NATIONAL COLLABORATING CENTRE FOR **MENTAL HEALTH**

The Sexual and Reproductive Health Rights, Inclusion and Empowerment (SHRINE) programme

An evaluation of pilot sexual and reproductive health clinics at the Bethlem Royal Hospital. Report.

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1. Executive summary

The need for sexual and reproductive health clinics for people with severe mental illness

People with severe mental illness (SMI) experience many inequalities in their physical health, including sexual and reproductive health (SRH). Historically people with SMI have not had full access to SRH services, which has resulted in higher rates of sexually transmitted infections (STIs), sexual dysfunction and unplanned pregnancy. In addition, patients may be hesitant to use traditional SRH services due to anticipated stigma or issues accessing services that are off site or have long waiting times. These factors create a pressing need for accessible and on-site SRH services for people with SMI.

The Sexual and Reproductive Health Rights, Inclusion and Empowerment (SHRINE) programme was a King's Health Partners initiative, comprising a multidisciplinary group of SRH and psychiatric healthcare professionals from London trusts. The SHRINE programme sought to deliver and evaluate SRH care for targeted communities in London boroughs.

The pilot

A pilot of monthly on-site SHRINE clinics at the Bethlem Royal Hospital in South London was carried out from June 2022 to February 2023.

Eight wards participated in the pilot, which involved:

- staff training, to increase staff confidence in discussing SRH
- quality improvement (QI) support for the participating wards, to increase referrals to the SHRINE clinics
- an evaluation of the pilot (reported in this document).

Who was involved

The pilot was funded by the London Vision Partnership Community Board. The delivery of the pilot was a collaboration between the SHRINE programme, including SHRINE's programme manager and doctors, South London and Maudsley NHS Foundation Trust, and the National Collaborating Centre for Mental Health (NCCMH), who provided QI support and evaluated the pilot. The NCCMH prepared this report.

Clinic visits

During the pilot, there were 51 referrals to the on-site SHRINE clinics. This was a 5.8-fold increase from before the pilot, when SRH clinics were off site – this is of some consequence because of the travel time involved previously, and the cost to the organisation.[a] Of these referrals, six participating wards were referring to SRH clinics for the first time.

Previously, most referrals to the off-site SRH clinic had been for contraception. During the pilot, referrals were made more equally for multiple SRH concerns, including STI testing and sexual function. This suggests that during the pilot, a wider range of concerns were being addressed for patients that may not have been addressed when the clinics were off site.

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a To leave the ward, the patient needs to be granted Section 17 leave, and staff need to be available to escort the patient to the appointment. The round trip may take several hours, depending on the distance between the ward and SRH clinic.

What went well

In addition to the increased uptake and provision of SRH care, patients and staff provided positive feedback on the SHRINE clinics in the patient and staff focus groups conducted for this evaluation. A strong theme in both groups was a desire for the clinics to be a long-term feature of the wards.

Fifteen patients provided feedback after their clinic appointment and all feedback was universally positive, either agreeing or strongly agreeing that they felt comfortable speaking about their SRH, they were listened to and taken seriously, their needs were resolved and they understood what was explained to them.

A survey completed throughout the pilot showed that staff knowledge of SRH improved, with the percentage of staff who agreed or strongly agreed that they had good knowledge of SRH increasing from 53% at the start of the pilot, to 94% at the end.

What we learned

While staff knowledge of SRH increased, confidence to discuss SRH remained largely unchanged and the reported frequency of conversations on the ward decreased over the pilot. Results from one of the evaluative surveys also suggested that staff would feel more confident if they knew other members of staff were also having discussions about SRH, suggesting a collective effort is needed on a ward to change the culture.

The uptake of the QI support provided by the NCCMH was low. This included low attendance at learning sessions, limited uptake of coaching sessions offered to the wards and little testing of Plan, Do, Study, Act (PDSA) cycles on wards and data collection. Staff reported in the focus group that the busy nature of their work contributed to lack of engagement, plus the challenge of getting staff involved in the project.

What we recommend

The results of the evaluation show the benefits of providing on-site SRH clinics and therefore we recommend that on-site clinics are funded/provided in South London and Maudsley NHS Foundation Trust and introduced in other NHS mental health trusts across the country.

SRH can be challenging to discuss and it can take time for people to feel comfortable talking about it. Therefore, we recommend training for staff before the introduction of on-site clinics, together with safe spaces such as reflective practice to maximise the potential of on-site clinics and ultimately meet the physical health needs of patients.

Support from senior leadership in an organisation is key, both for securing funding and for supporting staff to increase their knowledge of and confidence in SRH.

2. Background

2.1. Context

People with SMI experience many health inequalities,[1] including difficulties addressing wider physical health needs.2 This is due in part to inequitable access to standard care for diseases associated with lifestyle factors, as well as reduced likelihood of being considered for screening services or baseline testing of factors such as blood pressure.[1]

One important aspect of physical healthcare that has been historically neglected in people with SMI is SRH care, despite the fact that they are often sexually active.[3,4] As a result of the lack of access to information and services needed to support choices around SRH, people with SMI are at high risk of STIs, sexual dysfunction and unplanned pregnancy.[3,5]

Mental health staff have been reported to be unsure of how to address SRH issues in patients with SMI due to inadequate knowledge, personal attitudes about sex, including how their professional role fits with sexual health concerns, and feeling uncomfortable discussing traditionally 'taboo' topics.[6] Patients may also be hesitant to use traditional SRH services due to anticipated stigma or issues accessing services that are off site and/or have long waiting times.

2.2. The SHRINE programme

The SHRINE programme is a King's Health Partners initiative, comprising a multidisciplinary group of SRH and psychiatric healthcare professionals from Guy's and St Thomas', King's College Hospital and South London and Maudsley NHS Foundation Trusts. The SHRINE programme, which is unique in the UK, aimed to address the disparity in SRH support for psychiatric inpatients by testing the feasibility and acceptability of providing on-site SRH care, using a human-rights based approach.

There were four key elements to the programme:

1. **Training for staff on SRH**
2. **Delivery of on-site SRH (SHRINE) clinics to patients on participating wards**
3. **QI support for each ward**
4. **Evaluation of the impact of the programme on staff and patients, to inform future changes and funding.**

The NCCMH provided the latter two elements of the SHRINE programme in the pilot that took place at the Bethlem Royal Hospital, which is part of South London and Maudsley NHS Foundation Trust.

2.3. Participating wards

Eight wards at the Bethlem Royal Hospital took part in the programme. This included a mother and baby unit (MBU)[b] and seven secure wards at River House for adults aged 18–65:

- Brook Ward: a male rehabilitation ward
- Chaffinch Ward: a male low secure pre-discharge ward
- Effra Ward: a male rehabilitation ward
- Norbury Ward: a male psychiatric intensive care unit (PICU)
- Spring Ward: a female assessment, treatment and rehabilitation ward
- Thames Ward: a male admissions unit
- Waddon Ward: a male forensic intensive psychological treatment ward.

b When the MBU was closed for renovation in December 2022, the trust was offered to have an alternative ward or unit take part in the programme. Ruskin Ward, a female ward in the Maudsley Hospital, therefore took part. They participated in some parts of the evaluation, but not all.

3. Methods

3.1. Overview

This section sets out the methods for the two elements of the SHRINE programme that were delivered by the NCCMH: (1) the QI support for wards, and (2) the evaluation of the pilot at the Bethlem Royal Hospital.

3.2. The QI approach

To support teams to deliver targeted SRH care to patients in a way that was feasible and acceptable, a QI approach was used. Each ward was offered regular support from a QI coach to progress the programme within their wards. This enabled staff and patients to take ownership, learn and shape the new approach being tested on their wards. The key elements involved in this process are described in the sections below.

3.2.1. Design session

A design session was held with staff from participating wards to explore the key topics or drivers that teams had to work on to ensure all patients in the participating wards were supported and encouraged to attend the SHRINE clinics. The session was delivered online with a total of six staff representing four of the participating wards.

The outputs from this session led to the development of a driver diagram (see Figure 1), which visually represents the theory of change – that is, what drives or contributes to the achievement of the programme aim. This was a helpful way to break down the aim into smaller topics and themes that staff felt were important to achieve the aim of the programme.

The group at the design workshop started to generate change ideas for each of the secondary drivers in the driver diagram. These were small changes that the wards could make to normalise conversations about SRH on the wards and increase referrals to the SHRINE clinics. QI coaches then continued these conversations when working directly with the wards to generate further ideas, which were collated in a change idea menu.

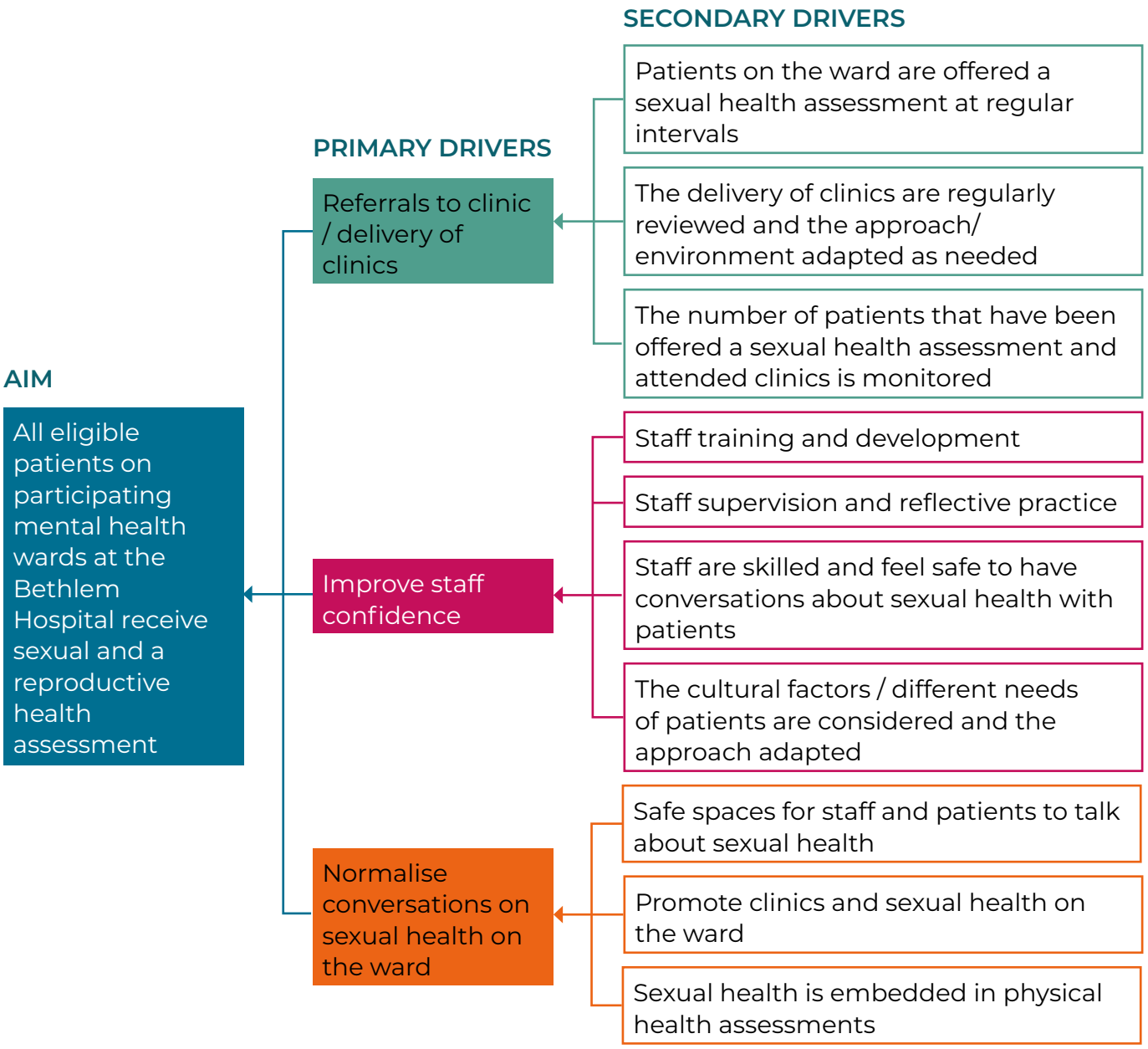

Figure 1: Driver diagram (theory of change) for the SHRINE pilot at Bethlem Royal Hospital

3.2.2. Coaching sessions

Each participating ward was asked to set up a core project team to manage the QI work. Project teams included a range of staff, such as ward managers, nurses, psychologists, activity coordinators and psychiatrists. Each team was allocated a QI coach to support them develop and progress their work. QI coaches planned to meet with project teams regularly (fortnightly) with the aim to:

- teach teams about QI methodology
- support teams to engage patients in their projects
- support teams to generate and test ideas using a PDSA approach and implement successful changes.

In addition, QI coaches organised and facilitated online monthly learning sets to bring teams together to share learning.

Due to the heavy workload and limited capacity of project team members on the wards, it was difficult to arrange project team meetings. QI coaches arranged one or two meetings with most teams, often with a small number of project team members attending, apart from the MBU team who met with their QI coach more regularly.

Other challenges in engaging staff in the secure wards at River House are explored in Section 4.

3.2.3. Learning sets

Between July and October 2022, four 1-hour learning sets were delivered virtually using Microsoft Teams. The learning sets aimed to bring together all teams taking part in the project to give updates on key elements of the work and progress from each team, to collaborate and to share learning. The sessions included:

- reviewing the theory of change and exploring the key elements teams had to work towards to achieve the aim of the project
- supporting teams with data collection
- presentations from the project's patient advisor, providing a patient perspective on SRH in secure services, and ideas to engage patients in SRH clinics
- space for teams to give updates on their projects, and to share challenges, ideas and suggestions with each other
- updates from the evaluation team, such as sharing the aggregated results from the staff survey.

An average of seven people from participating teams attended each learning set (with no attendance from patients).

3.2.4. In-person coaching sessions

Due to the low attendance at the learning sessions, and difficulty in engaging individual teams in project team meetings, in-person learning sessions were delivered at River House that brought staff together from all participating teams. Staff were also encouraged to support patients to attend the sessions. QI coaches also visited wards to meet with staff and patient groups, and raise awareness of the project.

A total of three in-person sessions were delivered between November 2022 and February 2023. The sessions lasted 2 hours and included:

- reflective sessions on why SRH is important for people with SMI and patients in secure settings
- training in QI
- support for teams to generate ideas to test in their wards to increase the number of patients on the ward who had their SRH needs met
- support for teams to develop their plans to test their ideas
- engaging patients from the participating wards, who were encouraged and supported to collaborate on the project, and to generate and test change ideas
- space for teams to give updates on their projects, and to share challenges, ideas and suggestions with each other.

An average of 12 people from participating teams attended each in-person session (including two to three patients per session). During these sessions, attendees generated several change ideas, which linked to drivers identified in the driver diagram (see Figure 1). A 'menu of change ideas' was created as a resource for teams to use during and beyond the project. Most ideas focused on normalising conversations about SRH, which was an area that staff and patients identified as needing improvement. Staff also identified training in SRH as key to becoming more confident and skilled to speak with patients about SRH and supporting them to have their needs met.

At the end of the project, the QI team carried out a final visit to River House, to speak with staff and patients about how they planned to continue the positive work of their projects. Some of the ideas shared involved embedding SRH in physical health, ward rounds and one to ones with patients, and including SRH as an agenda item in staff meetings.

3.2.5. Other events where the QI team promoted SHRINE

In addition to the in-person coaching sessions, QI coaches promoted the project, and raised awareness of the importance of addressing the SRH needs of patients in inpatient mental health settings, at the following events:

- Spring Ward's in-person development day, attended by around 30 ward staff including the multidisciplinary team.
- Brook Ward's in-person development day, attended by around 30 ward staff including the multidisciplinary team.
- A forensic teaching session delivered online, attended by around 80 people, comprising:
    - consultants
    - specialty and associate specialist doctors/core trainees
    - forensic specialty trainees

  From:
    - South London and Maudsley NHS Foundation Trust
    - Oxleas NHS Foundation Trust
    - South West London and St George's Mental Health NHS Trust.
    - Ruskin Ward's business meeting, attended by 8 ward staff.

3.3. Evaluation methods

The evaluation of the pilot aimed to examine the feasibility and acceptability of delivering targeted SRH care to inpatients on acute mental health wards and was conducted alongside the QI project.

3.3.1. SHRINE clinic referral and attendance data

Referral forms were used to indicate where a referral to the SHRINE clinic was needed. The referral forms contained information about:

- the referring staff member
- the ward

- the referred patient, including their:
    - gender
    - ethnicity
    - age
    - sexual orientation
    - mental health diagnosis
- reason for referral.

Additional information was provided by the SHRINE clinics, including the number of:

- patients assessed in the clinic per month
- non-attendances and reasons for these
- discussions had and subsequent actions taken about:
    - contraception
    - pregnancy testing
    - cervical screening
    - STI testing
- female patients offered counselling on available contraception choices and subsequent acceptance of a form of contraception
- pregnancy tests conducted and outcomes.

To explore changes to patterns in referral and SRH outcomes as a result of the SHRINE pilot, SHRINE clinic data were compared with details of referrals made for SRH prior to the pilot. The baseline (pre-SHRINE pilot) data detailed referrals made for SRH appointments over 250 weeks, between 21 August 2017 and 29 March 2022. The SHRINE clinic data covered referrals made over 40 weeks, between 6 June 2022 and 14 March 2023. Comparisons between baseline and SHRINE pilot data were made using Chi-squared tests of independence. Yates' continuity correction was used where sample sizes were large enough and Fischer's exact test where this was not the case.[7]

3.3.2. Staff SRH training experiences

Three training sessions were delivered to staff by a specialty trainee in SRH to support the implementation of referrals to SHRINE clinics. The three sessions were structured as follows:

1. A general session on the basics of SRH, provided to all wards, including Ruskin Ward.
2. A session focused on contraception for the MBU and the female ward at River House.
3. A final session focused on the male wards at River House, which included input from a lived experience advisor.

Details about the aims of the sessions are in **Appendix 1**.

Training feedback forms were provided to attendees at the end of the first session. The aim of the feedback forms was to determine the relevance of the training content, and give the opportunity for trainees to give any general feedback. The full feedback form is in **Appendix 2**.

3.3.3. SHRINE clinic feasibility

Staff survey

A staff survey was developed to assess levels of confidence, knowledge and previous experience discussing SRH with patients. It also examined the frequency that conversations about SRH were taking place, and whether these were being initiated by patients or staff.

The survey was administered to staff of the MBU and to River House at three time points (T):

T1: June 2022

T2: November 2022

T3: April 2023.

Because the MBU closed down before the T3 survey was conducted, MBU staff views are represented in the T1 and T2 surveys only. River House staff views represented in all three time points. The survey provided to staff at each time point is in **Appendix 3**.

Data were analysed using descriptive statistics, and changes in proportions of responses were described over the course of the programme. Statistical comparisons were not conducted, as responses were anonymous and therefore paired data across time points (responses provided by the same participant) could not be identified.

Normalisation of processes

A modified Normalisation MeAsure Development (NoMAD) questionnaire[8] was administered at the end of the project to staff at River House to assess the extent to which change ideas for increasing conversations with patients about SRH had been implemented into routine practice on the ward, how this had impacted on their work, and the extent to which they expected this to become a routine part of their job. The questionnaire consists of three overarching normalisation questions about familiarity with and normality of having conversations with patients about SRH. Response options ranged from 0 (not at all) to 10 (completely). There were also questions focused on the extent to which respondents agreed with each of the four normalisation process constructs:

1. **Coherence**, which facilitates 'sense-making' of the process of having conversations with patients about SRH.
2. **Cognitive participation**, which captures how invested and committed staff might be in having conversations with patients about SRH in practice.
3. **Collective action**, which refers to the actions taken by staff to promote (or inhibit) the practice of having conversations with patients about SRH.
4. **Reflexive monitoring**, which highlights the extent to which staff and services assess the effects of the new practice, appraise how it is working and update their practice accordingly.

A full version of the NoMAD questionnaire, adapted for this evaluation, is in **Appendix 4**.

Responses to the NoMAD questionnaire were summarised using descriptive statistics.

3.3.4. SHRINE clinic acceptability

Focus groups

Three focus groups were planned, with:

1. Staff who worked on the wards during the delivery of the SHRINE programme
2. Patients from Spring Ward (the female ward at River House)
3. Patients from male wards at River House.

These focus groups explored barriers and facilitators to having conversations about SRH, experiences of the SHRINE clinics, and experiences of the QI programme. Learning and ideas for improvement or change in the future were also discussed. The facilitators followed a prepared topic guide (see **Appendix 5**), although conversations were allowed to flow normally to ensure full coverage of themes important to staff. The sessions were recorded using a digital voice recorder, before being transcribed verbatim by a member of the research team.

Staff focus group

Staff who worked on the wards during the delivery of the SHRINE programme and who felt able to contribute to discussions about it were invited to participate in the focus group. Interested participants were provided with detailed information about the study before providing written informed consent to participate. The focus groups were conducted in person by an assistant psychologist and clinic nurse.

Patient focus groups

Patients who were (a) on the ward during the delivery of the SHRINE programme (regardless of whether they used the SHRINE clinics) and were (b) able to contribute to discussions about SRH were invited to participate in the focus group. Interested participants were provided with detailed written and verbal information on the study, and they provided written informed consent to participate. Consent was provided to a clinical psychologist and patient involvement manager, who also both conducted the in-person focus groups.

Analysis

Transcripts of the staff and the patient focus groups were analysed together, for an overview of differences and similarities in experiences between the two groups. The data were analysed deductively (with broad themes arising from the questions asked) and inductively (with subthemes arising directly from the data) using framework analysis[9] by one researcher. Impressions of themes noted by the facilitators were also considered when coding the data, to give an alternative viewpoint.

MBU staff experience survey

As the MBU was due to close before the staff focus groups were conducted, an additional survey was offered to staff asking questions similar to those planned for the focus groups. The form gave staff an opportunity to report the barriers and facilitators to providing SRH support to patients, and the effect that these had had. Staff were also asked about changes to conversations about and practices relating to SRH, including how they had integrated SRH support into their practice. The full survey for MBU staff is in **Appendix 6**.

Respondents were provided with a list of possible barriers and facilitators, derived from QI coaching sessions, learning sets and surveys. Respondents could select as many options from the list as were relevant. They were given the opportunity to expand on their answers, and explain how these facilitators and barriers helped or hindered their delivery of SRH care to patients.

Patient feedback forms

Questionnaires about patients' experience of the clinics were developed. The questionnaires included the wait time, how comfortable and respected patients felt, their understanding of any information and/or treatment provided, satisfaction and general feedback. Patients were also asked to recall who initiated the conversation about SRH that led to their referral to the SHRINE clinic. To gather the information, questionnaires used Likert scales, tick boxes and free text boxes.

Staff on the wards advised the research team that some patients were struggling to understand/fill in the feedback forms. Following this, a more accessible, easier-to-read version of the survey was created. Existing questions were also revised to make them easier to understand. Clinicians were advised to give people the version that they thought was most appropriate, following their visit to the SHRINE clinic.

Data from the feedback forms were summarised thematically, and responses using either the original or easier-to-read version were considered together.

A copy of the original patient feedback questionnaire, and the easier-to-read version, can be found in **Appendix 7** and **Appendix 8**, respectively.

4. Reflections and learning from the QI coaches

This section summarises some reflections and learning from the QI coaches who worked with the wards.

4.1. Change ideas

The QI coaches reported that participating wards tested some of the following change ideas:

- staff training on SRH
- having SHRINE champions on the wards
- discussing and promoting the SHRINE clinics at existing spaces on the ward such as community meetings, tea talks and therapy sessions
- posters to promote the SHRINE clinics
- asking patients about SRH on admission
- bringing the SHRINE clinics into everyday conversations on the wards
- doctors from the SHRINE clinics attending the ward during vacant clinic appointments.

As take-up of the QI support offered to the wards was low, additional ideas might have been tested.

4.2. Settings

The QI coaches noted a difference in the acceptability and referrals between the MBU and the secure wards. Staff from the MBU met with their QI coach and actively worked on their QI project until the unit's closure for renovation. However, the challenge of a secure setting was evident for the seven wards in River House. For example, in forensic services patients often have long lengths of stay, some with no leave and no opportunities to have an active sex life; and some patients have a history of sexual offending. It is therefore important to provide training and support that address the needs of patients in these settings, and that can help staff feel confident and safe to speak with patients about their SRH.

4.3. Staff training and support

The QI coaches observed that staff required training and support to have conversations around sexual health and wellbeing, and expressed they would benefit from having training around boundary setting.

4.4. Barriers to discussing sexual health

The QI coaches reflected that discussion of sexual health can be challenging for patients and for staff, due to it being a 'taboo' subject in some cultures. For some patients who have committed a sexual offence, talking about sex can be difficult, particularly if they want to move on from their past.

The coaches noted that some staff had reservations about engaging in the work due to a lack of confidence in starting conversations about SRH with patients, while female staff did not always feel safe talking about sexual health with male patients, in particular those with a history of sexual offending.

4.5. Quality Improvement

The QI coaches found that there was a less rigorous use of QI in supporting the wards than planned because staff did not have time to dedicate to the work. For a QI project to be successful, a project team needs to be in place, with representatives from staff from a range of roles, as well as patients. The team need dedicated time to develop their project, generate and test ideas, and come together regularly to discuss and progress their work. It is important that the team is supported by senior leaders in the organisation, who can help overcome barriers to the work and provide support when needed.

5. Evaluation: clinic data

This section presents the results of the evaluation of SHRINE clinic referral and attendance data, compared with baseline data, to explore changes to patterns in referral and SRH outcomes as a result of the SHRINE pilot.

5.1. Referrals

The baseline dataset included 56 referrals made over the course of 250 weeks while the SHRINE dataset included 51 referrals made over the course of 40 weeks. This resulted in a baseline average of 0.22 referrals per week compared with an average of 1.28 referrals per week during the SHRINE pilot, a 5.8-fold increase.

Most referrals in both groups came from the MBU (baseline: 83.9% of referrals; SHRINE: 43.1% of referrals). Seven of 11 wards did not refer any patients at baseline while only one ward did not refer any patients during the SHRINE pilot. More information on the number of referrals by ward is in **Appendix 9**.

Staff making referrals during the SHRINE pilot included consultants (N=16), nurses (N=13), deputy ward managers (N=9), senior house officers (N=3), core medical trainees (N=2), modern matrons (N=2), SHRINE specialist registrars (N=2), a lead consultant (N=1), a mental health nurse (N=1), a nursing associate (N=1) and a student mental health nurse (N=1). Data on staff making referrals were not collected at baseline.

5.1.1. Characteristics of patients referred

At baseline, 54 unique patients (out of 56 referrals) were provided with an appointment about their SRH. During the SHRINE pilot, 39 unique patients (out of 51 referrals) were provided with a SHRINE appointment. Table 1 describes the characteristics of the 93 unique patients at baseline and during the SHRINE pilot. Although there was no significant difference between baseline and the SHRINE pilot in age, there was a significant difference in gender between the two time points ($\chi 2=11.75$, $p=0.001$), with significantly more males being referred for SRH during the SHRINE pilot.

Table 1: Characteristics of patients referred for SRH at baseline and during the SHRINE pilot

Category	Subcategory	Baseline		SHRINE	
		N	%	N	%
Gender	Female	53	98.2	28	71.8
	Male	1	1.9	11	28.2
Age	21–30 years	14	25.9	11	28.2
	31–40 years	27	50	18	46.2
	41+ years	13	24.1	10	25.6

Category	Subcategory	Baseline		SHRINE	
Ethnicity	Asian British	3	5.6	2	5.1
	Asian other	0	0	2	5.1
	Black African	4	7.4	2	5.1
	Black British	12	22.2	4	10.3
	Black Caribbean	0	0	7	17.9
	Black Other	0	0	1	2.6
	Mixed White and Black African	0	0	1	2.6
	Mixed Caribbean	0	0	2	5.1
	Mixed White and Black Caribbean	0	0	1	2.6
	White British	16	29.6	12	30.8
	White other	8	14.8	3	7.7
	Any other ethnic group	0	0	1	2.6
Sexual orientation	Bisexual	0	0	3	7.7
	Heterosexual	32	59.3	34	87.2
	Unknown	22	40.7	2	5.1
Mental health diagnosis*	F10 to F19: Mental and behavioural disorders due to psychoactive substance use	NR	NR	3	7.7
	F20 to F29: Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders	NR	NR	15	38.5
	F30 to F39: Mood (affective) disorders	NR	NR	9	23.1
	F40 to F48: Anxiety, dissociative, stress-related, somatoform and other non-psychotic mental disorders	NR	NR	4	10.3
	F50 to F59: Behavioural syndromes associated with physiological disturbances and physical factors	NR	NR	1	2.6
	F60 to F69: Disorders of adult personality and behaviour	NR	NR	7	17.9

5.1.2. Reasons for referral

Reasons for referral are displayed in Figure 2. While most referrals at baseline were for contraception, referrals during the SHRINE pilot were more equally spread across multiple SRH concerns. The proportion of referrals for contraception was significantly higher at baseline compared with during the SHRINE pilot ($\chi 2=14.28$, $p<0.001$), while the proportion for STI testing ($\chi 2=11.18$, $p<0.001$) and other reasons (Fischer's exact test, $p=0.001$) was significantly greater during the SHRINE pilot.

'Other' referral reasons included information about SRH, concerns about heavy or irregular menstruation, and concerns about skin rashes.

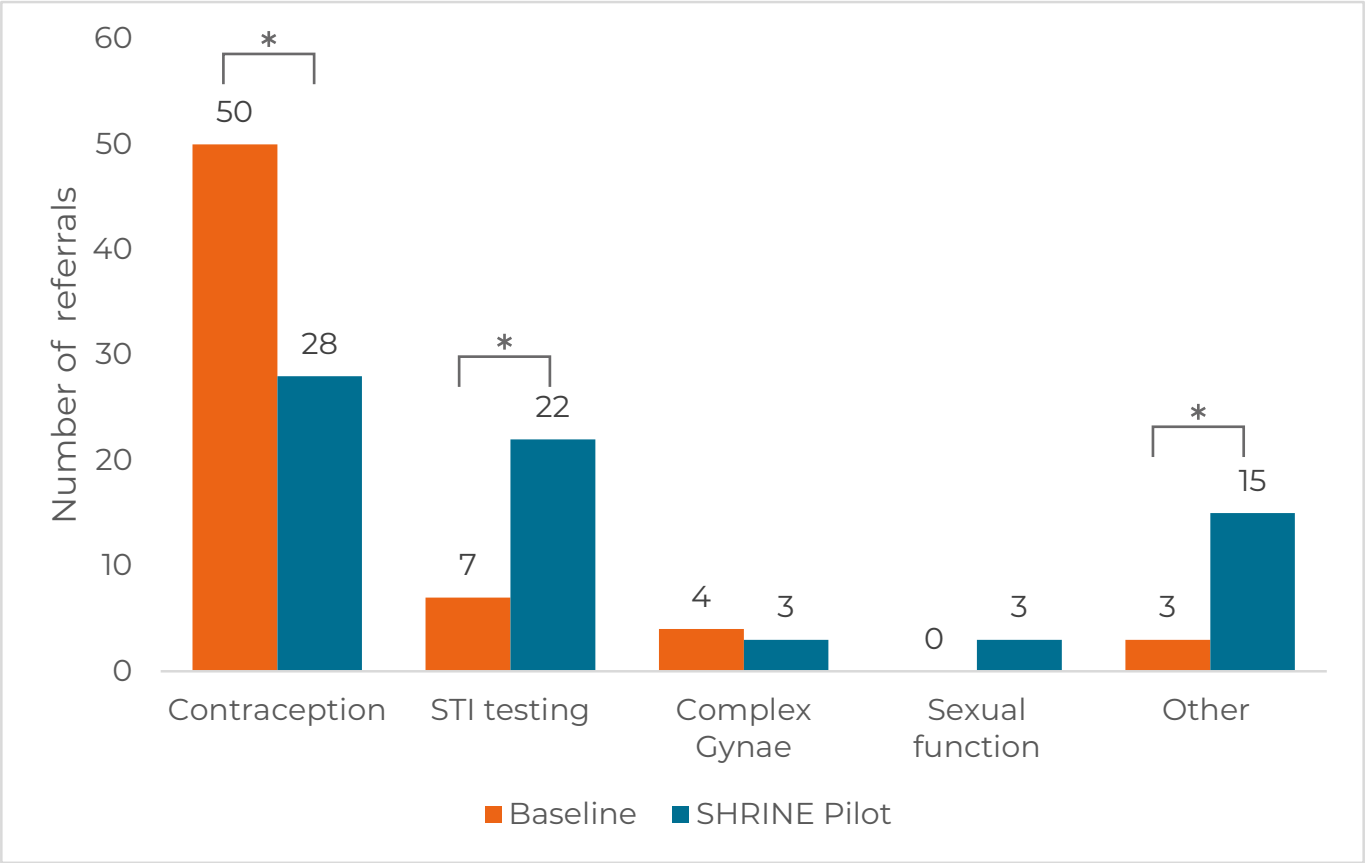

Figure 2: Referral reasons for patients at baseline and during the SHRINE pilot. Note: The terms along the x-axis are those that were used in the dataset. * indicates significant differences ($p<0.05$).

5.2. Appointments and clinic outcomes

5.2.1. Number of people attending appointments

At baseline, 39 out of 56 (69.6%) referrals resulted in attendance at an SRH appointment. Reasons for non-attendance included declining the service (N=4), attending an alternative service elsewhere (N=1), being too unwell to be seen (N=1), cancelling the service or reporting that the service was no longer required (N=8), being discharged before being seen (N=2) and reason not reported (N=1). Outcome data were also missing for one of the clinic attendances (referred for contraception). This patient was excluded from reports of clinic outcomes, leaving 38 clinic attendances. During the SHRINE pilot, 50/51 (98%) referrals resulted in an appointment. The reason for the one recorded non-attendance was that the patient absconded from the ward. Patients referred during the SHRINE pilot were significantly more likely to attend an appointment compared with baseline ($\chi 2=13.42$, $p<.001$).

5.2.2. Number of people receiving contraception

At baseline, 32 (65.3% of referrals for contraception) attended an appointment and discussed contraception, and 24 (49% of referrals for contraception) accepted a form of contraception. During the SHRINE pilot, 25 (89.3% of referrals for contraception) attended an appointment and discussed contraception and 17 (60.7% of referrals for contraception) accepted a form of contraception. There was no significant difference between the proportion of people who were offered contraception after referral, or the proportion of people who accepted contraception after referral between baseline and SHRINE pilot periods ($p>0.05$).

A total of 79.2 active contraception years were provided at baseline, an average of 0.32 active years per week. During the SHRINE pilot, a total of 62.8 active contraceptive years were given, an average of 1.57 active contraceptive years per week, which was a 4.95-fold increase.

5.2.3. Number of people accepting STI tests

At baseline, four (57.1% of referrals for STI tests) attended an appointment and were offered an STI test, and three (42.9% of referrals for STI tests) accepted this test. During the SHRINE pilot, 18 (81.8% of referrals for STI tests) attended an appointment and were offered an STI test and 10 (45.5% of referrals for STI tests) accepted this test. During the SHRINE pilot, people who were referred for STI tests were significantly more likely to be offered a test and significantly more likely to accept a test compared with baseline (Fischer's exact test, $p<.001$ & $p=.036$, respectively).

5.2.4. All clinic outcomes

A number of patients at SRH appointments discussed topics in addition to their original reason for referral. A summary of all clinic appointment outcomes (regardless of referral reason) can be found in Table 2.

Table 2: Clinic attendance outcomes for all referrals

Discussed in SRH appointment	Baseline		SHRINE pilot		Outcome	Baseline		SHRINE pilot	
	N	% of referrals	N	% of referrals		N	% of referrals	N	% of referrals
Contraception	36	65.5	32	62.7	Contraception option chosen	25	45.5	18	35.3
					Contraceptive injection	0	0	2	3.9
					Intra-uterine device/ system	9	16.4	4	7.8
					Implant	12	21.8	8	15.7
					Progesterone only pill	5	9.1	3	5.9
					Combined pill	1	1.8	1	2
Pregnancy test conducted	8	14.5	8	15.7	Positive test	0	0	0	0
Cervical screening	0	0	14	27.5	Cervical screening conducted	0	0	1	2
STI testing	20	36.4	32	62.7	Test conducted	12	21.8	11	21.6

5.3. Summary of findings: clinic data

Overall, the number of referrals increased during the SHRINE pilot, with average referrals per week being almost six times higher during the pilot compared with before. Referrals during the pilot were also more often for reasons other than contraception, suggesting that the pilot encouraged patients to raise concerns about a broader number of SRH issues. Patients referred during the SHRINE pilot were also more likely to attend an appointment, possibly illustrating that the lack of an on-site clinic during the baseline period may have been a substantial barrier to access for some.

Regarding contraception, although a higher proportion of patients referred for contraception were offered and accepted forms of contraception, the difference was not significant. Although the target of 25 women accepting a form of contraception was not met during the pilot, the increase in women being offered contraception suggests that longer-term roll-out of SHRINE clinics may facilitate more women to choose a form of contraception acceptable to them.

Regarding STI tests, patients referred during the SHRINE pilot were significantly more likely to attend an SRH appointment and be offered an STI test, and more likely to take an STI test. The proportion of patients referred for STI testing who took a test was just under the target of 50%.

6. Evaluation: staff training experiences

This section presents the results of the evaluation of SRH training delivered to staff to support the implementation of referrals to SHRINE clinics.

6.1. The training

The evaluation aimed to determine the relevance of the content of general training on the basics of SRH delivered to staff on all wards. For this general training session, the topics were: understanding of STIs; contraception; identifying SRH needs in patients; and how to address these needs. There is further information about the training in Section 3.3.2.

6.2. Responses

Nineteen staff members attended the first SRH training session, five attended the second session and six attended the third session (sessions 2 and 3 were not provided to all wards). The survey was distributed at the end of the first session.

Of those attending the first training session, eight members of staff completed the survey. Job roles of the respondents included junior doctor/doctor/consultant (N=3), nurse/mental health nurse (N=2), psychologist (N=1), matron (N=1), and deputy ward manager (N=1).

6.3. Session content

Respondents were asked to rate on a five-point Likert scale their agreement (ranging from strongly disagree to strongly agree) with the following statements:

- The content of the training was relevant to me
- The content of the training was pitched at the right level.

Everyone either agreed (3/8) or strongly agreed (5/8) that the content of the training was relevant to them. All respondents also either agreed (4/8) or strongly agreed (4/8) that the content of the training was pitched at the right level.

6.4. Understanding

Respondents were also asked to rate on a five-point Likert scale their understanding (ranging from none to very good) of STIs, contraception, identifying SRH needs in patients, and how to address these (retrospectively) before they attended the training and after.

Seven of eight respondents rated their understanding after the training as one point on the Likert scale higher than their understanding before the training, with the final respondent rating their understanding as good both before and after the training (understanding before median = 3 [average], range = 2 [limited] to 4 [good], understanding after median = 4, range = 3 to 5 [very good]).

6.5. Feedback/comments

Respondents were given the opportunity to provide any additional feedback or suggestions. Feedback was provided by five respondents and included comments that the session was helpful and informative (n=2), a great overview (n=1) and the right length (n=1). Respondents also noted that the training made them feel confident of what to do (n=1), how to ask sensitive questions and engage patients to talk about sex (n=1), and in turn support patients to get a referral or have their SRH needs met.

Two respondents offered suggestions for future training. These were, having in-person sessions, as this may allow for more discussion than via video (n=1), and offering similar informative sessions to patients on the ward (n=1).

6.6. Summary of findings: staff training experiences

Overall, the training was considered relevant and useful, with most respondents reporting an improvement in understanding as a result.

7. Evaluation: feasibility of SHRINE clinics

This section presents the results of the analysis of the staff survey and the NoMAD questionnaire used in the evaluation of the feasibility of SHRINE clinics.

7.1. Staff survey

7.1.1. Demographics

At T1, 30 members of staff from participating wards in River House (N=16) and the MBU (N=14) completed the survey. At T2, 36[c] members of staff from participating wards in River House (N=30) and the MBU (N=5) completed the survey at T2. At T3, 16 members of staff from participating wards in River House completed the survey. Staff had a range of job roles including nurses, social workers, occupational therapists and ward managers. The length of time they had worked in inpatient services varied greatly, ranging from less than 1 year to over 10 years. A full breakdown of respondents' job roles and time spent working in inpatient mental health services can be seen in **Appendix 10**.

7.1.2. Knowledge

At T1, 53% of respondents either agreed or strongly agreed that they had good knowledge about SRH. At T2, this had increased to 80%, and at T3 to 94%. Furthermore, the proportion of respondents who disagreed with this statement decreased from 30% at T1, to 3% at T2, and to 0% at T3 (see Figure 3).

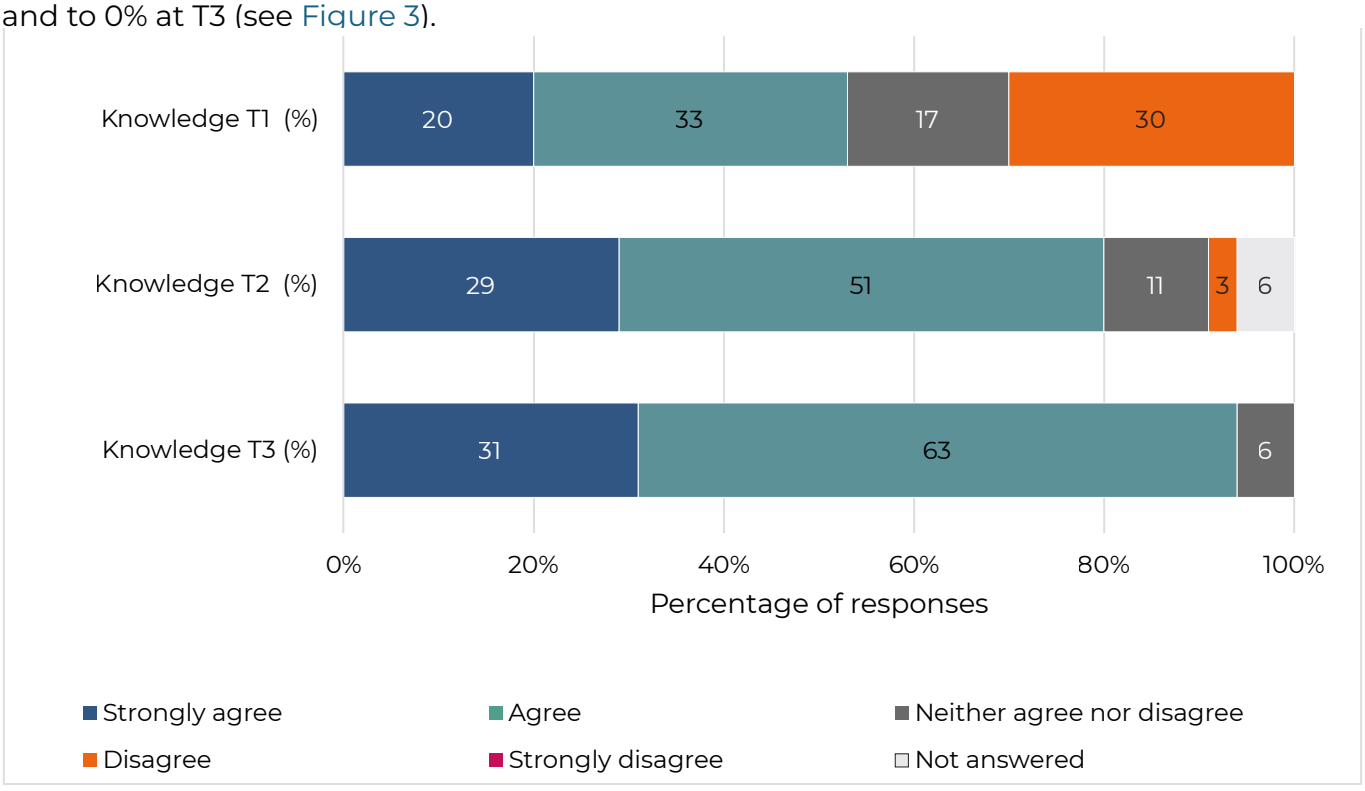

Figure 3: Level of agreement with having 'good' knowledge of SRH at time points 1, 2 and 3.

c One response was excluded due to insufficient detail, leaving 35.

7.1.3. Confidence

While 54% of respondents at T1 either agreed or strongly agreed that they were confident talking to patients about their SRH, 60% and 63% of respondents either agreed or strongly agreed at T2 and T3, respectively (see Figure 4). There was a decrease in the proportion of respondents disagreeing or strongly disagreeing that they were confident between T1 and T3 (23%, 17% and 13% at T1, T2 and T3, respectively).

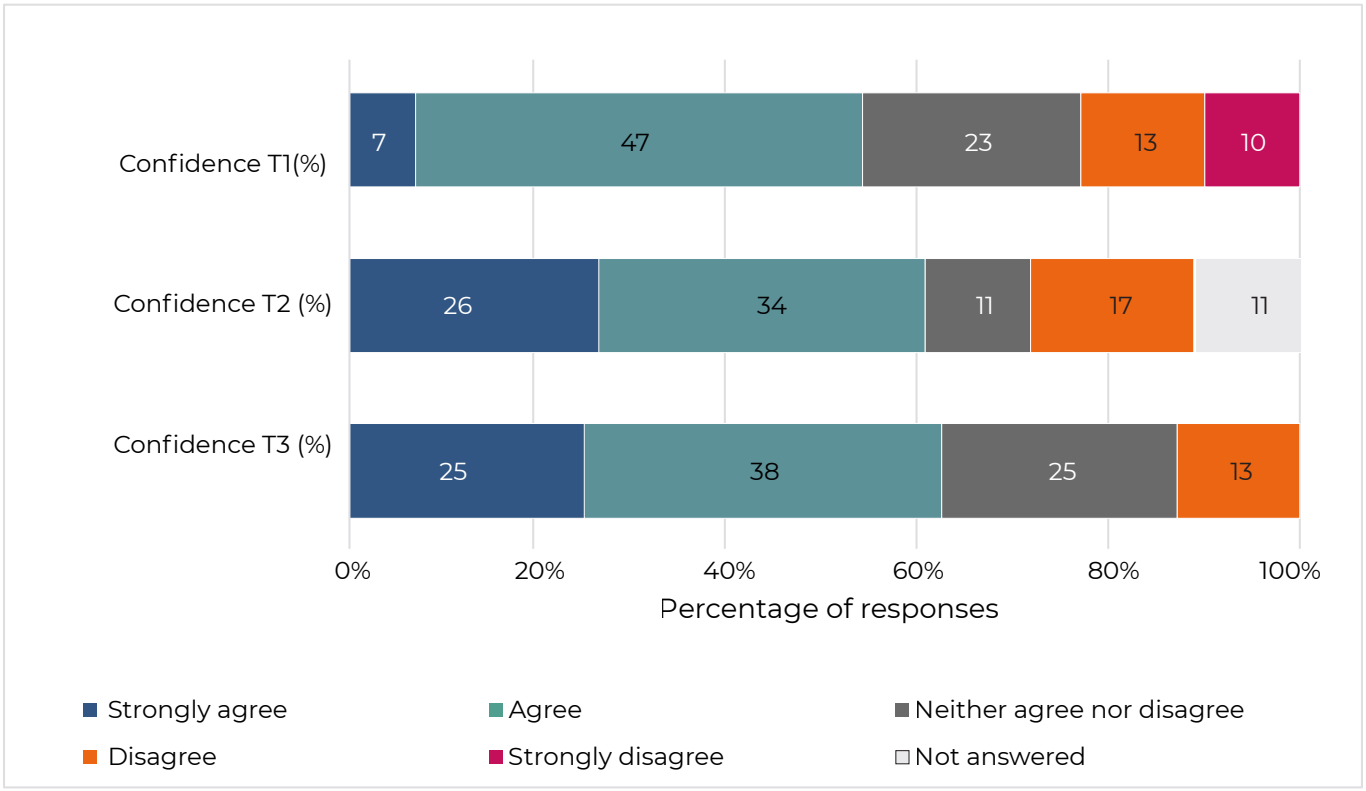

Figure 4: Percentage agreement with feeling confident talking to patients about their SRH.

7.1.4. Frequency of conversations on the ward

The data (see Figure 5) showed that conversations about patients' SRH were not initiated frequently during T1, with fewer than one-quarter of respondents reporting conversations initiated at least weekly by either the patient or staff. Over time this reduced substantially, with most respondents indicating that by T3 conversations were not initiated more than monthly, and 44% reporting that conversations were never initiated by patients nor staff.

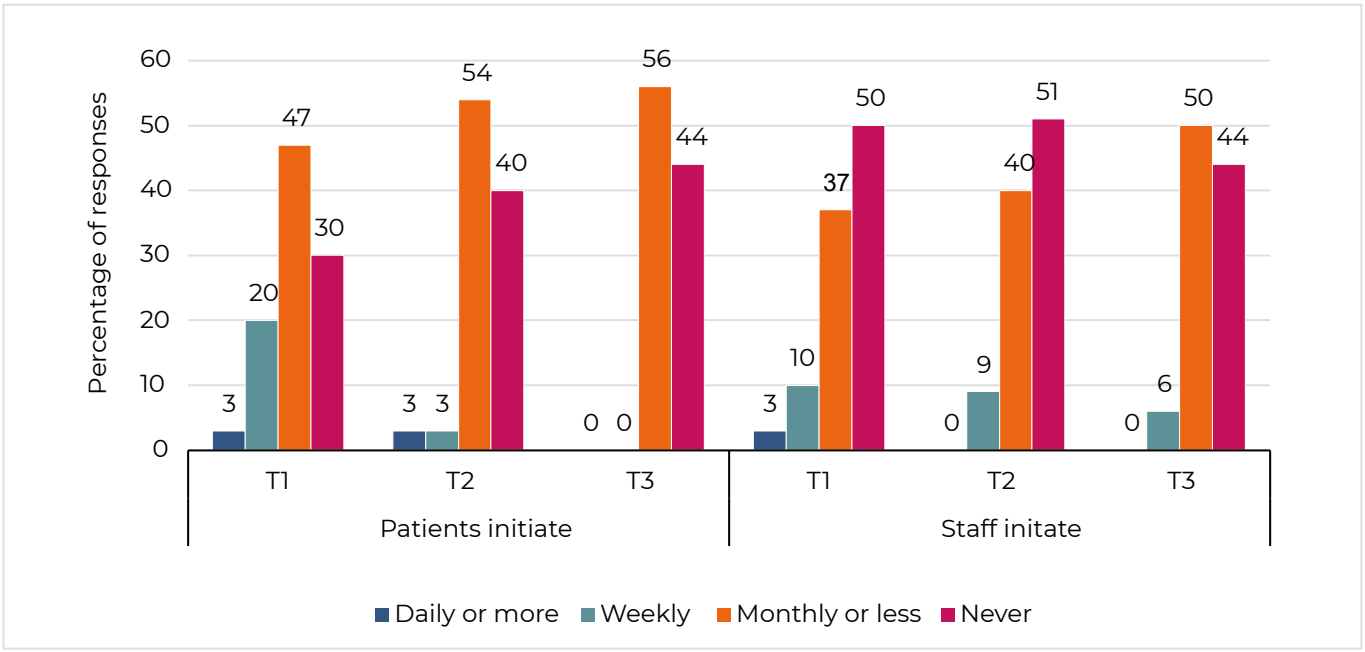

Figure 5: Perceived frequency of conversations about SRH being initiated on the wards

7.1.5. Experience

At T1, only a small proportion of respondents felt that they had much experience talking to patients about SRH (27% either agreeing or strongly agreeing). At T2 and T3, staff were asked to self-rate their experience of talking about SRH with patients with response options of 'no experience at all', 'a little bit of experience', 'moderate experience' or 'a lot of experience'. While 34% of respondents at T2 reported an increase in their experience, at T3 only 19% reported an increase. Only 6% at T2 and 2% at T3 reported a decrease in experience. Table 3 shows respondent ratings of their prior and current experience provided at both T2 and T3.

Table 3: Self-rated prior and current experience in talking to patients about SRH

	Prior experience T2 response (%)	Current experience (%) (T2)	Change (%)	Prior experience T3 response (%)	Current experience (%) (T3)	Change (%)
A lot of experience	3	11	8	6	13	7
Moderate experience	23	29	6	19	13	-6
A little bit of experience	43	34	-7	50	38	-12
No experience at all	29	17	-12	13	19	6
No response given	3	9	6	13	19	6

7.2. Normalisation of processes

The questionnaire asked three overarching normalisation (how practices became routinely embedded and integrated into their social contexts) questions about familiarity with and normality of having conversations about SRH. Response options ranged from 0 (not at all) to 10 (completely), followed by questions about the extent to which respondents agreed with each of the normalisation process constructs: coherence, cognitive participation, collective action and reflexive monitoring (see Section 3.3.3 for an explanation of these constructs). The NoMAD questionnaire was completed by 14 of the 16 respondents to the T3 staff questionnaire. A full copy of the NoMAD questionnaire, adapted for this evaluation, is in **Appendix 4**.

7.2.1. Overall

Although there was a broad range of responses, on average responses indicated that having conversations with patients on SRH still felt 'somewhat new' (mean=4.71, standard deviation [SD]=2.52). Respondents also felt on average that having these conversations was just less than 'somewhat' part of their normal work (mean=4.42, SD=2.62), and that it would 'somewhat' become part of their work in the future (mean=5, SD=2.48). Figure 6 shows the mean response to the three overarching normalisation questions.

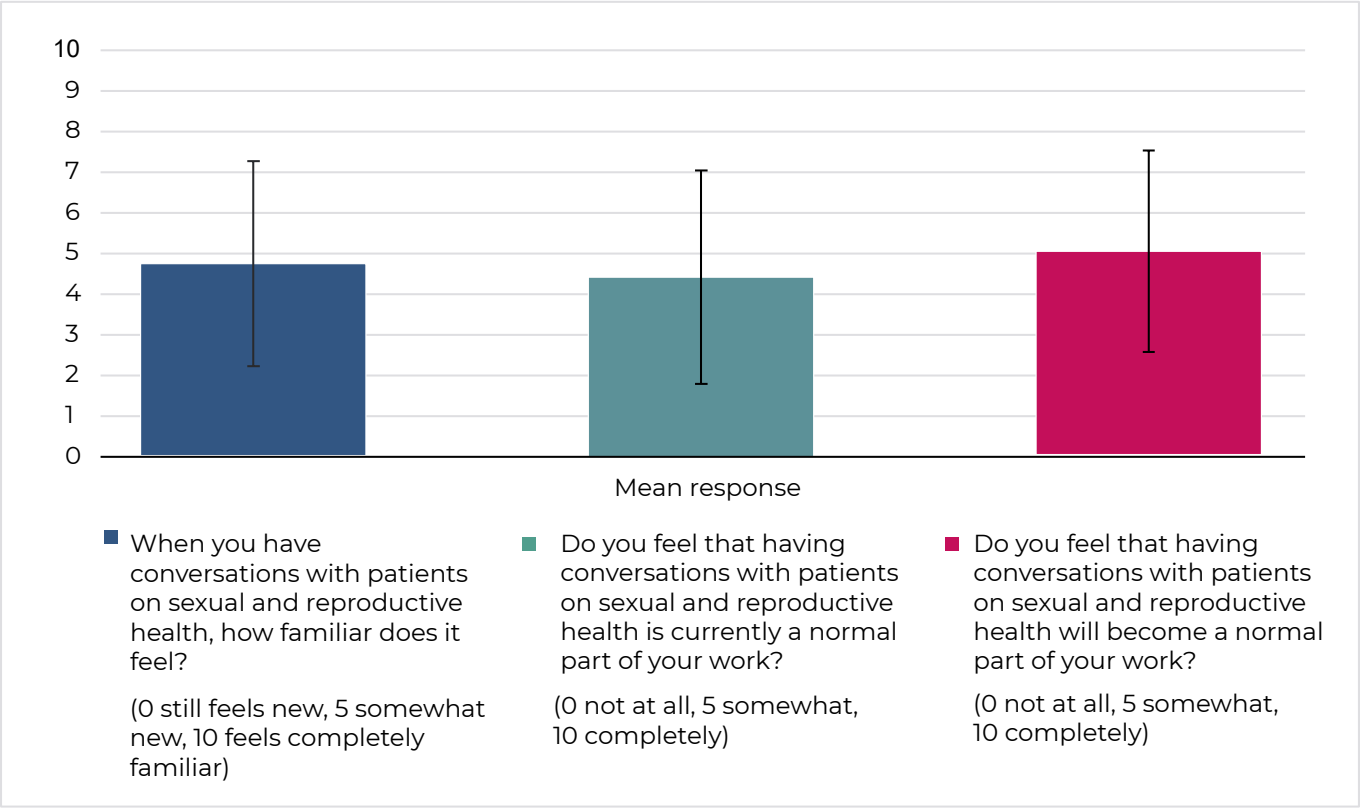

Figure 6: Mean overall normalisation responses (error bars represent SD)

7.2.2. Coherence

Responses on coherence were mixed, with a substantial proportion of staff having no opinion on related statements. While most (64%) respondents agreed or strongly agreed that they could see how having conversations with patients about SRH differed from their usual way of working, only 28% agreed or strongly agreed that all staff had a shared understanding of the purpose of these conversations, with 21% disagreeing that staff understood this purpose. Although only half of respondents (50%) understood how having these conversations about SRH with patients affected the nature of their work, most (79%) could see the value in having these conversations with patients.

7.2.3. Cognitive participation

Most respondents demonstrated cognitive participation, with 64% agreeing or strongly agreeing that there were people who were driving the practice of having SRH conversations forward, and 72% agreeing or strongly agreeing that having these conversations was a legitimate part of their role. Similarly, 79% agreed or strongly agreed that they were open to working with colleagues in new ways to have SRH conversations, and 85% agreed or strongly agreed that they would continue to have these conversations with patients. Only one respondent disagreed with any aspect of cognitive participation (being open to working with colleagues on new ways of having conversations).

7.2.4. Collective action

There was more disagreement noted for statements about collective action. Sixty-four percent agreed that they could easily integrate the practice of having these conversations with patients, although 7% (which is just one participant) strongly disagreed with this. Half of respondents (50%) felt that having SRH conversations disrupted their working relationships, although 36% disagreed with this, and 78% agreed or strongly agreed that they had confidence in the ability of others to have SRH conversations with patients. In terms of skill set workability, over half of respondents agreed or strongly agreed (64% and 57%, respectively) that the task of having SRH conversations with patients was assigned to those with the appropriate skills and that sufficient training was provided to enable staff to have these conversations, although 7% and 21% of respondents disagreed with these statements. Similarly, 64% agreed or strongly agreed (21% disagreed or strongly disagreed) that there were sufficient resources to support them to have SRH conversations with patients. About facilitation from management, 57% agreed or strongly agreed that there was adequate support in having SRH conversations, while 14% disagreed. One participant did not respond to the questions on collective action.

7.2.5. Reflexive monitoring

Overall, most respondents agreed with statements about their reflexive monitoring of the process of having SRH conversations. Although 50% of participants agreed or strongly agreed that they were aware of reports of the effects of having SRH conversations with patients, 21% disagreed or strongly disagreed. Most (79%) agreed or strongly agreed that, collectively, having these conversations with patients was worthwhile and 57% agreed or strongly agreed that they personally valued the effects of having SRH conversations. Finally, nearly all (79% and 79%, respectively) agreed or strongly agreed that they could use feedback to improve the initiation of SRH conversations and could modify how they integrate this into their work.

A summary of responses about the NoMAD constructs can be found in Figure 7 a –d.

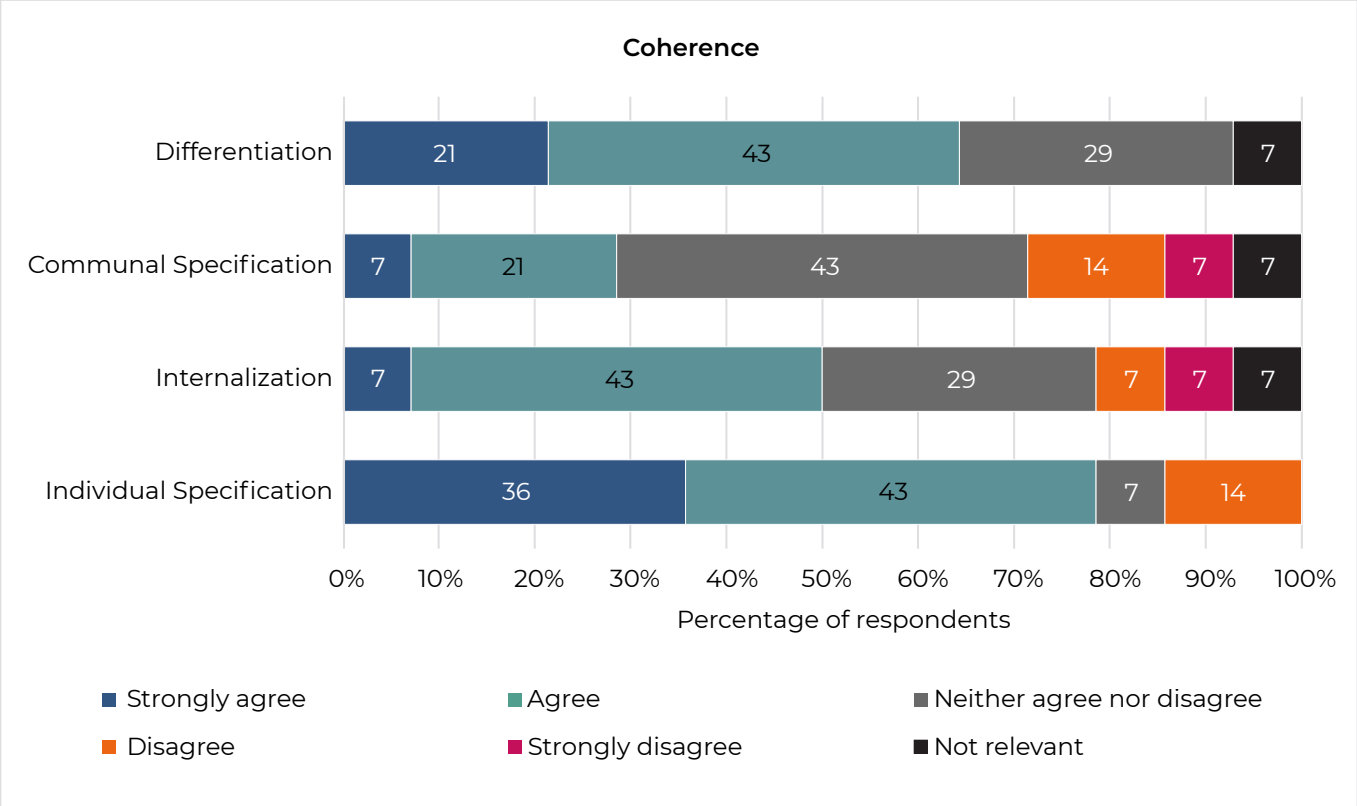

Figure 7a: Coherence responses

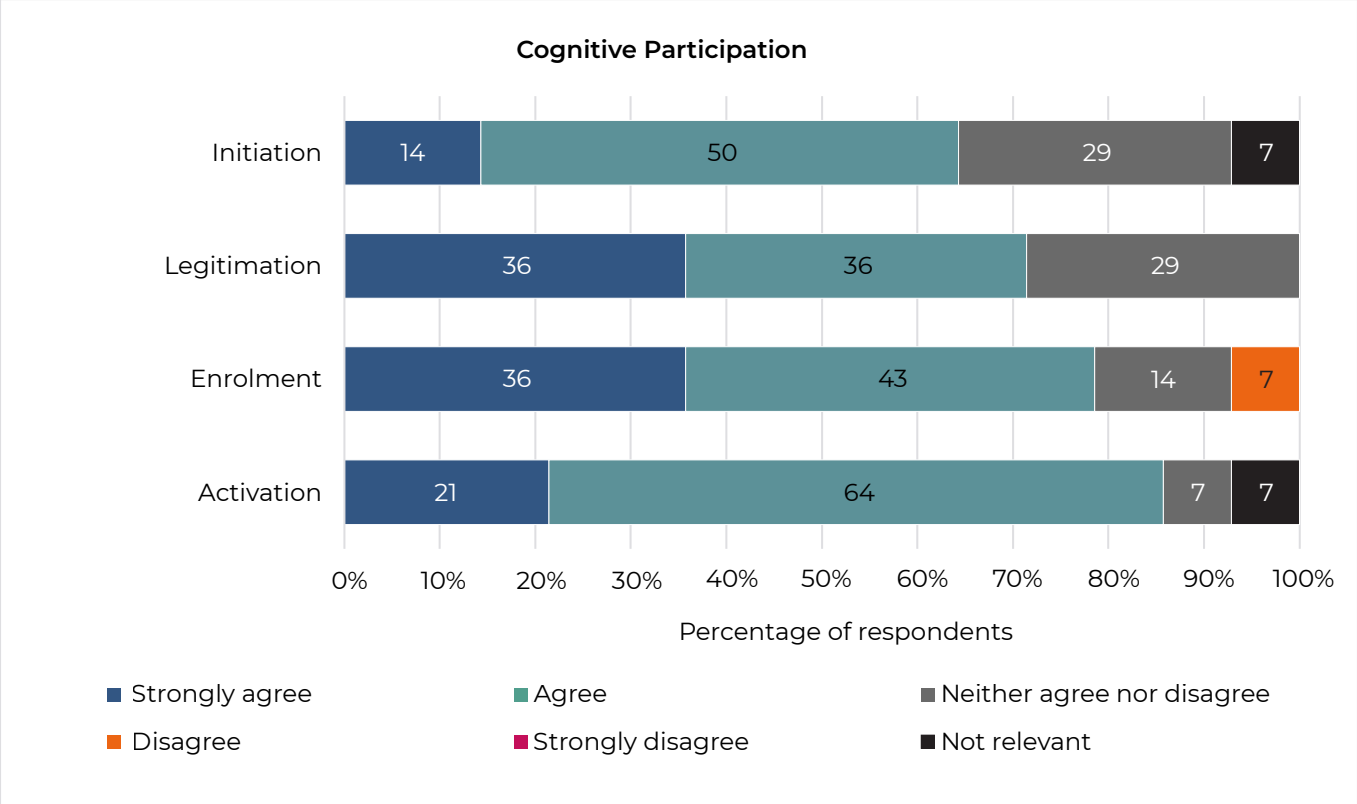

Figure 7b: Cognitive participation responses

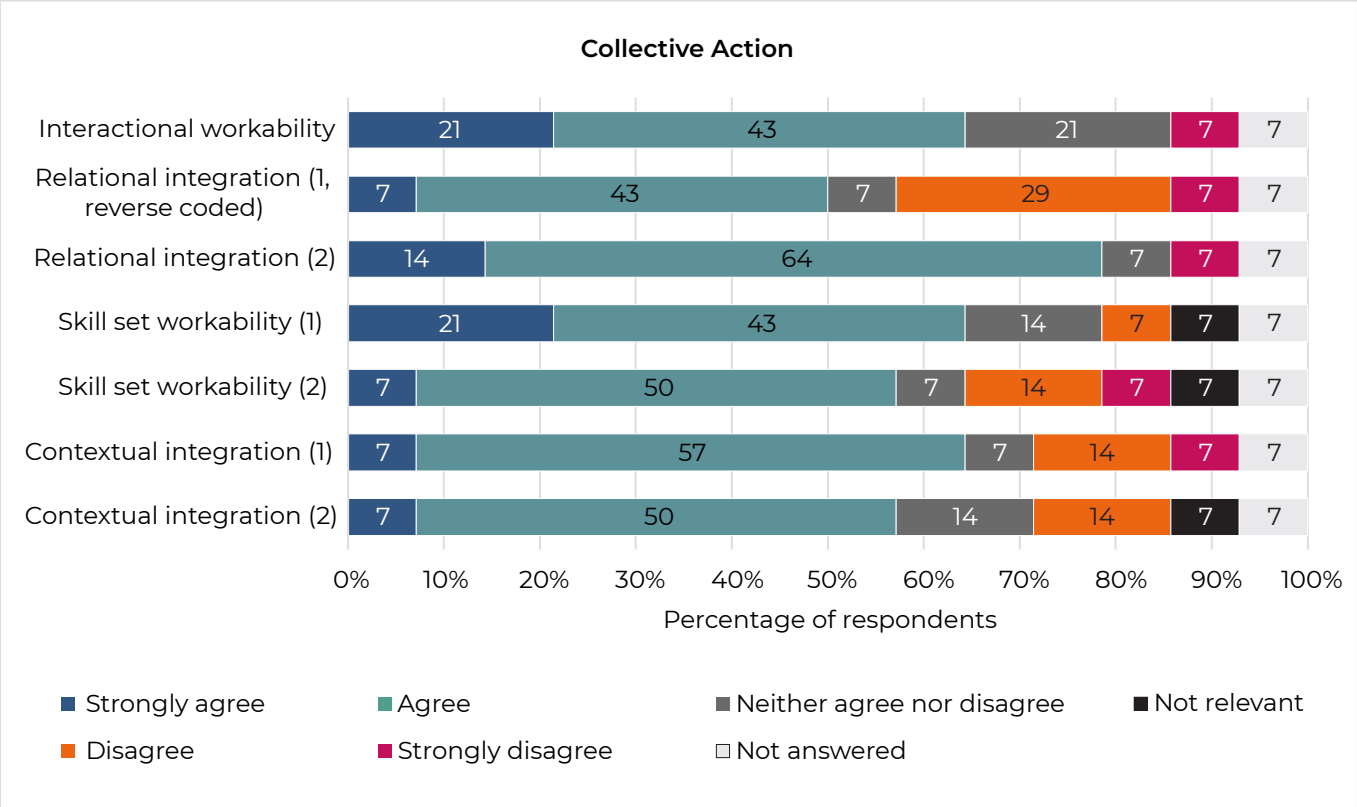

Figure 7c: Collective action responses

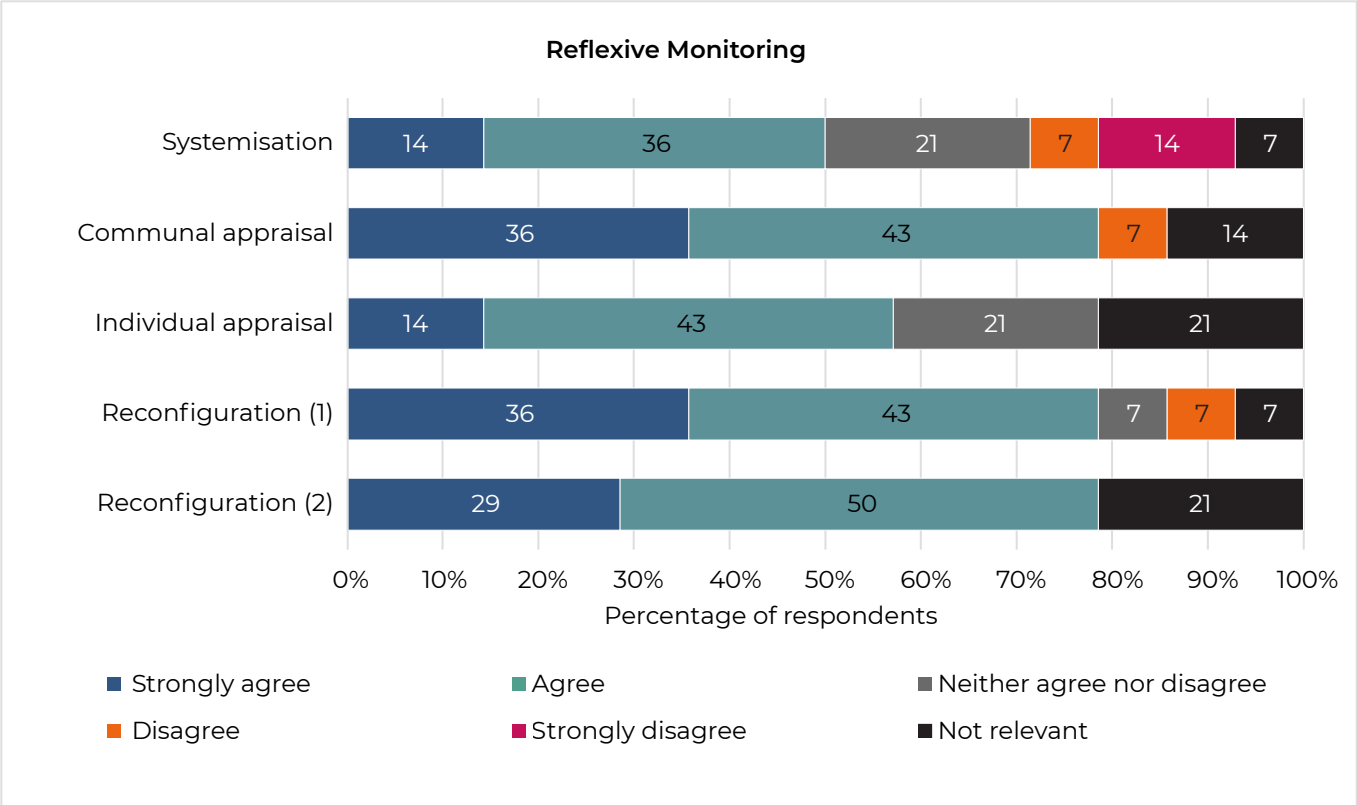

Figure 7d: Reflexive monitoring responses

7.3. Summary of findings: feasibility of SHRINE clinics

Overall, there was good indication that the SHRINE clinics were a feasible addition to the services, with staff reporting motivation and confidence to support patients with their SRH. However, there was some suggestion that initiation of conversations did not improve substantially and some respondents, particularly in the final wave of the survey, were less confident in their experience. Therefore, more support may be needed for staff to put what they have learned into action in the future.

The NoMAD questionnaire likewise indicated that overall, most respondents saw value in initiating SRH conversations. Respondents reported that initiating SRH conversations was a legitimate responsibility they could integrate with some adaptation, and that there was sufficient knowledge and skills within the workforce to do so. However, there was some uncertainty about whether all staff were on board, with some suggestion that incorporating these conversations could disrupt working relations and that not all felt support from management. This suggests that there may be benefit from providing additional support and training for more staff in this area, to improve the impact.

8. Evaluation: acceptability of the SHRINE clinics

This section presents the results of the analysis of the focus groups, and the staff and patient feedback surveys, used in the evaluation of the acceptability of SHRINE clinics.

8.1. Focus groups

8.1.1. Participants

Staff focus group

Seven members of staff and an additional student nurse took part in the focus group, which lasted 47 minutes.

Patient focus group

Three women from Spring Ward participated in one focus group; however, only one man from the male wards participated. Therefore, a one-to-one interview was conducted with him. The focus group for female patients lasted 53 minutes, and the interview with the male patient lasted 30 minutes. Demographic information for all participants is in **Appendix 11**.

8.1.2. Data structure

The three broad overarching topic areas were used as a starting point for analysis, and based on the questions asked. These were themes relating to:

1. conversations about SRH between patients and staff
2. the SHRINE clinics
3. the QI support provided as part of the project.

A total of eight themes and 26 subthemes were identified inductively across these topic areas. The themes emerging are summarised in the sections below. While eight of the 26 subthemes were endorsed by both staff and patients, seven were endorsed by patients only, and 11 were endorsed by staff only. The full framework of contributing quotes from both patients and staff is provided in **Appendix 12**.

8.1.3. Conversations about SRH between patients and staff

Patients and staff mentioned that, despite potential barriers, it was important for both parties to have conversations about SRH. It was felt that such conversations would improve patients' quality of life. It was implied that if staff did not raise SRH, patients may not feel comfortable bringing it up. One male patient expressed concern about seeming too demanding, despite others (particularly women) confirming that they felt comfortable with the topic. A number of additional barriers to conversations were mentioned, with both patients and staff raising concerns about confidentiality, lack of required expertise for such conversations, and stigma associated with discussing SRH in an inpatient setting. Staff also raised issues around staff safety and gender disparity between staff and patients.

Meanwhile, only patients identified perceptions of differences in priority placed on SRH between staff and patients. Several suggestions for breaking down barriers were given, although only the subtheme of 'more information and normalisation' was identified in both patient and staff focus groups. The themes and subthemes, with example quotes, about conversations around SRH between patients and staff are shown in Table 4.

Table 4: Themes and example quotes for conversations about SRH between patients and staff

Theme	Subtheme	Participant group	Example quotes
Importance of having conversations	**Improve quality of life**	**Both patients and staff**	**One patient from the female ward felt that conversations could improve the quality of life of the patient:** **'***I think it would be good to share your views around sex and intimacy because sometimes that's what your body might need, and it can make you feel better*.**'** **A member of staff agreed that conversations were important for patient quality of life:** *'It will improve their quality of life... Some of our patients have come that have had sexual intercourse with other patients on the ward. If we have all this in place to educate them and things to look out for all of them, that will help them*.**'**
	Provide patients with the opportunity to raise issues	**Both patients and staff**	**One patient from the male ward highlighted that without being informed about the clinics through conversations, they wouldn't feel able to bring up SRH issues:** **'***I wasn't really thinking about it, but when it was mentioned I thought, actually, let me do that. So that is the context around [it] ... for me to be thinking about it, I have to think about where actually, I wasn't aware of it being there. It wasn't part of my consciousness at the time*.**'** **A member of staff raised that once the conversation had been brought up, only then did patients mention concerns they had. Therefore, ensuring patients were aware of the clinics was important:** **'***They want to engage, you know, in relationships ... they want a bit of advice in order to keep themselves safe. You know, safe sex outside – all that came up*.**'**

Theme	Subtheme	Participant group	Example quotes
Barriers to having conversations	Concerns about confidentiality of discussions with staff	Both patients and staff	**One patient from the male ward and one from the female ward raised concerns about confidentiality of issues they might discuss, or about wanting to only share information with specialists:** **'***Not all staff are good at maintaining confidentiality. That's the outcome as well, sometimes staff can talk about other people. They might not be going into their details specifically, but if they can talk about other people to other patients then why would they not talk about patients to other staff?***'** **'***Though you want to share the information with the [SHRINE doctor] you might share more content with the sexual health [advisor] … unless you're going through a problem and the problem's unbearable***.'** **One staff member also mentioned that their patients may only wish to share their information with a specialist:** **'***There was still that difficulty of being open to the staff when they are requesting to complete the referral – a sheet to be sent to the sexual health clinic***.'**
	Feeling ill-equipped or a lack of knowledge	Both patients and staff	**One patient from the female ward reported that it was difficult to raise issues with some staff without relevant expertise:** **'***Sometimes it's a bit hard because all the doctors here, their profession is more on the mental health side and they lack the understanding with the physical side or towards reproductive areas***.'** **Similarly, two members of staff spoke about the major barrier to having conversations with patients as feeling they did not have sufficient knowledge or expertise in SRH:** **'***The staff were willing, it's just the limited knowledge we all have about this… I think some of the barriers we had initially was getting the message across to staff and explaining what it actually means to them***.'** **''***Cause often they don't have confidence from us because it's not a part of our [job].'*

Theme	Subtheme	Participant group	Example quotes
Barriers to having conversations (continued)	**Gender**	**Staff**	**Two members of staff mentioned that gender could act as a barrier for staff raising SRH issues with some patients:** **'***To speak to women and they don't want to talk to a man… they don't want to talk to me – "Why should I be talking about sexual things with a man?", and prefer to talk to… a female person… so, those are the kind of things that we see. But yeah, it can [go] either way… If you are female, maybe you want to talk to men on Spring [Ward] and not female***.'**
	Imbalance between doctor and patient priorities	**Patients**	**One patient from the female ward mentioned that they felt uncomfortable raising SRH issues because they felt that staff did not prioritise it as much as they did.** **'***Even if the medication is working for you, they shouldn't say that… they shouldn't compromise the fact that … because the medication is working, you can't stop it because it's having an effect in one area, like your reproduction. I feel like the doctors ignore that – they don't believe that you should stop it even if its interfering with your reproduction.***'**
	Not wanting to be perceived as demanding	**Patients**	**One patient from the male ward felt uncomfortable raising SRH issues themselves because they didn't want to appear too demanding:** **'***It would feel like, say for example I was gonna say, "Can I have a blood test, just to make sure that everything is alright with me?" Then it would come across as, like, you're just being "extra", you're just choosing to be extra for the sake of it rather than choosing to ensure that your health is fine***.'**

Theme	Subtheme	Participant group	Example quotes
Barriers to having conversations (continued)	Safety	Staff	**A key barrier to raising SRH mentioned by members of staff was concern about safety:** **'***A lot of reluctance from staff in regard to the client group we have… we have a lot of incidents around sexual inappropriateness from our patients, and that's why previously they were quite reluctant to have that discussion with the patient.'* **'***And don't forget, when you speak to a patient about something, they might twist that round and say something. You just need protection… it's true, a lot of times, the patient… you let them know about [inaudible] and you want to have a talk to them, [the patient] can use that conversation against you maybe, "Why are you telling me this?" So they can make it… enlarge it***.'**
	Stigma of SRH in an inpatient setting	Both patients and staff	**Stigma of discussing SRH was mentioned as a barrier by all four patients. Some mentioned feeling that ward doctors may feel too vulnerable:** **'***So…if somebody has had sex, and they are inside an institution, and that has occurred during the time they have been inside that institution, then that could be something challenging as well. Because they could be… drawing attention to something that [they] don't even wish to draw attention to, so there's that possibility as well***.'** **'***Maybe the consultant will be more judgmental around how you are in terms of sex, intimacy, reproduction and so on. Because they are under your care, we are under their care, they might say that we are too vulnerable for all of this, like too vulnerable to have a child, too vulnerable to engage in sex and intimacy, so… that's what I'm trying to explain.'* **Two members of staff also felt that stigma was a barrier to conversations taking place.** **'***It's probably about the stigma about talking about sex … people just don't feel comfortable – "Who am I talking to…what am I going to say to them?"***'** **'***It's quite an uncomfortable conversation when you are having it if you've not normalised it***.'**

Theme	Subtheme	Participant group	Example quotes
Instances of feeling comfortable	**N/A**	**Patients and staff**	**Despite staff concerns over raising SRH issues, two patients from the female ward reported that if given the opportunity, they would feel comfortable discussing some topics (for example reproductive health):** **'***I've been quite open about sexual health education when it comes to my needs and when the medication causes an effect to my reproduction not functioning as well as how it would be when not on medication.***'** **'***I don't think it should be uncomfortable***.'** **One member of staff also mentioned that patients felt comfortable discussing SRH, particularly after attending the SHRINE clinic, which contributed to more patients becoming aware of them:** **'***I think more of the patients were, at some point, willing to have that conversation, even amongst themselves – they attend the clinic, they go back and tell their peers that this is happening, and some of them have conversations. And they come to the nurse and say, "Listen, that patient needs to see a sexual health doctor…" So, the conversation was beginning to gain momentum.***'**
Things to help improve conversations	**Familiarity**	**Patients**	**One patient from the male ward suggested that conversations would be improved if they were always one-to-one, and from a member of staff who knows the patient well.** **'***I think maybe if primary nurses were able to mention it to their patients, so when it's the primary nurse or the social nurse, whether they join a one-to-one, or at the time when that type of clinic is available, they can mention that individually to the patient. I think that in itself would be more effective than broadcasting it at that community meeting, 'cause, although I get that the intention's good, a community meeting is really for everybody, so the staff, doctors, the whole rest of the connected staff, don't need to really be aware of that. Because it's not really for them, it's between specifically patients to access***.'**

Theme	Subtheme	Participant group	Example quotes
Things to help improve conversations (continued)	Champions	Staff	**One member of staff discussed the possibility of a site 'champion' who may have more expertise and could encourage discussions.** '*I think there is definitely room for improvement… maybe even just to have a few sexual health champions on the ward… you can't talk to everybody, but at least they would have the dedicated people that, they might be even more trained maybe to have those conversations and have more information about the clinics, and they can move forward with them*.' **However, concerns were raised by another member of staff that few would have the capacity to take this on:** '**…***because there is a lot going on and we have to be realistic about a champion and making sure that we align it to what fits best. So, whether we… it obviously depends on… whether the champions are able to take it on and understand this part of the role*.'
	More information and normalisation	Both patients and staff	**One patient mentioned that when staff were more knowledgeable it made them feel more comfortable** '*It depends on the person you ask, you can… how knowledgeable the person is*.' **Four members of staff agreed that providing staff with more information and normalising conversations around SRH would improve the frequency of such conversations.** '*Because sometimes they have got some patients, they [staff] have no knowledge so maybe they can't put it in place for their patient as well. Maybe we should involve more training of the staff, even the doctor because they might after, to talk to the patient as well. So, these people need more knowledge.'* '*I think it's good to revisit again and sensitise staff – give them more information on how to approach such challenging questions. Because if you don't equip staff to approach the patients, the lapse will be there, and by giving them more information and visiting them more often – let's say, on a weekly basis – every week*.'

Theme	Subtheme	Participant group	Example quotes
Things to help improve conversations (continued)	**Setting expectations about confidentiality**	**Patients**	**A patient from the male ward also suggested that to address concerns around confidentiality, expectations about the level of confidentiality of information shared could be set:** *'If something is gonna be shared, maybe parameters could be set in the way that someone can share it. If you've got parameters set up then you can say, "Right, I can share information – but these are the boundaries of sharing this information for disclosure for that." But then again, that's just an ideal because in reality it's just down to who is willing to abide by that.'*

8.1.4. Opinions on the SHRINE clinics

When discussing the SHRINE clinics, although staff mentioned side effects of medication and lack of time as barriers to attendance for some patients, a strong theme emerged of a desire for the clinics to be a long-term feature of the wards. For example, patients reported that SHRINE clinics could play a key role in providing them with somewhere to go to alleviate concerns around SRH. Also, staff felt it was important that patients had someone other than ward staff with whom they could discuss some issues relating to SRH. Similarly, both staff and patients felt that SRH support was important, given that patients can sometimes be particularly vulnerable (for example, to abuse). Staff also stated that the pilot had been too short for them. One patient who had used the SHRINE clinics reported that, although the staff involved were helpful, issues with soundproofing of appointments meant that they had been concerned about their privacy. The themes and subthemes, with example quotes, about patient and staff opinions about SHRINE clinics can be found in Table 5.

Table 5: Themes and example quotes for SHRINE clinic opinions

Theme	Subtheme	Participant group	Example quotes
Attendance barriers	Medication	Staff	**One member of staff reported that medication can be a barrier to attendance:** **'***The big challenge that we get on the ward is patients sleeping – like when they are on medication. They want to attend, but at times their medication just makes them weak and drowsy. So that's another barrier in not attending***.'**
	Timing	Staff	**Two members of staff mentioned that they had not had time for all patients who may want to use the clinics to be seen:** **'***Sometimes we had to cancel some of – actually, decline – some of the patients, because of the time limit that we had to work with.'* **'***You see a patient and you tell them about it [the clinic]… [but] you are not sure whether they can actually go… Or, they were not saying they're gonna come, and all of a sudden they say, "I'm gonna come". So that makes it difficult for [the SHRINE doctor] to squeeze them in***.'**
Desire for clinics to remain	Alleviate concerns	Patients	**Two patients from the female ward mentioned that the clinics were important for them because they offered a space to alleviate concerns over medication use and issues related to reproduction:** **'***Sometimes it can be quite scary when you're not a mother yet and you fear that you would not be able to have children in the future as a result of being on antipsychotics. You want to stay on antipsychotic medication, but it's really, exclusively hard to find that… list with the medication and with keeping the reproduction***.'** **'***They stopped giving me the medication at the moment… my periods have not come back yet – mine stopped totally. It has not come back yet, and I've told [the doctor] about it [and he said that] I shouldn't worry and that everything is going to be okay, but I am concerned 'cause I'm a 30-something-year-old woman, I have one child, and I do want to have [more] children in [the] near future. So I am concerned that it's now going to affect childbirth***.'**

Theme	Subtheme	Participant group	Example quotes
Desire for clinics to remain (continued)	Important to provide total care for vulnerable patients	Patients and staff	**Two patients, one from each ward, felt that the clinics should become permanent because they provide total care for patients:** **'***I think it's a good thing to have available. Especially for a hospital – a hospital should be able to help every aspect of human…it makes sense for that to be there*.**'** **'***There's so many STIs out there and it would be great if women's health can be checked because sometimes when you are mental health patients you are very vulnerable*.**'** **Two members of staff also reported that the clinics were an important part of care provision for people who are vulnerable and who remain in inpatient care**: **'***I think it's good for patients to have these options when you're in a secure environment… because [in] secure services people don't always have leave, and therefore you've got to provide things in-house. So I think it's helping with the health inequalities amongst our patient group*.**'** **'***We know in the mainstream, the patients come in and out they have more access to communities and all that. Our patients, they are coming from high-secure units, locked up for sometimes X amount of years… So bringing that… capacity to come and have that conversation with them, it goes a long way to addressing that aspect of their care*.**'**
	Pilot was too brief	Staff	**Three members of staff felt that the pilot was too short, and wanted the SHRINE clinics to return for longer so patients could have more opportunities to attend.** **'***That was [another participant's] point, wasn't it. That 6 months is too short and, clearly, I think we agree*.**'** **'***Prolong it – make it a bit more available for the patients. Just because they might have a change of heart, like, 'I don't want to do it now, I will do it next week'. I appreciate it, even with our GP one day, they say to you, 'Book me in for a GP'. You go call them, 'I don't want to go, book me for next time.' So, yeah, if they are here, I am sure we can sell it more to them with, 'Oh, you didn't go last month – why don't you go this time?' Or speak to your colleague and see what they talked about out there, that would be good*.**'**

Theme	Subtheme	Participant group	Example quotes
Desire for clinics to remain (continued)	Provide an alternative person with expertise to talk to	Staff	**Three staff members mentioned that the importance of the clinics lay in the offer of an alternative, person, with expertise in the area for patients to speak to:** **'***It's a lovely feeling that gives the patient that different person to speak to apart from us, which allows them to ask questions. They [are] coming to us, "I'm here to be treated for my mental health issue." They don't want you to talk about their physical health issue that is to deal with the GP. When it comes to sexual [health], they felt [it should be with] someone who has got knowledge about it as well***.'** **'***Our patients basically live in hospital, so having such opportunity to discuss things like that… I think sometimes having an outsider that has experience around [meetings] gives opportunity to discuss areas like that even if there are times where people might feel shy to discuss things. If someone is an external expert, then [our patients] understand that at least it's what you do and it's their opportunity to discuss it*.
Experiences of the SHRINE clinics	**Helpful SHRINE doctors**	**Patients**	**One patient from the male ward reported positive experiences of the clinic due to SHRINE doctor being particularly helpful:** **'***The clinician seemed like he was very helpful. I wanted him to carry out some tests, just to make sure that I'm okay, and all I can say [is] he was very helpful, the clinician was very helpful***.'**
	Negative experiences due to lack of confidentiality	**Patients**	**One patient from the male ward reported that their experience was negatively impacted by issues of confidentiality while waiting for their appointment:** **'***One of the things I that I was uncomfortable with was that when I was waiting …cause I now remember, there was actually two other patients that came with me on that occasion. Two of them had gone before me, and I do remember that when the second person went… I could literally hear the whole discussion… I could hear the whole conversation. And I think some of it was, they were raising their voices, but it did sound as though the wall was either too thin or maybe the proximity is wrong, or either way it wasn't confidential because I could hear a lot of what was being said inside the clinic****….I feel like, basically, if you're gonna turn up, be prepared to talk as though you are talking to anybody in terms of outside, so that's how I took it. So I was uncomfortable in that sense, in that my confidentiality was not really secure***.'**

8.1.5. QI support

Staff were also asked about the QI support provided as part of the SHRINE pilot project. They were keen for more training and extended support in raising SRH issues with patients, and also felt that patient involvement in this was key to learn from each other. However, barriers were identified in encouraging some staff to be involved in this support, namely due to the busy nature of working in inpatient settings, or for some, a lack of willingness to take on extra responsibility. The themes and subthemes, with example quotes, of opinions about the QI support are shown in Table 6.

Table 6: Themes and example quotes for opinions about the QI support

Theme	Subtheme	Example quotes
Desire for more training and extended support	**Learning from each other**	**Four members of staff reported that learning from patients and different staff members supported their learning:** **'***Regular training… regular teaching sessions, bringing staff confidence in… skilling them up, and also having the patients along and [saying], "Staff will be having these conversations with you." It's not that they are having an abnormal conversation, it's "We want to normalise that", but of course, however, we should know where to draw the boundaries as well. Those two things***.'** **'***I think that these patients listen to themselves. We must have some of them, to bring on board, who can speak to the others***.'**
	Forgetting what has been learned	**One member of staff explained that when the QI support stopped, staff forgot what they had learned:** **'***One thing that I see with the breakage or the stoppage [of the QI support] is the staff now need to start refreshing themselves on how to do this again****….But what you see now is, like you said, there is a lot of work we do, always busy… but all of a sudden, it is all gone from my head [laughs] and so you need to start telling me again that it's gonna start again. Then the staff needs to kind of embrace it again, and start running it like it should be***.'**

Difficulty getting staff involved	**Busy nature of work**	**Two members of staff explained that one reason for difficulty getting staff to engage with the SHRINE programme was the busy nature of their work:** **'***We run a very busy service here, so for them to have that time to continue to have meetings was a huge challenge [for] the staff. It's like an added workload for them to promote that aspect of the care***.'** **'***On my ward, they will put down [their] name, but when they want to go [on] leave they cancel it, 'cause it's the jobs again… it's the continuation***.'**
	Not willing or informed	**One member of staff mentioned that getting staff involved can be a challenge as they are not informed or willing to participate at first:** **'***I don't think anybody is willing to take on anything, [indicates participant] is my witness … on my ward, they are not interested***.'** **However, one member of staff mentioned that once staff were provided with information and time, they were keen to improve care for their patients:** **'***As progress, the staff were quite… there was more hunger for more information on how to deal with it on a ward level. And so that they would be able to support the patients and finish all the referrals to the appropriate area***.'**

8.1.6. Focus groups: summary

Overall, both patients and staff felt that conversations about SRH were important for the quality of life of patients. They also highlighted barriers, including concerns around confidentiality, lack of expertise, challenges with gender differences between staff and patients, safety, and stigma associated with discussions about sex in an inpatient setting. Staff primarily supported more information and normalisation of SRH discussions as the primary means to improve the frequency and ease of raising SRH with patients. Patients suggested that setting expectations about confidentiality and having discussions with members of staff they were most familiar with would support conversations and referrals.

In terms of the clinics themselves, staff and patients similarly felt that they were an important offering which should be extended, as they provided patients who may be vulnerable with a professional, separate from their usual care team, who had expertise in the area to alleviate concerns.

Only one patient who took part in the focus group had used the SHRINE clinic, but they reported some concerns about being able to overhear other patients in the clinic, which had an impact on their own experience. Despite this, they had a positive experience with the doctor in the clinic.

In reference to the QI support, staff wanted more such support, so as not to forget what they had learned. However, they did highlight that some staff were not engaged due to time pressures or a lack of understanding of the topics. This suggests that future QI involvement was thought to be important, but organisations may need to consider how staff can engage with such programmes in future.

8.2. MBU staff feedback survey

8.2.1. Responses

Nine members of staff from the MBU filled in the feedback survey. The respondents comprised nurses (56%), nursery nurses (33%) and occupational therapists (11%).

8.2.2. Facilitators to having coversations about SRH

The most selected facilitators to having conversations were feeling confident talking to patients about SRH and the integration of SRH into routine care, with eight out of nine respondents endorsing each of these. The MBU informed the researchers that SRH was routinely asked about at assessment, making it easier to start the conversation and allow patients the space to speak about it. This was closely followed by having trusting relationships with patients. The numbers and percentages of respondents endorsing each facilitator are shown in Table 7.

Table 7: Number and percentage of respondents endorsing each facilitator (N=9)

Facilitator	n (%) who selected this option
Feeling confident to talk about sexual and reproductive health	8 (89%)
Sexual and reproductive health being integrated into routine care	8 (89%)
Having trusting relationships with patients	7 (78%)
Patients wanting to engage in conversations about their sexual and reproductive health	6 (67%)
Good knowledge about sexual and reproductive health	4 (44%)
SHRINE training	3 (33%)
Previous experience talking to patients about sexual and reproductive health needs	3 (33%)
Session with my QI coach	0 (0%)
Nothing helped me with the project	0 (0%)
Other	0 (0%)

Respondents reported that the training helped to increase their confidence, learn new things or refresh their knowledge, and get up-to-date information about what was on offer. This in turn allowed them to advise and inform patients about what was on offer. The confidence that they developed also made it easier to start conversations with patients and discuss options. Knowledge of a clear referral pathway, along with having the clinic on site and having SHRINE doctors coming onto the wards to speak to patients, also made staff feel more confident about discussing SRH with patients.

Having trusting relationships made it easier to be open and honest, and made it easier to speak about SRH, a topic that could be considered taboo by some.

Routine was also discussed – for example, it helped make care more holistic on the ward by:

- making SRH a routine topic of conversation on admission
- being able to offer the SHRINE clinics straight away
- integrating conversations into the overall package of care.

8.2.3. Barriers and challenges facilitators to having conversations about SRH

Although four out of nine (44%) respondents indicated that they didn't experience any barriers or challenges in the SHRINE programme, there was some endorsement for challenges relating to lack of patient engagement, lack of confidence, lack of knowledge, staff shortages, time constraints and workload. The numbers and percentages of respondents endorsing each barrier are shown in Table 8.

Table 8: Number and percentage of respondents endorsing barriers (N=9)

Barrier	n (%) who selected this option
I did not experience any challenges or barriers	4 (44%)
Lack of engagement in conversations about sexual and reproductive health from patients	3 (33%)
My lack of confidence talking to patients about their sexual and reproductive health	2 (22%)
My own lack of knowledge about sexual and reproductive health	2 (22%)
Staff shortages	2 (22%)
Time constraints	2 (22%)
Workload	2 (22%)
Having a different gender identity from the patient	0 (0%)
Other	0 (0%)

When expanding on answers, respondents who experienced barriers reported that they felt the time did not allow for thorough and appropriate conversations, that wards were too busy, and that staff shortages meant that other clinical issues often took priority. One respondent also reported that SHRINE doctors were often present, meaning the responsibility of having conversations was often passed on to them.

8.2.4. Change in practice

All respondents indicated that there had been a change in practice over the course of the SHRINE programme.

When asked to expand and think about how practices had changed, respondents referred to increased knowledge and confidence, which allowed staff to be more open and have frequent conversations, and reduced embarrassment and hesitation around conversations about SRH.

Respondents also reported that conversations about SRH had become embedded into routine practice. For example, SRH was asked about on admission, and was often mentioned again prior to SHRINE clinics. Staff also reported that mention of the clinics sometimes led to more general conversations about SRH. When a patient declined, they were re-offered access to the clinics again in the future. This, coupled with the clinics being delivered on site, made them easy for patients to access – a factor cited as being important.

Some staff reported that though not directly involved in having these conversations, they were involved in roles such as supporting other staff to have conversations or signposting. Even where staff reported SRH care not being part of their routine practice, some reported feeling empowered to have conversations and get patients referred to the SHRINE clinics.

For these reasons, staff reported seeing more uptake or acceptance of SRH care and options such as contraception.

8.2.5. Additional support

Respondents reported that extension of the training (for example, providing it to more staff including bank staff, or at alternative times due to staff being on leave or because of shift patterns) could further support staff to help patients to access SRH care. However, training sessions were recorded and uploaded to the RCPsych website for staff to watch on demand. It is therefore possible that staff unable to attend trainings were not aware of this resource, and therefore this should be more widely advertised.

8.2.6. Feedback/value of the project

Five respondents also provided general feedback. All of them reported that the SHRINE clinics and associated training had been a valuable addition to the ward. One respondent also noted that some women on the ward have experience of domestic violence, and sex and pregnancy can be a concern. Enabling women to make their own choices without their partner, related to contraception and pregnancy during their time on the ward, can support them to take control of their fertility.

8.2.7. Summary: MBU feedback survey

Overall, staff views echoed those of the focus group participants. The key messages were that confidence in and feeling knowledgeable about SRH were major facilitators for having conversations about SRH with patients, while integrating this topic into routine practice with patients with whom staff were most familiar was also seen as helpful. Training and support were judged as important, and staff wished for this to be extended. Similarly to those issues raised in the focus groups, barriers included a lack of time for staff to be engaged, and lack of confidence or expertise.

8.3. SHRINE clinic patient feedback survey

8.3.1. Responses

Fifteen patients who had attended a SHRINE clinic filled in a patient feedback form. These included 12 patients from the MBU and three patients from Ruskin House. Six (40%) respondents reported that a member of staff had initiated the conversation on SRH, seven (46%) reported that they had started the conversation, and one (7%) reported that both they and a staff member had raised the issue. One respondent did not respond to this question.

8.3.2. Satisfaction and experience

Respondents were asked to rate how satisfied they were with the waiting time between having an initial conversation with a member of staff and having an appointment at the SHRINE clinic. This question was only asked on the original patient feedback form, and therefore results reflect views only of the 12 respondents from the MBU who used this version of the form. The respondents were generally satisfied, with responses (on a scale of 1 to 10) ranging between 7 and 10. Explanations of ratings included reports that the waiting time was short, which meant they were happy with it, or that they were seen almost straight away, including very soon after admission. One respondent commented that it would have been good if clinics were more regular to reduce waiting times between initial and further appointments.

All 15 respondents reported on their experiences in the clinic. These were universally positive, with all respondents either agreeing or strongly agreeing that they felt comfortable speaking about their SRH, they were listened to and taken seriously, their needs were resolved, and they understood what was explained to them. Table 9 provides further details of responses about clinic experiences.

Table 9: Respondent agreement with statements about clinic experience

	Level of agreement (%)				
Statements about clinic experience	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
I felt comfortable talking about my SRH and asking questions	87	13	0	0	0
I felt listened to and taken seriously	87	13	0	0	0
I got the advice and help I needed from the clinic	87	13	0	0	0
I understood everything	100	0	0	0	0

Respondents using the original questionnaire rated their overall satisfaction with their appointment(s) at the SHRINE clinic on a scale of 1 (not at all satisfied) to 10 (very satisfied). All 12 respondents reported being satisfied (rating satisfaction as at least 8), with nine giving the highest possible satisfaction rating (10). The easier-to-read questionnaire asked the three respondents to rate their happiness with their appointment, and two reported that they were 'very happy', while one respondent did not answer this question.

Explanations for satisfaction ratings included appointments being clearly explained (for example, using pictorial information) and respondents being given full information about their options. Other points related to the clinics being comfortable and the staff respectful, and feeling listened to by doctors who they felt were professional and helpful.

Many respondents also noted that the service was good and informative, and that they had a generally positive experience. One comment also related to continuity of care, with the respondent appreciating seeing the same clinician for both of their appointments. Others noted that it was a convenient service in which multiple sexual health needs could be met.

A suggestion for improvement was only given by one respondent, who noted that they had to travel to an alternative site for an appointment.[d]

8.3.3. Summary: Patient feedback survey

Overall, reported experiences of the SHRINE clinics were positive, including waiting times. Being taken seriously, having needs addressed and professional and helpful doctors contributed to this experience.

8.4. Summary of findings: acceptability

Overall, staff reported high levels of acceptability of integrating the SHRINE clinics into their care offering. However, despite views that these clinics were important for patients, there remained some barriers to raising SRH as a topic to support referrals to the clinics. To encourage more conversations, it appears to be key to address staff confidence and support normalisation of the topic. Working with both patients and staff to normalise SRH conversations may also go some way to addressing the perceived stigma of discussing SRH in the inpatient setting. Lack of staff engagement with QI support was reported to be primarily due to time constraints of staff working on busy wards. As respondents were keen for additional support to continue the conversation, alternative approaches to engaging staff alongside their work schedule could be considered.

In terms of patient experiences, the consensus was that patients found the SHRINE clinics acceptable and a positive experience. Views from patients who had not used the clinics also supported the idea that SHRINE clinics are an important contributor to wellbeing and help alleviate concerns about SRH, particularly women's concerns about their reproductive health.

d This appointment might have been additional, and therefore arranged in the way appointments were provided before or outside of the on-site SHRINE clinic pilot.

9. Conclusion

The evaluation of the SHRINE programme resulted in a number of key findings. First, there were more referrals for SRH and more attendances at SRH during the SHRINE pilot. This suggests that more conversations about SRH were taking place, and that on-site clinics reduced barriers to attendance for patients.

Uptake of the QI support offered to the wards was low, which meant the potential for testing multiple change ideas and changing the culture on the wards was limited. However, it should be acknowledged that part of the culture change can be enabled by support from senior management and helping staff to feel knowledgeable and confident in discussing SRH, through training and spaces such as reflective practice.

Data also indicated that staff generally felt that SHRINE clinics were feasible and acceptable, and that conversations about SRH were an important part of their role. However, staff also reported that the frequency of conversations reduced over time. Similarly, a clear message came through from staff that to increase their confidence in raising SRH issues, staff would appreciate further support and additional training, including for those in management roles so that staff would feel more supported. There were also calls for the topic to be normalised in the inpatient setting. As staff engagement was limited by time constraints, consideration of how important training can be provided to staff with busy schedules may be warranted.

Patient views supported the importance of the SHRINE programme, with feelings that the clinics were both important and a positive experience for those who had used them.

Abbreviations

MBU	Mother and baby unit
NCCMH	National Collaborating Centre for Mental Health
NoMAD	Normalisation MeAsure Development questionnaire
PDSA	Plan, Do, Study, Act
QI	Quality Improvement
SD	Standard deviation
SHRINE	Sexual and Reproductive Health Rights, Inclusion and Empowerment
SMI	Severe mental illness
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
T1, T2, T3	Time point 1, time point 2, time point 3

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