibility is highlighted, and this appears to be reflected in the current sexual health service landscape. The importance of having adequately trained staff – in both health and non-health roles – to deliver sexual health services is highlighted within the Framework, indicating that, “regular training, education and continuing professional development is vital to ensure the confidence and competence of the workforce.” (Scottish Government 2011, p12).
1.3. Primary care and community based practitioners

The importance of the role played by the primary care workforce in delivering sexual health services is acknowledged within the Framework, especially in the remote and rural settings where specialist services are more difficult to access. In general, primary care practitioners are often responsible for delivering a large proportion of frontline sexual health services, alongside specialist GUM and family planning clinics (Mullineux et al, 2008, Cassell at el, 2003). Flett and Banerjee (2007) stressed the relevance of sexual health to several areas of work within general practice, and that the GP is ideally positioned to understand the inter-related health issues for an individual patient, and provide a holistic approach to these. Sexual health services are often provided by staff who have little specialist education and training in sexual health, and the need for further training for GPs and practice nurses in areas such as sexual history taking and STI testing have been highlighted (Markham et al, 2005). Understanding the training and development needs of this workforce is therefore important in ensuring effective delivery of service, and implementation of the ‘Sexual Health and Blood Borne Virus Framework’.

Defining what is meant by the primary care and community health workforce is not straightforward within the context of delivering sexual health services, especially given the wide remit, and involvement of numerous partner agencies and health related disciplines in delivering these services. For the purposes of this scoping study, the workforce to be considered included the following practitioner groups:

- General practitioners
- General practice nurses
- Public health nurses (health visitors and school nurses)
- Community midwives
- Receptionists and administrative staff
- Health care assistants and healthcare support workers

1.4. Aims and objectives

The main aim of the scoping study commissioned by NHS Education for Scotland (NES) was to:

Understand the development needs of the primary care and community health workforces with regard to sexual health in NHS Scotland to enable the successful implementation of ‘The Sexual Health and Blood Borne Virus Framework 2011-2015’.
The scoping study consisted of a two-stage approach to understanding the current state of training and development of the primary care and community health workforce, and took place between August and November 2012. The first stage was a desk based review of existing work on training and development for the workforce, followed by a ‘listening exercise’ with key stakeholders in identifying gaps in training and development, in relation to sexual health.
2. Method

2.1. Design

A mixed method approach was adopted for this research, in order to gain an understanding of training and development needs of the primary care and community health workforces with regards to sexual health. The research was completed in two stages; the first of these was a scoping of existing work, reviewing previous research work and other documents relating to sexual health training for primary care staff. The second stage was a consultation with key stakeholders with a strategic or operational interest in delivering sexual health training, by means of an online questionnaire and semi-structured telephone interviews.

2.2. Ethics

Ethical approval was not required for this project as it was classed as audit/evaluation rather than research, and was solely concerned with ascertaining the opinions of NHS and other staff in relation to their professional role.

Participants agreeing to take part were informed of the purpose of the research, given the opportunity to ask questions, and informed that they would remain anonymous. They were asked to provide consent verbally before each interview, including giving permission for the interview to be recorded. Participants were also given the opportunity to withdraw from the research process at any time.

2.3. Procedure

Stage 1: Scoping of existing work

The first stage of the scoping study was to understand what work had been done in relation to sexual health workforce development since 2005. This included understanding the skills and competencies needed for both generic and specialist roles, along with the training needs and provision for the different practitioner groups making up the workforce. The scoping study looked at a number of information sources identified by NES, including:

- A previous scoping study of sexual health nurse training and development needs
- Training needs analysis work in this area undertaken by NHS Scotland
- The findings from the assessment of NHS Quality Improvement Scotland Standard 9, which relates to the training of staff delivering sexual health services, in each NHS Board area.

Other sources of information were identified to add to those provided by NES. A brief search of the academic literature was conducted, and relevant papers were identified. The key search terms used included the following:

**Workforce & setting:**
- General practi*; GP; Nurse (general practice, public health, school, family planning);
- midwife, Healthcare assistant; receptionist; primary care; community; Scotland

**Clinical area:**
- Sexual health, reproductive health, contraception, family planning, STI

**Training and development:**
- Workforce development, training, Continuing Professional Development, skill*, competenc*

Relevant papers were identified and accessed for review. A total of 49 papers and articles were downloaded as a result of the search process, with a number of others being identified through reference lists. These included academic research papers, and articles in practitioner journals relating to current practice and policy. Only 17 of these referred to practitioners based in Scotland. Alongside this, an internet search was conducted, including websites such as Wellbeing in Sexual Health (WiSH) along with a search of information from local and national organisations with an interest in training and development of healthcare workers in the field of sexual health. These included the British Association of Sexual Health and HIV (BASHH) and the Faculty of Sexual and Reproductive Healthcare, along with information from professional bodies representing health care professionals in Scotland. In addition to these, third sector organisations focusing on sexual health were also researched, to identify any involvement in development and delivery of training on sexual health at a local or Scotland-wide level.

Information relating to training and development of the sexual health workforce from individual NHS Boards was explored, to identify any evidence of local training needs analyses being conducted, and training that had already been implemented, including evidence of any local training initiatives. The sexual health strategy for each health board was reviewed, with a view to identifying the approach to training outlined for each health board.
Stage 2: Consultation with key stakeholders

The second stage of the scoping study involved a consultation to gather the views of a number of key stakeholders who have a strategic or operational responsibility for promoting and delivering appropriate training and CPD for health care workers in the field of sexual health. This aimed to give a better understanding of the key learning needs, actions that were currently underway to assess training needs and delivering these to the different groups of health care professionals, and any planned developments to ensure these needs are to be met. Gaps in meeting the training needs of the primary care and community health workforce were also identified.

Two methods were used to gather the information from the different groups of key informants. The first method was an online questionnaire survey, administered through Survey Monkey\(^1\) and sent out to lead clinicians and practitioners, and sexual health leads in each NHS Board.

The second approach was to conduct semi-structured interviews with key clinical leads and representatives from professional bodies and training organisations involved in delivering sexual health training. Appropriate staff members from across NHS Scotland and in partner organisations were identified and invited to participate in the research. Each participant was contacted by email initially, with follow up phone calls where necessary, which was to explain what the purpose of the research was and to arrange a suitable time for them to take part in a telephone interview.

Given the relatively short time scales which this work needed to be completed within, using semi-structured telephone interviews offered the best approach for a number of reasons:

- They allowed a large number of respondents to be contacted, from a wide range of occupational and geographical backgrounds.
- Time of health care personnel’s is often limited, making the logistics of organising face to face interviews difficult, especially in a short timescale.
- Costs of telephone interviews are moderate.

The questionnaire and interview schedule were developed in consultation with the NES project lead, with a key focus on clinical training; they included the following topics:

- How the training needs of the primary care and community health workforce were identified
- Current provision of training for each practitioner group
- Who the key training providers were

\(^1\) http://www.surveymonkey.com/
• How training provision was assessed in terms of its suitability and effectiveness in meeting the needs of healthcare workers
• What gaps existed in training provision, and at what level
• How could these gaps be filled most effectively
• What barriers existed in implementing training effectively
• Whether any emerging good practice could be identified

Two interview schedules were developed, the first for use with clinical and practitioner leads, and the second for external organisations providing sexual health training. A copy of the questionnaire and the interview schedules are provided in appendix xx.

2.4. Participants

The list of key stakeholders that were approached to participate in the consultation stage of the research was decided in consultation with NES. The online link to questionnaires, along with an information sheet about the scoping study, were sent out by email on behalf of the University of Worcester by key individuals and representatives of local and National working groups and committees to members of those groups. The groups who received the questionnaires included the following:

• Lead Sexual Health Nurses group
• Lead Sexual Health Clinicians
• West of Scotland Sexual Health Managed Clinical Network
• Sexual Health Lead Educators
• Sexual Health Health Promotion group
• General Practice Nurse group
• General Practice Managers group
• Heads of Midwifery – Lead Midwives Scotland Group
• Community Health Partnerships
• Community Pharmacy Leads

As the link to the questionnaire was sent out by intermediaries, with some element of cross posting, the precise number of people who received this information was unknown. However, it is estimated that this was received by approximately 130-140 individuals.

Participants for the semi-structured interviews were identified and invited to participate in two ways. A list of organisations providing training in sexual health, or with a responsibility to provide professional development for the different practitioner groups were identified, and key individuals
were approached and invited to take part. This was supplemented by an invitation at the end of the questionnaire for those who wanted to contribute to the research in more detail to provide their contact details so they could take part in a telephone interview. This ensured that as wide a range of participants from different health boards, organisations and practitioner groups were represented in the consultation.

2.5. Analysis

Quantitative data obtained from the electronic surveys were downloaded and analysed using appropriate descriptive statistical analysis, using Excel software.

The interviews were transcribed, coded and analysed using framework analysis (Lacey and Luff 2007, Srivastava & Thomson, 2009, Spencer & Ritchie, 1994). The analysis followed the five key stages of framework analysis. The first stage was familiarisation, which involved listening to the interview recordings and reading through transcripts, to identify key themes. The second stage involved developing the framework, based on the interview schedule, plus additional themes that emerged from familiarisation with the transcripts. Indexing and charting of the data were then undertaken, linking the data from the different participants to themes and emergent sub themes. Interpretation of the data then followed, looking for patterns within the data and identifying the key issues raised. Using this approach to analysis enabled an understanding of the participants’ views and attitudes towards training around sexual health in general, and more specifically in relation to primary care practitioners. These results were discussed and presented in the context of the findings from the initial review of policy and literature and other existing work conducted in stage 1 of this scoping study, to draw out the key strengths, needs and barriers with regards to training provision.
3. Scoping of existing work

3.1. Existing training provision for practitioners

A number of research studies have been conducted over the past few years in the UK which focus on the training and development needs of specialist sexual healthcare practitioners. Training is seen to be a key determinant in the quality of service provided (Kane and Welling, 2003), however despite this training provision for sexual health practitioners was seen to be inconsistent, and often made on the basis of management assumptions or lists from practitioners, rather than on audits of existing skills and analyses of gaps in competence (Hicks and Thomas, 2005). Whilst these studies touch on the training and development needs of primary care and community health care staff, none of these studies have these practitioner groups as their focus. A brief review of recent research around sexual health training for primary care staff was conducted to understand the extent of existing provision.

3.1.1. Nursing Staff

There appears to be little information or existing research focused specifically on the sexual health training of nursing staff working in a primary care or community setting, although there have been a number of studies around the sexual health workforce, which will include some primary care and community based staff.

A recent draft paper prepared for NES by the Scottish Lead Nurses SRH Forum provided an overview of the educational opportunities for nurses in sexual and reproductive health (Scottish Lead Nurses SRH Forum, 2011). This was part of the on-going work to develop a standardised approach to nurse education in SRH. Whilst this is focused on nurses providing specialist sexual health services, rather than general practice nurses, the content is still relevant to the availability of training in sexual health. It is recognised that nurses currently play a prominent and key role in delivering SRH services. It is desirable to have appropriate training that is embedded in clinical practice and is formally accredited to ensure a more consistent approach across the country. According to the report, SRH education for nurses in Scotland is primarily delivered by Higher Education Institutes, alongside NHS service providers. A range of courses were identified as being available, but with little standardisation or accreditation. This lack of standardisation may lead to confusion about the best approach to take to meet the needs of nursing staff working in different settings. Further details of HEI courses identified are provided in section 3.3.
The lack of consistency and standardisation of training for nursing staff in the UK was highlighted in a personal view on developments in nurse training by Mehigan et al (2010, who note that the provision of long Higher Education courses is not particularly appropriate for nurses working in general practice, given the time commitment and costs of these courses. They consider a number of ways to improve the training opportunities for nurses in SRH, and advocate joint training between clinicians and nurses. They support a combined approach including components of the Diploma of the Faculty of Sexual and Reproductive Health, e-learning combined and attendance of a ‘course of 5 (C5)’, which involves attendance at five one hour training sessions. Following completion of these elements, a Certificate of Completion of Clinical Practice is issued (Mehigan and Burnett, 2012). The authors assert that this approach would offer greater accessibility and be more suited to the needs of practice nurses, although only 13 nurses have used this approach so far. Mehigan et al.’s (2010) suggestions about the future of sexual health training for nursing staff generated a significant volume of responses, including one from the Scottish Lead Nurses SRH Forum (Craig, 2010). In this, Craig endorses the need for standardised evidence based SRH theory and practice education, along with a need for HEI or other formal accreditation and multidisciplinary training. The intention to review current HEI provision, and the use of the current career and education framework in relation to sexual health is discussed along with noting some degree of caution in adopting new proposals without proper evaluation.

Pre-specialist and specialist competencies have been developed by NES and lead nurses for nurses wishing to pursue a career in SRH. The competencies cover both generic and specialist skills relating to sexual health, with the post-registration pre-specialist level covering non-clinical aspects of care. Most recently, in 2011, a sexual health nursing portfolio was published (NES, 2011) to bring together the competency and career frameworks developed previously for post-registration pre-specialist level (NES, 2004) and specialist level (NES, 2005), along with the competency record book for post-registration pre-specialist level (NES 2007). The Royal College of Nursing (RCN) has produced a competency based framework for use by those working in sexual and reproductive health (RCN, 2004). The competency frameworks link in with the Knowledge and Skills Framework, used to guide and develop individuals throughout their career. The sexual health nursing portfolio was designed to be used by practitioners at all levels in a variety of settings, including primary care, in the field of sexual and reproductive health. The portfolio was designed to enable nursing staff to evidence their continuing professional development in sexual and reproductive health, and includes stages to identify evidence to support development of the competencies, such as attending relevant training courses.
3.1.2. Health Improvement Workforce

The Education and Training Task group of the National Sexual Health Advisory Committee was set up in the autumn of 2005 to “map the current sexual health education and training provision, identify gaps in training and to make recommendations to ensure the workforce is well equipped with the knowledge, skills and attitudes to implement Respect and Responsibility’. Action 14 of the national strategy was “to ensure that undergraduate, postgraduate and on-going CPD programmes provide staff with the range of skills and knowledge to respond to the sexual health agenda” (Scottish Executive, 2005). A report by Loots (2007) was prepared for the Advisory Committee to provide an overview of the learning and development needs and issues for the sexual health improvement workforce in Scotland. It included a desk based review of literature, policies and reports focusing on the training and development needs of the sexual health improvement workforce, along with a questionnaire survey of all those registered on the Sexual Health and Wellbeing Network, administered by NHS Health Scotland. This report covers the non-clinical workforce involved in delivering sexual health improvement, rather than the clinical practitioners delivering sexual health services. However, a number of practitioner groups identified within the health improvement workforce also fall into the primary care and community health workforce covered by this scoping study:

- School nurses
- GP receptionists and other clerical/administration staff
- Healthcare support workers

Issues around training in general, and particularly in relation to sexual health, for school nurses were identified from a report on school nurse needs assessment (Fast Forward and YouthLink (2006) as including the following:

- Lack of funding
- Limited staff resources to cover whilst attending training
- Many staff on part time contracts had limited time to train
- Two thirds had undertaken training in sexual health; one third would like training in sexual health
- Almost half had found training in sexual health particularly helpful
- The main barriers to developing needs-led work with young people were time and resources.
In a survey of 19 school nurses in England, they also reported that they had very little sexual health education or training during pre-registration training; often receiving only a single lecture (Thurston and Walker, 2011). The majority had attended one or two-day courses on sexual health once they had qualified, funded by the NHS or GP employers. While most would have liked further training on sexual health issues, the main barrier to achieving this appeared to be lack of time. In another study of 16 school nurses in England, concern was raised that school nurses were providing information to young people about sexual health without adequate training and knowledge on the subject; a need for further training on sexual health and teaching strategies was identified (Westwood and Mullan, 2006).

The report by Loots (2007) also identified through consultation with lead clinicians and local authorities that existing work on training needs for receptionists on sexual health was lacking. The need for all administrative staff in GP practices and other clinical settings who come into contact with patients and clients to have appropriate training to provide accessible, friendly and non-judgemental services was seen to be important, although it was acknowledged that there was little understanding of these training needs.

Other training needs for the health improvement and primary care workforce were identified by Loots (2007). These included training specifically about caring for patients with learning disabilities, and relating to ethnicity and cultural diversity. A review of existing provision of training and development was undertaken by Loots (2007), to look at the non-clinical training provision around sexual health in Scotland. This included a questionnaire, review of strategy documents and progress reports, and identification of courses offered by universities and colleges. The questionnaire generated 45 responses from practitioners registered on the Sexual Health and Wellbeing Network. This highlighted a range of training providers from within the NHS, local authorities and voluntary organisations, offering a variety of courses. A few of these courses were aimed at primary care staff in particular. The report concluded that most were run for half or one day, few of the courses identified appeared to offer any accreditation and for many it was not clear what the learning outcomes were.

A mapping exercise of sexual health improvement interventions conducted in Scotland highlighted a number of responses about training and workforce development (Burtney and Fullerton, 2011), although this was not the main focus of the report. The focus of the report was on sexual health improvement interventions; various responses about training and workforce development were provided within the interviews conducted. The importance of integrating sexual health training into
professions and workforces not directly related to health provision was highlighted. A small section of the report focused on primary care staff, with specific examples relating to training such as one Board offering SHARE (sexual health and relationships education programme) training to health visitors, with an Island Board providing additional training for GPs, as the majority of sexual health services were provided through primary care in this setting.

3.1.3. General Practitioners

The document review included gathering information about GP training, from a search of the internet, professional organisation websites and a brief literature search. Continuing Professional Development for GPs is provided at a regional level and there is some variability in the types of CPD available and the topics covered. Sexual health training does not appear to feature in the courses available in some areas, although CPD resources for GPs such as e-GP, developed jointly between the Royal College of GPs (RCPG) and e-learning for Healthcare (e-LFH) feature modules specifically on sexual health and related issues. Concerns about the lack of consistency in training of GPs in the UK around sexual health appear to have been raised over a number of years with sexual health training not generally being prioritised, and therefore impacting on service provision (Robinson, 2012). Research carried out by Markham (2005) with GP trainers in England identified that whilst many GP practices were providing basic sexual health services, GP registrars were seen to be relatively unprepared for sexual health care. Further training around sexual history taking, STI testing and HIV testing were highlighted as a particular need. However, there are examples of sexual health training programmes aimed at GPs and practice nurses that have been developed and implemented in different locations. For example, the SHIP (Sexual Health in Practice) approach that has been adopted in the West Midlands in England, and is aimed at and delivered by practice nurses, GPs and speciality registrars. It provides an integrated programme of sexual health training, resources and support, consisting of 5 half day training sessions and the provision of resources such as posters, checklists and prompts. It has two phases to encourage progression and reinforcement of messages. Overall it has reached a wide audience within the West Midlands region, and participants reported increased levels of knowledge and confidence in dealing with sexual health issues (Mullineux et al., 2008). There appears to be little published research relating to sexual health training programmes aimed specifically at GPs in Scotland.

A review of medical education and training in sexual health in Scotland, prepared for the National Sexual Health Advisory Committee (NSHAC) (define what initials stand for) Education and Training

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2 http://www.e-lfh.org.uk/media/41276/List%20of%20live%20eGP%20sessions.pdf
Task Group, conducted by Flett and Banerjee in 2007, using a desk based review of existing reports and policies, along with web-based searches and information gathering via interviews with key stakeholders. This aimed to look at current training opportunities at undergraduate and postgraduate levels, to consider whether the training provision was appropriate, understand where the gaps in training were and to identify opportunities for improvement. As for CPD, it was found that the delivery of sexual and reproductive health varied widely at undergraduate level. At postgraduate level, a number of training opportunities are available for doctors, including GPs. The Diploma of the Faculty of Sexual and Reproductive Healthcare, previously called the Diploma of Faculty of Family Planning, is available for GPs undertaking advance skill level sexual health work, and letters of competence are required for implant and intrauterine techniques. Local training programmes are available in some areas of Scotland. Flett and Banerjee (2007) go on to state that whilst more specialist training will be taken up by some GPs, the majority will continue to deliver more generic sexual health services, and the focus of training and development within general practice must focus on this group. They recommend that consideration should be given to providing rotational training opportunities in sexual health as part of GP training schemes.

3.1.4. Other practitioner groups

Little mention has been found of other practitioner groups within primary care and the community based healthcare workforce in relation to training and development and sexual health. Midwives for example, are expected to provide family planning advice as part of their role, and their training needs have to be fully understood to allow them to contribute most effectively to meeting sexual health strategies (Norris, 2007) and in helping to deliver the sexual health and BBV framework. Likewise, a report by Unite and the Society of Sexual Health Advisors (2008) in the UK reinforces the need for sexual health advisors to have the right skills to be able to deliver sexual health services, suggesting that the Specialist Community Public Health Nursing programme would enable sexual health advisors to access the relevant knowledge and skills.

The increasing role of community pharmacists in delivering sexual health services has also received some attention. Community Pharmacists responding to a survey carried out in Grampian stated that they had received little or no training in sexual health, and a need for training in this area was identified (Gale and Watson, 2011). The Royal Pharmaceutical Society points to resources provided by NES for pharmacists in Scotland to up-skill and develop new skills within sexual and reproductive health, and also those provided by Community Pharmacy Scotland.

http://www.fsrh.org/pdfs/Scotland.pdf
3.1.5. Remote and rural contexts

Worthy of comment are the specific training needs of those working in remote and rural settings. In these areas particularly community based nurses need to be ‘robustly trained generalists’ (Cantrell et al, 2010). In a report by Peacock and Fraser (2007) based on consultation with sexual health providers across different remote and rural parts of Scotland, they noted that the key issues around education and training of the sexual health workforce in remote and rural locations were challenging, and identified as follows:

- Recruitment can be difficult, lack of available cover means that attendance at training is problematic, with services having to be suspended or the staff member cannot attend.
- Significant financial costs for a staff member to attend a training course and locum and backfill costs are not always available; e-learning possibilities need to be explored further.
- Staff working on a part time or sessional basis means attending training is often difficult.
- Managed clinical networks and sexual health forums are seen as ways of enabling staff to communicate more easily and provide peer support.

3.2. Current training activity by Health Board

3.2.1. Review of standard 9 across health boards

As part of Respect and Responsibility strategy and action plan for improving sexual health care in Scotland, NHS Quality Improvement Scotland published a number of sexual health services standards in 2008 (NHS Quality Improvement Scotland, 2008). Standard 9 relates specifically to the training of staff delivering sexual health services (see box 1.1)

<table>
<thead>
<tr>
<th>Box 1.1 Standard Statement 9:</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Staff who deliver sexual health services are adequately and appropriately trained.</td>
</tr>
</tbody>
</table>

There are four essential criteria relating to this standard:

9.1 The NHS Board has a contracted arrangement for clinical services to be led locally by a consultant holding a certificate of completion of training in genitourinary medicine.

9.2 The NHS Board has a contracted arrangement for clinical services to be led locally by a consultant holding a certificate of completion of training in obstetrics and gynaecology with sub-speciality (or equivalent) training in sexual and reproductive health.
9.3 All health professionals providing sexual health interventions in both generic and specialist services demonstrate knowledge gained from post registration courses in sexual health and provide evidence of relevant continuing professional development.

9.4 There is a local induction programme for all staff in generic and specialist sexual health services which include training in confidentiality, information handling, the use of chaperoning for intimate examinations and child protection in relation to sexual health.

Additional clinical skills required include sexual history taking and intimate examination.

Healthcare Improvement Scotland undertook a review of 25 of the 47 sexual health standards in 2010 and 2011 in all territorial health boards across Scotland, to assess the extent to which these had been met (Healthcare Improvement Scotland 2011). This included standard 9.3, relating to appropriate training of generic and specialist staff. Ten of the 14 territorial health boards were assessed to have met the standard. A summary of the findings of the local reports for each NHS Board relating to standard 9 is presented in appendix xx.

Whilst the main part of the report for each area focuses on the training needs and development of specialist sexual health staff, most refer to specific work being carried out with primary care and community health practitioners. The level of engagement with the primary care workforce varies across the country, with some Boards having a comprehensive overarching plan of training and development which includes the primary care and community health workforce. For others, there has been limited success in engaging primary care practitioners in sexual health training.

Particular examples of training and development activities aimed at primary care and community based practitioners identified within the review of standard 9 include the following:

- Training roadshow for administrative staff
- GP practices invited to attend annual updates on a range of sexual health topics
- Clinical updates to GPs, practice nurses, pharmacists and others
- GP core education programme includes sexual health
- Training events specifically aimed at primary care, and delivered within GP practices
- Midwives and health visitors being trained in fitting LARC to target young mums
- Regular email newsletter sent out to GP practices from the lead clinician to provide updates on guidelines, training and local developments
- Staff members including nurses and midwives participating in a sexual health course at a local HEI.
3.2.2. Sexual health strategies/reports from the different boards

A review of sexual health strategies and action plans from each health board was undertaken, accessing documents that were readily available on the internet. The focus on sexual health training and development varies substantially between NHS Boards, with much greater attention in some areas than others. Whilst all areas should be producing a sexual health strategy as part of the implementation of ‘Respect and responsibility’, and the ‘Sexual health and blood borne virus framework’, there is a variable focus on training between different health boards.

A number of NHS Boards have well established programmes of training set up around sexual health, including training aimed at the primary care and community based health workforce. NHS Greater Glasgow and Clyde has a well-developed programme of training provided by the Sandyford Centre, a specialist GUM community based clinic (see box 3.1).

**Box 3.1 Good practice in Greater Glasgow and Clyde**

The Sandyford Centre coordinates and provides sexual health services and clinics for the Board. The training model adopted by Sandyford has been highlighted as a model of good practice (Poorman, 2010). The programme includes free sexual health training for health professionals based in primary care and other non-specialist settings. These courses can be delivered to primary care teams in their own work setting, and be tailored to the needs of individual practice teams. Other courses aimed at primary care and other staff are also delivered by Sandyford, including the SWISHH training days (Sandyford Workshops on Integrated and Sexual Health & HIV), which are delivered in Glasgow. They also support the Diploma Faculty of Sexual and Reproductive Healthcare and other related training.

Grampian also has a well-developed training programme which includes primary care staff within its target audience. There appears to be good cooperation between Grampian and Orkney in terms of service provision, although it is not clear if this extends to training. Other Boards that specifically mentioned sexual health training for primary care staff included Ayrshire and Arran, Borders, Forth Valley, Lanarkshire, Lothian, Shetland and Western Isles.

A number of strategies highlighted problems and barriers to delivering sexual health training including staffing capacity, and time to attend training. Another issue highlighted was the lack of a specific organisation or body with responsibility for delivering sexual health training for primary care.

The report by Loots (2007) also reviewed the sexual health strategies and annual progress reports from all the NHS Health Boards, to assess what education and training initiatives have been
provided, what additional training was required, and whether there was any funding for training. This was not aimed specifically at primary care needs. Overall, there was a mixed response about the level of training provision, with wide variations across the country. There was little evidence of a systematic approach to training needs analyses, and in places where training needs had been identified it was unclear how this had been determined. It was felt that there was a need for nationally available resources for training, rather than producing local training courses in each Board. Specific training needs identified through this review (Loots, 2007) included the following:

- confidentiality,
- discrimination,
- child protection,
- knowledge of services,
- info on STI’s, contraception and contact tracing
- need for Counselling training
- counselling for termination of pregnancy
- addressing the needs of disabled
- LGBT training.

3.2.3. Managed Clinical Networks

West of Scotland Managed Clinical Network (MCN)

The West of Scotland MCN was launched in 2009 and includes the 5 health boards in the region: Ayrshire and Arran, Dumfries and Galloway, Forth Valley, Greater Glasgow and Clyde and Lanarkshire (see box 3.2).

Box 3.2: Good Practice in the West of Scotland Managed Clinical Network

The MCN appears to be very active in developing and engaging member Health Boards in training and development activity in sexual health. There is a comprehensive training plan in place, with a range of resources for practitioners available on their website\(^4\). It includes information on:
- Shadowing
- Competencies
- Guidance documentation on IUD fitting, contraceptive implants, cervical screening and STIs.

The workplan includes several actions relating to training of staff within the member NHS Boards.

**Grampian Sexual Health Network**

The sexual health network aims to support sexual health provision, promotion and prevention, and provide high quality clinically effective care for all people across Grampian. The Sexual Health Network Education Group has taken responsibility for developing a training guide and programme for staff, both clinical and non-clinical, who contribute to the delivery of sexual health services in the area.

**3.3. Training by Professional Bodies and other organisations**

**Royal College of General Practitioners**

The RCGP is the UK wide professional membership body for GPs, working to promote excellence in primary care. The work of the RCGP includes GP education and training through the GP curriculum, and continued support through various courses, certificates and resources.

The GP training curriculum (RCGP, 2012) includes a section on sexual health, covering the basic competency and skills required of a GP relating to sexual health. The curriculum statements are updated on a regular basis, and also include pointers to on-going learning strategies and resources. The Introductory Certificate in Sexual Health is a training and development tool for GPs, practice nurses and generalist clinicians working in general practice, and provides a basic introduction to sexual health. It is promoted by the RCGP in Scotland, along with other events and courses relating to sexual health (see table 3.1).

**Table 3.1 courses run by the RCGP**

<table>
<thead>
<tr>
<th>Title</th>
<th>Topic</th>
<th>Duration</th>
<th>Format</th>
<th>Audience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual health in general practice</td>
<td>Being a GP, Commissioning, Consulting skills, Ethics and values, Patient safety, Health promotion and disease prevention, Mens health, Public health, Sexual health, Womens health</td>
<td>2 hours</td>
<td>Online learning</td>
<td>GP, GP Trainee, GP Trainer or educator, Medical student, Newly qualified GP, Practice nurse</td>
</tr>
<tr>
<td>Sexual health study day</td>
<td>What’s new in contraception: vasectomies, the what, how, risk counselling etc; genital appearance and concerns in adolescent and adult women; dispelling myths in intrauterine contraception; HIV in primary care; what’s new in HRT</td>
<td>1 day</td>
<td>Conference</td>
<td>GP, GP Trainee, GP Trainer or educator, Newly qualified GP, Practice nurse</td>
</tr>
<tr>
<td>Introductory Certificate in Sexual Health</td>
<td>1 day</td>
<td>Classroom based</td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>-------</td>
<td>----------------</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| The Introductory Certificate in Sexual Health is an educational tool for generalist clinicians and practice nurses already working in general practice and provides a basic grounding in sexual health issues. The three key aims of the course are:  
  • To develop the knowledge, skills and confidence of generalists in general practice and enable them to practice at the generalist level in sexual health.  
  • To improve the care of people with sexual health needs in general practice.  
  • To improve and promote the diagnosis and care of people with HIV in general practice. |  | GP, GP Trainee, Medical student, Newly qualified GP, Practice nurse, other allied professionals such as pharmacists. |

Faculty of Sexual and Reproductive Healthcare (FSRH)\(^7\)

The Faculty of Sexual and Reproductive Healthcare is a Faculty of the Royal College of Obstetricians and Gynaecologists which aims to promote high quality women’s healthcare through setting standards, clinical guidance and training in the UK. Through its training provision the Faculty grants diplomas, certificates, fellowship and equivalent recognition of specialist skills in sexual and reproductive care.

Training provided includes the Diploma of the Faculty of Sexual and Reproductive Healthcare, which includes GPs within its target audience. This has recently been updated with a greater emphasis on e-learning, with theoretical components of the course being provided online (Heathcote and Wilkinson, 2010). The Faculty also provides training for Letters of Competence (interuterine techniques, subdermal contraceptive implant techniques), a range of training on specific specialist skills and training to become a registered trainer. The website also provides clinical guidance and other relevant resources. The FSRH has also developed the e-learning project on sexual and reproductive healthcare on the ‘e-learning for healthcare’ website\(^8\), in partnership with the Department of Health, aimed at those working in gynaecology, sexual health, GPs and Practice Nurses.

Whilst GPs are included within the target audience for the FSRH, there appears to be little directed specifically at primary care practitioners. However, a joint statement released in September 2012 by

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\(^7\) [http://www.fsrh.org/default.asp](http://www.fsrh.org/default.asp)  
the Faculty of Sexual and Reproductive Healthcare and the Royal College of General Practitioners\(^9\) sets out the intention to promote joint working at a national and local level to enhance access to quality training for GPs and therefore improve patient care.

The intended outcomes of the joint approach are:

- to increase access to high quality SRH including Long Acting Reversible Contraception (LARC)
- to enhance access to training in SRH (in particular to LARC training) for GPs
- to develop joint pathways to training which may be accessed through either organisation, involving trainers from both organisations
- to ensure that previous training is appropriately recognised.
- to streamline the SRH training pathway post RCGP Specialty training, through the RCGP Introductory Certificate in Sexual Health to training options such as the LARC Letters of Competence and to the Faculty’s Diploma (DFSRH).

**Royal College of Nursing**

The RCN does not provide specific training on sexual health, but has been instrumental in developing a sexual health strategy, published in 2001 and in developing a competency framework for practitioners working in sexual health (RCN, 2004b). The strategy identifies that the key health care staff that require specific sexual health care practice education and training programmes are nurses, midwives, health visitors, specialist nurses and nurse consultants. One of the key priorities of the strategy was to “provide professional education and training in sexual health awareness for all health care professionals.” (RCN 2001, p2). The RCN has also published guidance on training for fitting IUDs (2003) and subdermal contraceptive implants (2004a). These are referred to in the RCN ‘Guidance for Nursing’ strategy (2001) about contraception and sexual health in primary care, which addresses some of the issues facing nurses in primary care about contraception and sexual health, including the diversity of training and experience.

**British Association for Sexual Health and HIV (BASHH)\(^10\)**

The British Association for Sexual Health and HIV (BASHH) was formed in 2003 through the merger of the Medical Society for the Study of Venereal Diseases (MSSVD; established 1922) and the Association for Genitourinary Medicine (AGUM; established 1992).

\(^9\) [http://www.fsrh.org/pdfs/JointRCGP_FSRHstatementTrainingSRH.pdf](http://www.fsrh.org/pdfs/JointRCGP_FSRHstatementTrainingSRH.pdf)

\(^10\) [http://www.bashh.org/](http://www.bashh.org/)
BASHH administer the 'STIFCompetency' (Sexually Transmitted Infection Foundation) course, a competency-based training package for both specialist sexual health care professionals and non-specialist practitioners who require additional skills to manage people with sexually transmitted infections. This was adapted from the Department of Health's best practice guidance 'Competencies for providing more specialised sexually transmitted infection services within primary care' (Department of Health, 2006), and encompasses the BASHH 'Standards for the management of sexually transmitted infections (STIs)' (BASHH, 2010), which states the need for multidisciplinary and standardised training across the professions where appropriate. The 'STIFCompetency' is designed for practitioners in General Practice, reproductive and sexual health, GUM Services, Pharmacists and other healthcare professionals.

Sandyford – SWISHH

Sandyford is the NHS Greater Glasgow and Clyde specialist sexual health service, which coordinates training across the health Board area. Staff from Sandyford provide training for the primary care workforce on a variety of topics, and will tailor the content of the training to suit the local context. They also deliver training at a GP Practice or surgery for Protected Learning events, or at wider CHP meetings.

Sandyford Workshops on Integrated Sexual Health and HIV (SWISHH) training days have been developed for Practitioners from Primary Care and hospital settings, to provide face to face training based on real-world scenarios led by specialists from local services. The course aims to build on previous courses such as STIF and e-learning. Sandyford also promote a wide range of other training opportunities for staff with both a specialist and generic interest in providing sexual health services.

Third Sector organisations

There are a number of third sector organisations involved in the promotion of good sexual health and in the provision of training to practitioners working in the community, who need an understanding of sexual health. These include UK-wide organisations such as the FPA (formerly the Family Planning Association)\(^\text{11}\), a charity focused on sexual health, which aims to make sexual health a priority for public health in the UK. One aspect of their work is to support health professionals through providing resources and training, including primary care practitioners. Their open training courses cover a wide range of issues, but are mostly delivered in London, although they do provide training at a local level if commissioned to do so. A case study is provided about a specific training

\(^{11}\) http://www.fpa.org.uk/
requirement in NHS Lanarkshire, to provide staff involved with a condom distribution scheme with tailored basic and advanced training to improve competence and confidence in discussing sexual health. Other Scotland-focused organisations providing training, focused on specific policy or geographical areas include:

- LGBT Youth Scotland\(^\text{12}\)
- Healthy Respect\(^\text{13}\)
- Caledonia Youth\(^\text{14}\)

**Higher Education Institutes**

According to the report on education in sexual health and reproductive health for nurses (NES, 2011), four Scottish universities currently provide courses on sexual health for nursing staff. The provision of training by Universities varies from short part time courses to full time degree level courses. The information in table 3.2 is based on the information in the report, supplemented by additional data from university websites.

**Table 3.2 Sexual Health courses provided by Higher Education Institutes in Scotland**

<table>
<thead>
<tr>
<th>Provider</th>
<th>Course</th>
<th>duration</th>
<th>Accreditation</th>
<th>Entry requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>University of the West of Scotland</td>
<td>Sexual and reproductive health</td>
<td>6 months, part time</td>
<td>Graduate certificate</td>
<td>Candidates must be registered nurses or midwives on either parts 1 or 2 of the NMC professional register with two years’ post registration experience</td>
</tr>
<tr>
<td>Robert Gordon University, Aberdeen</td>
<td>Reproductive Health</td>
<td>5 days</td>
<td>SCQF level 9; SCQG points 15; ECTS points 7.5</td>
<td>first level nurse working in settings where knowledge of sexual and reproductive health is required. The student should be able to provide evidence of SCQF8 level learning</td>
</tr>
<tr>
<td>Queen Margaret University</td>
<td>Sexual and Reproductive Health</td>
<td>1 yr FT 13wks FT/2-4 yr PT</td>
<td>MSc (180 credits) PGDip (120 credits) PGCert (60 credits)</td>
<td>Honours degree or diploma, preferably in a health-related or social science area. Not a clinical course.</td>
</tr>
<tr>
<td>Edinburgh Napier University</td>
<td>Modules include Sexual and reproductive health; sexual health and</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>

\(^{12}\) https://www.lgbtyouth.org.uk/

\(^{13}\) www.healthyrespect.co.uk/

\(^{14}\) www.caledonia-youth.org/
<table>
<thead>
<tr>
<th>University</th>
<th>Programme</th>
<th>Duration</th>
<th>Level</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stirling University</td>
<td>CPD module Sexual Health</td>
<td>n/a</td>
<td>SCQF Level 9, 22 credits</td>
<td>Diploma in Higher Education Nursing/Midwifery or equivalent Usually taken as part of undergrad nursing course; not being run after 2013.</td>
</tr>
<tr>
<td>Glasgow Caledonian University</td>
<td>Sexual Health</td>
<td>1 yr FT</td>
<td>MSc</td>
<td>To be eligible for entry to the MSc Sexual Health, candidates should possess an Honours degree and work within an appropriate sexual health context.</td>
</tr>
<tr>
<td>Abertay University</td>
<td>Sexual/Reproductive Health</td>
<td>1 yr FT/2 yr PT</td>
<td>MSc/PGDip</td>
<td>Applicants should have a degree and should hold an appropriate professional healthcare qualification. Applicants will normally have at least one year’s recent practical experience in the field of sexual and reproductive health.</td>
</tr>
</tbody>
</table>
Summary of findings

- There appears to be a wide array of training on sexual health available to health practitioners, although little to indicate what the uptake is amongst primary care staff and whether it meets the needs of those delivering sexual health services through primary care and general practice.
- The review of existing research and training opportunities identified some activity aimed at primary care, although little aimed specifically at this group as a whole. The availability of training varied geographically across Scotland.
- Particular gaps in training were identified for some practitioner groups; GPs and practice nurses have access to a greater level of training support than other practitioners working within primary care.
- Training on sexual health is provided by a number of professional bodies and third sector organisations, although much of the activity is focused on London, and is not aimed particularly at the needs of practitioners in Scotland.
- The training available appears to be ad-hoc, and dependent on what is available locally. There was little evidence of training being standardised across professional groups.
4. Questionnaire Results

4.1. Background Information

The questionnaire was developed to investigate the development needs of the primary care and community workforce in regards to sexual health in NHS Scotland. A total of 83 respondents completed the questionnaire, of which 16 identified that they were from sexual health specialist areas. The largest single professional group of respondents was nursing (30%). The sample consisted of 12 (14%) men and 70 (85%) women, with one unknown (1%). The respondents were experienced in their field, 80% had been in their current post for over 5 years, the average number of years in post being 9 years (See table 4.1).

Table 4.1. Respondents characteristics

<table>
<thead>
<tr>
<th>Sex</th>
<th>Number of respondents (N=83)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>12 (14%)</td>
</tr>
<tr>
<td>Female</td>
<td>70 (85%)</td>
</tr>
<tr>
<td>Unknown</td>
<td>1 (1%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Job role</th>
<th>Number of respondents (N=83)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurses</td>
<td>25 (30%)</td>
</tr>
<tr>
<td>Practice managers</td>
<td>9 (11%)</td>
</tr>
<tr>
<td>Consultants</td>
<td>9 (11%)</td>
</tr>
<tr>
<td>Clinical leads</td>
<td>9 (11%)</td>
</tr>
<tr>
<td>Health promotion/improvement officer</td>
<td>8 (10%)</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>5 (6%)</td>
</tr>
<tr>
<td>Education advisors</td>
<td>4 (5%)</td>
</tr>
<tr>
<td>Managers</td>
<td>4 (5%)</td>
</tr>
<tr>
<td>Directors</td>
<td>3 (4%)</td>
</tr>
<tr>
<td>GP’s</td>
<td>2 (2%)</td>
</tr>
<tr>
<td>National Co-ordinators</td>
<td>2 (2%)</td>
</tr>
<tr>
<td>Counsellor</td>
<td>1 (1%)</td>
</tr>
<tr>
<td>Health advisor</td>
<td>1 (1%)</td>
</tr>
<tr>
<td>Health Specialists</td>
<td>1 (1%)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of years in post</th>
<th>Number of respondents (N=83)</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-4</td>
<td>17 (20%)</td>
</tr>
<tr>
<td>5-9</td>
<td>31 (38%)</td>
</tr>
<tr>
<td>10-14</td>
<td>18 (22%)</td>
</tr>
<tr>
<td>15-19</td>
<td>9 (11%)</td>
</tr>
<tr>
<td>20-24</td>
<td>7 (8%)</td>
</tr>
<tr>
<td>25-29</td>
<td>0 (0%)</td>
</tr>
<tr>
<td>30+</td>
<td>1 (1%)</td>
</tr>
</tbody>
</table>
All 14 territorial Health Boards were represented by the questionnaire respondents (table 4.2). Some of the respondents work with more than one health board and therefore chose multiple responses. The highest responses were from the Ayrshire and Arran (12%), Greater Glasgow and Clyde (11%) and Lothian (11%) NHS Boards. The lowest number of responses were from the smaller NHS Boards (Western Isles (2%) and Orkney (1%)). Those respondents who specified ‘other’ work within the NHS National Service Scotland (2; 2%) and 3 (4%) work within NHS Education for Scotland. However, responses did not necessarily reflect the size of each Health Board.

Table 4.2. Number of respondents from each health board

<table>
<thead>
<tr>
<th>Health Board</th>
<th>Number of responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ayrshire and Arran</td>
<td>10 (12%)</td>
</tr>
<tr>
<td>Greater Glasgow and Clyde</td>
<td>9 (11%)</td>
</tr>
<tr>
<td>Lothian</td>
<td>9 (11%)</td>
</tr>
<tr>
<td>Dumfries and Galloway</td>
<td>8 (10%)</td>
</tr>
<tr>
<td>Fife</td>
<td>8 (10%)</td>
</tr>
<tr>
<td>Tayside</td>
<td>7 (8%)</td>
</tr>
<tr>
<td>Highland</td>
<td>6 (7%)</td>
</tr>
<tr>
<td>Grampian</td>
<td>5 (6%)</td>
</tr>
<tr>
<td>Other</td>
<td>5 (6%)</td>
</tr>
<tr>
<td>Lanarkshire</td>
<td>4 (5%)</td>
</tr>
<tr>
<td>Forth Valley</td>
<td>4 (5%)</td>
</tr>
<tr>
<td>Shetland</td>
<td>3 (4%)</td>
</tr>
<tr>
<td>Borders</td>
<td>2 (2%)</td>
</tr>
<tr>
<td>Western Isles</td>
<td>2 (2%)</td>
</tr>
<tr>
<td>Orkney</td>
<td>1 (1%)</td>
</tr>
</tbody>
</table>

Respondents were asked to identify which practitioner groups they work with to help deliver sexual health services. Some respondents work with multiple groups to deliver sexual health services and therefore chose multiple answers. Figure 4.1 illustrates that the majority of respondents work with general practice nurses (n=58) and GP’s (n=54) to help deliver sexual health services. Only a minority of respondents work with pharmacists to help deliver sexual health services (n=10).

Out of the 14 respondents who specified they worked with ‘others’ to help deliver sexual health services, 6 respondents worked with all staff in sexual health clinics, 4 respondents work with health improvement staff and 3 respondents work with strategic and policy staff to help deliver sexual health services. One respondent works with consultants to help deliver sexual health services and another works with local and management levels to help deliver sexual health services. These results are summarised as Figure 4.1 below.
4.2. Identification of training needs

In order to understand how the training needs of primary care and community health staff are identified, respondents were asked to indicate which training methods were currently used. Respondents could choose multiple answers as in some cases training needs were identified through different means. According to the responses (figure 4.2), the most common methods of identifying training needs were through staff meetings (n=46), personal development reviews (n=45), training needs analyses (n=30) and through existing training programmes (n=28). In 11 of the 14 NHS Boards, at least one respondent indicated that a TNA was used to identify training needs.

Eighteen respondents identified ‘other’ ways in which training needs of the primary care and community workforce were identified. These included: requests sent by staff (n=3); through feedback from service users, meetings and conferences (n=4); new guidelines, strategies or business plans (n=3); educational sessions (n=2); Reviews (n=2); training needs analysis (n=1); health improvement services (n=1); self-reporting (n=1); learning from incidents (n=1); and discussions with
partner service providers (n=1); A further 3 respondents were not sure how training needs were identified in the primary care and community workforce.

Figure 4.2. How training needs of the primary care and community workforces are identified.

In order to undertake training, staff need to be aware of what training is available. Respondents were asked how the primary care and community health workforce are informed about relevant training opportunities. Respondents could choose multiple answers as there could be a variety of ways this could be done. The results are summarised as Figure 4.3 below. 68 respondents indicated that staff were informed about relevant training opportunities through emails, 51 by adverts and flyers and 50 respondents through NHS/network websites. Newsletters (n=39), staff meetings (n=31) and personal development review meetings (n=22) were also used to inform primary care and community staff about training opportunities.

Other methods of informing staff about training opportunities identified by respondents included through network group meetings (n=5), by word of mouth (n=2), through educational events attended (n=1), or by strategic planning by directors (n=1). Two respondents didn’t know how primary care and community staff were informed about relevant training opportunities.
Respondents were asked if a training needs analysis (TNA) specific to sexual health had been completed in their area in the last 5 years. Over two-thirds of respondents (52; 70%) indicated that a sexual health training needs analysis had not been done in the last 5 years. The remaining 30% (22) who identified that a training needs analysis had been completed represented 12 of the 14 health boards. Those indicating that a TNA had taken place were asked if the training needs of the primary care and/or the community health workforce were highlighted in the training needs analysis. The majority of respondents (19; 86%) answered yes, indicating that the majority of training needs analyses relating to sexual health had highlighted the training needs of the primary care and community workforce.
4.3. Current training provisions

Respondents were asked to identify any practitioner groups which have a structured programme of sexual health training in place. Multiple answers could again be chosen for this answer. As illustrated in figure 4.5, of those who answered this question (n=45) the majority of respondents identified that GPs (n=37) and general practice nurses (n=35) have a structured programme of sexual health training. Fewer respondents identified that receptionists (n=8) and midwives (n=7) have a structured training programme in place relating to sexual health.

Figure 4.5. Number of responses for practitioner groups who have structured training programmes for sexual health in place

In terms of who delivers sexual health training to primary care and community staff in their area (figure 4.6), the key training providers were nurses (35 respondents), consultants (34 respondents) and professional organisations (n=31). A further 21 respondents said that higher education institutes provided sexual health training to primary care staff in their area. Whilst 25 respondents indicated that training was delivered within their home Health Board, sexual health training as also delivered by their managed clinical network (n=13) other neighbouring NHS boards (n=6).

Other training providers for primary care and community health staff identified by respondents were local specialist sexual health practitioners (n=5), NES (n=3) and third sector organisations (n=2).
On the whole both locally and nationally the majority of training is either delivered by nurses or consultants. Furthermore the majority of training is provided locally, i.e. at local hospitals. Overall online training had the fewest responses for where training was provided.

Respondents were given a series of statements, shown in table 4.3 and were asked to what extent they agreed with them. The majority of the statements received the highest response for neither agreed nor disagreed with the statements, as well as this some of the statements had similar responses for each of the options, possibly indicating a broad variation in approach to sexual health training across the country.
### Table 4.3. Statements to identify current training provisions

<table>
<thead>
<tr>
<th></th>
<th>Agree</th>
<th>Neither agree nor disagree</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual health training for primary care and community health staff is currently a priority in my area</td>
<td>38%</td>
<td>35%</td>
<td>27%</td>
</tr>
<tr>
<td>Sufficient resources for training in sexual health are available to meet the needs of primary care and community health care staff</td>
<td>25%</td>
<td>38%</td>
<td>37%</td>
</tr>
<tr>
<td>The current training programmes meet the needs of primary care and community staff in delivering sexual health services</td>
<td>28%</td>
<td>43%</td>
<td>29%</td>
</tr>
<tr>
<td>All primary care and community health staff (generic and specialist) receive training related to sexual health at induction</td>
<td>3%</td>
<td>44%</td>
<td>53%</td>
</tr>
<tr>
<td>Uptake of sexual health training for primary care and community staff is well monitored in my area</td>
<td>20%</td>
<td>44%</td>
<td>36%</td>
</tr>
<tr>
<td>Primary care and community health care staff have the opportunity to specialise in sexual health</td>
<td>44%</td>
<td>35%</td>
<td>21%</td>
</tr>
</tbody>
</table>
4.4. Gaps in training

Respondents were asked to identify three main gaps in training for the sexual health primary care and community workforce in their area. Respondents answers were grouped and pooled into categories which corresponded with each other, which is illustrated in table 4.4. The main gaps identified by respondents was training provision (26), followed by BBV (18) and sexual health updates (11).

Table 4.4. Gaps in training for the sexual health primary and community workforce

<table>
<thead>
<tr>
<th>Gap</th>
<th>Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Training provision</strong></td>
<td>26</td>
</tr>
<tr>
<td>• Training Needs Analysis across all disciplines</td>
<td></td>
</tr>
<tr>
<td>• Structured training programme</td>
<td></td>
</tr>
<tr>
<td>• More accredited trainers</td>
<td></td>
</tr>
<tr>
<td>• Standards for sexual health training</td>
<td></td>
</tr>
<tr>
<td>• Evidence based practice</td>
<td></td>
</tr>
<tr>
<td>• Awareness of training</td>
<td></td>
</tr>
<tr>
<td>• Improve availability and access of training making it less specialist</td>
<td></td>
</tr>
<tr>
<td>• Provision of training</td>
<td></td>
</tr>
<tr>
<td>• Make training for sexual health a priority</td>
<td></td>
</tr>
<tr>
<td>• Access/recruitment of Primary care staff</td>
<td></td>
</tr>
<tr>
<td><strong>Training about Blood Borne Viruses</strong></td>
<td>17</td>
</tr>
<tr>
<td>• HIV</td>
<td></td>
</tr>
<tr>
<td>• Partner notification</td>
<td></td>
</tr>
<tr>
<td>• Testing and diagnosis</td>
<td></td>
</tr>
<tr>
<td>• Basic Education/information</td>
<td></td>
</tr>
<tr>
<td>• Stigma</td>
<td></td>
</tr>
<tr>
<td>• AIDS and HEPATITIS C</td>
<td></td>
</tr>
<tr>
<td><strong>Sexual health updates</strong></td>
<td>11</td>
</tr>
<tr>
<td>• Regular updates</td>
<td></td>
</tr>
<tr>
<td>• Annual updates</td>
<td></td>
</tr>
<tr>
<td>• Updates in house</td>
<td></td>
</tr>
<tr>
<td>• Updates on current practice/material</td>
<td></td>
</tr>
<tr>
<td>• Cervical screening updates</td>
<td></td>
</tr>
<tr>
<td>• Contraceptive updates</td>
<td></td>
</tr>
<tr>
<td><strong>Tailored training opportunities</strong></td>
<td>10</td>
</tr>
<tr>
<td>• Tailored training across disciplines</td>
<td></td>
</tr>
<tr>
<td>• Tailored training opportunities for receptionist and admin staff</td>
<td></td>
</tr>
<tr>
<td>• Tailored training for health care professionals</td>
<td></td>
</tr>
<tr>
<td>• Tailored training for pharmacists</td>
<td></td>
</tr>
<tr>
<td>• Tailored training for district nurses</td>
<td></td>
</tr>
<tr>
<td><strong>Contraception</strong></td>
<td>9</td>
</tr>
<tr>
<td>• Emergency hormonal contraception</td>
<td></td>
</tr>
<tr>
<td>• Long acting reversible contraception (LARC)</td>
<td></td>
</tr>
<tr>
<td>• Intrauterine device and implant fitting</td>
<td></td>
</tr>
<tr>
<td>• Family planning</td>
<td></td>
</tr>
<tr>
<td><strong>General Sexual health training</strong></td>
<td>9</td>
</tr>
<tr>
<td>• Taking sexual health history</td>
<td></td>
</tr>
<tr>
<td>• Safe and effective practice for sexual and reproductive health</td>
<td></td>
</tr>
<tr>
<td>• Consultation skills</td>
<td></td>
</tr>
</tbody>
</table>
- Sexual health impact of health and well-being
- Referrals to and from sexual health
- GUM
- Partner notification/contact tracing

**STI**
- Genital symptoms (e.g. Chlamydia) 8

**Time constraints**
- Lack of protected time 8

**Location of training**
- Local training
- In-house training
- Training provided by other health boards 7

**Female Sexual health training**
- Cervical cytology
- Management of virginal discharge
- Mature women/menopause 7

**Induction Training**
- Initial Induction training 5

**Sexuality**
- Approaches to sexuality
- Men who have sex with mean issues
- Lesbian, gay, bisexual and transgender (LGBT) community 4

**Sexual health across the ages**
- Understanding of sexual health in the elderly population
- Young population 3
Respondents were asked to rate on a scale of 1 to 5 the extent to which the following shown in table 4.5 are barriers to training for the primary care and community health workforce. The biggest barriers to training shown by respondents was time, clinical commitments, lack of protected time and that other training needs are given a higher priority. Lack of appropriate content in training sessions and access to IT were seen to be less of a barrier to training within the primary care and community workforce.

Table 4.5. Barriers to training for the primary care and community workforce

<table>
<thead>
<tr>
<th>Barrier</th>
<th>Average Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time</td>
<td>4.3</td>
</tr>
<tr>
<td>Clinical commitments</td>
<td>4.2</td>
</tr>
<tr>
<td>Lack of protected time</td>
<td>4.0</td>
</tr>
<tr>
<td>Other training needs are given a higher priority</td>
<td>4.0</td>
</tr>
<tr>
<td>Lack of funding</td>
<td>3.8</td>
</tr>
<tr>
<td>Availability of staff to provide training</td>
<td>3.1</td>
</tr>
<tr>
<td>Staff on part time contracts</td>
<td>3.0</td>
</tr>
<tr>
<td>Timing of training sessions</td>
<td>2.8</td>
</tr>
<tr>
<td>Location of training</td>
<td>2.7</td>
</tr>
<tr>
<td>Lack of appropriate content in training sessions</td>
<td>2.5</td>
</tr>
<tr>
<td>Access to IT</td>
<td>2.0</td>
</tr>
</tbody>
</table>

4.5. Further comments and emerging good practice

Respondents were asked to provide any further comments or suggestions about the development and training needs of the primary care and community health workforce with regards to sexual health including any good examples of good practice. Twenty six respondents added comments, which centred around 4 themes: Skills and competencies, training provision, barriers and examples of good practice.

4.5.1. Skill and competencies

This theme highlighted skills and competencies which respondents felt the primary care and community workforce require. Some of the respondents felt that there was a lack of general skills.

‘training is important and should include good communication and listening skills’
Some respondents felt that primary care and community workforces required more access to more specific sexual health training.

‘issues of stigma and discrimination, late diagnosis of HIV’

‘sex in later life’

‘need to be aware of training needs in relation to supporting welling in sexual health, reducing discrimination and gender based violence’

‘simple partner notification’

Respondents also specified that particular disciplines need more tailored training to meet their needs.

‘midwifery courses should include training on contraception and STI across antenatal, intrapartum and post natal care.’

‘sexual health training for specialist nurses’

‘needs to be a major drive to equip GP’s and practice nurses to undertake STI and BBV testing underpinning by sexual history taking’

Furthermore, some respondents felt there should be differing levels of training courses made available to staff delivering sexual health services.

‘A middle of the road course/module maybe helpful for some’

‘more comprehensive courses’

4.5.2. Training provision

An emerging theme that was identified by respondents was that there was not enough provision for training in sexual health. Respondents identified that there were inadequate standards and career structures for sexual health across all disciplines.

‘I think the underlying problem is that there is no recognised/accepted standard....and no career structure for sexual health and reproductive health’
needs to be standardised across all of the groups, regular updates with different levels of provision depending on need’

‘the wider pharmacy population needs are not well addressed or regularly reviewed’

Respondents felt that there was not enough access to sexual health training.

‘very few providers of good sexual health training’

‘still need for easier access to training’

4.5.3. Barriers

Many respondents identified multiple barriers to accessing sexual health training. Respondents identified that funding, location and time were some of the biggest barriers to accessing sexual health training.

‘sexual health does not seem to be a priority so funding can be a problem’

‘getting to study days that incur a cost is impossible as we lack a budget to cover this’

‘its not always possible to attend HEI based training, and the amount of written assessment required is a barrier to some’

‘trying to organise events that are relevant and pertinent at a convenient time are the biggest barriers’

One respondent identified that the pressure of having to know about many different specialist areas was a barrier.

‘it is just one of many subjects that general practice are supposed to be able to know everything about’

4.5.4. Good practice

Respondents were asked to leave examples of good practice in relation to sexual health training. Some respondents had good examples and some of these were specific to disciplines.
‘Community pharmacy works very closely with the specialist services to address training needs and in some cases it has worked very well e.g. pharmacist led prescribing clinics for contraceptives’

‘In partnership with Waverley Care we have developed GP training to support GPs to raise the issue of HIV testing with the Black African community in Scotland’

‘A new NES practice nurse vocational training scheme provides content on sexual health, however it is being piloted this year and with only 12 new practice nurses’

One respondent had a few examples of good practice within their area.

‘shared resources – MCN, Nurse led training for LARC and an online training developed by RCOG/Faculty of SRH’
Summary of findings

- The majority of respondents were female and been in their current position for an average of 9 years. All of the 14 Health Boards were represented in the questionnaire, as well as the differing roles, however, the majority were nurses.

- Overall, the majority of respondents work with nurses to help deliver sexual health services; it also appears that nurses deliver the majority of training both locally and nationally to primary and community workforces.

- Responses indicate that the primary care and community workforces access the least training from neighbouring NHS Boards.

- Respondents felt that training provision was the largest gap in training and that time was the biggest barrier. Furthermore, respondents also commented that funding, location and time were also barriers to accessing sexual health training.

- Training needs were mostly identified through staff meetings and personal development reviews. Respondents reported that information about training opportunities was also provided through emails.

- Over two thirds of respondents indicated that a training needs analysis had not been completed in the last 5 years.

- GP’s and general practice nurses were identified as most likely to have a structured training programme. Midwives, receptionists and public health nurses (health visitors) were least likely.

- Respondents felt that there was a lack of training related to both generic and more specific sexual health, they also felt that there should be more training tailored for specific disciplines.

- Respondents also felt that there was not enough provision for training in sexual health, both in terms of access and inadequate standards and career structures for sexual health training across all disciplines.
5. Interviews with Key Stakeholders

Semi-structured interviews were conducted with 12 key stakeholders, including 4 respondents from training organisations and 8 respondents from the NHS. The sample comprised 2 males and 10 females, with an average of 8 years in their current post. The health boards that were represented in the interviews were: Borders, Fife, Grampian, Greater Glasgow and Clyde, Lanarkshire, Lothian and Shetland. There was also a representative from NES. NHS respondents were from a variety of roles and included a national co-ordinator, consultants, lead clinicians, a clinical director, a practice manager, a health promotion manager, head of nursing and an advance nurse practitioner. The training organisations that were represented in the interview were Skills for Health, Healthy Respect, Family Planning Association and Caledonia Youth. Respondents from training organisations included a chief executive, director and managers.

In order to protect respondents’ anonymity, letters are used to identify quotes.

Semi-structured interviews clustered around 11 themes:

- Identifying training needs;
- Commissioning;
- Training priorities;
- Availability and access of training courses;
- Training providers;
- Uptake;
- Resources;
- Publicising training opportunities;
- Main gaps in training provision;
- Barriers;
- Improving delivery and planning.

5.1. Identifying training needs

This theme identified how the training needs of the primary care and community workforce were identified. The majority of NHS based staff explained that the training needs of their staff were identified on an individual basis.

"it’s largely down to the individual to identify the need." F
“would be identified on an individual basis” G

"they will identify their own learning needs” B

Furthermore, interviewees also explained that training needs were also identified by a member of staff being aware that they have a training need.

“It’s generally an awareness within the practice.” H

“depend largely on the nurses themselves as to whether or not they feel they’ve got a learning need” B

Interviewees indicated that the training needs of the primary care and community workforce had either not been identified, a training needs analysis had not been completed within the primary care or community workforce for a long time or that when they had completed one, there had been poor response rates.

“Occasionally they do learning needs analysis and they’ll send out a questionnaire but the response rate for those questionnaires varies between, well, certainly less than 50%.” NHS B

“There’s not been a formal training needs assessment in [our health board] for a long time.... So it’s on an informal basis” E

“We as a service will not identify trainees as such” I

As well as this a training need analysis had not been completed within training organisations who provide some of the training to primary care or the community workforce, as it was expected that this had already been completed within the NHS Health Boards.

“we don’t do a formal training needs analysis... clearly the commissioner has already done the training needs analysis themselves, so they have made a decision about what it is exactly that they need, so that’s already been done” D

However, one of the training organisations did identify the training needs of the primary care and community workforce.

“we would be able to identify through competency sets where there is lack of knowledge or lack of skill” A
5.2. Commissioning
Commissioning for sexual health training was identified as a theme in the interviews. All NHS staff identified that there was no commissioning for training.

"We don’t have commissioning" B

"It’s not commissioned" E

“We’re not, as a general rule with one or two exceptions, explicitly commissioned by for example the health board or any other groups.” G

However, interestingly interviews with training organisations identified that they do get commissions for their training courses that they run.

"It would be with the NHS Boards in Scotland primarily that we work with and NHS Education for Scotland itself." A

“I get commissions from community health organisations or primary care people in Scotland for particular courses that they would like us to come and run for them.” D

5.3. Training Priorities
A theme that appeared throughout the interviews was that NHS staff felt there were training priorities within their Health Board. It was recognised by many of the interviewees that testing for BBV and STI’s was a training priority.

“encouraging STI testing in the community and particularly HIV testing.” E

“making HIV testing much more routine part of primary care, including offering access to testing and onward referral for people with conditions that might make people think of HIV but also as part of the routine for people who are in groups that have higher prevalence” G

“our priorities really are reducing STIs, you know, and increasing the uptake of BBV testing” I

Interviewees also explained that another key priority in their area was methods of contraception, which generally related to training around long acting reversible contraception (LARC).
“increasing awareness of and access to a range of contraceptive services including long acting reversible contraception” G

“continually promoting advice on long acting reversible contraception, promoting, providing training on the provision of long acting reversible contraception” E

“one of our priorities, to increase uptake of LARC in Grampian” I

Another significant training priority that was identified by interviewees was sexual health training for vulnerable groups, which included vulnerable young people, and vulnerable women.

“identification of vulnerable women particularly to identify those at greater need of sexual health intervention” G

“looking at sexual health in vulnerable groups and so on, so that’s the kind of key priorities.” I

“priorities around working with young people, particularly vulnerable young people” L

As well as this interviewees explained that cervical cytology was a priority in their area.

“At the moment cervical cytology is very important” B

“we don’t have provision for in remote and rural locations like Shetland is we don’t have any formalised training for cervical cytology” F

5.4. Availability and access of training courses

Availability and access of the training that was provided to primary care and community based practitioners was a significant and recurring theme throughout the interviews.

5.4.1. Availability

Interviewees explained what training courses were available for the primary care and community workforce to attend.
From the interviews it appeared that there were various structured training courses that were available for staff to attend.

“Nationally agreed programmes through the Faculty of Sexual and Reproductive Healthcare or the British Association for Sexual Health and HIV recognised postgraduate certificate qualifications in sexual health run by one of the local universities in Scotland, West of Scotland University runs that, and that’s the kind of main training” J

“we provide training on communicating with young people about all aspects of sexual health... We do work on the impact of alcohol on young people and their sexuality; we do work on the impact of pornography on young people and their sexuality. We also do a lot of work around learning disabilities, so people with learning disabilities and sexuality... but all it is basis with being more effective in communicating with young people about the issues” D

“there is quite an intensive training programme. We have weekly multidisciplinary staff training”. G

However, some of the interviewees identified that training is only made available once a member of staff has identifies that they have a learning need.

“If they show an interest, sometimes the practice nurses themselves wish to sort of specialise in this area and will let me know and see if I can get access to any information training schedules etc”. H

5.4.2. Access

Interviewees explained how they could access these training courses. One interviewee explained how all of the training courses can be accessed and booked online.

“we are moving over to the AT system, the all-time training system for training that they use in Grampian, so by spring of 2013, all of our training has to be accessed through the AT learning system, which means that all of our courses and conferences can be booked online, so it’s easier” I

Furthermore, certain interviewees felt that the training courses in their area were accessible for members of the primary care and community workforce to attend.
“I think for all that we’re very remote and rural I think we’re fairly well served with access to training” F

“we’ve kind of made it locally delivered, free of charge, accessible, we’ve tried to have face-to-face as well as e-learning packages, so I think we’ve tried to make it accessible to most people.” I

However, one interviewee had explained that training had been hard to access for members of the primary and community workforce because of cost.

“at the moment there’s an embargo on any non-statutory training, because of cost.” E

5.4.3. Improving access and availability of training

Interviewees identified ways to improve access and availability of training in sexual health for primary care and community based staff.

Interviewees identified that providing training courses online may improve access to sexual health training among the primary care and community workforce. This was due to either staff not having time to attend training courses, or being able to be released to attend training courses.

“An e-learning approach would probably be the most cost effective way of doing it because it’s less time out of practice” NHS B

“We should direct GPs towards the online and others towards the online resources provided” NHS E

“getting people released for training can be a difficulty, and I guess increasingly what we need to look to are online resources and blended courses, because getting people released to attend for training can be quite difficult.” L

Interviewees also identified that access and availability to sexual health training could be improved if those that had already attended training and where specialised in a particular area could deliver it to other members of the primary and community workforce. However, again there was an issue of the workforce being able to be released to be able to deliver training.

“those people who have always been trained and don’t really need more training, but actually put all of their energies into delivering training in a specific area” I
“it’s about doing some sort of assessment of who you’ve got and how they can be released if they need to be released from their day job if you like to actually run some training.” D

Interviewees also had general ways for how training courses could be improved to make it easier for primary care and community based practitioners to access them.

“I think whatever you do provide needs to be short, sharp, probably directed at the amount of exposure they have to it in terms of what they’re actually doing.” B

"I think improvements might be, one, wider availability and promotion of its availability” C

5.5. Training providers
Sexual health training providers were identified as a theme throughout the interviews. The majority of interviewees explained that key providers of sexual health training were those that were based locally to them.

“very small board, so the sexual health team” E

“So if it was a clinical issue we would probably go to our clinical colleagues first and say would you be able to do a wee input for us, we need to get up to speed on X Y and Z.” L

“we are probably the kind of key source, and all of our doctors or faculty instructing doctors, you know, so we provide the majority of training and sexual health in Grampian, in Aberdeen City, Aberdeen South and Moray.” I

“depends on the Health Board area and whether or not there is somebody in their area that can provide it locally. It might be a sexual health consultant, a nurse who is based in Health Protection Scotland or something like that.” B

Some interviewees identified that they did have some sexual health training from training providers at a national level.

“national level if we talk about higher education institutions then some of them do offer a sexual health course” B

“LGBT youth provide some training.” E
5.6. Uptake

A theme that emerged from the interviews was uptake; it explains how well attended sexual health training events for the primary care and community workforce had been. The majority of NHS staff felt as if attendance to training had been good.

"The uptake’s very good.” E

“we have our own databases...we trained 1000 people over a year, through a variety of training packages” I

However, one interviewee explained that although attendance had been good, there was no objective way of measuring if it had been effective for primary care and community based practitioners.

“Our training is always full, but I’ve got no real way of knowing whether or not that meets the needs of the primary care workforce.... our external training courses are always full and oversubscribed, so I suppose that is a good thing” G

However, Interviews with respondents from training organisations felt that sexual health training courses had not been well attended.

“in recent times it’s been very quiet; there’s not been anything particular that’s come in our direction recently.” A

“it’s been patchy uptake, again, probably for conflicting priorities within the practice setting” C

Furthermore, one interviewee from a training organisation stressed that when courses are commissioned their attendance is good as they have been advertised well; however open courses that had been provided with no commissioning had not been well attended.
“In terms of when they're commissioned, it’s brilliant, you know, the courses are full because the commissioner has kind of arranged it and they want the people to be coming on it. In terms of our open courses that we just offer, say we put a date on, the uptake on those is not so good” D

5.7. Resources

5.7.1. Resources available

A recurring theme throughout the interviews was resources. This theme related to resources available for the primary care and community workforce and what additional resources were required.

Interviewees from the NHS identified a range of techniques for how staff access or obtain resources. Interviewees explained how they disseminate any information they receive to members of staff.

“if I receive anything from the national then I will cascade that out across the different Health Boards through the network... but I really don’t know if they’ll read it or what they’ll do with it.” B

“It’s dissemination of any information that I get” H

Interviewees also identified that they have a library within their practice that staff can access. However, one interviewee explains that there is limited access to some of the journals.

“We have a library in the surgery” H

“have a little library here in the kind of staff office room that anyone can access..... we’ve got journals and the British Journal of Obs and Gynae, and the Journal for Family Planning that are accessible here. We’ve got limited, through the NHS there’s actually very limited access to other journals.” I

Furthermore, interviewees also identified that there are national resources which are made available for the primary care and community workforce staff.

“All of the staff in NHS Scotland have access to the knowledge network. There’s a regular e-newsletter so we have an internal e-newsletter that goes around and that is one of our primary ways of letting staff know about changes to policies, procedures, protocols.” G

“we make available national resources” E
Interviewees from training organisations also identified that they have resources that can be accessed by the primary care and community workforce. These included websites, leaflets and publications.

“e-bulletin and the website... supporting materials... produce quite a few leaflets... and posters to put up in places around confidentiality” C

“We have a number of publications to support people working in primary care and also in the community, which are on our website.” D

“They could access information on our website” K

5.7.2. Additional resources required

A recurring theme throughout the interviews was additional resources that were needed by the primary care and community workforce. These tended to focus around needed additional resources for staff; which included being staff being released, funding and time.

“paying them for the protected time, I think, you know. The main block at the moment is that there’s no funding for non-statutory training, so even though staff who are interested and willing to go for training cannot get any funding or even leave to do it.” E

“protected staff learning time for all devoted to sexual health rather than to anything else” G

“I think there are issues in terms of staff being freed up to attend training, and getting locum cover and so on,” I

“takes time and also resources to allow people to take care and to deal with that, and not just resources that are financial, but allowing people to take the time out of the workplace to develop their skills in these areas.” K

Furthermore, one interviewee explained that due to the difficulty in getting staff released for training, online resources would be beneficial.

“increasingly the world of reducing resources then, getting people released for training can be a difficulty, and I guess increasingly what we need to look to are
online resources and blended courses, because getting people released to attend for training can be quite difficult.” L

Interestingly another interviewee explained that online training would be a benefit, however, staff still need to be released to be able to complete it.

“I think they would argue money for back fill to release people to train...Because even if you have it online, as an online training, staff still need time out to actually sit and do the online training.” J

One interviewee explained that overall there needs to be more resources for primary care and community based practitioners to be able to learn or develop skills.

“There would need to be more resource if you were talking about facilitation of any types of learning.” B

5.8. Publicising training opportunities

Interviewees indicated ways in which training opportunities were publicised for the primary care and community workforces, many of these were through e-newsletters and websites.

“regular e-newsletter so we have an internal e-newsletter that goes around and that is one of our primary ways of letting staff know about external training that might be coming up.” NHS G

“via our website” A

“Website training and development page that we’re trying to put in all training on sexual health for young people on that page...we also do an e-bulletin” C

“We have on our website. We also have a brochure that we produce every year. We also do some marketing to people that we’ve worked with before, and also a lot through word of mouth actually is often how we get” D
5.9. Main gaps in training provision

This theme identifies the main gaps that interviewees identified there may be within current training practise within the primary care and community workforce.

Interviewees identified that there needs to be general training for sexual health with the primary care and community workforce.

“So probably some minimum training requirement before people can provide that level of advice... you know, you go on and do a diabetes module, you go on and do asthma modules, you wouldn’t dream of giving out advice about those conditions or give medication, but you could do it for reproductive or sexual health without any actual post registration training in it. I find that quite strange.” J

“sometimes we’re missing the kind of softer, the softer and quite hard to define training requirements around interpersonal skills and working on a holistic basis” K

“something that focuses on opportunities for communicating around sexual health in primary care is really, really key, because I think, it’s my personal view that opportunities are missed,” D

Moreover, many of the interviewees identified that there was a gap in training provision around generic training across all disciplines.

“ensuring that the whole practice has an awareness of discretion, confidentiality and a direction point as to know who to direct to if the girls certainly I’m thinking of reception.” H

“our sort of prime is to make sure that there’s a sort of generic level of training across the whole of Grampian. So everyone has a sort of basic level of knowledge of sexual health.” I

“interdisciplinary approach” L

Interviewees also felt that there were gaps around HIV testing.

“I think possibly there’s still confusion about testing for HIV... So at a national level I can probably say that practice nurses might need a little bit more about that and they’re often quite reluctant how to handle the result and how to deal with it; it’s not really an area of expertise for them.” B
Another significant theme that emerged was gaps relating to contraceptive training.

“issue of women accessing long acting contraception methods, like coils and implants” J

“gaps are understanding of long, no, understanding of emergency contraception” E

“Increasing awareness of and access to a range of contraceptive services including long acting reversible contraception” G

“How to issue contraception, how to deal with long term reversible contraception” K

One interviewee felt that there was a gap in current sexual health training provision around training for awareness of diverse communities.

“I think some awareness about diverse communities that primary care staff are facing is very, very important, especially in sexual health.” D

Furthermore, another interviewee felt that there was a gap in training provision for supporting vulnerable groups and gender based violence.

“Gender based violence and the support for the vulnerable around the sexual health” G

5.10. Barriers
A significant recurring theme that emerged from the interviews was there were barriers that prevented the primary care and community workforce from accessing appropriate training. These barriers centred around 4 subthemes including; time, access and availability of information, travel, cost and the releasing of staff.

5.10.1. Time
Time was reported by the interviewees as being a barrier to attending training events.

“The time, the practice nurses are generally very, very busy people and if you take them out of the practice then often they have to make up their appointment times at another time.” B
“I think the main thing is Protected Learning Time, that’s one of the biggest barriers I would say across the board, not just in community services, but it’s Protected Learning Time” A

“main barrier always is time to do things and being clear about what it is you expect people to do.” J

5.10.2. Access and Availability of Information

Interviewees also identified that access and availability of information concerning sexual health training was another potential barrier to attending training, both in terms of being aware of the training available and how to access it, as well as staff identifying that they have a training need.

“also easy access to the information.” A

“even knowing that you need that learning so identification of the learning needs are all potential issue” G

“possibly awareness of the range of training... people just are now unaware of how easy it is to access some training” J

5.10.3. Travel

Travel was also a barrier to attending training, which mostly related to those practitioners in Health Boards which are remote and rural.

“The remote rural, so if they have to travel any distance, you’ve got to add that on as well” B

“people who are in rural Scotland, because we don’t run a lot of courses in Scotland, not open courses anyway, they do feel some frustration when I say yeah we do have exactly the course you need, by the way it’s in London... I think a barrier is having to travel a lot, or having to travel even a bit” D

“being able to actually get to wherever the training is and it really being, you know, locally based I think is an important issue.” D

“because we’re so remote and rural, if you lived on the mainland you might say well there isn’t a course going on here at the moment but I could go to the next city, you know, have a day out and go and do it.” F
5.10.4. Cost
Interviewees also explained that the cost of training is a barrier to attending training, interviewees also identified that funding to be able to release staff and access cover for that staff member was a barrier.

“If you take them out of practice the GP is paying their salary, and again there’s the cost of that, so it needs to be cost effective, so unless they see it as being cost effective then I don’t think they’re likely to release them very easily.” B

“practitioners haven’t got the money to spend even, I mean our courses, for a one day course for example, you’re looking at about £120 to come on one of our one day courses” D (organisation)

“no funding for non-statutory training, so even though staff who are interested and willing to go for training cannot get any funding or even leave to do it.... So GPs basically have to pay for that themselves.” E

“argue money for back fill to release people to train... Because even if you have it online, as an online training, staff still need time out to actually sit and do the online training” J

5.10.5. Releasing staff
Furthermore, releasing staff to attend training events was identified by interviewees as another barrier to accessing sexual health training.

“not be released to do it, because there would be other priorities that they see as being more important in delivering care within their practice, so that’s to me a big barrier” B

“can’t be released, and maybe they have got the money but they’re being told they can’t be released to go on a course because it’s the time issue.” D

“In terms of primary care, I think there is issues in terms of staff being freed up to attend training, and getting locum cover and so on, and I think that’s where the gap is” I

5.11. Improving delivery and planning
Improving delivery and planning was shown to be a significant theme from the interviews.
Interviewees reported that the delivery and planning of training could be improved by identifying the training needs of the primary care and community workforce.

“I think that’s where greater involvement with the workforce planning people to establish actually what the workforce is expected to do to identify those skillsets, which would then, organisations will be better placed to identify the training needs requirements to meet service delivery, if that makes sense” A

“We could do a national needs assessment, and then we could discuss what we’d put in place.” E

“ask them about what they need and what their training needs are so again it’s speaking to the workforce.” C

One interviewee reported that as a network they had developed a training manual that could be used to help identify training needs and therefore may help to improve planning and delivery of training across disciplines.

“as a network we have developed a work plan of, and sort of levels of training manual, which will eventually be on the sexual health network website, which has levels from youth worker right through to GPs and consultant grade staff. What is the minimal training that we would like each of these grades of staff to have” I

Interviewees also identified that delivery and planning of training courses could be improved by having a standardised programme which provided some consistency nationally across all the health boards.

“generic baseline level and then you might have one that’s at a higher more intense level.” B

“It would be nice to have some, like a NES based either delivery programme or something that would complements that and would be like a fall-back position if the individual universities stopped running things, it needs to be something that’s a sustainable embedded programme of training that we could all access, maybe a series of levels like a foundation level, an intermediate level and a, you know, to complement the existing faculty training.” J

“if there was a standardised learning training process then everybody would know what they’re signing up to and the expectation of the skill when it’s finished.” H
One interviewee also reported that the delivery and planning of training courses could be improved by organising them at appropriate time so that all primary care and community workforce can access it.

“delivered at times that suit them such as like twilight sessions I would imagine, rather than saying that the whole practice has to shut for a day to come to these different things.” C
Summary of findings

- The majority of interviewees reported that training needs were not identified for the primary care and community workforce and suggested that a training needs analysis needed to be completed across all disciplines.
- It was reported that training was not commissioned within the Health Board.
- Interviewees reported that STI and BBV testing, methods for contraception, vulnerable groups and cervical cytology were all training priorities within their Health Board.
- There appeared to be various structured training programmes available for primary care and community practitioners to access. However, it also appeared that staff may not know what is available for them to attend, or how to access appropriate training.
- According to NHS respondents attendance to training events had been good which was contradictory to training organisation respondents. It also appeared that there was no objective method to measure the trainings effectiveness on the primary care or community workforce.
- It was identified that the majority of training that is provided is delivered locally by the sexual health team.
- The majority of the interviewees suggested that for staff to be able to attend training they need to be released from their work, which may involve both time and money.
- Interviewees reported that there was a gap in training for general training, HIV testing, contraceptive methods, awareness of diverse communities, supporting vulnerable groups and gender based violence.
- Barriers to accessing appropriate training appeared significantly throughout the interviews, these related to time, access and availability of information, travel, cost and releasing staff.
- Interviewees identified that the delivery and planning of training could be improved by completing a training needs analysis so that the primary care and community workforce needs can be identified and then can be met. Planning and delivery of training could also be improved by having a standardised programme of training nationally across all Health Boards and specific for different disciplines.
6. Discussion

This scoping study was undertaken to provide an overview of the current development needs of the primary care and community health workforces with regard to sexual health in NHS Scotland. This has been done in the context of ‘The Sexual health and blood borne virus framework 2011-2015’, which provides a single overarching strategy to address sexual health and wellbeing, HIV, hepatitis B and hepatitis C. In order to implement the strategy effectively, an appropriately trained and prepared workforce is needed, particularly in a primary care and community setting.

The primary care and community based workforces considered in this scoping study cover a wide range of professions and skills, with different priorities and involvement in sexual health. There has been some difficulty in establishing the collective needs of a group such as this, with no overarching organisational structure, or means of delivering a cohesive training policy. This points to the need for consideration of a more coordinated training focus nationally, with a potential role for NHS Education for Scotland, that can be implemented at a local level.

The consultation exercise indicated that the training needs of practitioners are generally identified on an individual basis, through staff meetings or personal development reviews, making it difficult to organise an overarching training plan for an area or for an organisation, unless there is some means of collating and combining these needs to produce a training strategy. Whilst only one third of respondents reported that a training needs analysis (TNA) focused on sexual health had been undertaken recently, these respondents represented 12 of the 14 health boards; the two thirds of respondents who stated that a sexual health TNA had not been conducted represented 13 health boards, indicating that where TNAs has taken place they appeared to have been done on a local rather than Board-wide level. The majority of TNAs that had taken place did include the needs of the primary care and community workforce. Carrying out a TNA is not without its problems, issues around poor response rates were noted in one area where a TNA has been conducted and therefore the resulting analysis may not have been a true reflection of the whole workforce. Where TNAs are carried out, respondents indicated that these should make use of the existing competency frameworks and skills sets to assess the current needs and competencies locally. This is similar to the finding found by Hicks and Thomas (2005), who developed a tool for assessing training and development needs of sexual healthcare practitioners in England, as training provision is still seen to be inconsistent with decisions made on the basis of individuals, rather than on audits of existing skills and analysis of gaps in competencies.
Prioritising sexual health training was another issue raised during the consultation process. While sexual health training for primary care and community health staff was considered to be a priority by over one third of respondents in the survey, it had to be recognised that this lies within the context of many other competing priorities for primary care practitioners. Specific priorities around sexual health training and development for the workforces identified through the consultation process in this study included the following:

- STI testing in the community
- Range of contraception available and promoting uptake of LARC
- Identifying and working with vulnerable groups
- Basic, generic level of understanding of sexual health across disciplines, including confidentiality, taking sexual health history and signposting.

Some of these training priorities were seen in Markham’s (2005) report, suggesting that these training needs have still not been met.

Current training provision and access to training varied significantly between boards and for different practitioner groups. There appeared to be a wide range of formal training opportunities available through professional organisations, a variety of more informal courses provided within NHS Boards and through managed clinical networks where these were established. This supports the findings of the Scottish lead Nurse SRH (2011) report and Mehigan et al (2010). Formal training for GPs and other practitioners was available through the RCGP, BASHH and the FSRH, with a number of postgraduate university courses aimed particularly at nursing staff. Although some Boards did have a clear training programme which includes all staff working in primary care, training at a local level appears in most health board areas to be more ad-hoc, provided most frequently by local consultants or specialist nursing staff, and in fewer cases, by third sector organisations. Where bespoke training is commissioned from the organisations providing training it would appear to be done on either a national or very local level. There may be further scope for looking at the level of community health partnerships in coordinating training requirements across the primary care and community workforce.

Additionally, it was suggested from both the questionnaires and semi-structured interviews that there was a need for training courses to be consistent, standardised and accredited, and that this should be tailored for specific disciplines. Findings suggested that there is a need for improvements in advertising training opportunities to the primary care and community workforces. This may improve their awareness of these opportunities and increase attendance.
Uptake of training by primary care staff was not considered to be well monitored for the majority of questionnaire respondents. Looking at this in more depth in the interviews, the uptake of training was reported as being good amongst the workforce being considered, in particular for training events that had been specifically commissioned. However, there was little evaluation of the effectiveness of this training for the primary care workforce. Training providers indicated that there has been fewer training courses commissioned recently and suggested that this was due to conflicting priorities and demands within the primary care setting. It was also reported that open courses are available for the primary care and community workforce, but these are not well attended.

Findings from the present report support those from the Scottish lead Nurses SRH report (2011), explaining that general practice nurses play a prominent role in SRH services including the delivery of training to other members of the workforce. It was also identified that general practice nurses have a structured programme of training. However, in the consultation process it became clear that not all sexual health training needs are met among all general practice nurses.

Similarly, according to Markham (2005), GP’s were seen to be relatively unprepared for sexual health care. In the current report they were seen to be the workforce with the most structured training programme in sexual health. This may reflect an improvement in the training of GPs in this area. In some cases it was identified that the needs of GPs had not been met. This further supports the need for a TNA.

Midwives were seen to have the least structured programme of training on sexual health. This suggests that community midwives may have limited training and therefore may be poorly equipped to provide family planning advice and other sexual health advice. This supports the findings of an early study by Norris (2007). The report highlighted that pharmacists may benefit from more tailored training opportunities as needs are currently not met and are not reviewed regularly. Again this reflected the findings reported by Gale and Watson (2011). It was identified from the current report that tailored rather than generalist training was needed across all the disciplines.

The format of training provision was considered as part of the scoping exercise. There were suggestions that more resources for training should be available online through e-learning packages, which can improve access and availability of training courses compared to face to face training. However, face to face training was seen to be the best way of delivering training on topics such as communication skills and sexual history taking, where the opportunity for discussion around the topics was considered beneficial for the participants (Thurston et al, 2011). E-learning appeared to
be used infrequently at a local level, most commonly being available through the professional organisations supporting training. There may be scope for providing e-learning resources aimed at practitioner groups where formal training programmes in sexual health are not currently available or accessible, and to provide a basic level of training for all practitioners.

However, although the use of an e-learning approach was suggested by some of those who participated in this study, as well as in other reports (Mehigan et al, 2010; Peacock and Fraser, 2007). There were some issues with this type of approach which were identified in interviews. Firstly, staff still need to be released to have time to complete e-learning, as well as locum; secondly, e-learning may not be beneficial for some training that requires in-depth group discussions.

There was an identified need for additional training resources to be targeted towards the primary care and community health workforce, with only a quarter of respondents agreeing that there were sufficient resources for staff training in sexual health and that the current training programmes meet the needs of this workforce. Libraries were housed in a number of surgeries, limited access to current journals was available through the NHS and all NHS staff had access to the Knowledge Network. However, the extent to which primary care staff accessed these resources was not examined in this study. Email and electronic newsletters appear to be the most frequent forms of communication to ensure that staff, including those in primary care, have access to updates in policies, procedures and protocols and also information about upcoming training opportunities.

The study sought to identify the gaps in current training provision. The main gaps identified through the scoping study included:

- Specific training for practitioner groups, with the needs of practice nurses being more frequently highlighted,
- Identifying opportunities to discuss sexual health with patients,
- Diversity awareness,
- Emergency contraception and LARC,
- Gender based violence and identification of vulnerable individuals,
- Communication and interpersonal skills,
- Basic training for receptionists and admin staff,
- Understanding multiple needs of patients, particularly young people.
Another related area was an identified need for increased training on BBV and HIV testing. This was mentioned frequently by both the questionnaire and interview respondents during the consultation process and is being addressed elsewhere through NES\textsuperscript{15}.

The main perceived challenges to accessing sexual health training were explored. Time was most frequently cited across all the respondents. It appeared to be the case that even when the funding was available to attend training, there were still barriers in terms of time, locum cover and other priorities that meant attendance was problematic. Lack of funding for non-statutory training was highlighted as a problem, particularly within GP practices. Other barriers or challenges identified in this study included access and availability of information, availability of staff to provide training, working patterns of primary care staff, and time and location of training. These issues are by no means new and have been raised in previous studies (Loots 2007; Thomson et al, 2008; RCN, 2004).

In terms of delivering the Framework, this states that “the Scottish Government and other partners will work together to ensure progress is maintained and that challenges do not become barriers to delivery” (p2, Scottish Government, 2011). In recognising what the challenges are and the context in which they exist, efforts can be made to ensure these do not become barriers.

In terms of improving planning and delivery of training, respondents highlighted the need to deliver training locally at a time that fits with existing commitments and to ensure its relevance to the target workforce, for example through the provision of twilight sessions. There was also the suggestion of having a standardised programme of training coordinated by NES available for different levels of need and expertise or similarly having a generic baseline level of sexual health training that gave everyone working in primary care a recognised level of competence. Suggestions also included having a single source of information about standards required from a youth worker in the community through to GPs and consultant level expertise. Adopting standards for sexual health training, similar to that produced by the Department of Health (2005) may be useful.

The issues raised through this scoping study have highlighted a number of specific challenges around the setting in which primary care teams work. This related particularly to remote and rural areas and to the Island boards which often had to provide a wider range of services where no specialist services were available locally. This reinforces the issues recognised in relation to Respect and Responsibility (Peacock and Fraser, 2007). Difficulties in receiving necessary training included accessing appropriate resources locally or having suitably qualified trainers available, having additional travel time and costs to attend external training, and lack of staff availability to provide

\textsuperscript{15}Information from NES about Blood Borne Viruses can be found at: http://www.nes.scot.nhs.uk/education-and-training/by-theme-initiative/public-health/health-protection/blood-borne-viruses.aspx

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backfill or locum assistance. However, despite the potential problems, respondents in some remote and rural areas did feel that their training needs were adequately met, and they could deliver a good service in relation to sexual health. It is not only Health Boards with remote and rural areas that experience these issues, the majority of participants identified similar issues relating to costs of attending training, locum, backfill and travel.

When considering training and development, there is a need to recognise the context in which the primary care workforce operates. This is often in a multi-agency partnership environment, with partner agencies involved in delivering sexual health services, education and advice at different levels. Particularly relevant is the Health Improvement workforce, who work very closely with colleagues in primary care and others delivering frontline services, with often some degree of overlap between the two. Some concern was voiced that the focus of this study was too narrow, with too much of a clinical focus and greater consideration should have been afforded to the non-clinical needs of the wider workforce. It is worth noting that a large proportion of good practice examples cited by respondents in both the questionnaire survey and interviews were based around partnership work with other agencies, in particular with the Health Improvement teams and local authorities.
7. Conclusions and Recommendations

It is apparent that there is a lot of work currently underway to meet the training and development needs of the primary care workforce. Whilst this scoping study has identified a number of examples of good practice where the needs of the primary care and community workforce are being understood and addressed, there are still a number of gaps, and differences geographically that need to be considered in order to meet the requirements of the Framework. There is scope for the good practice approaches to be built upon and adopted more widely. Additional support at a national level, and Board level, would help to ensure the workforce is adequately trained to deliver sexual health services and meet the requirements at a local level. Having an active Managed Clinical Network for sexual health appeared to be a particularly effective means of coordinating, publicising and implementing training across a wide range of practitioners, including those in primary care, with an interest in delivering sexual health services.

Training needs and gap analysis needs to be considered within the context of a multi-agency model of delivery of services. Partner agencies need to be considered within the overall training needs analysis for the successful implementation of the SHBBV framework.

At both stages of this report it was identified that there was a variety of sexual health training courses available for the primary care and community workforce to access. However, there was a need for these training courses to be consistent and standardised nationally, with a work plan tailored for each specific discipline. These training opportunities should be advertised effectively in a way that all the primary care and community workforce can access their availability. Furthermore, ways to try and reduce the barriers to training such as cost, time, releasing staff and travel need to be improved to enable staff to access any form of training.

Whether there are resources available to ensure that the primary care and community health workforce are trained adequately to be competent to deliver the sexual health and blood borne virus framework is an issue that needs to be addressed at a national and local level.
Recommendations

The key recommendations arising from this scoping study, in terms of the development needs of the primary care and community based workforce are summarised as follows:

1. Development of a strategic national focus on training in sexual health to provide consistency between and within Health Boards. Whilst this is not the sole responsibility of NES, coordination from a nationally based organisation would be useful in this context, in overseeing the development of standards for training in sexual health for all primary care practitioner groups. The coordinated national approach to training should allow flexibility in implementation at a local level.

2. There needs to be additional support at a national, Board and local level to overcome the barriers in accessing training by primary care and community health workforce, including support for providers in making training available in different formats as appropriate.

3. The primary care and community based workforce would benefit from a better awareness of the training that is available, to identify appropriate opportunities relevant to their daily practice. A single point of reference that signposts practitioners to relevant training opportunities would be useful. Members of the sexual health team who are specialised and received training in certain areas could provide training to others locally. Costs could be reduced if primary care staff could be invited to attend existing or on-going courses aimed at staff working in specialist clinics where appropriate.

4. There is a need for the development of a national online core learning resource that is accessible by all primary care and community based practitioners who need to deliver sexual health services. This should provide a basic level of knowledge and education, to ensure consistency between practitioner groups and also geographically across Scotland. This would also be of value to the Health Improvement workforce, and other partner agencies involved in delivering sexual health services.

A number of other areas for consideration at a Board and national level arose from the research; these are summarised below:

- NES should consider where it can most effectively influence and inform service redesign in increasing the recognition at a national and Board level of the need to prioritise sexual health services in GP practices. An increase in the priority given to sexual health services would provide the impetus to encourage training needs to be identified and addressed. GP
practices should have the message reinforced about the need to have appropriate training to deliver the ‘Sexual health and blood borne virus strategy’.

- NES should encourage local training providers to undertake a training needs analysis of primary care and community based practitioners to ensure that local training can be provided that meets the requirements of generalist and specialist staff in relation to skills and competencies needed to deliver effective sexual health services and implement the sexual health and BBV framework. The results of the TNA need to be collated to ensure that an action plan can be drawn up to best meet the needs of the workforce, whether this is at a Managed Clinical Network, Board, Community Health Partnership or practice level.
8. References


Cantrell, Nicoll and Sabin (2010) Education and Training for Community Nurses working in Remote, Rural and Island Contexts. RRHEAL/NES.


NHS Education for Scotland (2005) A Route to Enhanced Competence in Sexual and Reproductive Health Nursing (Specialist Level)


Royal College of Nursing (2004a) Inserting and-or removing subdermal contraceptive implants: guidance for nursing staff, London: RCN (publication code 002 240).

Royal College of Nursing (2004b) Sexual health competencies: an integrated career and competency framework for sexual and reproductive health nursing. RCN: London


Appendices

A. Review of Standard 9 by Health Board
B. Sexual Health strategies by Board
C. Sexual Health Questionnaire
D. Interview Schedule
## A. Review of Standard 9 by Health Board

<table>
<thead>
<tr>
<th>NHS Board</th>
<th>date of report</th>
<th>status</th>
<th>Summary of review findings</th>
<th>examples of training activities undertaken for primary care staff</th>
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<tbody>
<tr>
<td>Ayrshire &amp; Arran</td>
<td>May-11</td>
<td>Met</td>
<td>Generic TNA conducted in 2006 sexual health strategy currently being updated, to include workforce planning Corporate induction plus CPD plan for each staff group staff encouraged to attend appropriate training annual updates offered to GPs wishing to maintain sexual health competencies sexual health nursing and medical competencies reviewed through PDPs West of Scotland sexual health managed clinical network has taken on a key role in developing training across member NHS Boards - currently carrying out a gap analysis to determine training needs</td>
<td>training on insertion of contraceptive IUDs and implants Activity by West of Scotland clinical network: LARC fitting sessions aimed at GPs training roadshow for administrative staff shadowing scheme set up to help develop clinical expertise</td>
</tr>
<tr>
<td>Borders</td>
<td>Jul-11</td>
<td>Met</td>
<td>In house training update sessions run twice a year by Borders sexual health services, good attendance by all staff groups All 7 nurses employed by Borders sexual health service have family planning and cervical screening qualifications two doctors are registered trainers for the Diploma of Sexual and Reproductive Healthcare all staff have PDP to support professional development work closely with NHS Lothian to provide training lead consultant provided training for medical staff in genitourinary medicine</td>
<td>one training session is specifically aimed at GPs; nurses must attend at least one session training for healthcare support workers and admin staff provided in house all staff have completed alcohol brief intervention training.</td>
</tr>
<tr>
<td>Dumfries &amp; Galloway</td>
<td>Aug-11</td>
<td>Met</td>
<td>Provide a range of training to staff providing specialist sexual health interventions in sexual health services: All medical staff hold a diploma or membership of the Faculty of Sexual and Reproductive Health All registered nurses hold PG cert in sexual and reproductive health All nurses have PDPs in accordance with KSF NHS board has set up a clinical supervision group for nurses and healthcare assistants, meet every 6 weeks and provide opportunity to discuss training opportunities NHS Board offers training to medical and nursing staff including primary care and partner organisations a number of training courses available on a range of sexual health topics</td>
<td>Most GP practices have someone trained to fit LARC contraception GP practices invited to attend annual updates on a range of sexual health topics</td>
</tr>
<tr>
<td>NHS Board</td>
<td>date of report</td>
<td>status</td>
<td>Summary of review findings</td>
<td>examples of training activities undertaken for primary care staff</td>
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| Fife                      | Jun-11         | Met    | Consultants with the sexual health service are registered with the GMC, and have undertaken speciality training - 7 speciality doctors  
CASH doctors are: certified for the Faculty of Sexual & reproductive health; able to perform intrauterine techniques and insert subdermal implants; attended STI foundation course; they rotate to GU medicine for 4-6 months, supported by personal TNA, and undergo training under supervision of a GU medicine consultant.  
Nursing staff have portfolios of evidence of training, reviewed at an annual PDR; quarterly training within the Board plus protected learning time.  
Recently introduced a mandatory speciality training programme.  
NHS Fife was commended for outreach work with GP practices. | For primary care staff - survey in 2007 highlighted the need for training for GPs and practice nurses. NHS Fife has since delivered training and teaching to primary care staff. Support for primary care staff from sexual health services.  
Training to primary care staff includes:  
- clinical updates to GP, practice nurses, pharmacists and others  
- GP core education programme  
- practical training for doctors for the Faculty of Sexual & reproductive health  
- IU techniques and subdermal implant training at CASH clinics or GP practices |
| Forth Valley              | Jul-11         | Met    | provides training to central specialist sexual health staff on a regular basis, with monthly lunchtime sessions. Also evening and full day training sessions have been developed to overcome problems attending lunchtime sessions.  
Central staff updated by email - other staff can access info on the staff shared drive.  
speciality doctors in sexual health are assessed against the West of Scotland speciality doctor competencies.  
West of Scotland SHMCN has a shadowing scheme to allow sharing of ideas and practice.  
STI Foundation and Diploma of the FSRH available from neighbouring NHS Boards, training priorities are identified as part of the appraisal process. TNA also developed for primary care healthcare providers; analysis of this was used to inform structure and content of proposed training and education programmes to maintain and develop core skills in the provision of sexual and reproductive health care. | Primary care staff are supported by the recently updated primary care sexual health guidance. They receive updates and undertake sexual health training through a tailored programme. |
| Greater Glasgow & Clyde   | Apr-11         | Met    | supports health professionals providing sexual health interventions to demonstrate knowledge gained from post reg courses and develop within their role.  
Sandyford is the GGC sexual health clinic - accredited by the Royal Colleges for postgrad speciality study in SRH and GU medicine.  
Hold weekly in-house teaching and training sessions covering a range of disciplines.  
Sandyford is accredited by the Royal Colleges for post grad training in SRH and GU medicine. It follows the NES national competency standards for nurse training and career framework for nursing in SRH.  
Involved in the West of Scotland MCN, and has led to revision and sharing of information protocols and training for staff; competence development and regional roadshows for non-clinical SH staff.  
Sandyford is accredited for Educational Providers Accreditation Scheme Scotland. Each professional group within primary care is required to adhere to codes of practice set by regulatory bodies (NMC, GMC) | It supports improvements in clinical standards by providing internal and external training events for primary care and acute providers. Provides training events for primary care staff. |
<table>
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<tr>
<th>NHS Board</th>
<th>date of report</th>
<th>status</th>
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<tbody>
<tr>
<td>Grampian</td>
<td>Jun-11</td>
<td>Met</td>
<td>ensures that all staff providing sexual health interventions are appropriately skilled and demonstrate knowledge gained from CPD. Training audit was conducted in 2008. NHS Grampian has developed its own certificate in sexual health, offered particularly to primary care practitioners. Have been commended for acknowledging the importance of primary care in delivering sexual health services, and in targeting for LARC training, at remote and rural areas, areas with limited access to contraception or high levels of deprivation. Practitioners need to complete refresher training after 5 years. Robust training programme for specialist staff. All nurses have annual PDR to discuss training needs. Audit workshops are held to discuss improvements and address training needs. Training is fully funded to reduce barriers to access. Recognition of the importance of partnership work in delivering sexual health services, supported by ongoing training and development.</td>
<td>NHS Grampian certificate can be used to obtain more detailed knowledge on sexual health interventions and can act as a refresher for professionals to ensure they remain up to date and competent. Deliver training to community nurses in substance misuse services to fit contraceptive implants. Midwives and health visitors are being trained in fitting LARC to target young mums.</td>
</tr>
<tr>
<td>Highland</td>
<td>Apr-11</td>
<td>Met</td>
<td>healthcare professionals are supported to gain post reg training &amp; development opportunities. No TNA carried out, but training needs have been identified. Learning needs are detailed in PDPs. All sexual health staff receive alcohol brief intervention training. Nurses have undertaken post grad studies in SRH; medical staff have undertaken STIF course; admin staff have attended minute taking courses, STI surveillance system coding days and observational visits to other depts. Board provides annual Diploma of the FSRH and STIF. Brook Highland has been working to develop a staff development plan for 2010-2014, considered a good model to ensure staff development needs are captured. TNA will be undertaken by Mar 2011.</td>
<td>Annual sexual health update training day offered to all health professionals, well attended, including by GPs, but not mandatory.</td>
</tr>
<tr>
<td>Lanarkshire</td>
<td>Jun-11</td>
<td>Not met</td>
<td>NHS Board provides a significant amount of training to specialist sexual health staff, system in place to identify training needs of this staff group. CPD session run for one morning every fortnight covering a range of topics. TNA has been conducted to identify training needs of core and sessional staff. Have undertaken training with specialist services including women’s health unit, practice nurses and community pharmacy staff. Board compiles an annual training summary of relevant training provided by sexual health, sexual health promotion staff and third sector organisations. This contains a summary of the content of the training, who delivers it and frequency. Encompasses a wide range of staff from GPs and primary care practitioners to sexual health staff, midwives and youth workers.</td>
<td>Has been limited success engaging GPs in training. Board is encouraged to adopt a formal and systematic approach to scheduling and delivering training for primary care and GPs.</td>
</tr>
<tr>
<td>NHS Board</td>
<td>date of report</td>
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<td>Summary of review findings</td>
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<tr>
<td>Lothian</td>
<td>Aug-11</td>
<td>met</td>
<td>provides a large number of opportunities for further training for health professionals providing sexual health services. Chalmers Sexual and Reproductive Health Centre recently opened. Specialist staff has protected learning time and in-house training; specialist medical nursing and clinical support staff have one to one meetings with managers to assess training needs. Provide training for many different health professionals including GPs, practice nurses, midwives, health visitors and school nurses. Empower management system is used to record training needs of staff across the NHS Board, but not in primary care.</td>
<td>Annual update is provided for primary care, always well attended, with the most recent attended by almost half of the 126 GP practices in Lothian. Recent practice nurse survey is still being analysed.</td>
</tr>
<tr>
<td>Orkney</td>
<td>Sep-11</td>
<td>Not met</td>
<td>offers various training events to staff involved in delivering sexual health services such as STI Foundation Course and chlamydia updates. TNA undertaken in 2011, but resulted in ad hoc training events rather than a programme of training. Disparity between independent and Board appointed GP practices in support for training and services offered. Level of expertise of GP depends on level on appointment.</td>
<td>sexual health service organised training for GPs and practice nurses in partner notification in 2010, attendee numbers were low. Regular email newsletter sent out to GP practices from the lead clinician provides updates on guidelines, training and local developments. GPs are able to contact specialist services for help and advice.</td>
</tr>
<tr>
<td>Shetland</td>
<td>Sep-11</td>
<td>Not met</td>
<td>comprehensive induction for all staff includes topics relevant to sexual health such as confidentiality; staff in sexual health and wellbeing clinic also have local induction. External trainers provided STI foundation course and family planning training to GPs, practice nurses and other healthcare providers in 2007.</td>
<td>local training has been provided to practice nurses by a GP with special interest in gynaecology and sexual health, e.g. to increase the provision of LARC in community settings.</td>
</tr>
<tr>
<td>Tayside</td>
<td>May-11</td>
<td>Met</td>
<td>systems are in place to ensure staff are appropriately trained and have access to ongoing support to maintain their skills. Developed a set of core competencies for medical staff based on the objectives created by the west of Scotland MCN. Local standards have also been agreed for each band of nursing based on NES competencies. Also used for identifying training needs. Healthcare assistants involved in triaging patients undergo significant amount of training with the senior charge nurse. Local induction for sexual health staff includes admin &amp; clerical staff. Specialist services also provide significant amount of training to primary care staff.</td>
<td>Annual update days held with primary care professionals address a broad range of subjects; training is supported by protocols, referral pathways and patient group directives. Developing a training programme for Midwives</td>
</tr>
<tr>
<td>NHS Board</td>
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<td>Summary of review findings</td>
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<tr>
<td>Western Isles</td>
<td>Aug-11</td>
<td>not met</td>
<td>Induction programme for all staff within the Board includes child protection, chaperoning and confidentiality. Training advertised on NHS Board learning network. Concerns that low number of cases seen could impact on staff skills. No evidence that all staff competencies are up to date, no refresher courses undertaken by staff.</td>
<td>10 GPs trained in LARC. 4 GPs have diploma in SRH. 3 GPs attended STI foundation course. 1 GP undertaken training at Sandyford (NHSGGC) 8 staff members including community nurses &amp; midwives participated in sexual health course at University of Abertay, Dundee.</td>
</tr>
</tbody>
</table>
### B. Sexual Health Strategies by Board

<table>
<thead>
<tr>
<th>NHS Board</th>
<th>Documents reviewed</th>
<th>Sexual health training for primary care and community based staff</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ayrshire &amp; Arran</strong></td>
<td>NHS Ayrshire &amp; Arran Sexual Health Strategy 2011-2016</td>
<td>The new strategy lists one of the achievements since 2005 as being the development and implementation of workforce skills training programmes. Actions for delivering the new strategy build on this, with a specific action to deliver staff training programmes on sexual health in a range of settings.</td>
</tr>
<tr>
<td><strong>Borders</strong></td>
<td>Borders sexual health annual report 2011/12 September 2012</td>
<td>Some training is provided for primary care staff through visits to general practice teams, and STI training for GP registrars. Regular GP update newsletters are produced, along with study half days for GPs.</td>
</tr>
<tr>
<td><strong>Dumfries &amp; Galloway</strong></td>
<td>Sexual Health and Wellbeing strategy for Dumfries and Galloway 2007-2010</td>
<td>Training in the strategy relates mainly to health improvement, although one of the potential problems in delivering the actions is identified as the capacity of staff to undertake the work, including time to attend relevant training. There is no mention of training specifically for primary care staff.</td>
</tr>
<tr>
<td><strong>Fife</strong></td>
<td>The strategy document was not easily accessible on the internet; minutes from strategy groups are available online Fife Health and Wellbeing Plan 2011-2014</td>
<td>Includes sexual health, in a health improvement capacity. Some training is provided for this, although it is not clear who the intended audience is.</td>
</tr>
<tr>
<td><strong>Forth Valley</strong></td>
<td>Forth Valley Sexual Health Strategy 2006 to 2011 Sexual Health training needs analysis (Primary care) 2010</td>
<td>Family planning services provide training and updating for general practitioners and nurses. Training and education is covered in one section of the strategy and includes clinical skills training, generic staff training and training providers, stating the importance of coordinating the various training opportunities available within the Board. Four action points relate to training, including primary care staff, including detailed clinical skills requirements at tiers 2 and 3. Competencies for non-specialist sexual health care in primary care are listed, covering sexually transmitted infections, contraception and reproductive health, special issues/groups and practice/admin issues. Not clear who has completed this or how it has been used.</td>
</tr>
<tr>
<td><strong>Greater Glasgow &amp; Clyde</strong></td>
<td>Sexual Health Strategy 2005 NHSGGC sexual health planning framework update 2011-2012 Sexual and reproductive health in primary care: guidelines Sept 2010</td>
<td>A Sexual Health Promotion Trainer is employed to provide training to primary care practices, amongst other groups, to complement the clinical training offered by Sandyford. The strategy indicted that a training needs analysis of primary care staff had recently been completed. The planning guidance states that there is an increased emphasis on moving routine sexual health services to primary care from Sandyford. This document provides a number of guidelines that support the provision of high quality sexual health</td>
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</tbody>
</table>
services within Primary Care. Training is available to all GP practices within the Board to support the guidelines. The guidelines include identifying the sexual health learning needs of all staff.

<table>
<thead>
<tr>
<th>Area</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Grampian</strong></td>
<td></td>
</tr>
<tr>
<td>Sexual Health Network Education group – remit and aims</td>
<td>Remit is to provide recommendations to the Sexual Health Network Executive on the development and sustainability of training and education in sexual health to all professionals delivering sexual health across the sexual health network. Includes a number of courses aimed at professionals with general sexual health remit including admin and reception staff and primary care staff. Areas covered include signposting to local sexual health services; gender based violence training; access to RCGP introductory certificate in sexual health; selected FSRH e-learning modules; fast track LARC training for GPs and nurses; Diploma in sexual and reproductive health (DFSRH) for GPs and other doctors; sexual health network diploma for nurses; and a series of locally held sexual health workshops delivered free for doctors and nurses providing sexual health advice and treatment. Includes developing programmes of clinical and non-clinical training, primary care staff are not highlighted specifically within this. The training strategy within Grampian has been driven by national policy and also by local training needs audits undertaken in 2008. The strategy takes account of gaps identified, including cost, location and availability.</td>
</tr>
<tr>
<td>Training Guide for Sexual Health 2011-12</td>
<td></td>
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<tr>
<td>Workplan for 2011-2012</td>
<td></td>
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<tr>
<td>Grampian Sexual Health and Blood Borne Virus Strategy 2011-215</td>
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</tr>
<tr>
<td><strong>Highland</strong></td>
<td></td>
</tr>
<tr>
<td>The Highland Council: Second Highland Sexual Health Strategy Sept 2006</td>
<td>Multi agency sexual health strategy – does not make any mention of training primary care staff.</td>
</tr>
<tr>
<td><strong>Lanarkshire</strong></td>
<td></td>
</tr>
<tr>
<td>Lanarkshire sexual health strategy and action plan 2005-2008</td>
<td>The action plan lays out specific training for GPs and practice nurses, with one plenary session planned. A number of other training sessions around awareness and attitudinal training are mentioned, targeting the general health workforce. The strategy also highlights the need for a review of education, training and support available to members of primary health care teams.</td>
</tr>
<tr>
<td><strong>Lothian</strong></td>
<td></td>
</tr>
<tr>
<td>2011-2016 Lothian sexual health and HIV strategy</td>
<td>Although support for delivering services through primary care is mentioned, the strategy does not cover training for primary care health staff. “No specific body has a responsibility for delivery of sexual health training for primary care in Lothian. There is evidence across the UK that practice nurses may be delivering sexual health interventions without specific training. We have been working with the Family Planning service and GUM to offer teaching and training for primary care staff on sexual health issues.”</td>
</tr>
<tr>
<td>SEXUAL HEALTH AND THE LOTHIAN CHPS Report by Dr Ewen Stewart, August 2010</td>
<td></td>
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<tr>
<td><strong>Orkney</strong></td>
<td></td>
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<tr>
<td>A sexual health and relationships strategy for Orkney 2005</td>
<td>Little mention about training for primary care staff; the main training focus is on education and health promotion, and multi-agency training on sexual health and relationships. However, the strategy does advocate sharing sexual health and wellbeing</td>
</tr>
<tr>
<td>Geographical Area</td>
<td>Reference</td>
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<tr>
<td>Orkney Blood Borne Virus (BBV) Sexual Health Action Plan 2008-2011</td>
<td>Information amongst health professionals, through professional development and training, to overcome some of the challenges faced by health professionals, especially in the more remote practices, when dealing with issues they may only see occasionally in the course of their work. The action plan states that the lead clinician will ensure an audit of training needs is undertaken, with plans to address emerging issues. The key action in relation to training is about ensuring a confident and competent workforce, including clinical and non-clinical staff. To address this a STIF course and DFFP Sexual and Reproductive Health theory course delivered to Primary Care and hospital based staff April 2008 and a Training Needs analysis being undertaken.</td>
</tr>
<tr>
<td>Shetland</td>
<td>Sexual Health in Shetland annual report 2010-11 August 2011</td>
</tr>
<tr>
<td>Tayside</td>
<td>Tayside Sexual health and relationships strategy – enhancing sexual health and wellbeing for all April 2005</td>
</tr>
<tr>
<td>Western Isles</td>
<td>The Western Isles Sexual Health Strategy 2007-2012</td>
</tr>
</tbody>
</table>
C. Sexual Health Questionnaire

The University of Worcester is conducting a survey on behalf of NHS Education for Scotland to explore the sexual health training and development needs of the primary care and community health workforce. This is to enable the implementation of ‘The Sexual Health and Blood Borne Virus Framework 2011-2015’.

This questionnaire is being sent to key stakeholders involved in the development and implementation of sexual health strategies across Scotland. It aims to provide an overview of the current training provision and requirements of healthcare practitioners involved in delivering sexual health services in a primary care and community setting.

Please answer all the questions as fully as possible. The questionnaire will take approximately 5-10 minutes to complete.

Section 1: Background Information

Please provide some background information about yourself:

1. What is your gender?
   - Male ☐
   - Female ☐

2. What is your Job title?

3. Number of years in post:

4. Which health board do you work within?
   - Ayrshire and Arran ☐
   - Borders ☐
   - Dumfries and Galloway ☐
   - Fife ☐
   - Forth Valley ☐
   - Grampian ☐
   - Greater Glasgow and Clyde ☐
   - Highland ☐
   - Lanarkshire ☐
   - Lothian ☐
   - Orkney ☐
   - Shetland ☐
| Tayside | ☐ |
| Western Isles | ☐ |
| Other (please specify) | ☐ |

5. Which of the following groups do you work with to help deliver sexual health services? Please tick all that apply.

- GP’s
- General practice nurses
- Public health nurses-school nurses
- Public health nurses – health visitors
- Midwives
- Healthcare support workers
- Other (please specify)

---

**Section 2: Identifying training needs**

6. How are the training needs of the primary care and community workforce identified? Please tick all that apply

- Staff meetings
- Personal development review
- Training needs analysis
- Existing training programme
- None of the above
- Other

7. How are primary care and community based staff informed about relevant training opportunities? Please tick all that apply.

- Email
- NHS/network websites
- Newsletters
- Staff meetings
- Adverts/Flyers
- Personal development review meetings
- None of the above
- Other (please specify)

8. Has a sexual health training needs analysis been completed in your area in the past 5 years?

- Yes ☐
- No ☐
If Yes, were the training needs of the primary care and community health workforce highlighted in the training needs analysis?

Yes ☐ No ☐

**Section 3: Current training provision**

9. Is there a structured programme of sexual health training in place for the following groups?
   Please tick all that apply.
   
   - GP ☐
   - General practice nurses ☐
   - Public health nurses – School nurses ☐
   - Public health nurses – Health visitors ☐
   - Midwives ☐
   - Receptionists ☐
   - Health care support workers ☐

10. Which of the following deliver sexual health training to primary care and community staff in your area? Please tick all that apply.

   - GP’s ☐
   - Consultant’s ☐
   - Nurse’s ☐
   - Home NHS Board ☐
   - Neighbouring NHS Board ☐
   - Managed clinical network ☐
   - Professional organisation (e.g. RCN, RCGP) ☐
   - Higher Education Institution (e.g. University) ☐
   - Other (please specify) ________________________________

11. For each of the training providers identified in the question above, in which locations do they provide training? Please tick all that apply.
12. For each of the training providers identified, which groups do they provide training to? Please tick all that apply.

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<tr>
<th>Provider Type</th>
<th>GP Practice</th>
<th>General Practice Nurses</th>
<th>Public health nurses – School nurses</th>
<th>Public health nurses – health nurses</th>
<th>Midwives</th>
<th>Receptionists</th>
<th>Health care support workers</th>
<th>Not Applicable</th>
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<tbody>
<tr>
<td>GP’s</td>
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<td>Consultant’s</td>
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<td>Nurse’s</td>
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<td>Home NHS Board</td>
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<td>Neighbouring NHS Board</td>
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<td>Managed clinical network</td>
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<td>Professional organisation (e.g. RCN, RCGP)</td>
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<td>Higher Education Institution (e.g. University)</td>
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<td>Other (please specify):</td>
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</table>

13. To what extent do you agree with the following statements?

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Uncertain</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
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</thead>
<tbody>
<tr>
<td>Sexual health training for primary care and community health staff is currently a priority in my area</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Sufficient resources for training in sexual health are available to meet the needs of primary care and community health staff</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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</tr>
<tr>
<td>The current training programme meets the needs of primary care and community staff in delivering sexual health services</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>All primary care and community health staff (generic and specialist) receive training related to sexual health at induction</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Uptake of training in sexual health amongst the primary care and community health workforce is well monitored</td>
<td>☐</td>
<td>☐</td>
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</tbody>
</table>
Primary care and community health care staff have the opportunity to specialise in sexual health

Section 4: Gaps in training

14. What would you consider to be the three main gaps in training for the sexual health primary care and community workforce to be, in terms of skills and competencies?

1. 

2. 

3. 

Section 5: Areas for further improvement

15. On a scale of 1 -5 (where 1 = Not at all, and 5 = A lot) please rate the extent to which each of the following is a barrier to training for primary care and community health care staff:

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<thead>
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<th></th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
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<tbody>
<tr>
<td>Time</td>
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<tr>
<td>Clinical commitments</td>
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<td>☐</td>
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</tr>
<tr>
<td>Lack of protected time</td>
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<tr>
<td>Other training needs taking priority</td>
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<tr>
<td>Lack of funding</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Lack of appropriate content in training sessions</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Availability of staff to provide training</td>
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<td>☐</td>
<td>☐</td>
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<tr>
<td>Location of training</td>
<td>☐</td>
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<tr>
<td>Access to IT</td>
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<td>☐</td>
<td>☐</td>
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<tr>
<td>Staff on part time contracts</td>
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<tr>
<td>Timing of training courses</td>
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<tr>
<td>Other (please specify)</td>
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</tbody>
</table>

Section 6: Emerging good practice

16. Please provide any further comments or suggestions about the development and training need of the primary care and community health workforce with regards to sexual health including any good example of good practice.
17. This survey is part of a larger piece of research to help us identify the development and training needs of the primary care and community health workforce with regards to sexual health in NHS Scotland. The next stage of the research will be to conduct interviews with key stakeholders, to explore some of the issues around training needs in more depth. If you would be willing for a researcher to contact you at the interview stage please provide your contact details below.

Name: 

Email Address: 

Telephone No: 

Thank you for taking part
D. Interview schedule: sexual health scoping study

Introduction

Thank you for agreeing to take part in this research. My name is (...) and I am from the University of Worcester. We are undertaking a scoping study on behalf of NHS Education for Scotland to get a better understanding of the development needs of the primary care and community health workforces with regard to sexual health. This is to support the successful implementation of ‘The sexual health and blood borne virus framework 2011-15’ published last year.

There are a number of topics I’d like to cover, looking at your understanding of the current sexual health training provision for the different primary care and community health practitioner groups, where you think the gaps in provision exist and how this can be addressed.

The interview will be recorded, and transcribed for analysis, although any direct quotes used in the final report will be anonymised. Are you happy with that?

Have you got any questions before we start?

Background information

• Can you confirm which health board/organisation you work for?

• What is your role? Can you describe this role in relation to training, sexual health services, and primary care/community health?
  
  o Which primary care or community health practitioners do you work with?

• Number of years in post?

Identifying training needs

• Thinking about the primary care and community workforce, how are their training needs identified in relation to sexual health?
  
  o Is this reviewed on a regular basis?

• How is this information collated? What action is taken as a result of identifying these training needs?

• How is training in sexual health commissioned for primary care and community health staff?

Current training provision

• What are the priorities in your area in terms of providing training for primary care and community health staff?

• Is there a structured programme of sexual and reproductive health training in place for primary care and community based staff?
For which practitioner groups?
- When is this available (e.g. induction/annual refresher course)?
- What skills/competencies/knowledge area does it cover?
- Is any sexual health training compulsory?

Who are the key training providers for primary care/community health staff in relation to sexual health?
- Prompt: local staff, local/neighbouring NHS Board, MCN, university, professional body

How is uptake and effectiveness of current training opportunities monitored for primary care and community health staff (Board and/or local level)?

What resources and support are available for staff to assist with training and development, and keeping up to date with changes in policy and practice?
- Access to books, journals and latest research; WiSH and other websites for professionals; Newsletters; peer support; attendance at workshops/conferences
- Protected time for training and development
- Use of career frameworks/ CPD portfolios for sexual and reproductive health to inform training and development

Is there a managed clinical network on sexual health in your area? What do they do to support primary care/community health staff?

Do you provide, or are you aware of, training for partner agencies working with primary care/community based health staff to deliver sexual health services? (e.g. LA’s, third sector organisations)

Gaps in training
- How well do you think the current training provision meets the needs of primary care and community based staff in relation to delivering sexual health services?
  - Are there issues for particular practitioner groups or geographical locations?
- What do you think are the main gaps in training provision and uptake for primary care and community staff, in terms of their skills and competencies?
- What changes do you think should be made to improve access to or availability of sexual health training?
- What additional resources would be needed to implement improvements in training for primary care and community staff?

Barriers and facilitators to promoting training
• What are the main facilitators in ensuring primary care and community health staff can access appropriate training in sexual health?

• How do you think the planning and delivery of training could be developed to better meet the needs of the primary care and community health workforce?

• Are there any barriers that prevent primary care and community based staff from accessing appropriate training?
  
  o Prompt: Anything specific to the area or setting in which they are working (e.g. remote/rural/island; population demographics; staffing levels)

Identifying good practice

• Are you aware of any examples of good practice for engaging the primary care and community workforces in sexual health training in your area?
  
  o What are they, how do they work, key success factors?
  
  o How could these be rolled out to other areas?

We have covered all the points I wanted to raise with you. Have you got any additional comments/thoughts about the current training needs of primary care and community health staff in relation to sexual health that you would like to add?

Thanks and close interview