

**Promoting Chlamydia screening through
providers in Norfolk and Waveney:
Final project report**

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1. Introduction

Chlamydia is the most common sexually transmitted infection in the UK, with up to one in 10 sexually active 15-24 year olds testing positive. The Government has committed to a major long-term public health prevention and control programme – the National Chlamydia Screening Programme (NCSP) – to offer opportunistic screening and thus impede its spread.

The Norfolk and Waveney Chlamydia Screening Programme (NWCSP) is charged with meeting targets of 25% (in 2009/10) of 15-24 year olds accepting an opportunistic Chlamydia screening test. In 2007/08, just 3.8% of the target audience were screened.

A DH/NMSC social marketing learning demonstration project has been established in Norfolk and Waveney to support the local screening programme. A multi-stranded programme is underway to encourage uptake across the range of providers, but with a particular focus on healthcare and youthwork settings. Qualitative research has indicated a number of reasons for providers being reluctant to fully participate, including their comfort, confidence and skill in discussing sexual health issues with young people. DH/NMSC therefore asked COI to:

- Review existing training materials that aim to encourage and equip providers to offer Chlamydia screening and other related sexual health services (Phase A)
- Develop a ‘gold standard’ training course to help providers develop the confidence and strategies to introduce the topic of Chlamydia screening (Phase B)
- Provide recommendations, based on the project learning, on who should deliver the intervention on an ongoing basis and how it might be communicated to target audiences (Phase C).

This report summarises the project’s key activities, findings and outcomes.

2. Phase A

Phase A activities comprised:

- literature review of evidence of:
 - what works in increasing uptake of Chlamydia testing
 - what works in encouraging professionals to offer Chlamydia testing
 - what works in developing professionals’ communication skills
- review of national and local resources
 - NCSP resources for professionals
 - Local sexual health and communications training
- Close study of specially-commissioned qualitative research reports into the attitudes, preferences and learning needs of local (potential) providers by:
 - Define research
 - Kate Melvin research

The key findings are summarised below.

2.1 Which factors obstruct or encourage opportunistic Chlamydia screening in general practice?

The available evidence cites the most significant barriers to the promotion of opportunistic screening in general practice as:

- Lack of knowledge of the epidemiology and presentation of Chlamydia and the benefits of testing
- Assumption that it mainly happens elsewhere
- Low general interest in sexual health
- Lack of time and competing external demands
- Worries about discussing sexual health
- Lack of guidance
- Lack of incentives
- Understanding of when and how to take specimens

2.2 What part is played by communication skills?

GPs' skills and confidence in communicating the screening offer is critical to improved screening rates, so we also reviewed the growing body of work on communication skills in general practice. The BMA has identified a series of personal barriers to effective communication:

- lack of skill and understanding (of what good communication involves)
- undervaluing communication and giving it lower priority than the treatment of illness
- lack of inclination – due to lack of time, lack of confidence, worries about confidentiality or reluctance to deal with uncomfortable topics
- human failings, such as tiredness or stress
- inconsistency in providing information
- language competence

These barriers are in part rooted in medical training which has traditionally equipped doctors within a strictly medical model that emphasises authority and certainty and neglects psychoosocial issues, partnership and negotiation. It is also exacerbated by the very real pressures of modern clinical practice, including lack of time, constant interruptions and competing priorities.

The last decade has seen significant effort to improve clinicians' communication skills, with the following posited as key benefits:

- opportunities for professional growth
- expansion of remit, knowledge and skill base
- reduced complaints and litigation
- less wasted time
- improved outcomes
- improved clinician-patient relationships

2.3 And other professionals?

Most of the evidence focused on doctors and, to a lesser extent, nurses – the relationship between GPs and practice nurses and the nature of GP leadership was a significant factor for the latter. There is less evidence available on opportunistic Chlamydia screening in community pharmacies. However, there is significant potential in this sector and large numbers of community pharmacists are already offering Chlamydia screening. Many of the enablers and blocks cited in relation to GPs may also be pertinent for pharmacists. The literature cites the following factors as blocks:

- inadequate financial incentives
- confidentiality
- time and pressure of work
- availability of trained pharmacist

And the following as enablers:

- accessible (convenient location, no need for an appointment)
- heavily used by young people
- pharmacists often not seen as authority figures but in service role – may be perceived as more friendly and non-judgmental

2.4 What works in providing learning interventions to health professionals?

There is good evidence on what works in teaching communication skills to doctors, and in promoting clinical behaviour change. In teaching communication skills, the following methods have been found to be effective:

- providing evidence of current deficiencies in communications, reasons for them, and the consequences for patients and doctors
- offering an evidence base for the skills needed to overcome these deficiencies
- demonstrating the skills to be learned and eliciting reactions to these
- providing an opportunity to practise the skills under controlled and safe conditions
- giving constructive feedback on performance and reflecting on the reasons for any blocking behaviour

Learning interventions that aim to secure clinical behaviour change are more effective if they:

- are multi-faceted, reinforcing and reaffirming messages through a number of channels
- encourage active learning through role-playing and small group discussions
- affirm existing skills and experience and focus on enhanced professional expertise
- use clinical peers as role models, pressure and support
- are reinforced over time
- 'speak doctors' language' – use language, evidence and references that are appropriate for the audience

2.5 Qualitative research in Norfolk

The two reports from Define and Kate Melvin identified a range of factors which contribute to providers' low Chlamydia screening rates; in this document we will only focus on those that are within the scope of this intervention. The studies used different samples, and their findings are not identical, but some clear findings emerged. The most significant of these were:

- Opportunistic screening is an 'add on' that is not integrated within workplace processes or normalised within the professional culture. Extra effort is needed to remember and process it.
- GP practices and pharmacies are often not places where either young people or health professionals expect or want to talk about sex.
- Many health professionals are uncomfortable with raising Chlamydia with a young person, especially if the presenting issue is not sex-related, for fear this may be perceived as judgmental, intrusive or inappropriate. However, there is also some discomfort with the universal offer as an erosion of clinical judgment.
- Scarcity of time is a key issue, and the fear that the screening offer may open a can of worms that will expose them as out of their depth. Linked to this is some resentment of this as yet another 'dumped' central Government initiative, and remuneration issues.

- There may be a lack of urgency: there was some scepticism about the evidence of health impact, and awareness that in any case others are also making the offer.

However, there was acceptance of the issue as important and some enthusiasm for learning, and doing, more. There was acknowledgement of the value of training, though this was sometimes won through prolonged discussion of the skills and knowledge required for effective practice in this area.

2.6 Analysis of learning needs

The studies illustrated the following learning needs:

1. Improving knowledge
2. Tackling perceptions and attitudes
3. Defining and developing the required skillset

Improving **knowledge** (in order to increase motivation to act, and offer providers the necessary understanding to discuss the issues with the target group) included the need to improve understanding of why Chlamydia is being targeted specifically, and how the screening programme fits with work on other infections, plus the rationale for the target audience and evidence on what works – in other words, the need to explain and justify why we are taking this approach at this time and how we can be confident it will work. This area falls within the remit of the CSO's induction session for new sites, so was not the focus of our proposed intervention.

Perceptions that needed to be addressed included:

- that discussion of screening requires a specialist knowledge and skillset in sexual health
- that the offer requires a lengthy conversation, full sexual history taking and/or result in other issues being raised which cannot be resolved within the consultation period
- that it is inappropriate to talk about Chlamydia screening unless the individual has presented on a sexual health related issue
- that making the offer will be received as judgemental or inappropriate, so impacting on provider-patient relationship or provider reputation

Tackling these perceptions is key to increasing buy-in and motivation to be an active contributor to the screening programme. In addition, issue of professional roles: pharmacists tend to perceive their role is in treatment rather than screening, while GPs may feel less motivated to adopt clinical practices that are routine and do not require clinical judgement.

The specific **skills** required include:

- how to deal with accompaniers (e.g. parents, interpreters, children)
- how to introduce the subject/transition from a conversation on an unrelated issue
- how to handle questions, concerns and objections
- how to close off the conversation
- dealing with groups, overcoming peer-group influences, and using peer group positively
- any requirement for different approaches when dealing with young people of different ages or sexes.

The greatest issue appeared to be having the confidence to raise the subject with a good understanding of how to handle the conversation in an efficient manner which still reassured the patient.

The potential participants in Kate Melvin's study voiced clear preferences for the learning intervention, including:

- convenient venue, preferably within the workplace
- opportunity to discuss case studies
- not using role play
- an opportunity to share ideas and experiences with other colleagues
- networking opportunities with providers
- some form of accreditation
- dynamic and inspiring facilitator

There was a strong preference for face-to-face training, despite the known difficulties in attracting healthcare professionals (particularly GPs) to attend sessions. There are a range of practical issues including providing backfill if training takes place during normal working hours. For some providers (e.g. nurses) there may be difficulty in obtaining permission to attend.

From this review we developed a proposed approach with criteria specifying that the intervention must be:

- **accessible** (in location, timing, language and learning styles)
- use participants' own skills and experience to lever their **confidence**
- provide a **quick and easy** offer process while honouring clinical judgment
- offer strategies for initiating **conversations** around sexual practice
- offer opportunities to **problem-solve** specific issues
- address the **realities** of integrating opportunistic screening into daily practice
- affirm **multi-agency, multi-disciplinary** working
- aim to create **behaviour change** that can be evaluated
- be **clinically sound**
- support existing **local arrangements and relationships** of the CSO
- be suitable for **application (with minimal adaptation)** to other professional groups in other parts of the country.

We attempted to meet all these criteria during the subsequent development of the learning resource.

3. Phase B

The learning achieved from Phase A, combined with the advice and recommendations of the steering group, clarified the tasks for Phase B as:

- **developing a workshop** aimed at improving providers' skills and confidence in discussing Chlamydia screening with young people
- **pre-testing** the study day in Norfolk and Waveney
- **piloting** the study day in Norfolk and Waveney
- **evaluating** the pilot

3.1 Workshop development

The aim of the workshop was to help participants develop their:

- **understanding** of young people's attitudes to sexual health and in particular to Chlamydia and Chlamydia testing
- **skills** in initiating the offer of opportunistic Chlamydia testing and in managing any subsequent discussion, and
- **judgment** in responding appropriately and effectively to a range of situations

The workshop was designed to complement, rather than replace, the existing *Chlamydia: Are You Getting It?* half-day course that is offered locally and the dedicated 'how to' induction sessions that

the CSO health advisors offer to new providers. Their focus is on the practical information necessary to facilitate the screening offer. The focus of this study day is on skills, confidence and behaviour.

We considered the possibilities of different **learning formats**, including e-learning and other forms of self-directed distance learning, which offer the advantages of fitting into individuals' working lives and competing priorities, and which are also easy to roll out and replicate elsewhere. However, they are reliant on high levels of pre-existing individual motivation and commitment and are the most likely competing priority to be squeezed out if time are short. Our target audience for this intervention is very busy, with many competing priorities, and needs to be persuaded and motivated to accord higher priority to Chlamydia screening. In addition, individual learning makes it harder to capture the benefits of peer sharing and support, and to practise new skills with others, all of which are important tools for this topic. Finally, we were mindful of the very clear preference of the potential participants surveyed by Kate Melvin for face-to-face learning. So we chose to proceed with a traditional group workshop with no more than 12 (preferably 6-8) participants.

It was agreed early on that the **length** of the workshop should not exceed three hours. This does not give much time for learning, practising and refining communication skills, but it was felt to be unrealistic to expect health professionals to give up more than one half-day. Further, we developed a modular workshop design that allows the three hour bloc to be split into three one-hour modules that can be delivered separately within regular professional/practice update meetings. We feel that one 3-hour bloc is preferable to three one-hour blocs, but it was felt important to be flexible and work with the grain of health professionals' working lives.

The **content** of the workshop included:

- identification of the benefits of screening – for their patients, and for themselves
- generating insights into young people's values, beliefs and behaviours in relation to sexual health and screening
- inviting them to share their own values and beliefs and how these may impact on clinical behaviours
- exploration of the multiple layers within a Chlamydia conversation and ways of keeping these appropriate and effective
- case studies to develop their skills in particular situations e.g. child protection, men who have sex with men

We worked through this content using a mix of **learning methods**, including presentation, facilitated discussion, group role play, case study work in pairs, and asking participants to identify critical success factors in effective implementation. The learning was supported with handout material. The two most important learning methods used were:

- **group role play**, which allows the capture of at least some of the benefits of individual role play, but feels safer and more acceptable within a small group that will not have time to build up trust within a half day session
- development of '**scriptlines**' for participants to use when making the screening offer, responding to the insight that *beginning* the conversation is the single hardest thing about it, and that rote learning and practising an opening line until it becomes almost automatic is a powerful weapon in overcoming provider reluctance.

We also needed to be clear from the start about what the workshop wouldn't cover and couldn't solve: issues around remuneration, length of consultation appointments, overload of central targets, laboratory processes, and incentives to participation. CSO presence or easy access is very helpful in managing these issues effectively.

Underpinning the workshop content was a clear understanding of **benefits and costs** associated with offering Chlamydia screening, which were cited overtly and covertly through the workshop to secure engagement and retain focus. The transaction with the target audience is that increased offering of opportunistic screening will deliver the following benefits:

- Chlamydia is widespread; treatment is easy; you can make a real difference to your patients
- You will enjoy improved outcomes (and extra income) for very little effort
- Here is an opportunity to enhance your professional skills and transfer that benefit across to other sexual health issues
- You will win more trusting and open relationships with your young patients
- The costs are minimal: this is quick and easy, and CSO will support you all the way.

The **facilitators** for both pre-test and pilot were Tara Kaufmann and Andy Mazzei. Tara is a strategic consultant at COI with a background in sexual health and training. Andy is an advanced practitioner in the sexual health promotion unit at Norfolk PCT, and a highly experienced sexual health trainer. We would have liked to include a clinician, but none was available. Nevertheless, we felt Tara and Andy comprised a strong team, with useful complementarity in national and local knowledge.

3.2 Pre-test

The pre-test took place on 24th September 2009, in Norwich. There were 7 participants: 1 GP, 1 pharmacist, 1 drugs worker and 4 nurses, recruited by the CSO Solutions Group and participants from Kate Melvin's study. We would have preferred more participants, and in particular more GPs, but it was a real struggle to recruit those we did get.

Due to time restrictions and the need to create sufficient time to allow for full feedback and discussion, the pre-test group did not 'run' the entire workshop. Instead, we presented an overview of the entire programme then tested the most important exercises with them, eliciting their feedback all the way (see Appendix A).

Feedback was collected throughout the session, in final discussion at the end, and in happy sheets. Encouragingly, the participants were very enthusiastic about the workshop – particularly the group role play – and provided lots of useful suggestions.

3.3 Pilot

The pilot workshop took place on 7th October 2009, in Norwich. There were 6 participants: 2 GPs, 3 nurses, and 1 CSO. Again, we struggled to recruit sufficient participants and were very disappointed not to achieve higher numbers. However, the six that were there were motivated and enthusiastic and helped create an enjoyable three hours.

Appendix B shows the workshop agenda.

3.4 Evaluation

The workshop was evaluated in two ways:

1. **Reaction** was measured with individual evaluation forms
2. **Learning** was measured with subjective self-assessment of skills and confidence pre- and post-workshop.

Both evaluations produced very positive feedback (see Appendix C for full evaluation report). It is, however, important to be clear about the limitations of these. These include:

- **Sample limitations.** If resources had allowed, we would have piloted the workshop with more participants, in different areas, and with different professional groups.
- **Behaviour change.** We would have liked to measure impact on behaviour and screening uptake in the longer term (3 and 6 months post-learning) but local resources and the timescale of the project did not allow for this.

Our evaluation, then, can be said to show positive indications that the workshop has value and was appreciated by participants, but its effectiveness still needs to be tested through further replication and assessment of impact on behaviour and outcomes.

4. Phase C

The last phase of the project comprised two activity streams:

- Development of **resource pack**
- Development of **recommendations**

4.1 Resource pack

In order to facilitate easy replication, we developed a resource pack that can be downloaded from the internet and used in a range of contexts. It comprises:

- A front cover sheet, with DH and NSMC branding
- An introduction sheet, explaining why the resource has been developed and how it can be used
- A workshop plan, setting out the workshop agenda and aims
- Trainers' notes, with detailed advice on how the workshop can be delivered for maximum impact
- Powerpoint presentation, which can be adapted to meet local needs
- A handout on Chlamydia and the NCSP
- A handout on evidence-based insights into young people and Chlamydia
- An evaluation sheet

4.2 Recommendations

Learning from the process of developing and delivering the workshop was captured and distilled into a number of key recommendations for future development and replication. These are detailed below.

4.2.1 Delivery implications

1. Don't take for granted providers' confidence in their communications skills and ability to discuss sexual health issues effectively. The policy of opportunistic testing has relied heavily on the argument (and fact) that screening can be offered quickly and simply without the use of clinical expertise – in short, almost anyone can do it – but it is important to acknowledge that this is still easier when providers are (a) confident about when a fuller conversation is required, and (b) able to handle that conversation should it be necessary.
2. Therefore, all local CSOs should be encouraged to offer some kind of communications skills training as an integral part of their support offer to local providers.

3. The workshop works best with 'natural teams' of professionals who understand and share each others' work ethos, systems and experiences. So it should ideally be delivered to either uniprofessional groups or multiprofessional groups that naturally work together e.g. staff teams from GP practices.
4. Facilitators should be experienced and highly skilled to handle some of the issues and tensions that may arise when discussing sexual health. Ideally, at least one of them should have clinical credibility, such as a GP champion.
5. The biggest obstacle by far to successful replication is the challenge of getting participants to attend. There is also a strong likelihood – as happened at our pilot – that the people most likely to come along are the people already highly motivated to perform a high level of screening – in other words, the risk of preaching to the converted. There is no easy answer to this, but it is strongly recommended that recruitment starts early, is intensive, focuses on personal connection and uses incentives (including financial incentives) where possible.
6. It is vital that this workshop is 'owned' by the CSO and integrated within their activities. It should not be seen as a stand-alone intervention, and will be more effective if it is integrated and complemented by personal contact and ongoing support.

4.2.2. Communications implications

1. We need to acknowledge that the messages of the NCSP programme are not always coherent with the professional view – for example, BASHH were reluctant to accredit the workshop because of their view that only professionals fully qualified in sexual health medicine should offer Chlamydia testing. Professional pride is – naturally - a significant factor in motivating clinicians to develop their practice and doctors may not be highly motivated by something that 'anyone can do it – even a dump bin'. Yet GPs' motivation and leadership is essential to engaging someone – anyone – within GP practices to offer testing. We need to communicate with providers in a way that promises the resource output will be low but also affirms their professional expertise and promises some professional gains (e.g. greater skills in discussing all aspects of sexual health, more trusting relationships with young patients).
2. Among the pre-test and pilot participants, there was high acceptance of pro-active Chlamydia screening but not of making an opportunistic offer in non-sexual health contexts. The argument for offering testing to *all* young people in *all* contexts has not yet been won, and needs to be more effectively communicated.
3. A number of the participants really struggled to make the offer without a 'hook' or reason: e.g. 'well, since you're talking about your sexual relationship...' This is really problematic in terms of making the offer non-judgemental. In fact, some participants felt they had to be convinced that someone was at risk themselves, before making the offer. If health professionals cannot quite rid themselves of the notion that the Chlamydia screening programme is for promiscuous young people, we cannot expect young people to take the offer positively. This aspect has to be communicated very carefully and effectively.
4. A key issue that came up again and again was the difficulty of offering screening to a young person accompanied by their parent, partner or child. Providers really need help finding ways of dealing with this – either in making the offer (appropriately) anyway, or finding alternative ways of getting the information across.
5. The question of resources is always significant: health professionals are usually very hard pressed and reluctant to open the door to what might be a long conversation. Frankly, some might not welcome more open, trusting relationships with young people – it might be easier to

keep them distant and secretive! The case needs to be made of the longer-term resource savings of high testing rates ('a stitch in time...').

6. The resource will be used locally if it is communicated through, and owned by, CSOs. They need to perceive this resource as a tool which they can use repeatedly and in a range of contexts with potential providers in order to motivate their participation, and with current providers in order to improve screening rates.
7. Important messages for CSOs on this resource are:
 - Research has found that communications skills and confidence is a significant issue among providers and potential providers
 - This is a cost-effective intervention that will help increase confidence and skills
 - It will also help engage local providers with you and with the local programme
8. Important message for potential participants are:
 - This is an opportunity to make a real difference to your patients/clients, enhance your professional skills and transfer that benefit across to other sexual health issues
 - You will gain more trusting and open relationships with your young patients
 - We are asking for only three hours of your time. In return, we will give you the skills to be really effective in meeting your Chlamydia targets, and we will provide you with ongoing support afterwards.

5. Conclusion

As always at the close of a project, it is helpful to reflect on what worked well, what didn't, and what could be done differently next time. For this project, the key achievements were:

- We captured good quality evidence on what works in learning approaches to improving health professionals' skills and confidence in discussing Chlamydia with young people
- That evidence was translated into a workshop that combined brevity with depth and was very well received by participants
- Usefully, it identified that the target audience is not just potential providers, but current providers who do not fully accept or endorse opportunistic screening for *all* young people, and who can be helped to engage with that and so increase their screening rates
- Resource materials were developed that can be easily adapted and used elsewhere

What could have worked better?

- The main disappointment was the low number of participants recruited, despite great efforts to do so. This was partly due to the inherent problems of getting health professionals to attend non-essential training, and perhaps partly due to local conditions and the existing relationships with CSO and providers.
- There were multiple clients in this project, and our relationship with CSO was rather distant (for a number of unavoidable reasons). If we were doing the project again, I would like to resource more attention to the relationship with the CSO, which is critical for continued local implementation.

- The resource does need testing in different settings and with different participants (including different professional groups) and resources did not allow for this within this project.
- We were not able to organise accreditation within the lifetime of this project, though initial work was done on this and it is to be hoped that at some stage this will happen.

Above all, perhaps, it is important to acknowledge that this project was an NHS pilot and, like all NHS pilots, its longer-term value is dependent on resources, relationships and continued replication. We hope it will prove a useful contribution to the continuing work to improve Chlamydia screening rates across the country.

Tara Kaufmann
21st December 2009

APPENDIX A

Chlamydia conversations: skills and insight for discussing testing with young people Pre-test meeting agenda: 1st draft

10: Welcome and introductions

Presentation: explanation of **what we're doing and why**:

- NCSP
- NSMC/DH pilot with Norfolk & Waveney
- Define and Kate Melvin studies
- Rationale and aims of this intervention

Discussion: participants' views and experience

Presentation of **programme** and explanation of how it will work

Create the need: facilitated discussion of participants' likely perceptions of benefits of offering Chlamydia screening

11: Coffee

What makes an effective conversation? Small group discussion to identify the elements of an effective and acceptable conversation about Chlamydia screening – feedback about what was identified and whether this was an effective exercise. Followed by 'envelope' exercise to identify personal/professional blocks and challenges – how did this feel? Will participants disclose? Is it safe enough?

What young people want and need. Short presentation synthesising national evidence on young people's values, beliefs and behaviours in relation to sexual health and screening. Discussion: does this chime with their experience? Will participants respond to this?

Special situations. Discuss what situations pose a particular challenge, or are hardest to 'get right'. In small groups look at case studies: have we picked the right situations/people? Do they sound authentic and relevant? What are we looking to get out of them? Is there anything missing?

Critical success factors. Facilitated discussion on:

- What 'comfort factors' need to be in place on the day
- What negative attitudes/responses may need to be anticipated
- What may impede translation of training into performance
- What is reasonable to ask/exhort in terms of changed behaviour
- Have we missed anything?
- Have we got anything wrong?
- Any other advice for us?

Wrap up and thanks

APPENDIX B

Pilot workshop plan

Session 1: Chlamydia and you

- 10: Introductions
- 10.10: The benefits of Chlamydia screening – for you, for young people, for the NHS
- 10.20: What makes an effective conversation about Chlamydia? (And what doesn't?)
- 10.40: Overcoming your own blocks and barriers

Session 2: Understanding young people

- 11: What young people want and need
- 11.15: Creative conversations: developing scriptlines

Session 3: Challenges in practice

- 12: Special situations: testing scriptlines in challenging contexts
- 12.35: Critical success factors
- 12.50: Evaluation

- 1: Close

APPENDIX C

Evaluation

The Chlamydia workshop was evaluated in two ways:

3. **Reaction** was measured with individual evaluation forms
4. **Learning** was measured with subjective self-assessment of skills and confidence pre- and post-workshop.

Ideally, we would have measured impact on behaviour and screening uptake in the longer term (3 and 6 months post-learning) but local resources and the timescale of the project did not allow for this.

The participants

There were five participants: two GPs and three nurses (one of the nurses worked in a drug and alcohol service, the other two in general practice). They were recruited to the pilot through their participation in Kate Melvin's research and this may have skewed the sample in favour of those interested enough in Chlamydia to agree to make time to be interviewed. Indeed, the participants' self-assessment of their skills and confidence in relation to Chlamydia screening indicates that they were already motivated, experienced, and aware.

One participant self-assessed her skills and confidence as very low. Unfortunately, she was not available for the post-workshop evaluation, though the final evaluation will include her.

In addition to these five participants, a CSO staff member joined the pilot workshop and completed an evaluation form.

Reaction to workshop

At the workshop close, all six participants completed an evaluation form. This reminded them of the learning objectives:

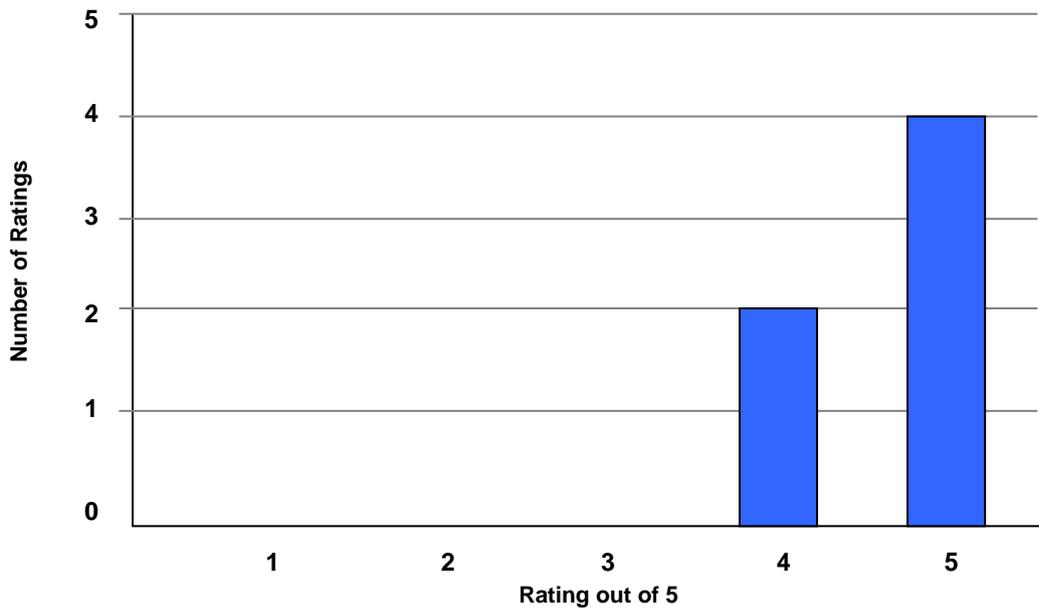
"The learning objectives of this workshop were to help participants develop their:

- **Understanding** of young people's attitudes to sexual health and in particular Chlamydia and Chlamydia testing
- **Skills** in initiating the offer of opportunistic Chlamydia testing and in managing any subsequent discussion
- **Judgment** in responding appropriately and effectively to a range of situations and needs"

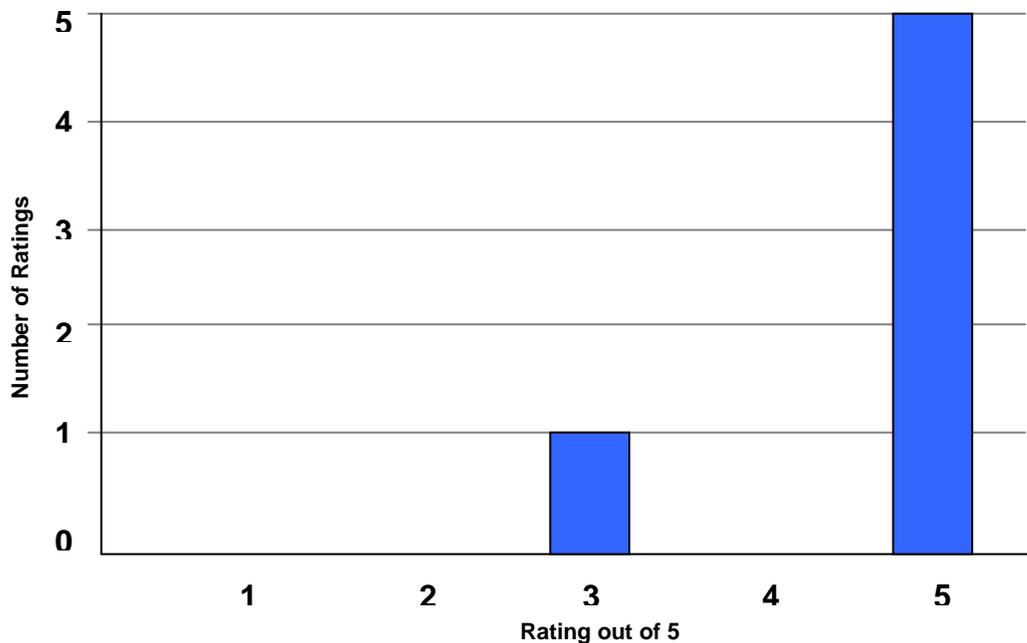
Participants then responded to the following questions:

What is your overall rating of how well these objectives were met? (On a scale of 1 to 5, 5 being highest)

Overall rating of how the objectives were



To what extent was the course relevant to your job?



Which discussion was the most valuable for you? Why?

“Discussing the things that work and don’t work with bringing up the subject of Chlamydia -> very helpful to relate to our practice.”

“Awkward scenarios. Other people’s input and ideas.”

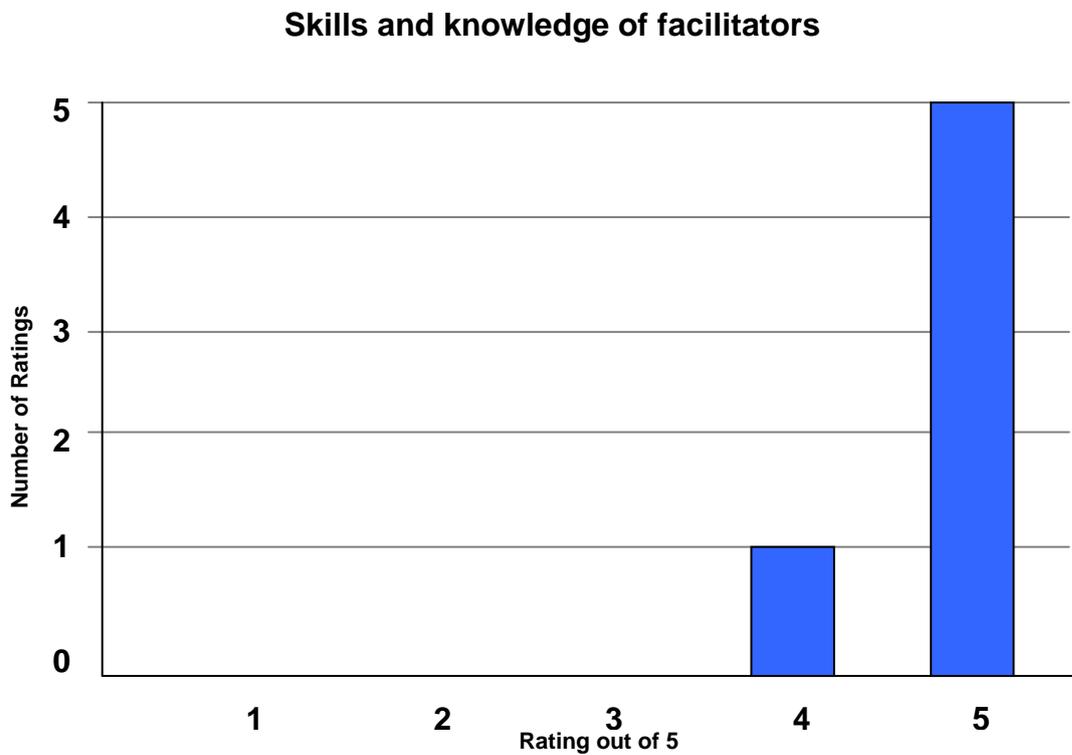
“Interactive sessions – Very helpful to share feelings/issues with colleagues.”

“All.”
“All of it.”
“Found both very valuable.”

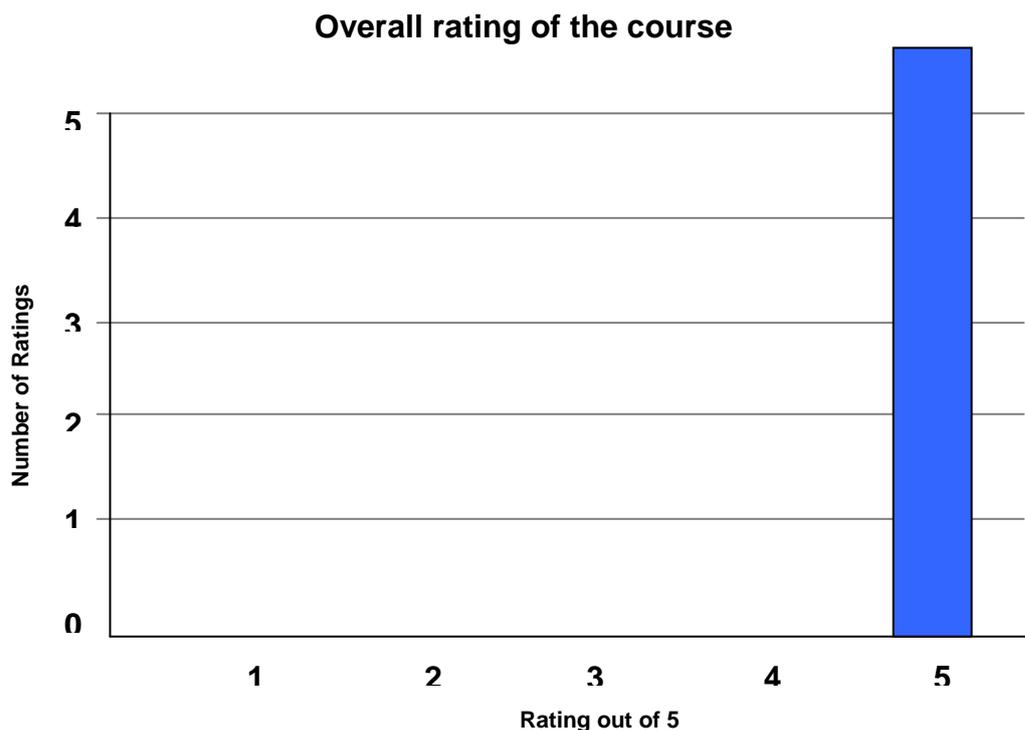
Which discussion was the least valuable for you? Why?

“Possibly the role play but all of the programme was very helpful.”
“All valuable.”
“None really.”
“Nil.”
“None.”
“Scenario, role play good, way presenting involving group.”

How highly did you rate the skills and knowledge of the facilitators?



What is your overall rating of the course?



How could it be improved?

“All very good and enjoyable.”

“No significant changes.”

“Decision on how training programme is cojoined with CSO induction training.”

Self-assessment of learning

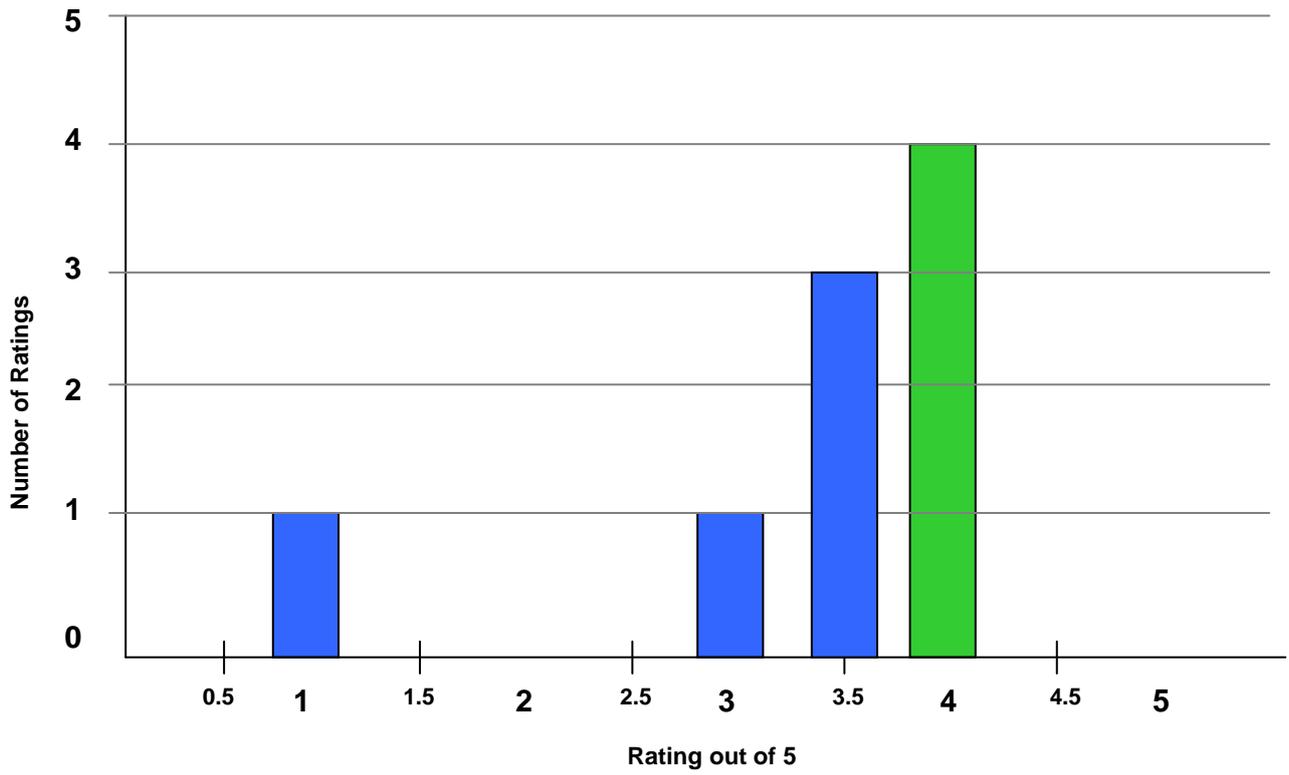
One week before the workshop, the facilitator contacted all participants by phone to discuss their needs and expectations. She also asked them to assess, on a scale of 1 to 5 (5 being highest), their own:

- Understanding of young people’s attitudes to sexual health in general and Chlamydia in particular
- Skills in initiating the offer of Chlamydia screening
- Ability to respond appropriately and effectively to a wide range of situations that may flow from the Chlamydia offer

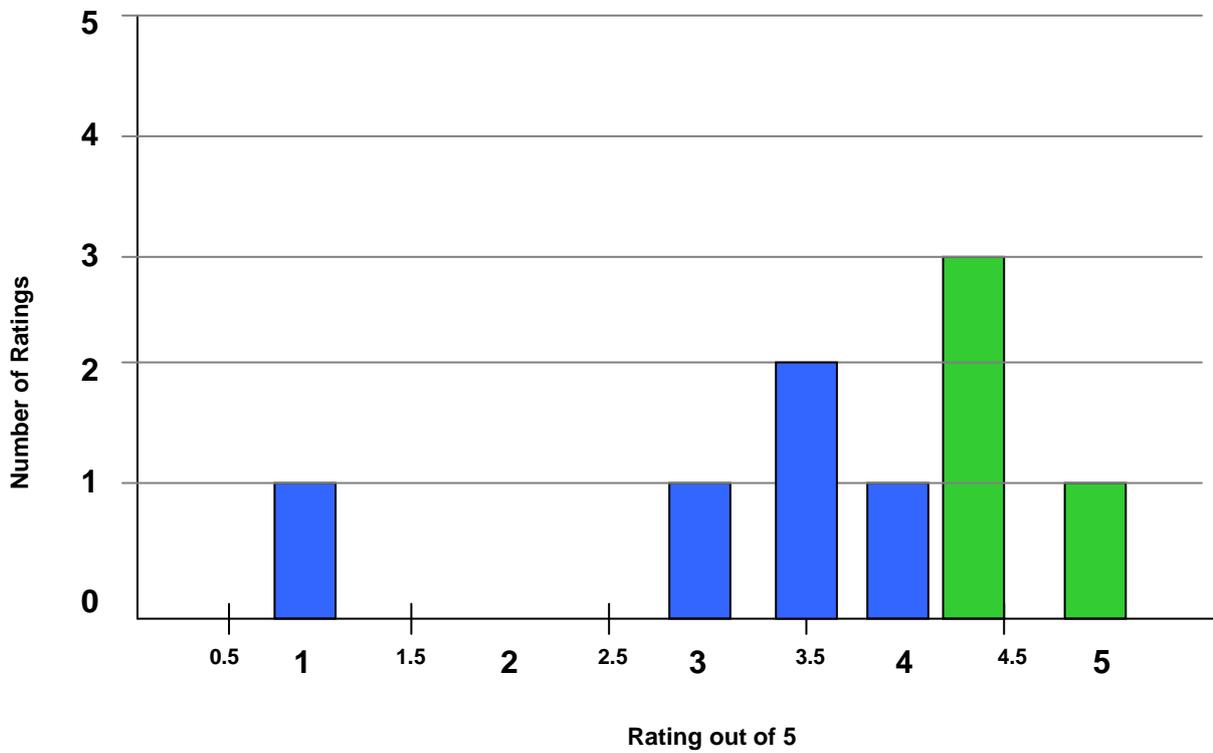
Two weeks after the workshop, the facilitator made contact again to ask participants to self-assess against the same questions. The results are illustrated below: the ‘before’ responses are represented in blue, and the ‘after’ responses in green.

NB. It should be noted that one participant was not available for the post-workshop contact; the same participant who self-rated the lowest pre-workshop.

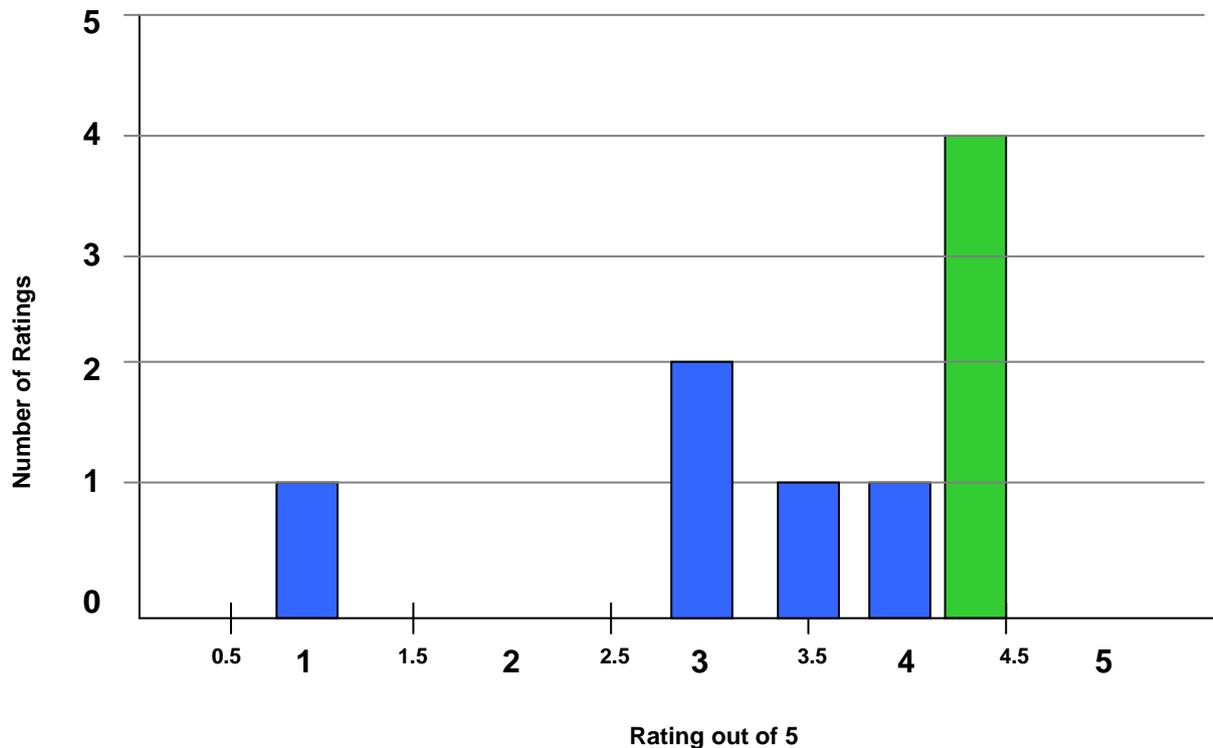
Understanding of young people's attitudes to STI's & Chlamydia



Skills in initiating the offer of chlamydia screening



Ability to respond appropriately & effectively to a wide range of situations



“I did find the afternoon enjoyable and extremely useful.”

“The training session was effective and I think would be extremely useful if it was offered to all the screening sites”

“I found the session aboutf thinking of difficult situations and how you would approach them very good.”

“I think it would be a mistake to try and shorten the training session too much as it does work very well as you have it currently.”

“The role play was really good.”

“It was great to hear from people who work with young people all the time.”

“Really good to learn more about what makes young people tick. Sometimes we assume they know stuff, and when you dig deeper - they don't.”

“I thought it was very good, and it was fun as well. It's really nice to come away from a training event feeling upbeat, rather than the usual, 'Oh, more work to do'.”

“It was nice having the doctors there as well. I really enjoyed their different perspective.”

“A useful tool for passing on information and getting people on board. I would recommend it to my colleagues.”

“The workshop was brilliant and fun as well as informative.”