

# Progress and priorities – working together for high quality sexual health

Review of the National Strategy for Sexual Health and HIV

Produced for the Independent Advisory Group on Sexual Health and HIV  
by Medical Foundation for AIDS & Sexual Health (MedFASH)  
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This report outlines what has been achieved and addresses the key barriers which have impeded implementation. Most importantly, it recommends a wide-ranging set of actions required at national, regional and local level to respond to the new operating environment and drive further improvements

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# Foreword



**Baroness Joyce Gould, Chair, Independent Advisory Group on Sexual Health and HIV**

*Progress and priorities – working together for high quality sexual health* is published at a time when Government reaches a critical point in its plans for the future of the NHS. Lord Darzi's innovative work in *NHS Next Stage Review – High Quality Care for All* shows how to deliver results in a devolved NHS.

The Independent Advisory Group on Sexual Health and HIV was set up to monitor the progress of *The national strategy for sexual health and HIV*. Seven years into the original Strategy, we have commissioned MedFASH to undertake a review of what has been achieved, and what still needs to be done.

They have looked at what action is required at all levels; from the national approach to regional and local delivery, from leadership to challenging inequalities in sexual health.

The publication of *Progress and priorities* is timely as it comes just after Lord Darzi's review. It is with delight that we welcome the inclusion of sexual health as one of the recommended top six priority

commissioning goals. Lord Darzi's work sets objectives for regional and local delivery without the restrictions that targets can impart.

As a result of Lord Darzi's review, local NHS and associated organisations will be assessing their approach in terms of sexual health.

I recommend *Progress and priorities* as required reading for all who plan local delivery of sexual health services. The actions advocated in this report will drive further improvements.

Since *The national strategy for sexual health and HIV* was published seven years ago, we have seen considerable action and funding from the Department of Health to improve services. However, the NHS is a very different place with a very different structure to what it was in 2001.

Now, NHS decision making has devolved to a local level, and PCTs and local authorities are commissioning services.

This is enormously empowering – but it is also the reason why sexual health service provision is patchy across the country.

We **must** have leadership and commitment to sexual health at a local level. If this doesn't happen, we are

We want our population to be in good sexual health and well educated in how to protect themselves against STIs and unplanned pregnancies. To have services that meet their needs in a non-judgemental and supportive way.

in danger of slipping back into the dark days when GUM clinics were to be found in portakabins, and sexual health services were an afterthought when decisions were taken around planning service provision.

It is also time to place emphasis on prevention. Twenty years ago, HIV rates were contained because strenuous measures were taken to prevent its spread. There are lessons to be learned from this work. Prevention must be a major plank in any PCT's plan for tackling and improving sexual health.

As Chair of the Independent Advisory Group on Sexual Health and HIV, I would like to take this opportunity to salute and thank our members, all leaders in the field of sexual health, for their work. Their advice to Government on delivery of the National Strategy's aims has been invaluable.

The Independent Advisory Group always recommends a holistic approach to sexual health. We need to understand this in terms of integration – not only of services – but as part of all human life.

A handwritten signature in blue ink that reads "Joyce S. Gould". The signature is written in a cursive style with a horizontal line above the first name.

We want our population to be in good sexual health and well educated in how to protect themselves against STIs and unplanned pregnancies. We want them to have services that meet their needs in a non-judgemental and supportive way, at a time and in a location that they can access easily.

Now is the moment to press our foot firmly on the accelerator and make sure that sexual health services are in place which meet the current and future needs of our population.

*Progress and priorities* gives us the fuel to do so.

# Preface

**Ruth Lowbury, Executive Director,  
Medical Foundation for AIDS & Sexual Health  
(MedFASH)**



It was a privilege for MedFASH to be asked by the Independent Advisory Group (IAG) to undertake this review of the first *National strategy for sexual health and HIV*. It was also a major challenge, as the task was huge and the timescale tight. We have sought to do justice to the wide scope of sexual health and HIV, while remaining focused on how to accelerate implementation of the Strategy.

We needed to find out how policy and structural changes were influencing the commissioning and delivery of sexual health and HIV services. For this, we convened meetings with a range of experts and practitioners to share their experience and it is this which forms the backbone of the report's recommendations. We were struck by the enormous commitment and energy (sometimes also frustration) of the individuals we met, and hope this report will support them in acting as agents of change to deliver sexual health improvement.

MedFASH is indebted to a large number of individuals who helped in many ways with the review. Baroness Gould has been unstinting in her support and encouragement. IAG members have provided expert advice and offered links with local and regional contacts. Particular thanks are due to the review group leads: Derek Bodell, Patrick French, Kate Guthrie, Christine Owen and Helen Ward.

Many other individuals took part in meetings or answered queries. Although of course they did not always agree, we greatly appreciate their

A handwritten signature in blue ink that reads "Ruth Lowbury". The signature is fluid and cursive, with the first name "Ruth" and last name "Lowbury" clearly legible.

willingness to debate and search together for solutions. We also value the learning shared by service users from their personal experience which enriched the review, and the contribution of local case studies, to whose originators we are grateful. The Department of Health (DH) provided funding to the IAG to enable this review to happen, and a number of officials helped with essential information, advice and guidance.

Lastly, and above all, I must thank the members of the project team for their expert input, flexibility, good humour and sheer hard work. Helen Christophers helped plan the review, ran expert groups and drafted key recommendations along with other parts of the report; Dr Sue Mann trawled through literature, investigated and managed a meeting on indicators, and drafted major sections of the report; Jan Norton facilitated meetings of professional stakeholders and service users, and collected case studies. Magnus Nelson provided a strong base of organisational and communications support within MedFASH and Hilary Tranter designed and delivered this report to impossible deadlines.

At the end of this review, we are confident in saying there has been real progress in implementing the national Strategy. This has been the case in some areas more than others, and we hope this report will prove a catalyst for the replication of progress across the board, leading to a reduction in sexual health inequalities and enabling the population of England to enjoy high quality sexual health.

# Executive summary

**In 2001, the Government published *The national strategy for sexual health and HIV*. This was a major milestone: it placed sexual health and HIV firmly on the national agenda and set out an ambitious 10-year programme to tackle sexual ill-health and modernise sexual health services in England. This review assesses the impact of the Strategy to date and highlights significant developments which have taken place since publication. It outlines what has been achieved and addresses the key barriers which have impeded implementation. Most importantly, it recommends a wide-ranging set of actions required at national, regional and local level to respond to the new operating environment and drive further improvements. It also proposes a sexual health and HIV indicator set with which to measure progress.**

The period since the Strategy's launch has been a time of unprecedented policy change, both in health and local government. The landscape is now very different, with devolved decision-making in the health service and an increasingly important role for local authorities as strategic leaders and partners in setting health and well-being priorities, and identifying targets based on local need. Reducing health inequalities and addressing inequities in service access and provision have continued to be a dominant feature of government policy, including in the recent NHS Next Stage Review. Structural changes affecting all NHS organisations have been accompanied by significant developments in commissioning, as well as the introduction of new financial mechanisms and the arrival of a more diverse range of providers.

Service modernisation has also reached sexual health, bringing with it more effective use of the multidisciplinary team, including the development of nurse consultants and nurse practitioners, and the extension of nurse-delivered services. As well as the broadening of existing roles to take on aspects of sexual healthcare, new roles have also developed in a range of hospital and community-based settings, with the potential to significantly increase capacity. There have been widened opportunities for delivering sexual healthcare through community pharmacies and greater involvement in sexual health promotion through non-healthcare providers such as social workers, youth workers and prison staff. In addition, advances in testing and treatment technologies, and changes in approach to patient management have created opportunities for innovation in prevention, diagnosis and treatment, including the possibilities

of self-management; and continued improvements in communication technologies have influenced the way in which the public and service users access and receive information.

Within this changing context, considerable progress has been made, and many of the central commitments within the Strategy and accompanying implementation plan have been delivered. There have also been some real improvements in the sexual health of the population and in service provision, including falling teenage pregnancy rates, improvements in access to NHS-funded abortions, transformed Genitourinary Medicine (GUM) services with significantly improved access to testing and treatment, and the introduction of chlamydia screening in every Primary Care Trust (PCT) across the country. These improvements have been underpinned by the development of standards and best practice guidance across the whole of sexual health. This is a reflection of the national commitment and target-driven priority placed upon improving sexual health during the initial period of the Strategy.

At local level, progress has been characterised by the development of more modern, integrated services, as well as the widening of primary care and community sexual health provision. In addition, managed networks and collaborative commissioning have helped to ensure clinical governance and quality standards are in place, and that services are commissioned around patient need and best value. Yet progress across the country has been patchy, and the impact of constant policy reform, the burden of financial deficits and the need to keep pace with clinical and technological change has placed very

real challenges at the doorsteps of Strategic Health Authorities (SHAs) and PCTs, and all those engaged in providing services and improving sexual health promotion and HIV prevention.

Although the original vision of the Strategy (holistic sexual health and integrated care, based on patient need) is still current, the clinical model on which it is based has limited the degree to which its implementation has successfully addressed the wider determinants of sexual health, including social exclusion, poverty, stigma and substance abuse. Also the lack of prominence given to contraceptive and reproductive health as a core part of sexual health provision, alongside the need to more adequately address psychosexual support and include sexual assault, are important challenges that need to be addressed.

Key barriers to more effective implementation of the Strategy to date have included:

(i) national targets and indicators that include only some elements of sexual health; (ii) diversion of sexual health funds and top slicing to meet PCT deficits; (iii) lack of 'champions' and senior people with experience in sexual health commissioning and prevention; (iv) competition and conflict between primary care, community and hospital-based services; (v) variable progress in engaging GPs in providing sexual health services; (vi) continued disinvestment in community contraceptive clinics; (vii) limited understanding of needs assessment to drive commissioning and prevention; (viii) limited progress in developments with data, supporting IT systems and national tariffs; (ix) slow build-up and dissemination of the evidence base, and lack of focus on longer-term investments and cost savings; (x) lack of progress in tackling stigma surrounding sexual health; and (xi) absence of a strong voice for sexual health service users or advocacy for sexual health in local communities.

Despite some notable progress and improvement, the scale and nature of sexual ill-health and inequalities in England today are still of grave concern, with increasing diagnoses of HIV and sexually transmitted infections (STIs), and increasing demand for abortion. The following further action is now required in relation to the Strategy's aims: improving professional and public knowledge of the most effective methods of preventing pregnancy, and ensuring access to the full range of methods, including long-acting reversible contraception (LARC); further improving access to abortions and locating services in more community-based settings; maintaining and extending prompt access to testing

and treatment for STIs; increasing HIV testing in a range of existing and new settings, and reducing late diagnosis; improving the well-being of people living with HIV through programmes which involve them in managing their sexual health and individual care; increasing local investment in prevention programmes targeting those most vulnerable and at risk, as well as those already infected; intensifying action to tackle stigma associated with sexual health and HIV; improving support to all young people and adults to acquire the knowledge and skills to stay healthy and to improve sexual health at all life stages, through access to good-quality sex and relationships education (SRE), lifelong learning programmes and regular information campaigns.

It is important not to underestimate the effort and commitment needed across Government and throughout the NHS and local government to tackle the inequalities in sexual health, and sustain and continue broader improvements in this area. Key recommendations from the review are not specific to particular aspects of sexual health but are broad and cross-cutting. They address action required at local, regional and national levels to respond to the changes that have taken place since the Strategy was published, and to build on levers that are available to accelerate progress. Priority action is needed in **five key strategic areas**.

#### **Prioritising sexual health as a key public health issue and sustaining high-level leadership at local, regional and national levels through:**

- designated accountability for driving forward sexual health improvement at PCT and local authority (LA) level
- development of a single local inter-agency scorecard for active performance management by PCTs and SHAs/Government Offices (GOs)
- comprehensive sexual health needs assessments and review of local sexual health strategies in response to changing needs and service reconfiguration
- sound leadership and performance management at regional level, and a dedicated regional function to 'support and challenge'
- continuing national support for local delivery via National Support Team
- incorporating sexual health and long-term care for people with HIV in regional visions developed as part of the NHS Next Stage Review

#### **Building strategic partnerships through:**

- actively engaging in joint planning mechanisms to ensure sexual health and HIV are prioritised



- via Local Strategic Partnerships (LSPs), Joint Strategic Needs Assessments (JSNAs), and Local Area Agreements (LAAs)
- using PCT/LA joint appointments of public health specialists to develop more systematic partnership working
- ensuring PCTs forge strong links with Children's Trusts and Mental Health Trusts
- acknowledging the third sector as an equal partner and engaging it in needs assessment and strategic planning
- ensuring sexual health is represented in other relevant local health improvement plans (eg. staying healthy, alcohol, drugs, mental health)
- closer working between SHAs and GOs across the wide variety of government policies that impact on sexual health
- a more integrated cross-governmental approach to address the impact of inequalities and the wider determinants of sexual health

#### **Commissioning for improved sexual health through:**

- adopting a holistic commissioning model which looks at sexual health in an integrated way and commissions along the care pathway
- commissioning at an appropriate level to ensure fair, effective and best value provision
- linking service networks to the commissioning process and business agenda, and using them to inform and improve commissioning quality
- skilling up sexual health commissioners to meet world class commissioning requirements
- strengthening the public voice in commissioning
- disseminating evidence where investment in sexual health interventions provide good value for money and are cost-effective
- producing an easily accessible sexual health and well-being framework, and self-assessment tool to support commissioners
- accelerating the development of tariffs which allow for different service models and reflect the real cost of services

#### **Investing more in prevention through:**

- ensuring effective sexual health promotion and HIV prevention is commissioned according to local need and is adequately resourced
- ensuring prevention is an integral part of all sexual health service provision
- developing a national prevention framework to facilitate a more co-ordinated approach to prevention across government departments and improve synergy between national and local prevention initiatives
- intensifying efforts to tackle stigma

- improving dissemination of evidence about what works and what is cost-effective, particularly in relation to African communities, gay men and young people
- making Personal, Social, Health and Economic (PSHE) education and all elements of SRE a statutory subject

#### **Delivering modern sexual health services through:**

- ensuring sexual health and HIV services are included in local reconfiguration work, particularly in relation to primary care centres/polyclinics
- specifying local quality standards in accordance with national standards and ensuring the performance of all those providing sexual health and HIV services is monitored in relation to these
- establishing and further developing sexual health and HIV networks to cover all areas of the country
- labelling services more clearly and maintaining open access at all levels
- increasing the level and quality of services provided by general practice, and including sexual health in the future development of the Quality and Outcomes Framework (QOF)
- improving workforce planning and training, and linking this to service developments and changing models of care

As the NHS shifts further from central control, it falls increasingly on PCTs and LAs to ensure they know the sexual health and HIV needs of their local populations, and are adequately addressing them in terms of both sexual health promotion and service provision. The significant expertise and commitment among those working in the sexual health field needs to be harnessed by local leaders to ensure that reducing sexual health inequalities, and improving sexual health and well-being, have a place at the forefront of local public health policy. If local organisations and partnerships fail to prioritise sexual health now, they risk having to deal with the real human and financial consequences further down the line, characterised by more infections and unintended pregnancies, and higher treatment and social care costs. More effective local delivery needs to be supported by continued national action on a number of fronts, including stronger interdepartmental links to ensure more consistent cross-governmental policy in tackling the wider determinants of sexual health.



*Sexual health is an important part of physical and mental health. It is a key part of our identity as human beings together with the fundamental human rights to privacy, a family life and living free from discrimination. Essential elements of good sexual health are equitable relationships and sexual fulfilment with access to information and services to avoid the risk of unintended pregnancy, illness or disease.*

*Better prevention, better services, better sexual health – The national strategy for sexual health and HIV (2001)*

1.1 The first national Strategy for sexual health and HIV<sup>1</sup> was published in 2001, and was a key instrument for placing sexual health firmly on the national agenda. It set out an ambitious 10-year programme to tackle sexual ill-health and modernise sexual health services in England, and focused on achieving its aims (Table 1) through better prevention, improved commissioning, modernised services and better support for people with HIV and STIs.

1.2 Considerable progress has been made in implementing the Strategy and the accompanying action plan, which provided the framework for its delivery. The Strategy’s original vision of holistic sexual health and integrated care which responds to the needs of different populations remains relevant to a more contemporary view of sexual health. Nonetheless, since publication, the NHS has been through a constant process of reform, while different Government departments and local authorities have taken on new roles relevant to health, creating a new context for delivery. Shifts in the composition of the population, and cultural and behavioural developments, along with improvements in technology have also resulted in a change in relevance and emphasis for some areas of sexual health over others. In addition, although there has been much progress in many areas of sexual

health, sexual ill-health in the population appears to be worsening in a range of ways, with increasing diagnoses of STIs and HIV, and more unwanted pregnancies resulting in increasing demand for abortion. There is more work to be done at both national and local levels in order to reverse this trend.

### Reviewing the strategy

1.3 Following publication of the Strategy, the Independent Advisory Group on Sexual Health and HIV (SHIAG) was set up to advise on its implementation. The group has been active over the intervening years in addressing a wide range of the more challenging issues for sexual health. In 2007, SHIAG commissioned the Medical Foundation for AIDS and Sexual Health (MedFASH) to take stock of progress with the Strategy and review its impact to date, outlining developments since its publication and making recommendations for the future. The review was intended to highlight the range of organisational, policy, clinical and service delivery changes that have taken place and assess the impact these have had on implementing the Strategy. In addition, the review process aimed to identify a set of process and outcome indicators for measurement at national and local levels to accompany the final recommendations.

1.4 The review process took place over a six-month period. During this time, a number of review groups and regional meetings were convened with key experts, stakeholders and service users to inform, advise and support the review (see Appendix 1). Through this process, people from a range of backgrounds contributed to the review, including GUM and contraceptive services, general practice,

**Table 1 | Aims of the Strategy**

- Reduce transmission of HIV and STIs
- Reduce prevalence of undiagnosed HIV and STIs
- Reduce unintended pregnancy rates
- Improve health and social care for people living with HIV
- Reduce the stigma associated with HIV and STIs

pharmacy, commissioning (specialised, PCT and practice based), public health, local authorities, Government Offices for the Regions, the third sector and the research community, as well as different groups of services users accessing a range of sexual health and HIV services.

1.5 Sexual health and HIV are complex areas which cannot be addressed in all their aspects within this necessarily limited review. In particular, HIV presents strategic challenges additional to those relevant for other aspects of sexual health, and is impacted by a number of different legislative and policy developments. Detailed analysis and many helpful recommendations have been made elsewhere by HIV organisations and notably in the report of the SHIAG's own seminar on public health policy and HIV (2007)<sup>2</sup>, though it is not possible to reproduce or appraise these in this short report. The aim of this review has been to focus specifically on the issues that relate to, and are likely to accelerate, implementation of the sexual health and HIV Strategy in its next phase. As such, many of the issues discussed and recommendations arising are not specific to particular aspects of sexual health (whether HIV, STIs, unintended pregnancy or other topics) but are broad and cross-cutting. They address barriers to, and levers for, change at local, regional and national levels.

The aim of this review has been to focus specifically on the issues that relate to, and are likely to accelerate, implementation of the sexual health and HIV Strategy in its next phase.

1.6 It should also be stressed that this is not a rewrite of the Strategy, still less a new strategy. It does not seek to examine in detail every part of the original Strategy document, nor to redefine its key concepts. Where the review has identified a need for updating or reassessment of significant parts of the Strategy, this has usually been included in the recommendations, but it would not have been possible to undertake that updating as part of the review itself. In particular, a number of people have suggested it is time to create a new definition of sexual health. We do not believe it would have been appropriate or feasible for us to do this as part of this limited review.

1.7 The recommendations that have emerged from this report are intended to represent a synthesis of findings both from desk-based research among stakeholders on all issues, and views differed as to the desirable areas for emphasis or most important priorities in the review. Nevertheless, common themes emerged, particularly in relation to the barriers and levers for implementation of the Strategy at local level, and these form a key part of the report.

# SECTION 2

## Changing context for sexual health

2.1 The period since the Strategy's launch in 2001 has been a time of unprecedented policy change, both in health and local government. The landscape is now very different, with devolved decision-making in the health service and an increasingly important role for local authorities (LAs) as strategic leaders. Structural changes affecting all NHS organisations have been accompanied by reform of commissioning, new financial mechanisms and the diversification of providers. Service modernisation has reached sexual health, bringing with it more effective use of the multidisciplinary team (MDT), and supported by a range of technological advances. This section of the report provides a brief overview of these major contextual changes and their relevance for sexual health and HIV.

2.2 The process of change is still ongoing, with the future direction of the NHS laid out in *High quality care for all: NHS Next Stage Review final report*<sup>9</sup>. The report sets out a vision of an NHS with quality of care for all at its heart, providing more personalised services with more information and choice to service users and the public, working in a range of partnerships and empowering frontline staff to lead change, and supporting further development and flexibility in the provision of primary and community health services. Improving sexual health is one of the six key goals identified for the comprehensive well-being and prevention services to be commissioned by Primary Care Trusts (PCTs) in partnership with local authorities. This goal will need to be addressed in the strategic plans to be published by PCTs to deliver the regional visions created as part of the Next Stage Review.

### Key policy developments

#### Devolving power and decision-making to local level

2.3 Soon after publication of the sexual health and HIV Strategy, the Government started to move from the tight system of central performance management outlined in *The NHS plan*<sup>4</sup> towards devolution of decision-making power to local organisations, reflected initially within *Shifting the*

*balance of power*<sup>5</sup>. This has remained central to all subsequent policy development, emerging as a central theme through the Public Health White Paper *Choosing health: making healthier choices easier*<sup>6</sup>, the White Paper *Our health, our care, our say*<sup>7</sup>, and more recently the NHS Operating Framework<sup>8</sup> underpinned by the *Vital signs* framework<sup>9</sup>, where the emphasis is on developing locally defined strategic priorities in line with local need.

2.4 Nonetheless, against this backdrop of local devolution, elements of sexual health have remained prominent in the national priority frameworks, and have driven real progress in some areas. Notably, reducing teenage conceptions has continued as a cross-governmental priority; 48-hour GUM access, the rollout of chlamydia screening and, until recently, improved access to abortion, have all been key national targets. Like *Vital signs*, the National Indicator Set (NIS) for local authorities and local authority partnerships<sup>10</sup> signals a further move to local priority-setting, with a reduced and restricted set of national indicators. This highlights the importance for sexual health of retaining a profile at local level.

#### Strategic partnerships with local authorities and local authority partnerships

2.5 *Choosing health* represented a renewed commitment to health improvement and reducing health inequalities, which built on earlier policy developments, notably the Wanless report *Securing good health for the whole population*<sup>11</sup> which outlined the benefits of achieving a society more fully engaged in health, and it has been reiterated and further developed in subsequent health and social care policy<sup>12 13 14</sup>. Along with *Strong and prosperous communities – the local government White Paper*, it also emphasised a more substantial role for local strategic partnerships, and an increase in joint working was identified as a requirement for driving the health improvement agenda, with Local Area Agreements (LAAs) as the key vehicle for achieving this. *Our health, our care, our say* further emphasised the need for PCTs' Local Delivery Plans (LDPs) and LAAs to become

more aligned. Joint Strategic Needs Assessment (JSNA)<sup>15</sup> was identified as a statutory duty to be implemented from 2008 and forms the basis for co-operation between local authorities (LAs) and PCTs in assessing the well-being and healthcare needs of their local population. JSNA will inform the future strategic priorities for LAAs and the selection of local targets from the new National Indicator Set (NIS)<sup>16</sup> against which local authorities and local authority partnerships will be performance-managed<sup>17</sup>.

2.6 The two NIS indicators which directly relate to sexual health – under-18 conceptions and chlamydia prevalence in under-25s<sup>18</sup> – offer a potential lever for the engagement of local authorities in sexual health. Identifying other priority indicators that are relevant for sexual health or HIV, and to the achievement of which action on sexual health and HIV can contribute, is crucial for developing areas of joint commissioning and provision. The need for local authorities to take a role in sexual health promotion has become increasingly recognised<sup>19 20</sup>.

Transmissible infections have no regard for geographical boundaries, and there are potential dangers in leaving public health control of STIs and HIV to competing services without common quality standards or a requirement for collaboration.

2.7 The social care elements of the NIS are particularly strong and complement a long-term condition model of care increasingly appropriate to HIV, which has the potential to contribute to achievement of some of these targets. Educational attainment targets are also important for sexual well-being, with low attainment a risk for unwanted pregnancy and STIs<sup>21</sup>, as well as HIV<sup>22</sup>.

2.8 Children's Trusts and Children and Young People's Strategic Partnerships have created an opportunity to address the sexual health needs of young people. Developed in response to the *Children Act 2004*<sup>23</sup> and *Every child matters*<sup>24</sup>, they provide a vehicle for integrated provision for 0-19 year-olds, based on joint assessment of needs with

a focus on the most vulnerable. Within teenage pregnancy, Children's Trusts set out to work closely with partners and identify gaps where most targeted support is needed. This includes focusing on schools with low attainment and linking with services for youth outreach, making these partnership structures important vehicles for meeting the wider needs of vulnerable young people and tackling inequalities.

### Tackling inequalities

2.9 Building on the *Independent inquiry into inequalities in health*<sup>25</sup>, reducing inequalities has remained central to government policy with the introduction of specific targets and the launch of *Tackling health inequalities: a programme for action* in 2003<sup>26</sup> in recognition of the entrenched gap in health between advantaged and less advantaged groups. The programme highlighted the need for cross-governmental action, but also recognised the need for local solutions to local inequality issues. It emphasised that more targeted prevention and support for vulnerable communities were needed, as well as increased responsiveness of mainstream services to diverse needs. To address inequities in service provision, the use of health equity audits to inform the planning and provision of NHS services became a requirement<sup>27</sup> and more recently it has become an obligation under race, gender and disability equality legislation for statutory organisations to carry out and report on equality impact assessments. Tackling health inequalities will continue as a central plank for future NHS strategy, with the direction of travel as outlined in *Health inequalities: progress and next steps* (2008)<sup>28</sup>.

2.10 This strategic priority reinforces the commitment in the sexual health Strategy to tackle inequalities in sexual health, namely the highest burden of ill-health borne by women, gay men, teenagers, young adults, black and minority ethnic groups, and more deprived communities. It also adds strength to the measures in the Strategy designed to wipe out inequity in service provision.

### Involvement of service users and the public

2.11 Maximising the voice of service users and the public has been key to the contemporary vision of the NHS<sup>29</sup> and also an integral part of JSNA and LAAs. The *Local Government and Public Involvement in Health Act*<sup>30</sup> made it a statutory duty for providers to demonstrate response to patient feedback.

2.12 Meaningful engagement with users of sexual health services, who experience stigma associated with sexual ill-health and whose use of services is

often transient, represents a particular challenge. Most user feedback has relied on periodic patient satisfaction surveys, comment cards or complaints, although more innovative methods have been used, such as mystery shoppers<sup>31</sup>, and these could be further explored and developed. Local Involvement Networks (LINks) are the main current local mechanisms for engaging users in world class commissioning. Since these are at an early stage of development, they represent a new opportunity although it is unclear how they will engage meaningfully with sexual health networks and service users.

2.13 Users of HIV services have a long tradition of involvement and play a prominent role in a number of local and national forums, both HIV-specific and with a broader remit. Through these, they have had an input to the planning and improvement of local services, the development of local strategies, the commissioning of specialised services including HIV treatment and care, and the development of national treatment guidelines. However, as individuals with HIV have become more able to live healthy and fully functional lives, and to look beyond the impact of HIV, there seems to have been a dwindling of enthusiasm for activities that focus on their illness. It has always proved harder to engage significant numbers of service users from African communities, where the fear of public disclosure may be greater, while those who are most vulnerable, such as people seeking asylum, are less likely to become involved.<sup>32</sup>

## **Organisational change and other NHS reforms**

### **Structural changes supporting new policy developments**

2.14 There have been two major NHS reorganisations since the Strategy launch. *Shifting the balance of power*<sup>33</sup> precipitated the abolition of Health Authorities and the devolution of purchasing power to PCTs with the aim of creating an NHS where services were more responsive to local need. *Commissioning a patient-led NHS*<sup>34</sup> resulted in further NHS reorganisation, where the number of PCTs was cut by half and Strategic Health Authorities (SHAs) were reduced from 28 to 10. This was intended to increase the commissioning efficiency of PCTs. It also created co-terminosity between the majority of PCT and local authority boundaries and between those of SHAs and Government Offices (GOs), potentially facilitating development of closer relationships between health and social care, and supporting a greater shared focus on improving public health.

2.15 Current reforms which support a strengthening of local accountability give local authority Overview and Scrutiny Committees and LINks more significance. Aside from setting the strategic direction and supporting PCTs in delivering this, SHAs maintain a performance management role, facilitating the delivery of government targets. However, there has been a lessening of emphasis on the performance management function, and regional structures are increasingly being called upon to focus on overseeing implementation of world class commissioning and managing the balance of competition and collaboration<sup>35</sup>. This is important in sexual health, as transmissible infections have no regard for geographical boundaries, and there are potential dangers in leaving public health control of STIs and HIV to competing services without common quality standards or a requirement for collaboration.

2.16 The new role of the Regional Directors of Public Health as head of both GO public health and SHA public health has afforded opportunities for integration and closer working. A major role is in influencing LAA development, ensuring that the opportunities for health gain within the agreements are maximised. At the regional level, there is potential for public health teams or Regional Public Health Groups (RPHGs) to support inter-agency working, as well as to promote local prioritisation of prevention and to foster the activities of sexual health service networks.

### **NHS System Reform**

2.17 Shortly after the Strategy was published, the Government also embarked on a process of NHS reform encompassing a package of changes which included strengthened commissioning, competition and contestability between providers, and financial reform.

### **Commissioning Reform**

2.18 *Commissioning a patient-led NHS* strengthened the commissioning role of PCTs<sup>36</sup> and placed more emphasis on commissioning for outcomes – healthier, longer lives and reduced inequalities rather than focusing on clinical interventions per se. *World class commissioning*<sup>37</sup> outlined the next steps for commissioners in developing this role and identified the need to hold core organisational competencies. Collaboration with partner organisations is crucial to world class commissioning. The *Commissioning framework for health and well-being*<sup>38</sup>, also lays out the steps needed to commission health and social care jointly, building on the strategic direction set by



*Our health, our care, our say.* The delivery of care in partnerships between statutory and a range of third sector providers, and through new models of service provision, is therefore reflected in the contemporary commissioning framework.

2.19 The required skills for commissioning sexual health services under the new arrangements, ensuring collaboration across a diverse range of providers while maintaining quality, have become increasingly complex. Analytical, financial, communication and leadership skills will be needed, and effective commissioning will reflect the ability to co-ordinate tasks across the wider workforce<sup>39</sup>.

2.20 Practice based commissioning (PBC) was introduced in 2005 as part of the wider move to improve the quality of care in general practice and the community. The outcome of introducing this alternative contracting mechanism will depend on how GPs and other commissioners choose to explore and develop it. PBC gives general practice its own notional budgets for commissioning care for its population. It was designed to encourage general practice to seek out innovative methods of delivery via new sites and providers outside hospital settings, to ensure the needs of its patients were well met, and to generate efficiency savings which could be ploughed back into improving patient care. It was also intended to motivate practices to 'look after' their populations more through public health initiatives. The place of sexual health within PBC has yet to be firmly established. *High quality care for all: NHS Next Stage Review final report*<sup>40</sup> suggests that further transformations in the commissioning and delivery of general practice and community-based services are likely.

2.21 In 2006, responsibility for commissioning prison healthcare was transferred from the Prison Healthcare Service to PCTs. This change was designed to move towards the principle of equivalence in the quality of care between prisons and the NHS. PCTs are expected to develop prison healthcare delivery plans based on assessment of needs, and in the light of *Choosing health*, to take a public health approach, aiming to find the causes of health inequalities and social exclusion among prisoners and trying to prevent them.<sup>41</sup> The Strategy identified people in prison as a vulnerable group whose sexual health needs should be assessed, who should be targeted with information and supported to access services. The move of commissioning responsibility to the NHS supports implementation of these aspects of the Strategy.

### Market reform and patient choice

2.22 Patient choice is another key plank of the reform agenda. There has been a drive to expand the diversity of providers with increasing involvement of independent sector, third sector and social enterprise organisations for provision of care outside NHS hospital settings. Entry into the market by non-NHS providers has been encouraged. The vital role that some third sector organisations play in designing and delivering services was recognised in the report of the Government's third sector review<sup>42</sup>, which set out a programme of support including significant investment in the Futurebuilders Fund to provide loans and grants to organisations looking to deliver public services in all areas. In sexual health, there has been a significant expansion in the role of new providers, especially from the third sector, beyond what must have been envisaged at the time of the Strategy's publication.

2.23 The Strategy's vision of choice and open access for service users, achieved through collaboration between providers in managed service networks, offers a framework to inform the commissioning of these new providers. The NHS Next Stage Review provides pledges that service change will be for the benefit of patients, clinically driven, and locally led, with the involvement of patients and the public, and that existing services will not be withdrawn until new and better services are available.<sup>43</sup>

### Financial reform

2.24 In 2002, a new system of payment for hospital-based care was announced, to be introduced on a mandatory basis for Foundation Trusts from 2005 and for all Trusts from 2006. Payment by Results (PbR) moved away from block contracts by introducing a tariff system for financing treatments or procedures in consultant-led services. This was intended to standardise payment levels and incentivise hospitals to increase activity, but it has been rolled out relatively slowly in some areas of healthcare. At present the tariffs do not cover some types of service provided in the community, such as contraception. They also do not have to cover some types of independent provider, such as those in sexual health, and the tariffs are not yet sufficiently 'unbundled' to enable provision of different elements of care across settings.

2.25 Tariffs have been established for inpatient HIV care and outpatient GUM services, as well as hospital abortion provision. Indicative tariffs exist for contraceptive and HIV outpatient services, and further work is underway to improve and pilot



pricing in these areas. The principle of open access to services is central to the Strategy: the new requirement (as of April 2009) for de-hosting and cross-charging to be in place in GUM alongside PbR supports this by ensuring that PCTs pay for the care of their own residents, and removing any incentive to restrict access by patients from other areas. However, the development of tariffs for only some areas of sexual health has not helped the implementation of another fundamental principle of the Strategy, service integration (see 4.19).

2.26 PbR does not apply to the commissioning of primary care services, but funding for these has also been transformed. Not long after the publication of the Strategy, which had made clear recommendations for the role of general practice in sexual health, there was a major change in the contracting arrangements, notably the introduction of the new General Medical Services (GMS) contract alongside other contracting routes to support provision of a wider range of services closer to home. GMS contracts are held by a majority of GPs<sup>44</sup> while flexibility for provision of services within primary care has been created by development of alternative non-GMS contracting mechanisms such as Personal Medical Services (PMS), Alternative Provider Medical Services (APMS) and PCT Medical Services (PCTMS), which are locally negotiated arrangements. Around 40% of GPs hold PMS contracts although the range of available contracting routes within primary care offers the potential for PCTs to use an expanding range of providers including pharmacy, and the third and independent sectors.

2.27 The new GMS contract outlines three categories of service: essential, additional and enhanced. The contract rewards practices according to the quality of specified essential and additional services through the Quality and Outcomes Framework (QOF). Though take-up is voluntary, the QOF has been very widely adopted nationally. Local QOFs can also be developed for non-GMS practices, and should apply a similar framework and rewards.

2.28 For provision of the other elements of sexual healthcare that are recognised as being more specialised, GMS contractors can offer local enhanced services (LEs), where GPs opt to provide a service for additional payment. Enhanced services were developed as part of the new contract in order to expand the range of services that could be offered in primary care and reduce demand on secondary care. Comparable arrangements can be made with PMS practices using service level agreements.

2.29 In contraception (an 'additional' service), the QOF rewards only having a written policy for responding to requests for emergency contraception and for providing pre-conceptual care. No other aspects of sexual health are included in the framework. LEs for aspects of sexual health have been developed in a number of places, often for provision of long-acting reversible contraception (LARC) or chlamydia screening.

2.30 In line with the policy of devolving decision-making to local level, ring-fenced funding, which provided control from the centre, has been almost completely phased out. At the time of the Strategy's publication, ring-fenced funding was still in place for HIV prevention, but following its removal the following year, all monies allocated to the NHS for HIV and sexual health were included in PCTs' baseline budgets, allowing them the option to divert this funding to other local priorities or deficits. The AIDS Support Grant, which is used to fund social care for some of the most vulnerable individuals and families affected by HIV, remains ring-fenced and was recently uplifted to take account of rising numbers in need.

### **Clinical and service delivery developments**

2.31 New mechanisms of delivery through a diverse range of providers and across new settings are part of recent NHS reforms, offering the potential to increase access for harder-to-reach groups and reduce inequalities. Role redesign supported by training, care pathways, accountability and safety protocols such as patient group directions (PGDs) has increased flexibility of provision and paved the way for new providers to enter the market. This policy supports the Strategy's drive for expansion in the sexual health workforce with a broadening of existing roles to take on new aspects of sexual healthcare, as well as the development of new roles outside existing specialist services. This was further reinforced by *Choosing health* in laying out its vision for modernisation of sexual health services. Such action has created an increase in capacity, which was key to achieving the GUM 48-hour access target, itself a strong driver for such changes<sup>45</sup> along with the rollout of the National Chlamydia Screening Programme (NCSP).

2.32 Development of the multidisciplinary team, with full and effective use of the skills of all its members, is essential for the delivery of efficient, modern healthcare, and has been a major plank of NHS modernisation. It includes more autonomous

roles for nurses, including nurse consultants and nurse prescribers, and the development of nurse-delivered services. Such developments have been increasingly taken up in sexual health, building on the recommendations of the Strategy (see Section 3).

2.33 Greater self-management has formed part of the NHS's approach to managing long-term conditions, and technological advances are facilitating its expansion into other aspects of healthcare, including diagnostic testing. Self-taken chlamydia samples have been the main mode of delivery of the NCSP in many areas. Central booking services have been set up to facilitate self-referral for abortion. Further opportunities for self-management in sexual health are being sought through increased availability of pregnancy testing, condom provision and STI testing, with access to support as required<sup>46</sup>.

### **Technological and other advances** **Prevention, testing and treatment** **technologies**

2.34 Technological change has been a driver for new mechanisms of service delivery and created opportunities for innovation in prevention, diagnosis and treatment, including widening the possibilities in self-management.

2.35 New diagnostic technologies have had a particular impact, providing greater accuracy, earlier detection, non-invasive sample collection, rapid results and near-patient testing in clinical and non-clinical settings. These developments have enabled sexual healthcare providers to increase service capacity and efficiency, and expand the range of settings and professionals that can offer testing.

2.36 Developments in prevention technologies have included HPV vaccination and non-occupational post-exposure prophylaxis for HIV, while on the treatment side, drug treatments for HIV continue to improve and medical abortion is more widely adopted.

### **Communications technology**

2.37 Continued progress in communications technology has influenced the ways in which people develop social networks as well as how they access and receive information such as sexual health promotion or test results.

2.38 Social networking through internet chatrooms has made meeting casual sex partners easier, although this does not necessarily mean greater risk taking.<sup>47</sup> Targeted prevention initiatives through

chatrooms, particularly for gay men, have been trialled and met with some success.<sup>48</sup>

2.39 Various studies have attempted to quantify the importance of the internet as an information source for sexual health: 98% of people have computer access, and young people appear to seek advice quite commonly online<sup>49</sup>, although across all groups only 3% of people actually report using the internet as an important information source on sexual health<sup>50</sup>. The computer remains a rich source of information with still untapped potential, but information alone is unlikely to change sexual health behaviour<sup>51</sup>. However, initial analysis of trials investigating interactive computer-based sexual health promotion initiatives show that these can lead to improvements in knowledge and attitudes, with some reporting positive behaviour change such as increased condom usage<sup>52</sup>.

2.40 Technologies such as mobile text-messaging, email and 24-hour secure telephonic access systems have increased the ease of obtaining test results, cut unnecessary clinic visits and helped to reduce non-attendance rates by sending appointment reminders. Such systems have been developed both within GUM clinics and the National Chlamydia Screening Programme, and have been found highly acceptable to service users. Texting and email communication of results can also support the 'care closer to home' agenda, particularly for HIV care, where electronic communication of CD4 counts and viral-load monitoring may all contribute to lessening the need for frequent attendance at specialist treatment services<sup>53</sup>.

2.41 The internet has also increased the availability of unregulated tests and treatments in sexual health, however. This has been an issue particularly in HIV testing where, although illegal in the UK, tests can be purchased online from overseas suppliers, and are of variable quality. Concerns have increased over the availability of drug treatments through the internet with those for erectile dysfunction being some of the ones more commonly bought<sup>54</sup>.

# SECTION 3

## Progress in improving sexual health and implementing the Strategy

### Sexual health in 2008

3.1 Securing improvements in the sexual health and well-being of the population in England will continue to present a real challenge to all of those charged with this responsibility at national, regional and local level. The HIV epidemic in this country has changed significantly, with unanticipated increases in heterosexual diagnoses from people infected overseas, and undiminished levels of newly acquired infections in gay men. Despite the availability of more effective drug treatments and expanded testing opportunities, too many people are still being diagnosed too late, facilitating ongoing transmission and leading to avoidable illness and death.

3.2 Overall, diagnoses of sexually transmitted infections continue to increase, most alarmingly among young people, some black and minority ethnic groups, and gay men, with recent rises also seen among those over 45<sup>55</sup>. Significant numbers of women experience unintended or unwanted pregnancies, many of which are preventable. In addition to this, despite a reduction in teenage pregnancy rates in recent years, teenage conceptions are still high, particularly in some deprived areas. Availability of community contraceptive services continues to vary across England, and access to the full range of contraceptive methods (including long-acting reversible contraception) remains limited. Access to both early and late abortion services also varies significantly across the country and some women continue to face difficulties in being referred for an abortion in the first place. Further, services for those experiencing sexual problems or who have suffered sexual assault remain fragmented and on the periphery of sexual health provision, although a cross-government action plan on sexual violence and abuse seeks to address this.<sup>56</sup>

3.3 Little is known about changes in behaviour through the lifetime of the Strategy, although indicators of sexual ill-health and recent surveys among different population groups suggest risk behaviour is continuing. One-third of young people report inconsistent condom use<sup>57</sup> and almost half of gay men report an episode of unprotected anal

intercourse in the preceding year<sup>58</sup> (with higher levels of risk reported by HIV-positive gay men<sup>59</sup>). Frequent use of alcohol and other drugs is associated with higher numbers of sexual partners and decreased likelihood of using protection<sup>60</sup>. Sexual behaviour among heterosexuals varies by ethnic group and gender. Black African and black Caribbean men report higher levels of sexual risk behaviour and higher incidence of STIs compared to white, Indian and Pakistani men. Meanwhile, white women report higher levels of risk behaviour than other ethnic groups; however, they are less likely to report STIs than black Caribbean and black African women<sup>61</sup>.

3.4 The population of the UK is ageing, and the 'baby-boomer' generation is now at the later stage of mid-life. Sexual behaviour research in this group has been minimal, but in a recent large survey of almost 8000 people over 50, two-thirds said they were sexually active (65%), and more than one in ten said they did not use contraception with their current partner to avoid STIs, while also not knowing about their partner's sexual history<sup>62</sup>. These findings are borne out by evidence of increasing GUM attendance and a doubling in STI diagnoses among those aged 45 and over between 1998 and 2003, with men and people aged 55-59 more likely to be affected.<sup>63</sup>

*See Table 2: Sexual health in 2008*

### Strategy targets

3.5 The Strategy set some ambitious goals for improvement of the nation's sexual health and laid out a number of targets against which progress could be measured (Table 3). National surveillance systems have enabled close monitoring of sexual health over the period for which the Strategy has been in place, particularly in HIV, STIs, conceptions and abortion. While progress has been encouraging in some areas, overall the picture is one of worsening sexual health<sup>64</sup>. It is inevitably difficult to disentangle the impact of the Strategy from the influence of external factors such as demographic shifts, altered patterns of migration, changes in legislation, cultural norms, behaviour and attitudes. Nonetheless it is vital to take stock of the current

**Table 2 | Sexual health in 2008 – illustrative examples****Sexual behaviour**

- 51% of people said they would always, and 14% said they would never or rarely, use a condom with a new sexual partner.<sup>i</sup>
- Of men who had sex with another man over the last year, 36% were consistent condom users. 53% had had anal sex at least once without a condom.<sup>ii</sup>
- Frequent use of alcohol and other drugs is associated with high numbers of sexual partners and decreased likelihood of using protection.<sup>iii</sup>

**Contraception**

- The most frequently used method is the contraceptive pill (27%) followed by the male condom (22%).<sup>iv</sup>
- Only 10% of women under 50 report using LARC as their method of contraception although 45% would use this method if offered.<sup>v</sup>

**Pregnancy and abortion**

- The teenage conception rate declined by 13.3% (in 15-17s) between 1998 and 2006.<sup>vi</sup>
- Abortion rates are highest in 18-24 year-olds, peaking at age 19 (36 per 1000 women aged 19, compared to 18 per 1000 aged 15-44).<sup>vii</sup>
- 68% of NHS-funded abortions in 2007 took place at under 10 weeks compared with 51% in 2002 (a 33% increase).<sup>viii</sup>
- The proportion of medical abortions has more than doubled in the last five years, reaching 35% of all abortions in 2007.<sup>vii</sup>
- 32% of all women undergoing abortion in 2007 had had one or more previous procedures (28% of Asian women, 48% of Black women).<sup>v</sup>

**Sexually transmitted infections**

- Numbers of new STI diagnoses at GUM clinics have risen steadily over the last 10 years. The highest rates are in young people and men who have sex with men (MSM).<sup>viii</sup>
- 16-24 year-olds account for nearly half of all STIs diagnosed in GUM clinics.<sup>ix</sup>
- Men who have sex with men account for a fifth of new diagnoses of gonorrhoea and over half of new episodes of syphilis seen in GUM.<sup>x</sup>
- 9.5% of women and 8.4% of men aged under 25 test positive for chlamydia when screened.<sup>ix</sup>
- Black Caribbeans continue to have a very high incidence of STIs, accounting for 17% of all gonorrhoea diagnoses though they only comprise 1% of the UK population<sup>xi</sup>

**HIV<sup>xi</sup>**

- 73,000 people are estimated to be living with HIV in the UK, including one-third who are unaware of their diagnosis.
- An estimated 43% of those living with HIV are men who have sex with men, and 35% are people born in sub-Saharan Africa.
- Over 52,000 people accessed care for HIV in 2006, a tripling in numbers since 1997. The increase was greatest in London, but the largest proportionate increases were outside London.
- Late diagnosis accounts for 35% of HIV-related deaths.<sup>xii</sup> An estimated one-third of all HIV diagnoses and 40% of those in black Caribbeans and black Africans occur late (CD4 count <200)

**Public knowledge and attitudes**

- 79% of people were aware HIV could be passed on by sex between a man and woman without a condom in 2007, 12% less than in 2000.<sup>i</sup>
- 70% believe that people with HIV deserve the same level of support and respect as someone with cancer, compared to 77% in 2000.<sup>i</sup>
- One third of people living with HIV in London reported being discriminated against because of their infection, almost half of these saying this had involved a healthcare worker.<sup>xiii</sup>
- 40% of young people state that the quality of SRE in schools is poor or very poor.<sup>xiv</sup>
- 30-50% of people in secondary schools attracted to the opposite sex have directly experienced homophobic bullying.<sup>xv</sup>

## Sources:

<sup>i</sup> National AIDS Trust (2007) *Public attitudes towards HIV*<sup>ii</sup> Weatherburn P, Hickson F, Reid D et al (2008) *Multiple chances: findings from the United Kingdom Gay Men's Sex Survey 2006*. Sigma Research<sup>iii</sup> Bellis M, in Independent Advisory Group on Sexual Health and HIV report (2007) *Sex, drugs, alcohol and young people: a review of the impact drugs and alcohol have on young people's sexual behaviour*.<sup>iv</sup> National Statistics Omnibus Survey (2007). *Contraception and Sexual Health 2006/07*. Office for National Statistics<sup>v</sup> Armstrong N, Davey C, Donaldson C (2005) *The economics of sexual health*. fpa<sup>vi</sup> Office for National Statistics and Teenage Pregnancy Unit, 2008<sup>vii</sup> Department of Health (2008) *Abortion statistics, England and Wales: 2007*<sup>viii</sup> HPA (2008) *Continued increase in sexually transmitted infections: an analysis of data from UK genitourinary medicine clinics up to 2007*<sup>ix</sup> HPA (2008) *Sexually transmitted infections and young people in the United Kingdom: 2008 report*<sup>x</sup> HPA (2008) *All new STI episodes seen at GUM clinics in the UK: 1998-2007*<sup>xi</sup> Health Protection Agency (2007) *Testing times: HIV and other sexually transmitted infections in the UK*<sup>xii</sup> British HIV Association Clinical Audit Report 2005-6 (2006) *HIV related deaths in the HAART era*<sup>xiii</sup> Elford J et al (2007) HIV-related discrimination reported by people living with HIV in London, UK. *AIDS and Behavior*, vol 12, no 2, p255-64<sup>xiv</sup> UK Youth Parliament (2007) *Are you getting it?*<sup>xv</sup> Hunt R (2007) *Speak Out*. Stonewall

situation and identify areas of particular need for the ongoing successful implementation of the Strategy.

*See Table 3: Summary of sexual health Strategy targets*

### Prevention and diagnosis of STIs and HIV<sup>65</sup>

#### Gonorrhoea

3.6 There has been an overall reduction in diagnoses of gonorrhoea in GUM clinics just exceeding the Strategy target, which aimed to reduce new infections by 25% by 2007, if diagnoses approximate to new infections. Most of this is attributable to recent reductions among heterosexuals, although while diagnoses of gonorrhoea among gay men continued to rise until 2006, in 2007 a considerable reduction occurred. These figures for gonorrhoea in gay men still represent between 20 and 25% of all diagnoses, and suggest ongoing transmission in this group. Black Caribbeans are also disproportionately affected, with 17% of infections in this group, one that represents just 1% of the population. In addition, young people carry a significant burden of infection, with 40% of diagnoses in females being among teenagers.

#### Syphilis, and other STIs in gay men

3.7 Although deemed to be close to eradication a decade ago, there has been a rapid increase in diagnoses of syphilis in both gay men and heterosexual men and women since 2002, mostly in localised outbreaks. This now appears to be stabilising. A significant feature of this resurgence of syphilis is the high proportion (roughly one-third) of gay men diagnosed with syphilis who also have HIV. Since the Strategy was published, other STIs

that disproportionately affect HIV-positive gay men have emerged, notably lymphogranuloma venereum and sexually transmitted hepatitis C infection. This highlights the importance of ensuring effective sexual health services for people with HIV, especially gay men.

#### Hepatitis B vaccination

3.8 Increasing hepatitis B vaccination in groups at risk of infection was a major aim, and uptake of vaccine among gay men newly attending GUM clinics increased to 92% receiving a first dose in 2006 compared with 86% in 2002, just exceeding the Strategy target. However, only 38% of those offered vaccination went on to complete the course of three doses in the clinic at which they began the course. Hepatitis B vaccination rates have increased among injecting drug users (IDUs) with two-thirds now vaccinated<sup>66</sup>, although rates of hepatitis C and HIV have increased in this population (to almost half, and one in 75, respectively<sup>67</sup>), suggesting unsafe injecting practices. One-quarter of IDUs reported sharing equipment in the preceding month, and there is still the potential for an explosive epidemic, especially if measures to minimise transmission risk, such as needle exchanges, are not maintained.

#### Chlamydia

3.9 Diagnoses of chlamydia in GUM have increased since 2002, related to a range of factors including improved sensitivity of tests, increased uptake of testing and possibly changes in sexual behaviour, with the increase being proportionally greatest among gay men. As with other STIs, young people also continue to bear a large proportion of the burden of infection, with chlamydia diagnoses highest in 16-19 year-old women and 20-24 year-old men.

3.10 The National Chlamydia Screening Programme (NCSP) was established in 2003, and was designed to reach asymptomatic under-25 year-olds outside GUM. It has now achieved coverage across all PCTs, although screening rates in most remain below the targets of 15% in 2007/8 and 17% for 2008/9. In many settings, positivity rates are above 10% of those screened, and are particularly high in prisons and abortion services<sup>68</sup>. Rates in some ethnic groups, notably Black Africans, suggest the programme may not be reaching those at highest risk<sup>69</sup>. Further, while not many tests in men are done in general practice, they exhibit high positivity, illustrating a potential missed opportunity<sup>70</sup>.

#### New HIV diagnoses

3.11 Annual new diagnoses of HIV have remained at approximately the same level over the past three

**Table 3 | Summary of sexual health Strategy targets\***

- Reduce by 25% the number of newly acquired HIV and gonorrhoea infections by the end of 2007
- By the end of 2004, all Genitourinary Medicine (GUM) clinic attendees to be offered an HIV test on their first screening for sexually transmitted infections (and subsequently according to risk):
  - Increase uptake of the HIV test by those offered it in GUM clinics to 60% by the end of 2007
  - Reduce by 50% the number of previously undiagnosed HIV infected people attending GUM clinics who remain unaware of their infection after their visit by the end 2007
- Increase the uptake of hepatitis B immunisation in homosexual and bisexual men attending GUM clinics as follows:
  - Uptake of the first dose of hepatitis B vaccine, in those not previously immunised, to be 90% by the end of 2006
  - Uptake of the three doses of hepatitis B vaccine (i.e. the full course), in those not previously immunised, to be 70% by the end of 2006
- For women who meet the legal requirements, access to an abortion within 3 weeks of the first appointment with the referring doctor

\* In line with the move to minimise the number of centrally determined targets following *Shifting the balance of power*, the 'targets' in the 2001 Strategy were amended to 'standards' and 'goals' in the implementation action plan published in 2002.



years, having increased by about 50% between 2000 and 2005 to more than 7,500, a move in the opposite direction from the Strategy target of a 25% reduction in newly acquired infections. (Diagnoses do not approximate to new infections, but there is some evidence that among gay men, new infections have been occurring without any significant change in annual rate.) Of the 6,840 new diagnoses reported to date in 2007, 56% were infections acquired through heterosexual sex, and 38% through sex between men. The majority of infections in heterosexuals are among black Africans, most thought to have been acquired in Africa. Infections acquired heterosexually within the UK are slowly increasing, mostly among people whose partners probably became infected in Africa, although recent research has suggested that the proportion of infections in Africans which are UK-acquired may have been underestimated<sup>71</sup>. Among gay men, there is no evidence of a decrease in transmission, and new diagnoses each year continue to rise. 5.4% of gay men were estimated to be living with HIV in 2006. Half of the total population living with HIV is based in London, although rates of increase in regions outside London have been proportionately greater.

### HIV testing

3.12 Increases in HIV diagnoses are in part due to improved testing uptake, as well as changed patterns of migration. Uptake of HIV testing in GUM clinics has increased across all groups, reaching

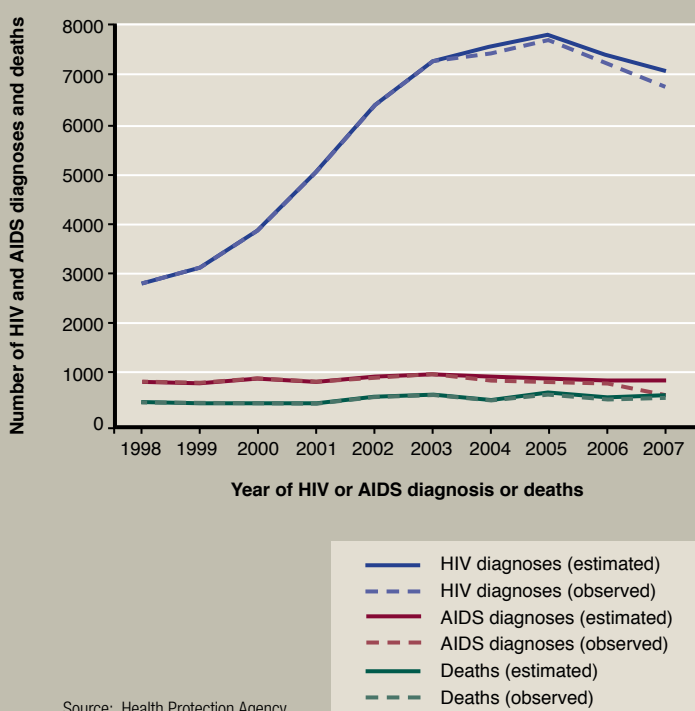
73% of all attendances and 85% of gay men, well in excess of the 60% target set by the Strategy. Uptake of testing is greater in clinics where there is an 'opt-out' testing policy<sup>72</sup>. The proportion of those leaving the clinic unaware of their diagnosis has decreased, from 50% in 2002 to 37% in 2006, with a smaller decrease in gay men, from 58% to 47%, and thus not reaching the 50% reduction target set by the Strategy. The proportion of apparently undiagnosed HIV-positive gay men attending GUM who choose not to test for HIV is a cause for concern, although this figure should be viewed with caution, as some men may not declare their HIV-positive status when attending sexual health services. The likelihood of remaining undiagnosed was higher among those with an acute STI, and these individuals, because of the STI co-infection, are more likely to transmit HIV.

3.13 Uptake of HIV testing in the antenatal setting has also increased, with 89% of HIV-infected pregnant women diagnosed prior to delivery in 2005 compared with 84% in 2002. However, national figures mask regional variation, with 6 out of 9 regions yet to reach their 90% uptake target.<sup>73</sup> Interventions made possible by diagnosing HIV prior to delivery can reduce the rate of mother-to-child transmission from around 25% to 1%, but since HIV prevalence rates have increased alongside testing rates, and HIV-positive women are more often choosing to become pregnant in view of the reduced transmission risk, the numbers of perinatally infected children, while very low, remain roughly constant. On an individual basis, HIV diagnosis in pregnancy can be devastating, and women have called for a more couple-focused approach to HIV testing<sup>74</sup>, as well as more routine testing prior to pregnancy. Anonymous seroprevalence<sup>75</sup> of HIV in women terminating their pregnancies is higher than that within the antenatal setting, but HIV testing is not routinely offered in this context, although research has shown this can be done successfully<sup>76</sup>.

### Undiagnosed and untreated HIV infection

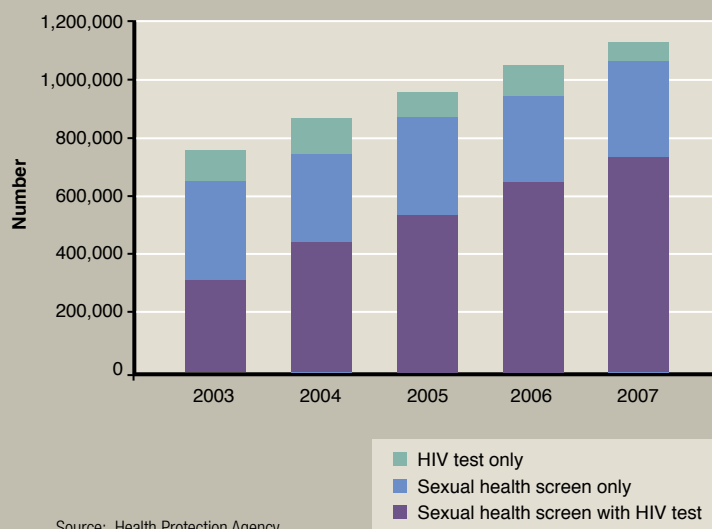
3.14 Undiagnosed and untreated HIV infection is a significant risk, both for the health of the individual and for onward transmission of infection. About one-third of the estimated 73,000 people living with HIV in the UK are thought to be unaware of their infection. This figure is lowest among heterosexual women (25%) due to antenatal HIV screening and highest amongst heterosexual men (38%) and injecting drug users (39%), highlighting the importance of continuing to recommend HIV testing for the latter group. Many individuals continue to be diagnosed late in the course of infection,

Figure 1 | HIV and AIDS diagnoses and deaths, UK, 1997-2007



Source: Health Protection Agency

**Figure 2 | Numbers of sexual health screens and HIV tests at GUM clinics, UK, 2003-2007**



resulting in potentially avoidable mortality, in spite of a high proportion having been seen in clinical settings during the year preceding diagnosis<sup>77</sup>. Late diagnosis is more common in heterosexual, older and black African populations, highlighting inequalities in access to, and uptake of, testing among these groups.

### Primary HIV infection

3.15 Recently attention has turned to estimates that newly acquired (primary) HIV infection, when individuals are highly infectious but usually still unaware they have HIV, accounts for up to half of all transmissions<sup>78</sup>. With some HIV tests still providing negative results at such an early stage in infection, this presents difficult new challenges both for timely testing<sup>79</sup> and for prevention.

### Barriers to HIV testing

3.16 Stigma remains arguably the greatest barrier to testing, with potential to further compound the marginalisation that communities at higher risk already face. One-third of HIV-positive individuals report having experienced discrimination, half of which occurred in general practice<sup>80</sup>. People living with HIV identify a need for the education of hospital, and more particularly primary care, staff in the reality of living with HIV<sup>81</sup>.

3.17 For migrants from overseas who are not entitled to free NHS secondary care but may be at significant risk, lack of access to effective treatment is likely to be a further disincentive to HIV testing. Not only do they face a greater chance of HIV-related illness and death if undiagnosed, but for

the NHS, the resulting emergency treatment of advanced disease (provided free) is likely to be less cost-effective than providing routine antiretroviral therapy<sup>82</sup>. A recent High Court ruling that people refused asylum should be entitled to free NHS treatment may increase the numbers of people coming forward for testing and care.

3.18 There is concern that the policy of criminal prosecution for reckless transmission of HIV, pursued since 2001, may have functioned as another barrier to testing<sup>83</sup>. New guidance from the Crown Prosecution Service seeks to reduce the inconsistencies which may have exacerbated this impact of the policy.<sup>84</sup>

### Health and social care of people with HIV HIV as a long-term condition

3.19 Roughly 52,000 people in 2006 were living with diagnosed HIV and accessing care<sup>85</sup>. Annual increases in new infections combined with low rates of mortality mean that this total number has continued to rise year on year. While still a life-threatening condition, HIV in England is now a long-term manageable condition for most of those infected. It affects people from childhood through to old age, and with this improved survival have come emergent health problems associated with sustained use of highly active antiretroviral therapy (HAART), long-term HIV infection and ageing generally, such as heart disease and cancer. Among those for whom HAART fails, the reasons include late diagnosis resulting in limited treatment options, and infection with a drug-resistant strain of HIV. A further frequent cause is inadequate adherence to demanding drug regimens: some individuals choose not to start therapy when clinically indicated, and high levels of adherence are often hard to achieve, requiring multidisciplinary support<sup>86</sup>. People with HIV also need reproductive health and sexual health services, as well as general primary healthcare unrelated to their HIV.

### Social needs and entitlements

3.20 While many now live relatively healthy lives, significant numbers of people with HIV are faced with problems of unemployment, poverty, social exclusion and mental ill-health, which often require non-medical solutions. The rising proportion of infections among heterosexuals means more families are affected, creating changing demands for social care and community support; some population groups affected, such as people seeking asylum, are particularly vulnerable.

3.21 In the face of stigma and discrimination, people with HIV may experience difficulties finding

jobs or secure housing. The current review of Disability Living Allowance 'special rules' eligibility, being carried out because of improvements in life expectancy, is likely to increase the hardship faced by some individuals in this situation. On the other hand, the extension of the Disability Discrimination Act in 2005 to cover people with HIV from the point of diagnosis (rather than when symptomatic) provides some protection from overt discrimination, although there is no evidence yet of its actual impact on people living with HIV.

### Unintended pregnancy

#### Conceptions

3.22 There has been an increase in overall conception rates since 2001 from 72.2 to 78 per thousand women age 15-44<sup>87</sup>. However, under-18 conceptions dropped to their lowest rates for 20 years in 2006 having decreased from 42.7 to 40.4 per thousand since 2002<sup>88</sup>. This is a testament to some of the successes of the Teenage Pregnancy Strategy, but wide local variations persist and the most recent provisional figures show a slight rise. Higher rates are associated with deprivation and lower educational attainment<sup>89</sup> yet some of the most marked progress has been achieved in areas of greatest need.

#### Abortions

3.23 Although more than 85% of those at risk of pregnancy report using contraception<sup>90</sup>, both total numbers of abortions and abortion rates have increased since the Strategy was published, suggesting a high unmet need for contraception or for support to use contraception more effectively.

In 2006, 193,700 abortions were performed, with the rates highest in 19 year-olds at 35 per thousand women, and the increase greatest in 18 year-olds. Abortion rates have decreased in those over 30 in part related to delays in childbearing.

#### Repeat abortions

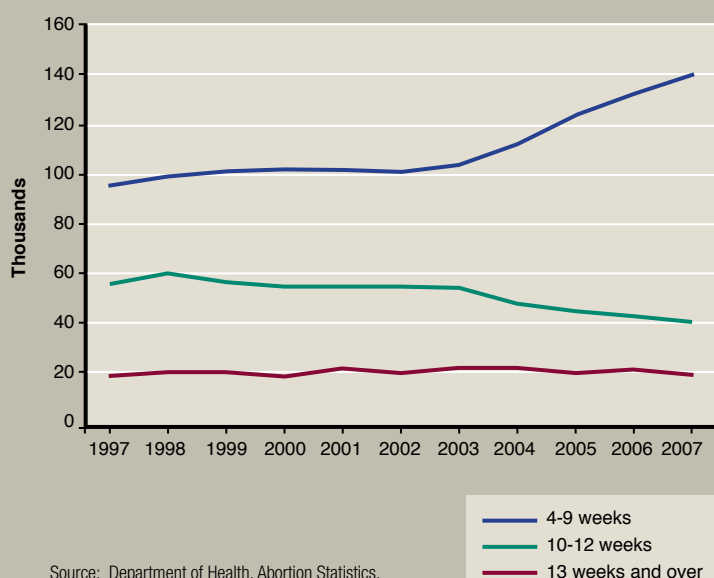
3.24 Repeat abortions increase with age, and rates have remained relatively constant over the lifetime of the Strategy at just under one-third of procedures. However, the number of repeat procedures is significantly higher among black women, where this figure reaches 44%. Although the relationship of repeat abortion to contraceptive usage is complex, the percentage of abortions that are repeat procedures is sometimes used as a proxy measure of access to contraception.

#### Contraception

3.25 People seek contraception from a range of sources, most commonly community contraceptive clinics or general practice. Proportions of people accessing different services have changed little since 2002 with about one-fifth of women aged 16-49 reporting that they have sought advice from community contraceptive services in the preceding five years, although there has been a decline in attendances over the past year<sup>91</sup>. The 16-19 age group represents an increasing proportion of those attending these clinics in preference to general practice, and there has also been a 48% increase in the number of (largely young) men using community contraceptive services. General practice is the majority choice for contraception, with 80%<sup>92</sup> citing their GP as their contraceptive provider. The proportion of individuals accessing pharmacy for general contraception has changed little over the intervening years of the Strategy in spite of the fact that 55% of women obtain their emergency contraception from pharmacies compared with 20% in 2002.

3.26 There has been little shift in the method that people report using, with the combined pill being the most widely used by women at risk of pregnancy (42%) and condoms being the next most favoured method<sup>93</sup>. More than 85% of heterosexual men and women using condoms cite prevention of pregnancy as the primary reason<sup>94</sup>. In spite of evidence for both effectiveness and cost-effectiveness of long-acting reversible contraception (LARC), only 10% of women in the most recent surveys report use of these methods, although they represent the primary method prescribed in 21% of those attending community contraceptive services. Analysis of prescribing data suggests that use of intrauterine systems and

Figure 3 | Numbers of abortions by gestation weeks, 1997-2007



Source: Department of Health, Abortion Statistics, England and Wales 2007



**Table 4 | Key sexual health targets in national frameworks****Public Service Agreement (PSA) targets**

- Reduction in under-18 conception rate by 50% from 1998 baseline by 2010 as part of a broader strategy to improve sexual health

**Vital signs framework**

- Under-18 conception rate per 1,000 females aged 15-17
- Prevalence of chlamydia
- Guaranteed access to a GUM clinic within 48 hours of contacting a service

**National Indicator Set**

- NI 112: Under-18 conception rate
- NI 113: Prevalence of chlamydia in under-25s

implants are gradually increasing in general practice<sup>95</sup> since publication of the NICE guideline<sup>96</sup>.

**Impediments to sexual well-being****Sexual difficulties**

3.27 The absence of sexual difficulties and freedom from sexual violence are essential prerequisites for sexual well-being, but there is a paucity of data available to measure these, or indeed sexual well-being itself. Many people reveal having sexual difficulties at some point in their lives which represent significant barriers to sexual enjoyment<sup>97</sup>, although problems tend to be under-recognised<sup>98</sup>. A high proportion of older people, in particular, report having difficulties but fail to seek help mainly due to embarrassment.<sup>99</sup>

**Sexual assault**

3.28 The global lifetime risk of sexual assault among women is 20% and more than 57,000 rapes were reported in England and Wales in 2007, although rates of reporting appear to be on the decline<sup>100</sup>. Vulnerable people such as young women, sex workers and people with disabilities are disproportionately affected. Sexual assault is also associated with poverty<sup>101</sup> and, commonly, with alcohol use<sup>102</sup>. Only 20% of people who have experienced sexual violence report it to the police, with fewer than 6% of cases resulting in conviction. People who have experienced sexual assault have multiple ongoing sexual health needs including addressing pregnancy risk, risks of infection and psychosocial impacts. A Home Office study found the health-related costs of a rape case are £73,487, the highest of any crime.<sup>103</sup> These are made up of lost output and costs to the health service resulting from long-term health issues.

**Progress in implementing the Strategy  
National targets and prioritisation of  
sexual health**

3.29 Publication of the Strategy provided a useful catalyst for change and enabled a sharpening of

focus on sexual health at national, regional and local level. Over the same period of time, sexual health has achieved and retained its place within the national priority framework, and national target setting has reinforced a central drive in key areas of sexual health (Table 4).

3.30 In the early days following publication of the Strategy, concerns were raised that sexual health, and the services to address it, were worsening. The House of Commons Health Select Committee undertook an inquiry in 2002-3<sup>104</sup> to examine the effectiveness of the Strategy, taking a wide range of evidence from across the field of sexual health and HIV. Concluding that there was a crisis in the sexual health of the nation, the Committee identified, among the causes of this, a lack of central direction to suggest that this is a key priority. Since then, a number of targets and other measures have been put in place to raise the priority of sexual health and drive improvement, notably GUM 48-hour access.

3.31 An original commitment in the Teenage Pregnancy Strategy<sup>105</sup>, reduction in the under-18 conception rate by 50% by 2010, as part of a broader strategy to improve sexual health, has been a Public Service Agreement target since 2005<sup>106</sup>. This priority, also reflected in the Healthcare Commission annual assessment framework<sup>107</sup>, has enabled sexual health to remain within PCT Local Delivery Plan (LDP) monitoring lines. The GUM 48-hour access target was made one of the top NHS priorities for 2006/7 and 2007/8, and it became a national standard that has to be maintained from 2008/9.

3.32 Chlamydia prevalence and reduction in the under-18 conception rate have also continued to feature within the NHS Operating Framework<sup>108</sup> and *Vital signs*<sup>109</sup> as Tier 2 indicators (national priority for local delivery) and are among a range of possible indicators for selection from the National Indicator Set for inclusion in Local Area Agreements (LAAs). So far, 117 out of 150 LAAs have identified reducing under-18 conceptions as a target, and 15 have selected chlamydia. With these targets and indicators in place, there has therefore been a sustained drive for continued improvement coupled with a growing emphasis on shared responsibility between local authorities and PCTs.

**See Table 4: Key sexual health targets in national frameworks**

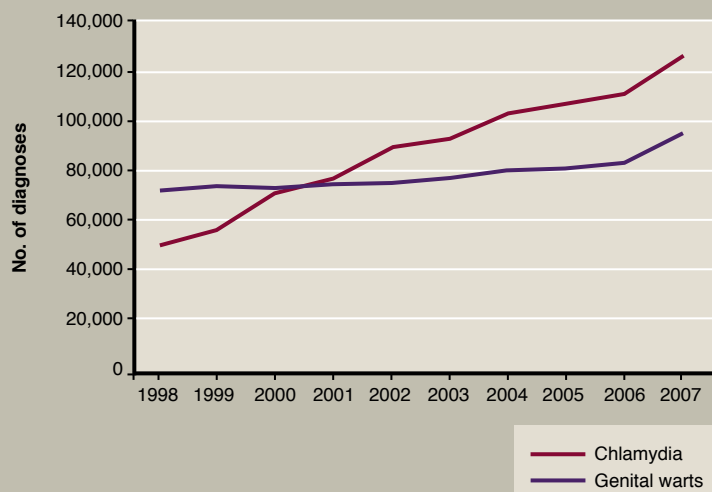
3.33 The prioritisation of access to Genitourinary Medicine (GUM) clinics and implementation of

chlamydia screening, alongside the teenage pregnancy target, have been important levers for national investment and support. Local successes in these key areas of sexual health serve to demonstrate the significant impact that national prioritisation and target-setting can generate.

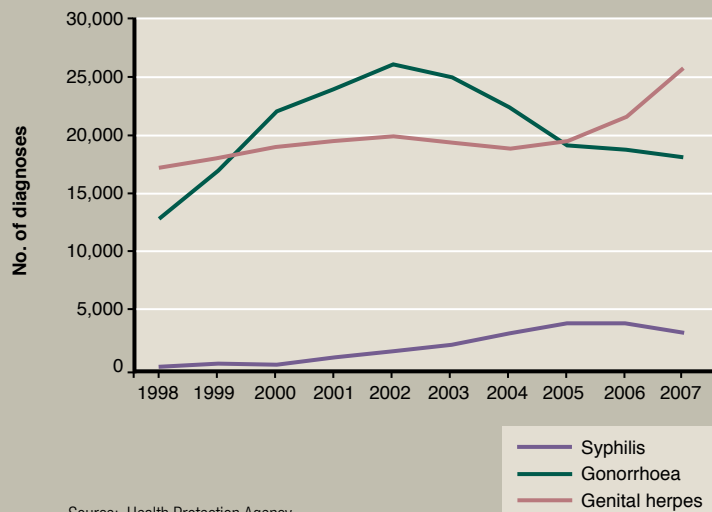
### National support for local delivery Improved access to GUM services

3.34 There has been a real transformation in GUM services since the publication of the Strategy, with significant improvement in waiting times and service capacity. This has been achieved through identifying 48-hour access as an NHS priority, focused attention from the MedFASH GUM review and the National Support Team for Sexual Health (see below), dedicated commitment to the issue

**Figure 4 | New diagnoses of selected STIs in GUM clinics in the UK, 1998-2007**  
A. Uncomplicated genital chlamydial infection and first attack genital warts



B. First attack genital herpes, uncomplicated gonorrhoea and primary and secondary syphilis



Source: Health Protection Agency

from commissioners and providers, and a huge countrywide effort from frontline staff. There has also been capital investment in GUM services, enabling new builds (eg. in Reading, Weston-Super-Mare, Crewe and Barrow-in-Furness, funded by Department of Health (DH) allocations), extensive rebuilds (eg. in Sheffield and the Royal London hospital, funded by Foundation Trusts) and development of IT systems (eg. across GUM services in Greater Manchester). Continuing improvements are still being seen. By March 2008, 98.9% of patients were offered an appointment and 86% were seen in GUM clinics within 48 hours<sup>10</sup>. This compares with just 38% seen within 48 hours in 2004, when waits of more than two weeks were frequent<sup>11</sup>. The achievement of this challenging public health target from a low starting point in the space of just three years represents a major success, from which much should be learned for improvement in other areas of sexual health.

3.35 The National Support Team (NST) for Sexual Health was formed in 2006 and tasked with working to support the 20% of PCTs most challenged in meeting the GUM access target. In reality, it has achieved much greater coverage and seen significant improvements achieved by most PCTs with whom it has worked. The NST was informed by, and collaborated with, the national review of GUM services, managed by MedFASH, which visited most of the GUM clinics in England between 2005 and 2007, making recommendations for service modernisation and improvement. Changes have further been supported at local level through publication of *10 high impact changes for GUM 48-hour access*<sup>12</sup> – which offers practical guidance for commissioners and providers on meeting the 48-hour target drawn from the experience of MedFASH and NST review visits – and then by new NST guidance, *GUM 48 hour access: getting to target and staying there*<sup>13</sup>, which builds on the former publication. The demand and capacity in sexual health services toolkit is due for publication shortly and will support demand management while ensuring that services respond to both patient need and choice.

3.36 As part of the range of improvements in GUM services, significant increases in the uptake of voluntary and confidential HIV testing have been put in place (see 3.12-3.13 above)

### Wider access to chlamydia screening

3.37 The National Chlamydia Screening Programme (NCSP) is managed by the Health Protection Agency (HPA), which employs a national team and

## CASE STUDY

## Implementing the National Chlamydia Screening Programme (NSCP)

In 2001/02, in response to the sexual health strategy, Lambeth, Southwark and Lewisham PCTs in South East London undertook a programme of training and service development in the management of uncomplicated STIs for primary care staff. GUM clinics at Guy's, St Thomas' and Kings supported local primary care services with training and clinical placements.

All four community contraceptive services and many local general practices developed their Level 1 and 2 provision. This provided a foundation of competence and experience which later supported the implementation and delivery of chlamydia screening as part of the NCSP.

Phased introduction of the NCSP began in 2003 and one of the 10 initial programme areas was a PCT consortium of Lambeth, Southwark and Lewisham. Chlamydia Screening Co-ordinators worked closely with the community contraceptive services' medical and nursing leads, and Practice champions, to establish widespread uptake of chlamydia screening and effective management within primary care.

Integrating chlamydia screening, and the treatment and management of positive clients and their partners, within community contraceptive services and general practice has been particularly successful and has ensured these PCTs have among the highest screening coverage levels achieved during 2007/08.

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regional co-ordinators to support implementation. Following successful pilots in Portsmouth and the Wirral<sup>114</sup>, and a commitment in *Choosing health*<sup>115</sup> to accelerate implementation with associated funding, the NCSP has now achieved phased rollout across 86 programme areas, allowing some coverage in all PCTs. PCTs are working towards screening 17% of sexually active 15-24 year-olds in 2008/9. Only four PCTs met the 15% target in its first year, 2007/8, with overall coverage being 4.9%<sup>116</sup>, although within this there were significant increases in screening volume in quarters 3 and 4. Performance will move closer to target in 2008/9 as the definition is widened to include all screens performed outside GUM (rather than just within the NCSP)<sup>117</sup>. However, modelling studies suggest that sustained coverage of 30-50% with robust partner notification is needed to control the infection and reduce onward transmission<sup>118</sup>, and this represents a significant challenge for many PCTs. In 2008/9, the sexual health NST is shifting its focus to the chlamydia prevalence indicator, working closely with the NCSP to increase screening volumes, collaborating with SHAs to identify those areas facing the greatest challenge, and providing support and monitoring to ensure rapid progress to target.

3.38 Although the chlamydia-screening pilots were delivered successfully, with general practice as the main provider, the involvement of general practice in the NSCP has been variable. Community contraceptive services have been the majority provider, although some GPs are doing tests that are outside, and not counted by, the programme. Local delivery has enabled recruitment of a range of screening sites and while there appear to be examples of good practice in a number of settings, there has been no one particular model associated with achieving greater screening coverage. The Boots Pathfinder programme (2005-2008) was launched to evaluate the role for pharmacy in expanding access to chlamydia screening<sup>119</sup>, and other community pharmacies have also contributed to local screening programmes. Currently they represent a small proportion of the number of screens provided, but appear to be broadly acceptable in spite of some confidentiality concerns<sup>120</sup>. The recent Pharmacy White Paper<sup>121</sup> has outlined an expanded role for community pharmacy in sexual health provision including chlamydia screening, and later in the year the Government will publish a template for PCTs to use in commissioning this service.

[See case study: Implementing the National Chlamydia Screening Programme \(NSCP\)](#)

## Improved access to NHS-funded abortions

3.39 There has been a considerable shift in access to NHS-funded abortions, with 89% of abortions funded by the NHS in 2007 compared to 78% in 2002<sup>122</sup>. Until last year, access to reproductive health services, including contraception, and a target to support an increase in the proportion of abortions performed under 10 weeks were part of the Healthcare Commission annual assessment framework<sup>123</sup>. Coupled with the Strategy recommendation for a maximum three-week wait from referral to abortion and £8 million additional investment to improve abortion services, the proportion of procedures performed at under 10 weeks increased from 51% to 68% between 2002 and 2007<sup>124</sup>, although wide variations in local access and service quality still persist<sup>125</sup>. It is estimated that still further increases in the proportion of abortions performed under 10 weeks would result in significant cost savings for the NHS, as a result of greater use of non-surgical and local anaesthetic methods<sup>126</sup>. Earlier abortion has created further opportunities to de-medicalise the process and to consider new models of provision<sup>127</sup> but although these options exist in some areas, there are wide variations in access.

3.40 Although there is clear evidence of target-driven progress in sexual health, targets have not

been the sole determinants of national action. The implementation action plan<sup>128</sup> that followed the Strategy itself set out 27 action points covering a wide range of activities required to realise the Strategy, against which significant progress has been made (see Appendix 2). Some key areas of progress are reviewed below.

### Testing technologies and strategies

3.41 Testing technologies have advanced considerably since the Strategy was published. Nucleic acid amplification technologies (NAATs) for chlamydia testing offer greatly improved sensitivity over the earlier ELISA tests. Following £8 million of additional government funding for laboratories to provide NAATs<sup>129</sup>, their use is now widespread in specialist services, although implementation of the NSCP has been hampered by their patchy availability in general practice. Development of less invasive tests using urine and saliva samples, as well as increased availability of point-of-care tests (enabling provision of rapid, on-site results) for both chlamydia and HIV, have increased the potential range of sites and providers through which tests can be delivered. Self-taken chlamydia samples are now a well-established part of the NSCP.

3.42 With the opportunities afforded by new testing technologies, the persisting rates of undiagnosed infection, and the developing role of community-based providers<sup>130</sup>, there has been a call for a new HIV testing strategy, with clearly defined outcomes, to co-ordinate efforts and build on achievements to date<sup>131</sup>. A range of new initiatives have aimed to increase access to, and uptake of, testing in the community and improve rates of detection, particularly of HIV, in healthcare settings. Internationally there has been a strategic shift towards universal opt-out testing policies<sup>132 133</sup>, and in the UK, antenatal HIV screening has demonstrated the feasibility of offering HIV testing in general practice settings<sup>134</sup>. A letter from the Chief Medical Officer and Chief Nursing Officer<sup>135</sup> has recommended increasing testing in all healthcare settings in an attempt to reduce the undiagnosed fraction. It should be within the capability of any trained healthcare worker to obtain consent for an HIV test in the same way as for other tests, and there is a move to encourage HIV testing wherever clinically appropriate<sup>136</sup>.

3.43 Advances in treatment technologies for HIV, including a wider range of antiretroviral options, easier drug formulations, greater standardisation of first-line prescribing and better monitoring tools, have simplified routine care,

allowing for less frequent check-ups and greater multidisciplinary team involvement. Development of more acceptable types of long-acting reversible contraception (LARC), which are easier to insert and extremely effective in preventing pregnancy as well as being cost-effective has created pressure to widen access to these methods<sup>137</sup>. For abortion, less invasive techniques have opened the possibilities for provision in a wider range of settings, and although there is evidence for the acceptability, effectiveness and safety of home-based medical abortion<sup>138</sup>, current legislation means treatment must be at least administered in a setting recognised for abortion provision.

### Service modernisation and integration

3.44 The integrated modern service proposed by the Strategy incorporated the main elements of sexual healthcare delivered through a three-level service model. The concept envisaged a comprehensive service responsive to local need, ranging from basic (Level 1) to specialist (Level 3) provision. The vision for Level 1 was for basic sexual health services provided by all GPs as well as some community pharmacists, nurses and others who had been appropriately trained, with choice and availability of open access everywhere. Since it was acknowledged as neither desirable nor cost-effective for all primary care teams to offer all aspects of more complex sexual healthcare, the Strategy proposed that a greater degree of specialisation be provided by Level 2 services through either primary care professionals who had undergone specialist training or family planning and GUM services working in conjunction with general practice. Level 3 encompassed the provision of more highly specialist services as well as responsibility for needs assessment, provider quality, clinical governance and training.

3.45 Crucial to the implementation of this model and to the overall Strategy aims was a strong central steer for the integration of STI and contraceptive services. This encouraged a more collaborative approach than had been seen before and provided a framework for development of a local comprehensive service based around patient need. Maintaining choice, open access and extended opening hours, along with ensuring users experience seamless care from one service level to another as needed, are key features of good service access. However, whether a configuration of individual services with dually trained staff, good collaborative links and integrated referral pathways or one with services co-located on a single site, or a combination, is the better model, has remained less clear.

## CASE STUDY

### Development of fully integrated Sexual Health service at Weston General Hospital and establishment of No Worries community team of Clinical Nurse Specialists working in Locality Centres and Schools

Previously, separate doctor-led traditional GUM and Family Planning clinics worked two sessions per week, each from a portakabin shared with other outpatient services. Total staffing was only 2.6WTE serving a 120,000 population. An HPA audit in 2004 found 4% of patients seen within 48 hours and ONS data (2001) demonstrated local teenage pregnancies increasing to 6% above the 1998 baseline.

A “ruthlessly honest” needs assessment was carried out between 2002-2004 and a successful bid made to the Department of Health for GUM Small Pilot Project funding. A nursing team of six was recruited, four of whom were already contraception trained. North Somerset PCT developed and advertised a No Worries community sexual health service in which these nurses were deployed to locality centres near schools to provide contraception and teach PSHE, assisted by a health promotion campaign.

In 2005 a Consultant was appointed to design a new clinic and joint clinical notes, and to ensure that fully integrated sexual health services were implemented. A ward was made available for conversion by the hospital trust and the new clinic was designed and built within seven months, with the aim of maximising efficient flowpath and aiding staff communication. The Consultant trained the nursing team in combined contraception/sexually transmitted infection care with a full range of Patient Group Directions. Ongoing governance and support of nurse-led services is provided via notes review and one-to-one supervision. All ten “high impact changes” were used to improve access.

The service now has a welcoming, purpose-built clinic offering 8 weekly sessions of integrated sexual health care. It has been nationally recognised for the best documented

improvement in 48 hour access (4-100%, 2004-6) and also demonstrated the third best reduction in teenage conception rate (a 36.6% reduction to 22.6 per thousand in 2006). Attendance figures have doubled each year (around 140 per month in 2004/5, to 800 monthly in early 2008). Very few young people now travel to the nearby major centre in Bristol whereas previously there was a significant cross-boundary flow.

There are regular meetings between the Clinic Manager and hospital management, with continual monitoring of demand. This has led to an incremental increase in support for new nursing and administrative staff appointments keeping capacity just ahead of demand.

A triage system has been introduced. In addition, a training and governance structure has been put in place to support a Health Care Assistant to facilitate care of entirely uncomplicated cases. A texting system for test results was introduced in 2007.

Crucial to the success of developing integrated sexual health services are strong medical and nursing leadership with a shared vision, a project manager with clinical experience, vigorously proactive commissioning and support from public health and the hospital Trust. Also key have been the recruitment, training, support and governance of clinical nurse specialists to provide nurse-led clinics in both hospital and community-based locations. Increasing demand on services has been met by making available additional resources to upgrade premises and to increase staffing levels and skill-mix.

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3.46 The One Stop Shop (OSS)<sup>139</sup> evaluation reviewed three very different models and sought to answer some of the questions raised about what integration should look like. It concluded that although the concept of having all services under one roof was acceptable to many staff and users, the key to integration was rooted as much, if not more, in common aims and collaboration between services. Further, in development of any single-site service, it was crucial to address the specific needs of particular, often vulnerable, groups who more frequently expressed a preference for stand-alone services such as dedicated young people’s services or gender-specific clinics. Evaluation of the OSS model based in general practice demonstrated the potential for successfully providing a comprehensive specialised service in this setting, but currently the coverage of even basic service provision in general practice is both limited and variable.

3.47 There have been innovative moves towards integration in many parts of the country, with

different models adopted, often building elements of service onto existing GUM or contraceptive services, or bringing the two together, reducing the need for referrals between services and ensuring the majority of sexual health needs can be met in one location. However, progress in integrating services has been variable at local level.

*See case study: Development of fully integrated Sexual Health service at Weston General Hospital*

#### Widened opportunities for the delivery of sexual healthcare

##### General practice

3.48 As the first port of call for large numbers of people with all types of health need, general practice has a unique opportunity and responsibility to identify and respond appropriately to sexual health need which may otherwise be invisible. More people in the OSS evaluation survey said they had used, or would use, general practice for advice on



contraception or STIs than any other service<sup>140</sup>. But individuals may not define their problem as 'sexual health' related, and general practice can play an important role in uncovering unmet sexual health need (eg. opportunistic chlamydia screening, asking young people about contraceptive needs, or spotting symptoms of undiagnosed HIV). This role is relevant for all practices as a basic standard of care (more or less equating to the Strategy's Level 1), but the extent to which individual practices have taken it on varies enormously. General practice is the majority provider of contraception, but data on its activities are limited and there is no routine surveillance of STI diagnoses or management in primary care. However, studies suggest there is significant room for improvement, with up to two in five people attending GUM having attended their GP first<sup>141</sup>, and men often treated for STIs in primary care settings without diagnostic testing<sup>142</sup>.

3.49 There have been examples of innovative local practice supporting the development of training linked to incentives to develop capacity and quality.

*See case study: Developing sexual health risk assessment in primary care, SHIP, West Midlands*

3.50 For more specialised care, PCTs need to commission services through a local enhanced

service (LES) if they see this as the best route to reach a population in need and/or achieve a national/local target. Within sexual health, LESs have been developed in areas such as participation in the NCSP, diagnosis and treatment of STIs, and insertion of LARC. The primary care contracting framework in sexual health<sup>143</sup>, which describes the key requirements for provision of a holistic service, has been developed to support the commissioning of enhanced services via a primary care contract or Service Level Agreement.

3.51 Practice based commissioning (PBC) has created opportunities for expanding sexual health provision in the community in preference to the hospital<sup>144</sup>, and is supportive of the overall modernisation agenda for multiple providers of sexual health. While PBC permits GPs to commission from other providers, it has been suggested that in practice, it may provide an incentive for general practice to deliver more services itself, and it remains to be seen what impact this might have on the maintenance of community services such as contraception. Nonetheless, to date PBC appears to have had limited influence on the way in which sexual health services are delivered, and although there are some early examples of developments, few have been identified that demonstrate really significant impacts. It will be important as it develops further in sexual health, that PBC ensures services commissioned are linked to

## CASE STUDY

### Developing sexual health risk assessment in primary care

**S**exual Health in Practice (SHIP), a continuing programme of professional development for general practice, has evolved in Birmingham through partnership between general practice and a sexual health promotion service. SHIP offers an integrated programme of training and resource support including free condoms and pregnancy testing kits. It focuses primarily on improving sexual history-taking and risk assessment - core skills to support differential diagnosis and ultimately detection of STIs in general practice where staff see patients from across the spectrum of risk. It also teaches clinical skills for Level 1 services.

SHIP training is devised and delivered by GPs and practice nurses supported by sexual health promotion specialists. It uses interactive methods, with clinical case studies, often drawn from trainers' own clinical practice, and is therefore highly relevant to the general practice setting. It suggests pragmatic solutions to time management and prioritisation and teaches clinical factual knowledge alongside verbal strategies and communication skills essential for risk assessment in general practice.

A strong emphasis on the clinical benefits of using risk assessment is used to reinforce motivation, along with communication triggers in consulting and waiting rooms such as posters, checklists, mouse mats, and a concise

sexual health risk computer template. This template also enables audits of clinical practice and further evaluation of the training's effectiveness. Ongoing support and information include practice visits, mail-outs and the SHIP website. Collaboration with SHIP offers the NCSP and teenage pregnancy lead an effective interface with a significant proportion of local practices,

Over 70% of practices in four PCTs are now part of SHIP and 1993 participants have attended at least one training course. Participation has risen from 35 to 203 practices since 2001, mainly due to additional PCTs commissioning the scheme. Their contracts specify that each practice should send one GP and one practice nurse on the training. However course participation figures far exceed the expected number, partly due to practice staff turnover, but more often because practices request extra places.

Evaluation (Mullineux et al, 2008) indicates that participants value SHIP's training approach and its relevance to practice, and has also revealed significant learning gains and impact on practice.

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## CASE STUDY

## HIV Health Support Service using Health Trainers

Two voluntary sector organisations, NAM and Terrence Higgins Trust (THT), are managing a joint project which plays to each of their strengths, using opportunities afforded by the development of new roles as part of NHS reform.

The HIV Health Support Service offers one-to-one or group meetings with a Health Trainer where people living with HIV can learn more about HIV, the treatments available and how to manage their own condition. It complements existing services and is particularly useful for individuals who have been newly diagnosed with HIV, who are thinking of starting or changing their treatment or who are experiencing side effects.

Health Trainers, a new role identified in *Choosing health*, can tailor their service to the individual, seeing them in their home, at their clinic or another venue, or speaking to them over the phone. A range of issues can be discussed, from HIV treatment and adherence to safer sex and disclosing HIV status to family and friends.

One element of the service is the provision of a lifecheck, which uses a series of statements as the basis for working with an individual to identify information needed or areas requiring further support. The person's lifecheck score

demonstrates their progress. Some clinics have liked this element so much they have adapted it for their own use.

There are eight HIV Health Trainers in the project, working across London. They all undergo accredited training, recognised by the Department of Health, as well as motivational interviewing training and internal training by NAM and THT. In addition, one of NAM's expert editors provides them with an essential update on the latest HIV information once a month.

The Health Trainers use outcomes agreed with commissioners as the focus for their work. Technological support provides information about each person's needs and their feedback on resources, together with a broader picture of service outcomes. Early monitoring shows that the service is being taken up by the target group.

The project was initially piloted in South London with funding from the South London HIV Partnership and has now been rolled out across London following a successful tender to the Pan London HIV Prevention Programme.

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local care pathways and networks, and provide care to locally agreed quality standards.

### Pharmacy

3.52 The role of pharmacists as key providers of sexual health has broadened significantly since the publication of the Strategy. Community pharmacists are already a major sexual health provider<sup>145</sup> – originally selling pregnancy tests and condoms – but they have now become the biggest provider of emergency contraception<sup>146</sup> and more recently have contributed to delivery of the NCSP<sup>147</sup>. Widened opportunities for delivery of sexual healthcare<sup>148</sup> and an increased role in sexual health promotion<sup>149</sup> are outlined in the new pharmacy White Paper and the update of the 1997 report on prevention in sexual health respectively.

### Third sector

3.53 The third sector has an increasing role in sexual health as a provider of local services. It has traditionally been a major provider of abortion, as well as of contraception for young people, social care and support for people living with HIV, and health promotion and outreach for communities which are at higher risk or socially excluded. Using the opportunities created by reforms in NHS commissioning and new diagnostic technologies, it is increasingly being commissioned to move into the provision of testing for STIs and HIV for those at higher risk, particularly gay men and black Africans, and chlamydia screening for young people.

### Other professionals and new roles

3.54 NICE public health guidance has stressed the need for greater involvement of other professionals, such as midwives and health visitors, for identification of, and intervention with, those most at risk of under-18 conceptions or STIs<sup>150</sup>. There has also been a move to expand sexual health provision through non-healthcare providers such as social workers, youth workers and prison staff. The role of the 'health trainer' was introduced as part of *Choosing health*, but has not been extensively applied to the area of sexual health. However health trainers are increasingly being used in HIV care to support people through diagnosis and treatment, and to facilitate their involvement in their own care<sup>151</sup>.

*See case study: HIV Health Support Service using Health Trainers*

### Workforce development

3.55 Commitments from the Strategy have led to essential developments in the field of education and training. It has supported a drive for expansion of the sexual health workforce, with a broadening of existing roles to encompass new aspects of sexual healthcare both within and outside specialist services. As a result, more professionals are dually trained to provide both STI and contraceptive services, and there has been an increase in the role of the nurse, with more nurse consultants, nurse prescribers, nurses working to patient group directions (PGDs)

and nurse-delivered services. Practice nurses have also taken an increasingly central role in sexual health at both basic and more specialised levels and, with access to recognised training in prescribing, and insertion of intrauterine devices and subdermal implants<sup>152</sup>, they may effectively lead sexual health provision at practice level.

3.56 The role of healthcare assistants or sexual health technicians has been developed in a range of hospital and community-based settings<sup>153</sup>. Employed to deliver a broadening range of basic-level sexual healthcare, they have the potential to significantly increase capacity, and as such have played a role in enabling GUM services to reduce waiting times and achieve the 48-hour access target.

3.57 Sexual health advisers, traditionally based within GUM clinics, have long had a lead role in partner notification, individual patient education and counselling, and helping to deliver outreach services for hard-to-reach and vulnerable population

groups. Their involvement will be key in delivering the structured education and STI prevention required by recent NICE guidance<sup>154</sup>. Within the community, the role of Sexual Health Advisers has expanded, with the opportunity for those who are also registered nurses to become Specialist Public Health community nurses.<sup>155</sup>

3.58 Core learning outcomes for sexual and reproductive health and HIV in undergraduate level medical education<sup>156</sup> and a training curriculum for foundation-level doctors<sup>157</sup> have been developed along with the incorporation of sexual health into the curriculum for general practice vocational training<sup>158</sup> and the development of an introductory certificate course for current GPs and practice nurses<sup>159</sup>, in an attempt to increase overall awareness of HIV and sexual health, reduce stigma and drive basic provision of services in primary care. Existing<sup>160</sup> and more recently developed training programmes,<sup>161</sup> as well as new competency frameworks for nurses<sup>162</sup> and GPs<sup>163</sup> provide learning opportunities for the delivery of more specialised sexual health services.

## CASE STUDY

### Identifying future workforce training and education needs

The Greater Manchester Sexual Health Network works with local organisations and key stakeholders to implement the national sexual health and HIV strategy and meet the challenging targets for improved performance in sexual health. The Network set out to make recommendations on future workforce needs, both nursing and support staff, for Greater Manchester Sexual Health Services (covering ten PCT areas) taking into consideration the future function and roles required in all three levels of service provision and national best practice guidance. The Network's objectives were to:

- undertake a baseline survey of current sexual health workforce
- determine current training and education undertaken and provided
- take key stakeholder views about current and future workforce ensuring links were made with Directors of Nursing and Workforce Development leads
- determine future workforce plan for local services
- inform the training and education strategy and plan for the Network

All nursing and support staff across the conurbation completed questionnaires and had the opportunity to attend focus groups. 12 lead nurses, 58 sexual health nurses and 23 support workers were involved in the baseline survey. A Project Lead and Project Steering Group were established, working to the Six Step guide to planning the workforce. The following challenges were identified:

- small departments with little skill mix opportunities
- gaining access to key stakeholders and influencers
- lack of time to reflect, with demand on services to meet 48 hour target

- profile and getting an appreciation of the needs for a sexual health workforce
- developing a sustainable career structure within some historically part-time evening posts
- acceptance of need to work differently with services that historically have been medically led

The above objectives were met and outcomes were as follows:

- consensus vision on future workforce needs
- findings built into workforce planning and education arrangements
- role development across sectors or conurbation considered
- new roles established with appropriate mentorship and training support eg. Trainee Assistant practitioners
- sharing of workforce information

A full report is being prepared to capture key learning including:

- Lack of contingency planning for periods of training or sickness absence
- No consistent definition of outreach
- Importance of meeting training needs
- Valuing, recognition and formal funding of clinical placements
- Potential to foster greater understanding of delivery partnerships through cross-sector training
- Consideration of how newly qualified staff can most effectively be employed in sexual health
- Streaming of patients, rather than triage
- Ensuring full use of staff skilled in LARCs

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Consistency of provision and uptake is variable, and standards for the provision of sexual health training<sup>164</sup> have been developed to provide the framework to support delivery by trained staff.

3.59 With more services provided in the community and an increasing role for non-NHS providers, the continuing renewal of the skilled clinical workforce will depend on commissioners allocating funding to training and building training requirements into contracts with providers. This is a key priority in all areas of sexual health, and particularly abortion, where more than half of NHS-funded provision is by independent and third sector providers.

*See case study: Identifying future workforce training and education needs*

### Managed networks

3.60 The Strategy recommended that integrated provision of sexual healthcare and HIV care be underpinned by the development of managed service networks, with membership from the full range of providers, and service user representation. These networks aim to promote and facilitate equitable service access and provision, adhering to shared quality standards and guidelines, with explicitly defined care pathways between organisations. They often function across PCT geographical and organisational boundaries (though sometimes networks for HIV cover a wider area than those for other aspects of sexual health), offering a needs-based approach to planning and delivery of sexual health services. They can reduce duplication and gaps in service across the network area, and make the best use of the resources jointly available, including staff. They hold the advantage of offering a co-ordinated response to particular population needs and offer an opportunity for agreeing mechanisms for accountability and performance management<sup>165</sup>. They may also take an overall lead in co-ordinating provision of education and training for staff across the network.

3.61 Whatever the model, networks should be person-centred and exist to meet the holistic needs of service users wherever they present within the local sexual health network. A person who is having unprotected sex runs the risk of unwanted pregnancy and of STIs, including HIV. The presence of one STI increases the risk of having acquired concurrent STIs. Thus, in addition to addressing contraception needs, potential service users need to be assured and advised about the availability of comprehensive STI and HIV screening. They require education and support about risk

reduction by behavioural modification, support with partner notification, and help with any associated relationship and psychosexual difficulties that can potentially impair their sexual and emotional well-being. Individual services should recognise the limitations of their own interventions in response to such holistic needs and advise how any omissions can be dealt with more appropriately within the care pathways that should characterise integrated or networked services.

3.62 National recommended standards for both HIV and sexual health services<sup>166</sup> set out the rationale and aims of network development, and their publication was followed respectively by a series of MedFASH regional seminars on HIV network development and a national conference on sexual health networks. Around this time, the momentum for network development in some areas of the country gathered pace. *Standards for HIV clinical care*<sup>167</sup>, produced more recently by the British HIV Association (BHIVA) with the Royal College of Physicians (RCP), the British Association for Sexual Health and HIV (BASHH) and the British Infection Society (BIS), rests on the delivery of HIV care through networks, proposing a more specific model of network structure and roles within it. Networks can be particularly valuable for areas of healthcare where patient numbers are low, needs are complex and specialist expertise concentrated in only a few centres round the country. This is the case for paediatric HIV. Following a national review of paediatric HIV services<sup>168</sup>, the Children's HIV National Network (CHINN) was set up in 2005 and recommended the establishment of regional networks by 2006.

3.63 Progress in sexual health and HIV network development has been variable nationally. Notably, networks have been established across the North West, and in London and Sheffield, but these differ considerably in both model and scope. HIV and GUM services have usually been core, while the degree of involvement of contraception and abortion services, general practice and third sector organisations, more variable. In some areas, the networks established have been 'professional networks' providing opportunities for clinicians to meet and share learning, rather than 'clinical' or 'service' networks, which relate more to the organisation and delivery of services. Successful service networks require collaboration between providers in order to meet population need. The challenge, in the face of a widening range of provider organisations with potentially competing interests, will be to ensure that this approach is not

## CASE STUDY

### Development of the Cheshire and Merseyside Sexual Health Network Care Pathway for Sexually Transmitted Infections (STIs)

In line with national strategic direction and the increasing numbers of testing facilities in community settings outside GUM, the Cheshire and Merseyside Sexual Health Network (CMSHN) developed a care pathway for people seeking information, testing or treatment for suspected STIs. The care pathway aimed to ensure equitable access and consistently high quality care from all providers throughout Cheshire and Merseyside.

The Care Pathways Working Group (CPWG) established to take this work forward brought together several enthusiastic individuals with different perspectives who worked in partnership across organisational and other boundaries in order to agree the pathway. Chaired by a GUM consultant, its membership included medical and nursing staff from GUM, and practitioners from reproductive health, the National Chlamydia Screening Programme and primary care, as well as senior representation from laboratory services, a PCT sexual health commissioner and the Sexual Health Network Lead.

#### Outcomes included:

- the care pathway itself
  - changes and improvements in clinical practice
  - a template for safer commissioning and delivery of STI testing and treatment within Cheshire and Merseyside, for use by PCT commissioners and clinicians
  - adoption of the pathway or modifications of it beyond Cheshire and Merseyside
- PCT commissioners across Cheshire and Merseyside now

use the care pathway as the basis for commissioning of STI services. Work is in progress to help service users access the most appropriate service to meet their needs and provide greater choice. The STI care pathway is linked into other pathways related to sexual health.

#### Learning from the process

- Cross boundary working through the network brings benefits in terms of support, innovation and learning from others.
- The inclusion of commissioners in the working group enabled greater understanding and co-operation between commissioners and providers.
- Working groups that have a very clear objective, are appropriately constituted to meet the objective and skilfully chaired can be very effective.
- Within a network, despite any professional or geographical boundaries, there is interdependence between services at Levels 1, 2 and 3 and commissioners. A misunderstanding of this point can lead to destruction of a local delicate sexual health ecosystem where the appropriate clinical standards of care expressed in the pathway are not delivered.

The CMSHN is based in Wirral PCT but works across eight Cheshire and Merseyside PCTs, Acute Trusts and third sector organisations.

The pathway can be downloaded from the CMSHN website ([www.cmshn.nhs.uk](http://www.cmshn.nhs.uk))

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threatened, especially where networks are provider- (rather than commissioner) led.

3.64 The funding and structure of networks has differed. Although their effective functioning in some areas has been due largely to the time and commitment offered by network members, some dedicated funding is usually required, especially for sustainability. For example, networks in London have found it necessary to appoint a network co-ordinator/manager in order to support clinicians who may be champions for the network but lack the ongoing capacity to organise meetings, develop a website, draft shared protocols, maintain the active involvement of all network partners, and so on. Those in the North West were established and jointly funded by commissioning PCTs (with seedcorn funding and support from SHAs before NHS reconfiguration), and they are led by PCT-appointed network directors or leads. Ultimately, the financial viability of networks will be dependent on their offering additional value to the commissioners who pay for the services they provide.

*See case study: Development of the CMSHN Care Pathway for STIs*

### Sexual health promotion and prevention National campaigns

3.65 Prevention strategies at national level have encompassed both national information campaigns and more targeted work. The *Sex Lottery* campaign and recently, in response to the *Choosing health* commitment, the *Condom EssentialWear* campaign have been aimed at sexually active young people, encouraging a reduction in risk-taking behaviour and an increase in condom use. Initial evaluations report high levels of campaign recognition and an understanding of the 'condom normalisation' message, with 56% of sexually active people asked saying they were more likely to use condoms because of the advertising, and 40% saying they were more likely to carry condoms<sup>169</sup>.

3.66 Integrated national campaigns between the Department for Children, Schools and Families and the Department of Health (DH), targeted at younger audiences, are part of a combined communications strategy across both sexual health and teenage pregnancy that also includes the *Condom EssentialWear* campaign. The current campaigns are

*Want Respect? Use A Condom and RU Thinking*, and are delivered through a range of media. Although television is cited as one of the preferred channels for receiving advice on sexual health<sup>170</sup>, current advertising restrictions prevent the promotion of condoms on TV before 9pm<sup>171</sup>, limiting the ability of campaigns to reach younger viewers. A review of the advertising code, due to take place later in the year, will reconsider this limitation, potentially enabling exposure for a greater proportion of the target population.

### Social marketing approaches

3.67 Evidence suggests that a targeted approach to prevention is needed if it is successfully to reach those most at risk. *Choosing health* set out the importance of a social marketing approach which uses market concepts to achieve behavioural goals tailored to the needs of particular groups. Nationally, a Social Marketing Development Unit has been set up in the DH to integrate social marketing into key workstreams and a pilot for the development of sexual health interventions is currently underway<sup>172</sup>. Qualitative research aiming to gain insight into drivers of sexual behaviour related to beliefs, age, gender and culture will inform the commissioning of initiatives appropriate to target audiences that may support more effective messaging and influence behaviour change. This approach has the potential to be used more widely in designing sexual health interventions. A number of local schemes have already been set up using this approach, including a programme of social marketing of condoms through vending machines in Manchester, which followed research with young people<sup>173</sup>. This was part-funded as a pilot by the DH.

### Targeted HIV prevention

3.68 The Strategy committed to supporting the development of nationally co-ordinated, targeted

HIV prevention work directed towards gay men and African communities through the DH-funded programmes, CHAPS (Community HIV and AIDS Prevention Strategy) and NAHIP (National African HIV Prevention Programme).

3.69 CHAPS is a partnership of community-based organisations, co-ordinated by Terrence Higgins Trust, that delivers HIV health promotion to gay men. *Making it count*<sup>174</sup>, developed by the partnership with a wide range of project stakeholders, provides the strategic framework for the planning, delivery and monitoring of health promotion work at national and local level. CHAPS provides direct national health promotion for gay men, including campaigns, as well as sector development and work with the research community for evaluation of programmes. Nationally, changes in knowledge and behaviours are monitored annually through the Gay Men's Sex Survey (GMSS), as is awareness of all CHAPS campaigns. Substantial increases in knowledge have been noted. For example, following a CHAPS awareness campaign on HIV post-exposure prophylaxis (PEP) in late 2004, awareness of PEP rose from 22.2% of all men in 2003 to 38.5% in 2005, and then to 48.4% in 2007 following campaign re-runs in 2005 and 2006. Awareness of PEP significantly increased in every demographic sub-group.

3.70 NAHIP, managed by the African HIV Policy Network (AHPN), works largely with African-led organisations to identify the HIV health promotion needs of African communities and support the implementation of work through a range of partners across England. *Doing it well*<sup>175</sup> has provided evidence-based good practice guidance for community-based prevention activity. NAHIP also works through national health promotion campaigns such as the African HIV testing campaign to encourage earlier testing, and through provision of local training and technical support for work with African communities. *The knowledge, the will and the power*<sup>176</sup>, a new plan of action for sexual HIV prevention interventions targeting Africans living in England developed by NAHIP partner organisations with Sigma Research, identifies obstacles to HIV prevention and focuses on how to overcome these in order to achieve change.

3.71 There has been a sustained programme of activities through CHAPS and NAHIP with strengthened funding over the past two years invested in action to address stigma and discrimination, and increase the evidence base of what works.

Evidence suggests that a targeted approach to prevention is needed if it is successfully to reach those most at risk. *Choosing health* set out the importance of a social marketing approach which uses market concepts to achieve behavioural goals tailored to the needs of particular groups.

### Local health promotion and prevention activity

3.72 Good practice and local innovation in prevention have been in evidence in some localities, with a range of interventions for young people such as C-card schemes, targeted work with gay men, and the recent development of prevention activities targeting black African communities in areas with higher HIV prevalence<sup>177</sup>. However, a lack of attention to prevention activity relative to acute service needs has been seen in Local Delivery Plans<sup>178</sup>. Greater attention to the needs of gay men and black and minority ethnic (BME) communities, and targeted prevention for vulnerable groups, are needed. Such services are frequently delivered by smaller third sector organisations with close links to their specific communities. Partnerships and compact agreements between statutory and third sector organisations are important for these relationships to flourish.

*See case study – PACSH.*

### Sex and relationships education (SRE)

3.73 Consistent good-quality SRE taught within Personal, Social, Health and Economic (PSHE) Education makes an important contribution to the duty on schools to promote well-being, and as part of the 'being healthy' and 'staying safe' outcomes of *Every child matters*<sup>179</sup>. It is also a core requirement for schools to achieve the National Healthy School Standard. Ofsted has

reported some improvement in PSHE Education (which includes SRE) over the past five years<sup>180</sup>. However, it has expressed concerns that schools give insufficient emphasis to the teaching of HIV, sexual health and the more sensitive aspects of SRE. Furthermore, young people continue to report poor-quality SRE, which is not meeting their needs<sup>181</sup>. A dearth of specialist teachers, low status of SRE and lack of guidance on what should be taught are often cited as challenges to delivery. To address the current weaknesses in SRE, the Government is conducting a review, which will consider how best to improve the delivery of this subject across primary and secondary schools.

3.74 Recommended good practice in SRE delivery includes providing a range of learning opportunities which focus on more than just the biological basics of reproduction<sup>182</sup>. Children and young people must be supported to develop personal skills, and explore attitudes and values<sup>183</sup>. Schools, however, are only required in statute to cover the biological aspects of sex within the National Curriculum for Science<sup>184 185</sup>. The broader aspects of SRE such as risk, accessing services, sexuality, delay, safer sex and pregnancy choices, which form a core part of PSHE Education, are not statutory. This is despite consistent calls for statutory PSHE Education from a wide range of professionals, parents and young people including the Sex Education Forum and

## CASE STUDY

### The Pan African and Caribbean Sexual Health Project

The Pan African and Caribbean Sexual Health (PACSH) Project is one of the main providers of community sexual health promotion for African and Caribbean people living in Enfield and Haringey. Jointly commissioned and funded by the PCTs and LAs of both boroughs, it is managed by the charity, Ethiopian Community Centre in the UK (ECCUK).

Since 2005 the PACSH project has provided both primary and secondary HIV prevention and support programmes, including condom and information resource distribution, HIV awareness and test promotion, community support services for HIV positive people and support services for newly diagnosed pregnant women. Other specific activities, such as chlamydia screening, and awareness, support and referral regarding Female Genital Mutilation (FGM) and teenage pregnancy, are also part of the project.

*Love safely* is a home visit and interactive programme focusing on promoting safer sex practice and improving levels of awareness of local African and Caribbean people. It engages individuals in discussion for a minimum of one hour in a safe setting where they feel free to talk about issues related to sexual health. It aims to encourage people

to go for an HIV test, where appropriate.

PACSH has developed very good links with local GUM clinics and drop-in centres and also works with more than 150 African and Caribbean outreach venues, conducting prevention activities with businesses such as hairdressers' shops, internet cafes, traditional food stores, minicab offices, social clubs and places of faith. It has eight paid employees and over 50 volunteers from various African and Caribbean countries of origin, speaking over 15 different African languages. PACSH Project activities have been independently evaluated, with positive findings particularly regarding the support of HIV positive people, creation of access to information resources and promoting the importance of HIV testing. On the basis of this, the project's commissioners have decided to move from annual to three-year funding.

ECCUK is also a member of the African HIV Policy Network (AHPN) and an implementing partner of the NAHIP Programme in North Central London.

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## CASE STUDY

## Developing guidance for commissioners on sexual health and blood-borne virus services in prisons in the South West of England

A rapid assessment of prison health in March 2007 revealed poor performance in the majority of prisons in the region on the two key performance indicators relating to sexual health and blood-borne virus services.

The South West Regional Sexual Health Task Group commissioned a multi-agency steering group with representatives from sexual health services, commissioners, prison health managers, prison governors, public health and the Health Protection Agency to develop guidance for commissioners on improving these services.

The group produced draft guidance with 19 key priorities that needed to be addressed to improve services. This was sent out for extensive consultation and the final guidance was launched at a workshop in May 2008. This identifies the support needed by partner agencies to implement the

guidance. Evaluation of the implementation is planned.

A recent review of prisons identified improvements in the sexual health key performance indicators, partly driven by the focus of this project. Staff from across the region have had an opportunity to network and share good practice, which many found valuable. Champions have been identified within various organisations. Working in partnership has been improved by the opportunity to share different perspectives.

Commissioners have welcomed the guidance which highlights practical steps that can support and guide their decisions in relation to prison sexual health.

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its 50 member organisations<sup>186</sup>, the Independent Advisory Groups on Teenage Pregnancy and Sexual Health and, most recently, the UK Youth Parliament.

3.75 SRE should be an integral part of the lifelong learning process, reaching beyond school and to the wider community. There has been a growing acknowledgment that schools should be linking SRE with sexual health services, as evidenced by a recent survey which showed that 29% of schools in England now have sexual health services on-site<sup>187</sup>. Evidence from UWE<sup>188</sup> has shown that that 61% of those attending on-site services would not have used alternative sexual health provision and that these services are particularly effective in reaching vulnerable young people. Guidance available for Further Education<sup>189</sup> settings to develop on-site sexual health services also highlights the importance of SRE for older teenagers. SRE needs in other non-school settings, including those of children not attending school and the support needs of parents, have been less systematically addressed to date, although guidance is available on sexual health information provision aimed at social workers<sup>190</sup> and youth workers<sup>191</sup>. NICE is developing guidance on PSHE in both school and community settings with a focus on sex, relationships and alcohol education<sup>192</sup> which should address the non-education settings.

#### Prevention technologies

3.76 There has been progress in the area of primary prevention technologies with a vaccine against HPV and cervical cancer approved and due for rollout in 12 and 13 year-old girls, starting later this year<sup>193</sup>.

This has the potential, over time, to radically reduce rates of cervical cancer. However, concerns have been expressed about the public health and cost implications, as well as the potential for increasing health inequalities, of the recent decision to choose a vaccine which will not prevent genital warts (as opposed to the competitor product).<sup>194</sup> The Government has been urged to keep under review the ongoing choice of vaccine<sup>195</sup>.

3.77 Growing evidence for the effectiveness of post-exposure prophylaxis (PEP) for non-occupational exposure to HIV has led to calls, supported by the Chief Medical Officer, for it to be made more generally available<sup>196</sup>. Research into HIV vaccine technology and microbicides represents ongoing work. However, progress has been slower than was hoped for, and any impact on prevention in the UK will be for the longer term.

#### Sexual health commissioning

3.78 Alongside prevention and new models of service provision, strong commissioning of sexual health services was fundamental to the aims of the Strategy, and this emphasis remains as a key lever for change. At local level, PCTs identify strong leadership and the presence of national targets, in particular the 48-hour GUM access target, along with targeted funding as the main drivers of commissioning<sup>197</sup>. With its emphasis on defining service specifications based on need, and the commissioning of user-focused services, world class commissioning provides an opportunity for improving sexual health commissioning, which has been hampered by the continued use of block contracts and widespread absence of service level agreements.



**Table 5 | Cost savings and cost-effectiveness**

Evidence of cost savings and cost-effectiveness	
<b>Contraceptive and abortion services</b>	<p><b>Contraceptive services are cost-saving.</b> Cost-saving measures include:</p> <ul style="list-style-type: none"> <li>• increasing uptake of LARC</li> <li>• access to services that provide full information and choice about the range of contraceptive methods</li> </ul> <p><b>Reducing delays in obtaining abortion are cost-saving</b></p>
<b>Screening</b>	<p><b>Screening strategies targeting high-risk populations such as pregnant women for HIV, and young women for chlamydia, are cost-saving, leading to early treatment, averting costs of complications (such as infertility) and onward transmission.</b></p> <p>Cost-saving measures include:</p> <ul style="list-style-type: none"> <li>• antenatal screening for HIV in high-risk women</li> <li>• antenatal syphilis screening</li> <li>• chlamydia screening for young women and groups at high risk</li> </ul>
<b>Treatment interventions and service organisation/delivery for STIs and HIV</b>	<p><b>Comprehensive and accessible STI treatment services are cost-saving, and partner notification and highly active antiretroviral therapy (HAART) are also cost-effective.</b></p> <p>Measures include:</p> <ul style="list-style-type: none"> <li>• STI treatment services in groups at high risk</li> <li>• temporary increases in the capacity of services to gain control of infection</li> <li>• partner notification</li> <li>• access to services with very short or no waiting times</li> <li>• antiretroviral treatment for HIV</li> <li>• routine HIV testing for STI clinic attenders</li> </ul>
<b>Health promotion and disease prevention</b>	<p><b>A range of interventions aimed at preventing HIV and promoting sexual health are cost-saving and are most cost-effective when targeted at high-risk groups.</b></p> <p>Measures include:</p> <ul style="list-style-type: none"> <li>• free condom provision for medium and high-risk groups</li> <li>• outreach programmes for high-risk, hard-to-reach groups</li> <li>• provision of HIV risk-reduction messages in gay bars</li> <li>• safer sex skills training session/cognitive behavioural intervention for men who have sex with men (MSM)</li> <li>• peer leader interventions for MSM</li> <li>• needle exchange provision for injecting drug users</li> <li>• high-quality integrated SRE</li> </ul>

Sources: Payne N and O'Brien R (2005) *Health economics of sexual health: a guide for commissioning and planning*, DH. fpa (2005) *The economics of sexual health*; NICE (2005) *Long-acting reversible contraception. Clinical guideline*

3.79 Commissioning consortia, as highlighted in the commissioning toolkit<sup>198</sup>, have been successfully implemented in some areas, with collaborative mechanisms for planning and procurement together with joint funding mechanisms and risk sharing. Co-terminosity between commissioning consortia and service networks can facilitate the relationships held with providers, and some networks have successfully agreed priorities for investment and commissioning, eg. for IT developments and laboratory testing. Consortia or specialised commissioning arrangements are important for commissioning high-cost and low-volume care where a critical mass of patients is needed to provide a cost-effective service and ensure optimum service quality. They have been particularly developed within HIV treatment and care, which falls under the definition of NHS 'specialised services'<sup>199</sup> commissioned by regional Specialised Commissioning Groups (SCGs), currently being re-organised and strengthened following recommendations of the 2006 review of specialised commissioning<sup>200</sup>. Consortium commissioning may also be appropriate for other higher-cost sexual health services such as later abortion and sexual assault referral centres (SARCs). However, in reality, commissioning consortium development has been patchy across PCTs.

3.80 The transfer to PCTs of commissioning responsibility for prison healthcare in 2006 has provided the opportunity for NHS commissioning to address the needs of a key group disproportionately vulnerable to sexual ill-health. Evaluation of a framework for tackling blood-borne viruses (including HIV) in prisons found examples of good practice, but suggested more guidance was needed for commissioners in this new area. Prisons are often included in the commissioning of local chlamydia screening and record some of the highest positivity rates. Data on STIs and blood-borne viruses (BBVs), including HIV, in prisons are not currently disaggregated in local datasets. The last survey of BBVs in prisons (which also measured undiagnosed infection) was in 1997. Commissioners are hampered by this lack of information on which to base needs assessment to inform commissioning.

*See case study: Developing guidance for commissioners on sexual health and blood-borne virus services in prisons in the South West of England*

### **Building the evidence base and promoting best practice**

3.81 Support for local-level Strategy implementation has been supplemented by publication of health

promotion<sup>201</sup>, commissioning<sup>202</sup> and sexual health needs assessment toolkits<sup>203</sup>, as well as standards for HIV and sexual health services<sup>204</sup>. The role of SHAs in supporting local organisations to deliver world class commissioning has also been increased<sup>205</sup>. Further support for commissioning is afforded by a gradual build-up of nationally available tools for commissioning of evidence-based care.<sup>206</sup>

3.82 A sound evidence base is needed to underpin all service development, and the Health Development Agency (now part of NICE) carried out reviews of effective prevention of HIV and STIs, and of teenage pregnancy<sup>207</sup>. NICE has also published evidence-based public health guidance on one-to-one interventions to prevent under-18 conceptions and STIs, focusing largely on groups most at risk<sup>208</sup>, and guidelines for the use of long-acting methods of contraception (LARC), including cost-benefit analysis<sup>209</sup>, although the extent of implementation of both these pieces of guidance is unclear. Evaluation of newer initiatives in sexual health such as the Boots Pathfinder project on chlamydia screening<sup>210</sup> and One Stop Shops have also been significant for informing future developments. Further cost-effectiveness analyses relating to implementation of LARC, reducing time to abortion<sup>211</sup> and a range of sexual health interventions<sup>212</sup> are also available to support robust commissioning of local services (see Table 5). The Sexual Health and HIV Research Strategy Committee (SHHRSC), convened jointly between the DH and the Medical Research Council (MRC) to address the research priorities of the Strategy, has supported a gradual expansion of the sexual health evidence base through funding a range of research projects, including research into effectiveness of sexual health service provision as well as pilot and exploratory studies of promising interventions. A list of these projects is at Appendix 4.

[See Table 5: Cost savings and cost-effectiveness](#)

### Additional investment for sexual health

3.83 Funding for sexual health and HIV has increased as part of overall annual increases in NHS and social care funding, with allocations for HIV treatment and care reflecting (albeit with a timelag) the rapidly rising numbers of people being diagnosed and receiving care. There have also been a number of injections of additional investment in sexual health in response to the Strategy and *Choosing health*, mostly in support of achieving national targets and priorities. The most recent example is the £26.8 million new investment for contraception in 2008/9, with further funding available in 2009/10 and 2010/11<sup>213</sup>. Appendix 3 contains further information on additional investment since the Strategy was published.

[See Table 6: Summary](#)

**Table 6 | Summary**

#### What have been the key drivers of progress?

- National targets
  - GUM access
  - Chlamydia screening
  - Abortion
  - Antenatal HIV screening
- Central funding for service improvements and modernisation
- National campaigns and targeted prevention
- High-level scrutiny of services via NST and MedFASH GUM review
- Standards for HIV and sexual health services and best practice guidance
- Integration of GUM and contraceptive services
- Managed networks
- Improvements in commissioning
- Technological advances
- Workforce development, especially in relation to nurses





# SECTION 4

## Key barriers to implementation

4.1 The Strategy has been instrumental in achieving real progress in sexual health, particularly in some of the areas highlighted in Section 3. However, it is important to recognise that some aspects have received more priority than others to date, both nationally and locally, and to acknowledge the range of factors which have acted as barriers to more effective implementation (see Table 7 for summary). Identification of these is a key step in considering what further action is required to respond to the changing context for sexual health and to further accelerate implementation.

### Identified barriers

#### Prioritisation, targets and investment

4.2 Although national targets around access to GUM clinics and chlamydia screening have resulted in a raised profile at local level in these areas<sup>214</sup>, there have been no similar targets to drive service provision in contraception, HIV or sexual health promotion. This is an important factor in the variable progress seen with local-level implementation of the Strategy, with only a minority of Local Delivery Plans (LDPs) in 2006<sup>215</sup> mentioning either HIV or contraception (35% and 37% respectively).

4.3 In addition, nearly two-thirds of *Choosing health* money pledged by the Government for sexual health did not reach its target in 2006/7; much of it was diverted to cover PCT deficits<sup>216 217</sup>, though the picture for 2007/8 seems to be more mixed. There also appears to have been relative disinvestment<sup>218 219</sup> in sexual health promotion and prevention, notably HIV prevention, despite this having been shown to be cost-effective, and in many cases cost-saving<sup>220</sup>. Lack of local incentives for funding sexual health promotion and prevention initiatives, coupled with the longer-term nature of returns on investment and difficulties in measuring outcomes, have led to an apparent disconnection between national priority and local action. There has also been some disinvestment in contraceptive services<sup>221</sup> with many areas struggling to continue to provide full clinical services while delivering comprehensive multidisciplinary training, clinical governance and outreach services. This

disinvestment has resulted in clinic closures<sup>222</sup>, with a potential increase in unintended pregnancies as well as a widening of inequalities, as vulnerable groups are disproportionately affected. More recently, GUM services have faced disinvestment and destabilisation in some PCTs with a potential threat to the Level 3 clinical governance role, where GUM provision has been put out to tender or shifted to Level 2 providers with a view to reducing costs.

4.4 There is a lack of senior, accountable sexual health leads at PCT and regional levels, with responsibility for sexual health often taken by general public health professionals or commissioners without specialist knowledge, reflecting an overall loss of specific expertise at local strategic commissioning level<sup>223</sup>. Frequent change in health services structure has led to a loss of key players in terms of sexual health expertise, commitment and responsibility, and there has been an absence of leadership, with the knock-on effect of poor engagement with sexual health by many PCTs.

#### Commissioning

4.5 Similarly, although improving sexual health commissioning was fundamental to the aims of the Strategy as a key lever for change, quality has remained variable. As with sexual health leads, commissioners responsible for sexual health at PCT level have often not had sufficient seniority to hold influence, and may hold responsibility for a diverse range of competing commissioning roles<sup>224</sup>. Commissioning reforms have led to changes in local workforce and a loss of expertise. One-quarter of sexual health/HIV commissioners<sup>225</sup> have been in their post for less than a year, with 11% of posts vacant. While the new NHS Operating Framework places increased emphasis on the local determination of priorities, the presence of local champions within commissioning to raise the profile of sexual health appears to be diminishing.

4.6 Commissioners have faced further challenges in taking a strategic approach to commissioning integrated services, because of separately held budgets and different commissioners responsible for

different aspects of sexual health. Conflicts between primary care, community and hospital-based clinicians, particularly with the advent of practice based commissioning, have often served to further heighten these tensions.

4.7 A joint approach to the commissioning of services according to need where key communities straddle PCT geographical boundaries has not always been evident. Commissioning consortia with local multi-agency planning groups working alongside clinical networks have been developed in some places, although not consistently, to address this issue. There is an absence of mechanisms particularly to commission higher-cost and/or lower-volume services other than HIV, such as mid-trimester abortion or sexual assault referral centres.

#### **Evidence and data to support commissioning and practice**

4.8 Evidence-based practice is a key lever for robust commissioning and practice improvement, but evidence has been slow to build, with research gaps in many areas of sexual health. For HIV and STI research, academic resources and leadership are relatively strong, and this has fostered growth in the evidence base although significant gaps remain, such as in relation to effective HIV prevention interventions for African communities. However, independent clinical research in contraception has been limited, with funding tending to be concentrated in the commercial sector, and few opportunities or training available to stimulate investigator-led research.

High-quality and timely surveillance data are vital to identify need, determine the value of prevention programmes, and help optimise service configuration at national, regional and local levels.

4.9 Relevant research findings have been insufficiently disseminated particularly to commissioners and frontline providers. Although there are many examples of local innovations in service development, there has been no central mechanism for making evaluations available to inform best practice commissioning. Innovation and

service reconfiguration need to be complemented by research on their public health impact.

4.10 Needs assessment, vital to linking healthcare provision with need, and one of the factors associated with better performance in local teenage pregnancy strategies<sup>226</sup>, has not consistently been part of the commissioning process for sexual health<sup>227</sup>. This has often led to services being commissioned on the basis of historical patterns rather than identified local need. Absence of data and lack of data flows between sexual health services have hampered the performance of adequate needs assessment, tracking of progress or the development of robust commissioning processes<sup>228</sup>. Weak linkages between commissioning, public health, health promotion, financial planning and services have further compromised the ability to commission according to need.

4.11 High-quality and timely surveillance data are vital to identify need, determine the value of prevention programmes, and help optimise service configuration at national, regional and local levels. Full utilisation of routinely collected surveillance data, made available at PCT level and upwards, is urgently needed, along with enhanced surveillance in specific populations and for new and emerging infections. The opportunity to strengthen evaluation of national prevention campaigns through the use of surveillance data on, for example, numbers of young people attending sexual health clinics or the possible impact of advertising on diagnosed infections, appears to have been missed; there is scope for greater collaboration on this between the DH, HPA and agencies developing campaigns.

4.12 Progress in local-level surveillance and monitoring has been limited, with delays in the implementation of the Common Data Set for sexual health, reducing the availability of local sexual health intelligence for needs assessment, service planning and audit. However, revised collection of data from GUM clinics from 2008 (GUMCAD) will enable more detailed collection of information on ethnicity, country of origin and sexual orientation, as well as PCT and lower-level (super output area) data. This new dataset is being rolled out in Level 3 services, and is to be piloted in Level 2 services. The recently introduced 48 Hour Genitourinary Medicine Access Monthly Monitoring (GUMAMM) dataset also provides improved data on services. A revised dataset for returns from contraceptive services (KT31) is being piloted in five PCTs and tested out with two IT systems to establish a data

standard. It will be important to ensure compatibility between this and other datasets used in sexual health, to facilitate their use in integrated services and the comparability of data between sectors.

4.13 Despite the scale of primary care and its central role in the Strategy's vision of sexual healthcare as well as in the emerging wider vision for the NHS of the Next Stage Review, there is still no good surveillance system for primary care to inform commissioning or service improvement. This is a priority, to ensure some compatibility or at least comparability of data between primary care and specialist services, and the HPA is now taking forward work on this, funded by the DH.

4.14 The Health Services and Public Health Research Board – 'parent' board of the joint DH and MRC Sexual Health and HIV Research Strategy Committee (SHHRSC) – has been disbanded, and health services research is now the responsibility of the National Institute for Health Research (NIHR). The implications of this are not yet clear for how future research to support the national sexual health Strategy will be supported, but there remains a need for research funding, strategic overview of gaps in the evidence base, and recommendations to address these. While there is now a much improved evidence base in UK sexual health (SHHRSC has supported 28 studies during its six years to date – see Appendix 4), an oversight body to direct and support research and surveillance efforts in sexual health is still needed, in order to ensure the evidence base to support implementation of the sexual health Strategy continues to grow.

#### **Integration and workforce development**

4.15 Although most services have embraced integration to some degree, there has been a lack of clarity about the meaning of integration between STI, contraception and abortion services and how it should be implemented, resulting in variable progress at local level. Different interpretations persist as to whether integration relates to the patient journey or joint working with minimisation of organisational barriers<sup>229</sup>. There is a lack of evidence or consensus on the characteristics of a service that reflects local need while minimising barriers to access. Competition and conflict between hospital and community provision, exacerbated by non-integrated budgets and by separate training structures, data-capture mechanisms and models of service provision, have further threatened the development of collaborative models. Contestability across a wider spectrum of providers offers a potential further threat, increasing

competition at the expense of co-operation. Tariffs may also act as an impediment, in that they offer potential cost-cutting incentives for developing Level 2 services, rather than commissioning based on population need with recognition of the role of Level 3 services in clinical governance and training across all service levels.

4.16 There have been wide variations in both workforce capacity and training to develop the required provider networks for a consistent integrated service from basic through to specialist levels. There are regional differences in the capacity of the specialist workforce<sup>230</sup>, with a shortfall in the recommended number of consultants for both contraceptive and GUM<sup>231</sup> services to oversee sexual health provision and provide an overall clinical governance framework. There is a low proportion of consultants to non-career grade specialists in community contraceptive services: many services are dependent on sessional and part-time doctors, without provision for continuing professional development of the existing workforce, or a sustainable succession strategy. The existence of separate career paths and specialties for doctors specialising in GUM or contraception, despite increasing areas of overlap in actual practice, creates additional barriers to the development of integrated services with rounded clinical leadership.

4.17 In some local areas, training of staff (within and outside the trainer's service) has often been unfunded and reliant on goodwill, and there has been no systematic approach to ensure standardisation and equity of training provision or to monitor uptake and achievement of recognised competencies among providers. In general, there is a lack of structural support for training of professionals, particularly nurses, in terms of funded and protected time to deliver and receive appropriate training. Local needs assessment in order to build capacity and workforce capability to address local priorities<sup>232</sup> within the constraints of supply and finance has too frequently been insufficient.

4.18 In particular, provision of the full range of contraception including long-acting methods, as recommended by NICE<sup>233</sup>, requires training of practitioners in appropriate techniques to acceptable standards. Full implementation of LARC could prevent 500,000 unintended pregnancies over 15 years with a net cost saving of more than £650 million<sup>234</sup>, yet there is currently a significant deficit of professionals trained to provide LARC, and insufficient capacity to train them. Community contraceptive services have a central training

role for other providers of contraceptive services, providing 80% of training for general practice and other practitioners in the community, but their capacity to provide this role has been hampered by inadequate investment, or even disinvestment, in many areas.

### Funding mechanisms and incentives

4.19 Partial implementation of Payment by Results (PbR) for sexual health and HIV services, with the introduction of tariffs for some services and some settings, but not for others, has led to further disjunction between hospital and community services, presenting barriers to commissioning across whole pathways of care. GUM tariffs for Level 3 services have been developed, as have HIV tariffs, which are currently only for inpatient care (although there are indicative HIV outpatient and contraception tariffs). A new outpatient HIV tariff is now in development, but this does not extend to the inclusion of social care, community HIV care or prevention. Abortion tariffs are only mandatory for NHS provision within hospital settings, and remain negotiable with independent providers. As yet, there are no tariffs for Level 2 STI services or for contraception, limiting opportunities for service expansion in response to need and creating disincentives for integrated provision, a key aim of the Strategy. In addition, there has been wide variation in the extent and speed of implementation of existing tariffs at local level.

4.20 Full implementation of PbR across all aspects of care, a breakdown of tariffs into more specific treatments/interventions, and implementation of cross-charging are necessary to maintain viable open access sexual health services, with PCTs honouring the commitment to fund the care of their residents wherever they choose to attend. However, the timescales for the development and implementation of a full set of sexual health tariffs are likely to be prolonged, in part due to the lack of IT and data infrastructure to support the change. Lack of adequate IT, particularly in contraceptive services, remains a huge barrier for the capture of robust and comprehensive data. Where IT systems are in place, there is a failure of linkage between contraception, abortion and STI provision, and the overall impact of data restrictions on sexual health service delivery has been highlighted<sup>235</sup>. The availability of relevant data is vital to establish need, ensure that providers with capacity and capability to meet that need are commissioned, and record activity for performance management. In addition, there is no common sexual health budget to counter conflict between incentives across the different

elements of service provision while the lack of cross-charging arrangements limit incentives for service improvement, particularly in areas where large numbers of non-resident clients characteristically attend. Local tariffs have been developed in some areas, but further progress on this and cross-charging is needed<sup>236</sup>.

### Involvement of general practice

4.21 Progress with implementation of basic sexual health service provision within general practice has been variable, in spite of continued evidence for demand. The apparent failure of the new General Medical Services (GMS) contract to address the priorities of the sexual health Strategy has caused frustration among local stakeholders seeking to increase and improve basic sexual healthcare in general practice, as advocated by the Strategy. Although the Strategy recommended that all practices provide basic Level 1 services, this has not been achieved, and there has been debate as to whether management of STIs or HIV qualifies as an 'essential' service in the terms of the contract<sup>237</sup>. Contraceptive provision exists as an 'additional' service, with a theoretical opportunity for practices to opt out of care, although in reality this does not appear to happen often.

4.22 Sexual health services do not hold a significant place in the Quality and Outcomes Framework, and there has therefore been a lack of incentive to improve the quality of even basic provision. However, the final report of the NHS Next Stage Review<sup>238</sup> announced plans to improve the QOF, particularly to focus on measuring prevention and clinical effectiveness. With sexual health improvement also identified in that review as a key commissioning goal, this might signal an opportunity to create such incentives for the future. Meanwhile, a set of sexual health indicators already exists, developed (but not adopted) as part of the review process informing negotiations on revisions to the QOF 2008. These have been published online<sup>239</sup> and might be considered for use at local level by PCT commissioners.

4.23 Although some PCTs commission local enhanced services (LESs) within general practice, the number of practices signed up to this varies enormously<sup>240</sup>, with fewer than 5% providing an enhanced service for the detection and treatment of STIs<sup>241</sup>. In some places, GPs may be reluctant to provide a LES, but in others PCTs may decide not to commission LESs, despite enthusiasm from local GPs. Standards of provision in general practice vary. More than two-thirds of practices<sup>242</sup> do not provide

a full range of contraceptive choices, out of line with current recommendations for expanding access to long-acting methods<sup>243</sup>.

### Social attitudes and stigma

4.24 Stigma, recognised as a feature in all aspects of sexual health, significantly has the greatest impact amongst marginalised groups who are also most vulnerable to negative health outcomes<sup>244</sup>. Its impact in reducing access to information and services leads to poorer health in groups that are already vulnerable. The Strategy committed to tackling HIV-related stigma and, since its publication, there have been a number of initiatives to address this, including the development of an action plan on stigma<sup>245</sup>, and the National AIDS Trust “Are you prejudiced?” campaign. Nonetheless, there is evidence that attitudes among the general population and healthcare professionals have not markedly improved since 2001, and may in some cases have regressed. The proportion of the population who believe that people who contract HIV through unprotected sex or drugs have only themselves to blame decreased between 2000 and 2005 but had started to rise again in 2007<sup>246</sup>. Studies among people with HIV have found significant levels of reported discrimination by healthcare providers: examples cited in one qualitative study included dentistry, maternity, accident and emergency, and general practice as well as HIV specialists<sup>247</sup>. In other areas of sexual health, stigma is also commonly experienced, with young people frequently describing professionals as judgmental and stigmatising, particularly in relation to under-age sex and termination of pregnancy<sup>248</sup>.

4.25 Despite its omnipresence in the media, and as a subject for humour, it is recognised that many people find it difficult to discuss sex without embarrassment, or to acknowledge its importance as a factor in general health and well-being. This difficulty is a contributory factor to the stigma associated with sexual health, and it is clear that further cultural shifts are required to enable greater openness and discussion about sex, sexual pleasure and sexual health. Local decision-makers are not immune from such difficulties, and may feel unease at prioritising areas of healthcare that are stigmatised, especially in the absence of a patient voice in sexual health (other than HIV), which was noted by the Health Select Committee<sup>249</sup>. The visibility of champions for sexual health and HIV, along with the use of evidence – of need, of effectiveness and cost-effectiveness of interventions, and of the experience of sexual health service users – are means which can be used to combat this.

### Clinical model of sexual health

4.26 The sexual health Strategy is weighted towards the clinical dimensions of sexual health and sexual ill-health, and is therefore limited in the degree to which it addresses the wider range of factors that influence sexual health such as poverty, social exclusion, inequalities, education, stigma and links with alcohol and drug use. It is important that national, regional and local organisations take a broader view of sexual health and its impact on general well-being, relationships, families, mental health and communities, to ensure it is not marginalised in relation to the local government agenda. The duty of local authorities to promote and improve well-being provides an increasingly important lever for sexual health.

4.27 Sexual health is a pertinent issue for the majority of the population from puberty to old age. The Strategy’s emphasis on sexual ill-health and the absence of disease rather than the promotion of sexual well-being and staying sexually healthy can work to exclude consideration of the needs of the broader public. The Strategy should address more effectively the differing needs of the population at all stages of the life cycle. Much work is being undertaken to address the needs of younger people, with a primary objective of reducing teenage pregnancy. However, there should be a greater focus on those over 18, who have some of the highest rates of unintended pregnancy and STIs. In addition, people in midlife and beyond, who represent a growing sector of the population, have sexual health needs, too. Educational campaigns targeted at teenagers may not seem relevant to them, and they can be at particular risk when coming out of long-term relationships, ill-equipped with knowledge or skills to negotiate safer sex. Maintaining a good sex life into later years can improve health and quality of life.

### Areas requiring further attention

#### Contraceptive services

4.28 Although contraceptive services are key to the Strategy’s aim of reducing unintended pregnancies, there was no explicit ‘route map’ for developments and improvements needed in this area. Without a clear indication of priority or actions required, local contraceptive services have not seen the improvements achieved in other more prioritised areas of sexual health, and have in some areas suffered from disinvestment in recent years. With some notable exceptions, they have frequently been unable to develop their services and restricted in their capacity to provide training for other local contraceptive providers<sup>250</sup>. Similarly, there has been little attention given to health promotion and public information to encourage uptake of contraception



(other than condoms). National information campaigns have been dominated by promotion of condom use with a lack of attention to other, more effective, methods of contraception.

4.29 Preserving community contraceptive services is essential to continued good-quality provision of contraception and effective reduction of unwanted conceptions in young people<sup>251</sup>. These services are open access with extended opening hours, complying with the patient choice agenda. They are often the preferred service, particularly for young people and other more vulnerable communities<sup>252</sup>. In spite of general practice being the majority provider, these services can be the central point for a network of services, supporting provision through training, clinical governance and care pathways, and providing helplines for professionals who need additional support<sup>253</sup>. As specialists embedded within the community, they also have the potential to address wider sexual health concerns including STI management, sexual health promotion, psychosexual issues, abortion, infertility and the sexual health needs of older people, as well as supporting the policy drive to shift services from secondary to primary care<sup>254</sup>.

4.30 Signalling intensified priority for contraception, the Department of Health (DH) recently announced welcome new funding to improve access and foster innovation, along with plans for a national information campaign on contraceptive choices for young people<sup>255</sup>. With almost half of the funds allocated directly to PCTs, it will be important to ensure this priority is reflected at local level and services are commissioned to deliver key outcomes, with the strengths that make them attractive to users<sup>256</sup>, including walk-in access, confidentiality, out-of-hours provision, on-site access to contraceptive supplies and provision of appropriate, reliable methods of contraception by qualified staff.

### Late abortions

4.31 Although the Strategy aimed to increase the proportion of abortions performed at earlier gestations, it did not address the particular needs of people requesting later abortion (after 13 weeks) which make up 11% of total abortions. Evidence suggests that women reach services late for a complex range of reasons which are only partially amenable to service improvements. They also tend to be more vulnerable<sup>257</sup> and may have complex difficulties<sup>258</sup>. Wide access to free pregnancy testing and direct-access booking facilities can contribute to minimising delays. Ensuring that professionals provide

clear information about onward referral if they are ethically opposed to providing abortion services is also important. Fewer than 2% of women require abortion beyond 20 weeks. This requires specialised procedures not provided by all abortion services, leading to geographical variations that can incur further delays and mean that women have to travel far afield despite RCOG guidelines recommending local access<sup>259</sup>. In recognition of the difficulties that may be encountered in accessing later abortion, development of a best practice protocol for commissioning of late abortion and a review of training needs for service provision has been recommended by the Chief Medical Officer<sup>260</sup>.

### Psychosexual support

4.32 Although the need to address psychological and sexual problems was recognised within the Strategy, this area of sexual health was not further developed in either the implementation action plan or commissioning toolkit, and other more prominent aspects of the Strategy were prioritised for implementation support in the years which followed.

4.33 Psychosexual problems and sexual dysfunction are relatively common in the general population<sup>261</sup>; services are provided by a wide variety of practitioners across a range of disciplines. In general practice, problems are under-recognised<sup>262</sup>, suggesting that people need help to find appropriate support. Although services are provided through a range of specialists across multiple locations such as mental health, GUM and psychosexual medicine, there are weak linkages and a lack of explicit referral pathways from frontline to specialist services, compounding under-recognition. Basic training in the recognition of psychosexual difficulties is available for medical, nursing and other clinical staff<sup>263</sup>, which can lead to more specialised training qualifications<sup>264</sup>. Nonetheless, provision of geographically accessible services and training is inconsistent. The discipline of psychosexual medicine is not a specialty in its own right, and the majority of service leads are not at consultant level and work in isolation. Consequently there has been a lack of progress in many services, perpetuating wide variations and geographical inequities in access<sup>265</sup>. Although there are pockets of high-quality service provision, a co-ordinated approach with standards for management of sexual difficulties has been lacking. However, guidelines and models of good practice are increasingly available.<sup>266</sup>

### Sexual Assault

4.34 Although not part of the original Strategy, freedom from sexual violence or coercion is also



Table 7 | Summary

**What has impeded progress?**

- Insufficient integration with other government strategies relevant to sexual health
- Absence of a more social model of sexual health and well-being to align it with local government priorities
- National targets and indicators that include only some elements of sexual health
- Limited progress in developments with data, supporting IT systems and national tariffs
- Lack of synergy between national prevention campaigns and local campaigns
- Slow build-up of evidence base and lack of focus on economic arguments
- Stigma associated with HIV and sexual health
- Lack of PCT commitment to and engagement in sexual health
- Constant health service reform (loss of local 'leaders/champions' and accompanying experience and expertise in commissioning and health promotion)
- Diversion of sexual health funds and top-slicing to meet deficits
- Continued disinvestment in community contraceptive services
- Competition and conflict between primary care, community and hospital-based services
- Variable progress in
  - (i) establishing sexual health networks
  - (ii) integrating services
  - (iii) engaging GPs in providing sexual health services
- Partial development of PbR, and poor understanding and application of tariff structure, leading to fragmentation rather than integration
- Under-investment in training and education to support service developments
- Weak links between commissioning, public health, health promotion, financial planning and services
- Poor data collection and management to aid effective commissioning
- Limited understanding and use of needs assessment to drive commissioning of prevention and services
- Lack of a strong voice for sexual health service users or advocacy for sexual health in local communities

an essential prerequisite for sexual well-being. Sexual assault is common but can result in long-term health problems and associated costs to the health service. Addressing problems early, in a co-ordinated partnership between organisations commissioned appropriately, should help to prevent these long-term costs and result in cost savings. Sexual Assault Referral Centres (SARCs), which are jointly commissioned between the police and the NHS, can provide a gold-standard holistic service for victims. In these centres, forensic examinations are carried out on behalf of the police or through victims self-referring, and services are often delivered out of hours by highly trained staff providing 24-hour cover. The victims are cared for immediately post-assault as well as according to their longer-term sexual health and psychological needs.

4.35 SARCs have increased in number since the publication of the Strategy, with 20 centres established across England and Wales, and another 18 planned this year. However, to support delivery, clinical governance and training by specialist units at regional level is required. Currently, quality and access to 24-hour support<sup>267</sup> remain variable. In addition, differences in access exacerbate existing inequalities, since sexual assault disproportionately affects vulnerable populations. The DH and the Home Office (HO) have been working jointly on a commissioning toolkit for developing SARCs.



# SECTION 5

## Action to drive forward the Strategy

5.1 Considerable progress has been made since the Government published the *The national strategy for sexual health and HIV* in 2001, and many of the central commitments within the Strategy and accompanying implementation action plan have been delivered. There have also been some real improvements in the sexual health of the population and in service provision, with falling teenage pregnancy rates, reduced rates of gonorrhoea, vastly improved waiting times for Genitourinary Medicine (GUM) services, improved access to abortion on the NHS and under 10 weeks, and the introduction of chlamydia screening in all Primary Care Trusts (PCTs). This is a reflection of the national commitment placed upon improving sexual health during this period, although the extent to which this commitment has been translated into local action across the country has been more variable<sup>268</sup>. Significantly, the implementation of the Strategy has taken place against a backdrop of high-level policy and structural changes in the NHS and across local government (see Section 2).

5.2 The review of the Strategy has provided an opportunity to take stock of what progress has been made and what remains to be done to accelerate implementation. Key actions identified from the review in relation to the Strategy's original aims are outlined below, followed by cross-cutting recommendations in five strategic priority areas to drive further improvements.

### Further action in relation to Strategy aims

5.3 Table 8 revisits the aims of the sexual health Strategy, adding an additional one of 'improving sexual health and well-being' to reflect current policy emphasis, and identifies the range of actions required in 2008 and beyond to move closer towards realising them.

[See Table 8: Strategy aims – further action required](#)

### Making it happen: driving the Strategy forward

5.4 In the five strategic priorities for action below are presented some recommendations, drawn from the

findings of the review, about what needs to be done to overcome the barriers and accelerate implementation of the Strategy. These recommendations are cross-cutting, rather than specific to particular aspects of sexual health, and they address structures, mechanisms and levers to make things happen.

5.5 The Strategy identified prevention and services as the two main arms for delivery. The ability of prevention activities and services to have an impact depend on the support and priority they receive through commissioning, partnerships and, above all, leadership, at all levels. These five issues are addressed in the key strategic priorities for action below.

5.6 The recommendations are directed at those with responsibility for sexual health and HIV at local, regional and national level:

- i) At local level, they are directed at Local Strategic Partnerships, and PCT, LA, NHS and Foundation Trust chief executives, and will be relevant to those responsible for public health, commissioning, finance, performance, and workforce development, and to clinical directors, statutory, third and independent sector providers, Children's Trusts/services and adult social care providers.
- ii) At regional level, they are directed at SHA chief executives, Government Office directors and Regional Directors of Public Health, and will be relevant to those responsible for public health, commissioning, market/provider development, and workforce development as well as regional leads for sexual health, teenage pregnancy and the National Chlamydia Screening Programme, the HPA regional offices and Public Health Observatories.
- iii) At national level, they are directed at the Department of Health and Department for Children, Schools and Families, and will be relevant to the Department of Communities and Local Government, the Home Office, Ministry of Justice, Department for Innovation, Universities and Skills, Office of the Third Sector and Department for Business, Enterprise and Regulatory Reform.

Table 8 | Strategy aims – further action required

Strategy aims	Focus for further action
<b>Reduce unintended pregnancy rates and improve care for women seeking abortion</b>	<ul style="list-style-type: none"> <li>• Improve access to the full range of contraceptive methods and regularly audit services</li> <li>• Improve professional and public knowledge of the most effective methods of preventing pregnancy (focus on adults as well as teenagers)</li> <li>• Protect and develop community contraceptive services to ensure their training and clinical governance role and preserve patient choice (but not excluding moves towards integration)</li> <li>• Increase availability and uptake of LARC</li> <li>• Develop a best practice protocol for commissioning abortion services</li> <li>• Improve access to NHS-funded early medical and surgical abortion and 2nd trimester abortion</li> <li>• Implement strategies to reduce the number of repeat unwanted pregnancies (by ensuring comprehensive care pathways are in place that include provision of appropriate contraception as part of post-abortion and post-natal care)</li> <li>• Extend locations for abortion services to community-based settings</li> <li>• Build the evidence base around factors affecting uptake and continuation of contraception</li> <li>• Take a strategic, needs-based approach to workforce capacity to ensure the contraceptive provider network meets service requirements</li> </ul>
<b>Reduce transmission of HIV and STIs</b>	<ul style="list-style-type: none"> <li>• Invest in national and local prevention programmes which target those most at risk and those already infected to prevent acquisition and onward transmission</li> <li>• Invest in and disseminate research which improves understanding of the reasons for continuing transmission and barriers to prevention, to tailor prevention interventions</li> <li>• Build the evidence base for what works and ensure this informs prevention programmes</li> <li>• Improve HIV incidence data (using the Serological Testing Algorithm for Recent HIV Seroconversion - STARHS) to enable monitoring of prevention effectiveness</li> </ul> <p><i>The actions in the box below will also help to achieve this aim</i></p>
<b>Reduce prevalence of undiagnosed HIV and STIs</b>	<ul style="list-style-type: none"> <li>• Develop and implement strategies to increase HIV testing in a range of existing and new settings (eg. in medical settings as part of routine diagnostic procedures, in general practice for identified at risk populations, in non-healthcare settings delivered by community organisations)</li> <li>• Ensure maximum uptake of antenatal screening and equity across providers</li> <li>• Improve understanding among professionals and policy-makers of the barriers (cultural, attitudinal, regulatory) to HIV testing, particularly in communities most affected</li> <li>• Facilitate prompt testing and treatment for STIs (including partner notification) by maintaining 100% access within 48 hours to GUM services, and expanding range of other services providing STI testing and treatment within 48 hours</li> <li>• Improve professional and public awareness of STIs, especially those which are asymptomatic</li> <li>• Expand the chlamydia-screening programme to reduce population prevalence, with effective partner management as a central component and key providers (especially general practice) actively involved to maximise coverage</li> </ul>
<b>Improve health and social care for people living with HIV</b>	<ul style="list-style-type: none"> <li>• Reduce morbidity and mortality associated with HIV through early diagnosis, timely access to clinical care and appropriate support to facilitate uptake of and adherence to highly active antiretroviral therapy (HAART)</li> <li>• Improve the well-being of people living with HIV through measures to involve them in managing their sexual health and individual care and in planning and evaluating services</li> <li>• Ensure services are integrated and meet the long-term condition management and social care needs of people with HIV</li> <li>• Recognise the central role of people living with HIV in preventing transmission, and integrate prevention into services and support provided for this group</li> </ul>
<b>Reduce stigma associated with HIV and other aspects of sexual health</b>	<ul style="list-style-type: none"> <li>• Improve public understanding and promote positive attitudes through leadership, visibility of people affected by HIV and other sexual health conditions, and informed public information and media coverage</li> <li>• Strengthen understanding in the sexual health and wider workforce (health, education, social care) of the needs and experiences of people living with HIV, facing an unplanned or unwanted pregnancy, or using sexual health services, and ensure policies and practices are in line with action to eradicate stigma</li> <li>• Review legislation and other government policies which fuel and reinforce stigma, and promote legislation and regulations which prohibit discrimination</li> <li>• Ensure sexual health services are positive and affirming for young people, and those of all ages, supporting them to take responsibility to have safe, fulfilling, healthy and pleasurable sexual relationships</li> </ul>
<b>Improve sexual health and well-being</b>	<ul style="list-style-type: none"> <li>• Support people to acquire the knowledge, skills and values essential to stay healthy, and to maintain and improve sexual health and well-being at all life stages (through access to good-quality SRE, life-long learning programmes and awareness and information campaigns)</li> <li>• Widen access to and scope of sexual health provision across general practice, primary-care health centres/polyclinics, pharmacies, schools, Further Education (FE) colleges and other youth settings, community/third sector organisations and workplaces where appropriate</li> <li>• Utilise research and social marketing techniques to understand more clearly what lies at the root of sexual risk-taking behaviours, particularly in relation to use of alcohol and drugs, and develop appropriate interventions to tackle these links</li> <li>• Review evidence about wider social determinants of sexual health and ill-health, and the factors affecting inequalities in sexual health, to inform policy development, educational interventions and service planning</li> <li>• Recognise psychosexual health as an integral part of sexual health, and ensure equitable access to psychosexual and sexual dysfunction services of consistent quality by ensuring geographical equity in provision and development of appropriate links between services</li> <li>• Adopt a holistic approach to sexual health to meet the needs of those vulnerable to multiple negative health outcomes (such as those who have experienced sexual assault, abuse and violence, the homeless, people in prison, sex workers, drug users, some ethnic minority groups, people seeking asylum and other migrants)</li> </ul>

## Priority for action 1: Prioritise sexual health as a public health issue and sustain high-level leadership at local, regional and national levels

5.7 Bold and committed leadership at all levels is needed to ensure sexual health and HIV continue to have priority in policy and planning, to combat the stigma which can impede efforts to improve sexual health and well-being, and to ensure the needs of those population groups most adversely affected by HIV and sexual ill-health are fully addressed. It is important not to underestimate the effort and commitment needed across Government, and throughout the NHS and local government, to continue and sustain improvements in sexual health and to tackle those challenges which have proved intractable. There need to be active local champions and clearer accountability in PCTs and LAs for driving forward implementation of strategic priorities. SHAs and GOs, with Regional Directors of Public Health as key players, have an important role in setting the regional strategic direction and making sure there are appropriate local responses to sexual health need. Leadership from the centre is also required, through ministers, senior departmental officials and others, to ensure the wider determinants of sexual health and outcomes associated with sexual ill-health are recognised and acted on by all relevant government departments, and that sexual health does not lose out nationally or locally to other less stigmatised, competing issues.

5.8 At local level, it is essential that there is more active engagement of senior decision-makers and stakeholders, including chairs and non-executives as well as senior employees, to ensure sexual health continues to have priority in PCTs' operational plans and in LAAs, to champion local sexual health strategies and action plans based on comprehensive local needs assessment, and to secure and maximise local investment. The sexual health and HIV Strategy has not had a consistently strong regional-local interface, nor has it been underpinned in all PCTs by joint working with local and other mainstream partners. Building sexual health targets into national planning and performance management systems has been necessary to prompt action at local level. Now that PCTs and local authorities (LAs) have greater freedom in setting local priorities and more effective mechanisms for joint working, the responsibility for prioritisation and driving the Strategy forward rests with them, along with decisions on levels of investment.

5.9 At regional level, SHAs and GOs, through sound leadership and performance management, should ensure that sexual health services are commissioned according to need, with a focus on prevention through to health and social care, and that all local organisations contribute effectively to priority-setting via the *Vital signs* and Local Area Agreement (LAA) processes. In addition, Regional Directors of Public Health have a critical role in bringing together SHAs and GOs on issues such as public health and inequalities, both of which underpin local action on sexual health. This is important in relation to joining up and aligning with other programmes to ensure coherence in delivery. The nature and scale of sexual health need varies between and within regions, with some bearing a heavier burden of ill-health overall and others experiencing population shifts and faster-changing needs. As SHAs consult on and further develop their regional visions, prepared as part of the NHS Next Stage review, they will need to consider how best to meet identified needs within their region, both to improve sexual health and to manage long-term care for people with HIV.

5.10 At national level, continuing to signal the priority afforded to sexual health via inclusion in PSAs, Operating Framework priorities, the National Indicator Set, and Healthcare Commission Annual Assessments is essential to give impetus to local effort and commitment. National support for local delivery, particularly through an extended role for the National Support Team for Sexual Health, will continue to be an important lever in driving

### CASE STUDY

#### Appointing a local Sexual Health Champion

Sheffield City Council has appointed Councillor Clive Skelton to the brand new role of Sexual Health Champion. Councillor Skelton is currently deputy chair of the health and community scrutiny board, a member of the Sexual Health Network and chair of the Licensing Board of Sheffield (giving him a unique opportunity to ensure the links between alcohol use and sexual risk-taking are clearly understood). Councillor Skelton will report to the cabinet on sexual health policy issues and will press the PCT and local authority to ensure sexual health moves up the local agenda. He will work closely with the Young People's Champion on teenage pregnancy and with a wide range of agencies and voluntary organisations striving to make Sheffield a 'Sexually Healthier City'.

Contact: Councillor Clive Skelton, [clive.skelton@sheffield.gov.uk](mailto:clive.skelton@sheffield.gov.uk)

improvements in local commissioning, prevention and service provision.

5.11 Building up and disseminating the evidence base on what works and what is cost-effective, and identifying critical areas for further research, needs to support all elements of the Strategy's further implementation – priority-setting, commissioning, prevention and services. At national level, there needs to be a clearer framework for identifying gaps and priorities for new research, combined with dedicated funding streams to pump-prime essential sexual health and HIV research, and opportunities for sexual health and HIV researchers to compete successfully and obtain funding from generic funding streams. More robust mechanisms are also needed to share the well-documented evidence that does exist as well as findings from new research, to ensure learning is shared, implications for practice and policy are clearly identified, and that evidence informs local decision-making and strengthens confidence about what works.

## RECOMMENDATIONS FOR IMPLEMENTATION

### LOCAL LEVEL

- Designate a **board-level lead for sexual health** who is accountable to PCT and LA chief executives and takes the lead on driving forward local strategy
- Ensure there are **high-level champions** for sexual health in LSPs, LAs, PCTs, third and independent sector organisations
- Build a **strong public health base for sexual health**, ensuring public health intelligence is used to improve understanding of sexual health inequalities, and to support the targeting of resources to those who have the greatest sexual health need and who can benefit most, while maintaining universal access. Maximise use of appropriate tools such as health equity audit and equality impact assessment
- Carry out a **comprehensive Sexual Health Needs Assessment at least every five years**, and ensure its findings are publicised and accompanied by an action plan which makes explicit funding allocations and organisational responsibility
- Identify **targets for sexual health** based on local need, and **review local sexual health and HIV strategies and implementation plans** to identify what action needs to be taken to accelerate progress and improve performance in

priority areas, highlighting areas for both targeted and universal provision

- Ensure **sexual health and HIV are included in other relevant health improvement plans** including those for staying healthy, alcohol, drug use, and long term conditions
- Use **Overview and Scrutiny Committees** and other local accountability mechanisms to examine specific issues in relation to local sexual health and HIV services.

### REGIONAL LEVEL

- Ensure sexual health is considered as part of the further work and development on **Strategic Health Authority visions** created as part of the NHS Next Stage Review
- Consider a dedicated **regional sexual health co-ordinator function**, working across the SHA and GO and in conjunction with regional leads for teenage pregnancy and the NCSP, to drive action with key partners, ensure integration of the sexual health agenda with other GO priorities including non-DH departmental programmes, and 'support and challenge' local delivery of the sexual health and HIV strategy
- Provide **strategic leadership and performance management** at regional level, monitoring progress against NHS Operating Framework requirements, *Vital signs* and LAAs, and assessing '**fitness for purpose**' to deliver sexual well-being and comprehensive sexual health services
- With the involvement of Public Health Observatories and HPA Regional Units, **gather and disseminate regional data** to support local needs assessment, priority-setting and commissioning, and turn information and data on sexual health into meaningful health intelligence for local and regional use. This is particularly important to inform Joint Strategic Needs Assessments for PCTs and LAs
- Disseminate and encourage the spread of **evidence-based best practice**.

### NATIONAL LEVEL

- Provide **strong and effective leadership** for sexual health and maintain it as a *priority public health issue* across government
- Develop a single local inter-agency sexual health **performance scorecard** to support active management, and assist with local prioritisation and the monitoring of improvement and progress by PCTs and SHAs/GOs, as appropriate
- Strengthen national support to local services by extending the role of the **National Support**



**Team** (NST) to other areas of sexual health service provision (eg. contraceptive and abortion services)

- Use the **National Support Team to share learning and disseminate good practice** (eg. develop the High Impact Changes publication approach taken for GUM 48-hour access, extending to chlamydia screening and contraceptive services)
- Ensure there is an **overarching body or mechanism for strategic overview and planning in sexual health research**, involving the DH, the HPA and the research community, and with input from policy-makers, commissioners and practitioners
- Review the research funded by the DH/ MRC Sexual Health and HIV Research Strategy Committee and through other funding streams (eg. National Prevention Research Initiative), to **identify continuing evidence gaps** and establish effective mechanisms to foster evidence building and knowledge transfer
- Establish a **central register of research and good practice** not published elsewhere, with inclusion subject to selection criteria and peer review
- Build **infrastructure and training to support independent clinical research** in sexual health, particularly in areas where it is currently weak, notably contraception.

## Priority for action 2: Build strategic partnerships

5.12 Active partnerships in delivering the Strategy are the best hope for effective local action on a broad front. It is clear that the NHS is only part of the solution to improving sexual health. Other players such as LAs, and the third and independent sectors can all have an impact on this, as well as non-governmental bodies such as the HPA and service user organisations. Partnership working has been key to the successful implementation of the Teenage Pregnancy Strategy<sup>269</sup>, and successive government policies have called for local organisations to raise their game to work more effectively in partnership. Co-terminosity between PCTs and LAs plus priority-setting and planning mechanisms such as JSNA and LAAs should be used to make more headway in this area, building on the partnership duty established by the Health Act 1999.

5.13 The third sector should be involved as a key partner at all levels. Locally, it has an important role in both sexual health promotion and, increasingly, the provision of clinical and social care as part of the current expansion in the range of providers. Much of the work with marginalised communities is undertaken by third sector organisations. While there is currently reported variation in the degree to which statutory organisations engage with the third sector for the planning and commissioning of services, a call has been made for the sector to become an equal partner in policy-making and planning, as well as provision<sup>270</sup>. At national level, sexual health third sector organisations provide cost-effective services and initiatives for the public and professionals, advice for policy-makers including government, and an independent public voice on sexual health.

5.14 As well as the Department of Health, other government departments need to play a role in ensuring consistent cross-government policy in addressing the impact of inequalities and the wider determinants of sexual health. The role needs to be explicitly acknowledged at regional and national levels.

## RECOMMENDATIONS FOR IMPLEMENTATION

### LOCAL LEVEL

- Actively develop **joint planning and partnership mechanisms** and ensure sexual health and issues that impact on sexual health, especially in relation to inequalities, are prioritised via Operating Plans, LSPs, JSNAs, LAAs
- Use **joint PCT/LA appointments of Public Health Directors and specialists** to develop more systematic partnership working between PCTs and LAs on sexual health, support the development of sexual health improvement strategies and improve the engagement of Local Strategic Partnerships with sexual health
- Work in partnership with **third sector organisations**, as well as providers from all sectors, and recognise the value they can add to needs assessments, strategic planning and service user empowerment, as well as the delivery of services
- Ensure there are strong links between the health and education sectors (via Children's Trusts), and that there is **shared responsibility** for prevention and linked service provision (eg. school nurses)
- **Build links with Mental Health Trusts** to explore and foster a greater role for them in improving sexual health and reducing sexual health inequalities, for example by offering psychological support for people living with HIV, or developing more widespread psychosexual services, and also by ensuring care pathways are in place for users of mental health services who have sexual health needs and vice versa.

### CASE STUDY

#### Partnership between Police and NHS – the Havens

The Metropolitan Police invited King's College Hospital (KCH) to tender for a 24-hour sexual assault referral centre/forensic examination service and this was set up in the Department of Sexual Health at KCH in 2000. Previously, waiting times to see a doctor had been unacceptably long and forensic examinations had been carried out in inadequate premises and conditions.

Following early success, two further services were set up across London, and the three "Havens" can now provide care to any adult or child in the city who has been sexually assaulted. Close links with GUM / Sexual Health services facilitate the provision of additional care, and the sharing of sexual health expertise and training for clinicians. A doctor and crisis worker collaborate to provide forensic examination and aftercare, offering support to the client and each other.

The services achieve high levels of user satisfaction, meeting immediate needs in a sensitive and co-ordinated way. They are jointly funded by the Metropolitan Police and London PCTs and have links with a wide range of other agencies.

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### REGIONAL LEVEL

- **GOs and SHAs** should actively work together (with Regional Directors of Public Health playing a key role) to connect and integrate the wide variety of government policies that impact on sexual well-being and sexual ill-health (especially those tackling inequality and promoting equality and social inclusion more broadly)
- Encourage the development of strong and innovative **partnerships between PCTs and LAs** to reflect the wider determinants of sexual health and the needs of those most affected by negative sexual health outcomes, and mark the shift in focus from treatment and care to prevention and well-being. These partnerships need to extend across different LA stakeholders engaged in community cohesion and social inclusion, Children's Trusts/services and social care.

### NATIONAL LEVEL

- Adopt a more **integrated, cross-governmental approach** which recognises the importance of good sexual health in achieving general well-being and keeping people healthy, as well as the relationship between sexual ill-health, poverty and social exclusion. Explicitly, it should link sexual health policy to all other related policy areas at national, regional and local levels. Draw up a map of these links and the opportunities they provide to further sexual health, in order to direct national and regional effort, and support those working at a local level in making the connections across various policy areas
- Review how elements of the sexual health and HIV Strategy focusing on young people can be better integrated at national, regional and local level with the Teenage Pregnancy Strategy to meet the **holistic sexual health needs** of *all* young people in terms of both education and service provision
- Give due recognition to the unique role the **national third sector** has in driving forward and shaping developments in sexual health and HIV. In line with the strategy set out in government's review of the third sector<sup>271</sup>, ensure it is a valued and core part of the continuing national dialogue, and that it is appropriately funded to sustain and support this role
- Engage and fully involve the **professional bodies representing sexual health providers**, such as doctors, nurses and health advisers, to offer leadership within their professions in support of innovation and service evolution.

## Priority for action 3: Commission for improved sexual health

5.15 PCTs and LAs need to fulfil their responsibility for commissioning comprehensive sexual health and HIV services (including prevention and social care) based on analysis of the health needs of their local population and evidence-based care pathways. They need to secure funding to ensure that population need is met, providers adhere to quality and access standards, and appropriate outcomes are achieved to improve health and meet national and local targets.

5.16 Commissioners should adopt a holistic commissioning model which looks at sexual health in an integrated way and commissions along the care pathway from prevention to treatment and social care and support where necessary. This should be facilitated by the shift in focus from block contracts to commissioning based on activity to achieve specified outcomes. Commissioners need to commission health improvement activity as part of service level agreements (SLAs) with all providers, and establish required performance within a quality framework.

5.17 Commissioning should be undertaken at the appropriate level to ensure fair, effective and cost-

effective provision of different aspects of sexual healthcare, from practice based commissioning at sub-PCT level to consortium commissioning across PCTs. HIV treatment and care should be commissioned at regional level through Specialised Commissioning Groups (SCGs). Commissioning at multi-PCT level can support the development of sexual health and HIV networks, which provide shared care pathways, protocols and service standards between services in an area often encompassing a number of PCTs. Networks can also be a valuable vehicle for commissioners to gain input from a broad base of clinical and service expertise, and to encourage service providers to work together and share resources rather than competing against each other.

5.18 It is important that sexual health commissioners benefit from developments at the centre to ensure they are embracing the necessary skills set for world class commissioning. PCTs and LAs should ensure that support is available locally to those commissioning sexual health services to develop these skills, to address current gaps in local commissioning and plan for the future.

5.19 PCTs, as stewards of local health funding and decision-making, need to ensure that the basic requirements of world class commissioning are in place so that they are increasingly able to access data and information sets which can help establish need, and measure the capacity and capability of providers to meet that need. They should know the costs of services they are commissioning and be able to compare investments across all aspects of sexual health. A central sexual health budget will make this easier. National and regional support in ensuring informed sexual health commissioning, and in developing improved data and tariffs as well as other commissioning tools, is essential. Improving patient experience and strengthening of the public 'voice' in commissioning requires PCTs to develop more innovative ways of engaging the public and users of sexual health services in their commissioning, as well as assuring transparency and legitimacy in PCT decision-making.

### CASE STUDY

#### Patient & Public Involvement in HIV commissioning consortium

The London Specialised Commissioning Group, on behalf of all the London PCTs, established the London HIV Consortium to commission HIV treatment and care services from 24 HIV service providers for 25,000 Londoners.

A Patient & Public Involvement (PPI) Subgroup of the HIV Consortium was set up in 2005. This provides a formal forum for service users, clinicians and service providers to engage with commissioners and inform the delivery and development of HIV services. Co-chaired by a clinician and a service user, its membership is open to service users, service user groups and HIV service staff involved in PPI.

The PPI Subgroup has worked with commissioners and clinicians on the development of patient pathways and service models, as well as a tool to assess service providers' compliance with required standards for PPI. It has also held an annual pan-London event, attended by 100 people, to share best practice on PPI in HIV services. Consultations have been undertaken on a number of issues, with the findings summarised and fed back to providers and commissioners.

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### RECOMMENDATIONS FOR IMPLEMENTATION

#### LOCAL LEVEL

- Bring together all budgets for sexual health (across GUM, contraception and abortion services, health promotion and prevention) and commission from this **central budget**

to support implementation of the local sexual health strategy, ensuring that adequate funding is available to support all aspects of sexual health need. Consider also including budgets for psychosexual, sexual dysfunction and sexual assault services

- Take action to ensure the use of PbR and the establishment of permitted variations on tariffs preserve **patient choice, open access and quality-assured services**, and ensure **local pricing development** takes account of the clinical governance, education and training roles of lead organisations sufficient to support new providers in primary and community settings. It is vital that local pricing in new Level 2 services includes all the core components expected in mainstream services, such as opt-out HIV testing or achieving the 48-hour access target (through hub and spoke arrangements, where necessary)
- Ensure services, and health promotion and prevention activities, are commissioned by a **strong multi-disciplinary team** which includes public health and benefits from expert clinical support, understands local sexual health needs, engages the public in commissioning and has access to evidence on effectiveness and cost-effectiveness of interventions
- Establish **collaborative commissioning arrangements** where aspects of sexual health and HIV provision (prevention and services) can be more effectively commissioned between PCTs
- Link service **networks** to the commissioning process and business agenda, and use them to engage with providers, to inform and improve commissioning quality and practice as well as service planning and delivery
- Develop training programmes to **strengthen the commissioner skill base** in sexual health in line with world class commissioning
- Use **benchmarking against national data** in order to identify when local, or regional, performance is out of line with the national average
- Ensure that an **information infrastructure** is in place to inform sexual health commissioning, which includes appropriate IT as well as systems for data collection and analysis
- As soon as the data arising out of the new GUMCAD system are available and it has been rolled out into Level 2 services, utilise it to provide **locally accountable surveillance information** to underpin local strategy development, as well as local implementation of the national sexual health and HIV Strategy.

## REGIONAL LEVEL

- Help build **informed sexual health and HIV commissioning** in accordance with world class commissioning principles and practice, and ensure local commissioning tackles inequalities in health outcomes and service provision, and delivers sexual health improvement.

## NATIONAL LEVEL

- Collate and disseminate evidence to support sexual health commissioning, illustrating where **investment in sexual health interventions** provides good value for money and is cost-effective or cost-saving
- Produce an easy-to-use, accessible **sexual health and well-being commissioning framework** to support commissioners to work with an increasingly diverse range of providers, and help drive up the quality of the services and sexual health promotion and prevention activities being commissioned. (The framework should include: needs assessment and user involvement; availability and use of data; model templates for commissioning sexual health; model SLA contracts across all sexual health and HIV care pathways; key outcomes; best value investments; national standards and best practice)
- Refine current GUM and abortion tariffs to reflect differing levels of complexity and **accelerate the development of appropriate tariffs** for (i) community contraceptive services; (ii) integrated sexual health services; (iii) HIV outpatients; (iv) chlamydia screening. Tariffs should reflect real costs of services (across the whole pathway including all elements of care), and should allow for different service models. They should also have built-in flexibility to avoid perverse incentives
- Provide **interim advice** to local organisations on how to maximise use of new data sets (GUMCAD, GUMAMM, revised KT31) and those currently available to assess need, track trends and monitor performance, and prioritise the rollout of the **Common Data Set** for Sexual Health and HIV, ensuring there are adequate IT systems to support full implementation
- Develop a sexual health **self-assessment tool** to support those responsible for commissioning and delivering sexual health at a local level, and promote use of the **sexual health indicator** set (see Section 6) to complement national targets and give a more comprehensive picture of sexual health improvement at national and local levels.

## Priority for action 4: Invest in prevention

5.20 More consistent investment in prevention is essential if PCTs and LAs are to deliver on the commitments outlined in the 2008/9 NHS Operating Framework and the new performance framework for local authorities and local authority partnerships. PCTs receive funding for prevention as part of their overall resource allocation. They should ensure this is used to commission a programme of effective sexual health promotion and prevention activities based on local need. Well-resourced health promotion services are needed to support this activity, and assist in the expansion of self-management programmes. Although the Government continues to undertake sexual health promotion and HIV prevention activities at a national level, this should complement local activity rather than substitute it.

5.21 It is important to have an integrated approach to sexual health promotion and HIV prevention that covers all life stages and communities: comprehensive sex and relationships education (SRE) in schools and other youth settings, general awareness campaigns for young people and adults which join up messages on preventing unintended pregnancy and infections, and specific targeted initiatives for those more at risk from unwanted pregnancies, STIs and HIV.

5.22 Prevention should be an integral part of all sexual health service provision. It lies at the core of contraception services, while testing and screening for STIs and HIV, which increase diagnosis and enable prompt treatment, are in themselves preventive by reducing onward transmission. Within all services, the inclusion of health promotion advice is crucial. Support for people living with HIV as agents of HIV prevention should be a core ongoing function of HIV treatment and care services. Services for population groups particularly at risk of negative sexual health outcomes should also play a role in their prevention. For example, drug services should acknowledge and address prevention and testing for blood-borne viruses (including HIV and hepatitis B and C), with care pathways into services, among all their clients. The impact that services can have on prevention should be explicitly acknowledged as an important element of comprehensive local prevention programmes.

5.23 There is a need for a more coherent and co-ordinated approach to prevention across government departments, to bring together the wide range of relevant actions which play a part in prevention. These should include measures to remove barriers to effective prevention, including regulatory and legislative restrictions, as well as discrimination and the stigma which drives it. Closer links should also be established nationally across government, and locally between health, local government and other key agencies engaged in health promotion initiatives on alcohol and drug misuse. Better synergy is needed between national and local prevention initiatives, including campaigns and social marketing, and there should be more systematic communication from the centre on what is currently known about the cost-effectiveness and impact of prevention activities.

5.24 Personal, Social, Health and Economic (PSHE) Education, which includes SRE, should be made statutory in schools and at least of a minimum standard. The same provision should be ensured for young people not in schools and supported by the development of national guidance for settings such as Further Education and work-based training providers, pupil referral units, Young Offender Institutions (YOIs), residential homes, foyers and hostels. There is ample evidence that increased exposure to SRE in schools has beneficial effects in terms of sexual health status<sup>272</sup>. PSHE Education is critical to young people's well-being, equipping them with the skills and knowledge to make safe and responsible choices regarding their sexual health and well-being, and to develop positive

### CASE STUDY

#### Gay men's HIV prevention strategy for Brighton and Hove

In Brighton and Hove 80% of residents receiving treatment for HIV acquired the infection through sex between men. In response to ongoing transmission, the PCT is continuing its targeted, strategic approach to HIV prevention for gay men and ensuring that investment in HIV prevention is in line with local epidemiology.

Work on the third edition of the local Gay Men's HIV Prevention Strategy (2008–2011) is about to begin. Based on the *Making it count* planning framework, the strategy sets out action for all partners (eg. gay community groups and businesses, individual gay men) as well as the PCT. A strategy Development Group will have wide membership from agencies undertaking gay men's prevention and from the gay community. Consultation on the draft strategy will be actively promoted through the media and email alerts.

The Strategy will inform the PCT's wider HIV and sexual health commissioning intentions. All commissioned gay men's HIV prevention will support achievement of the targets and outcomes of the strategy. Agencies funded to provide this work are expected to attend, and monitored for attendance at, regular meetings of the Sussex Gay Men's HIV Prevention Network, a forum for information exchange, sharing best practice and continuing professional development.

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behaviours and attitudes in relation to associated issues such as drugs, alcohol, bullying, homophobia and HIV. Making PSHE Education statutory will secure its place in the curriculum with equal access for all young people, and will ensure schools have appropriately trained teachers and a more consistent approach to monitoring and evaluation.

## RECOMMENDATIONS FOR IMPLEMENTATION

### LOCAL LEVEL

- Ensure **well-resourced health promotion services** (within or across PCTs, and ideally across a network area) to lead and direct social marketing and awareness-raising campaigns and targeted community-based/outreach initiatives, and to support the health promotion and prevention role of services
- Ensure **sexual health promotion and the prevention of HIV, STIs and unintended pregnancy** are included as a core strand in local sexual health and HIV strategies, and are adequately resourced
- Ensure there is more **effective communication** within PCTs and LAs about what is currently known of the impact of sexual health promotion and HIV prevention activities, particularly in relation to African communities, gay men and young people
- Ensure **prevention activities are included in service specifications**, including post-abortion contraceptive advice and provision in the commissioning of abortion services, partner notification to agreed auditable quality standards for all providers of STI testing and treatment, and HIV prevention support as part of HIV treatment and care
- Take action to **implement NICE guidance on prevention of STIs and under-18 conceptions**
- Make the **links between sexual risk behaviour, alcohol and drug misuse**, and ensure that campaigns are integrated and co-ordinated.

### REGIONAL LEVEL

- Ensure the promotion of sexual health and well-being, and the prevention of HIV, STIs and unintended pregnancy, are **a core part of SHA visions** (developed as part of the NHS Next Stage Review) and their implementation
- Facilitate **cross-PCT commissioning of prevention activities** where appropriate, especially for those whose lifestyle means they are best targeted outside their PCT of residence (eg. gay men).

### NATIONAL LEVEL

- Develop a **prevention framework** for sexual health and HIV to direct and guide health promotion and prevention activity, and ensure better synergy at national and local level. The framework should identify the wide range of government actions required to achieve success (eg. reducing stigma, SRE, social marketing interventions, general awareness-raising and targeted work, regulatory/legislative barriers) and prioritise key areas for more intensive effort. It should identify outcomes in relation to good sexual health and well-being, and also identify robust and well-resourced structures to support evidence building and knowledge transfer
- Critically **review the Tackling HIV stigma and discrimination implementation plan**, and identify what further action is needed across government and sectors to accelerate progress in relation to HIV, as well as addressing other aspects of sexual health
- Collate and disseminate more effectively what is currently known about the **impact of prevention** activities and identify where more research is needed on the effectiveness of different interventions
- Investigate and **disseminate evidence on the cost-effectiveness, or cost-saving**, of local-level prevention initiatives
- Make PSHE Education and **all elements of SRE a statutory subject** at all key stages and ensure schools have the information, knowledge and skills to deliver it. This will ensure consistent provision in all schools and contribute to meeting the *Every child matters* outcomes and the well-being duty.



## Priority for action 5: Deliver modern sexual health services

5.25 A comprehensive package of sexual health service provision should be commissioned based on local need. At its core, it should include contraception and abortion, fast-track STI diagnosis and treatment, HIV diagnosis, treatment and care (including social care), and prevention activities within services, as well as specialist psychosexual and sexual assault services in partnership with other agencies. (Some services, such as HIV treatment and care or SARCs, should be commissioned jointly across PCTs.) The Strategy recommended further integration of local service organisation and delivery, and commissioners should work with providers to achieve greater integration in line with local needs and informed by the available evidence.

5.26 PCTs should ensure that all providers (NHS, third sector, independent) supply sexual health services which are auditable against robust quality standards as defined in SLAs, and subject to clinical governance across a local health economy. Government reform in the NHS increasingly requires services to be more focused on patients' needs and choices, offer more integrated care and to be delivered 'closer to home' in more community-based settings. These strands were core to the three-level service model outlined in the sexual health Strategy<sup>273</sup>. The entry of multiple providers into the sexual health field has intensified the need

for a model of this kind, which identifies the different levels of provision required for a comprehensive local service, and defines a clear role for specialist services in ensuring high-quality clinical standards and governance. This role should be built into SLAs, and specialist services maintained and kept financially viable to ensure it can be carried out. While the elements of care identified in the three-level model remain broadly the same (with some shifts in level mainly because of new testing technologies), the number and range of community providers delivering some or all elements of Levels 1 and 2 are expanding (to include GPs, pharmacies, primary care centres/polyclinics, outreach services and sexual health services provided by the third and independent sectors). Users should experience an equal quality of care, whichever of these providers they choose to use, and the services need to be linked by care pathways as part of a network, for timely and seamless user flow.

5.27 Better clarity of service labelling, along with the maintenance of open access at all levels, is required to ensure service users access appropriate healthcare without delay. Currently services labelled as 'sexual health' offer a varied range of provision, from those offering advice only to those with a limited range of tests and minimal access to treatment and partner notification, through to a full GUM and contraceptive integrated service. Clear information is necessary to ensure the needs of all are appropriately met and those less able to negotiate the maze of services do not receive an unequal standard of care.

5.28 There should be further establishment and development of sexual health networks and HIV networks (which may or may not be integrated), with a view to achieving full coverage across the country. Usually established across PCT/LA boundaries of natural communities or commissioning consortia, network development and effective functioning can be facilitated by either the inclusion of commissioning within the network, or the engagement of commissioners in supporting and using the network. Managed sexual health and HIV networks have played a key role in a number of areas in assuring clinical and service governance, supporting the development of integrated care pathways and leading service innovation. This role is becoming increasingly important at the current time of major service reconfiguration, particularly the move towards more provision in non-hospital settings and the growing diversity of providers. In this context, the involvement of all significant local providers in the network is critical.

### CASE STUDY

#### Agreeing objectives for service development and quality in primary care through PMS

**W**altham Forest PCT worked with 10 PMS practices during 2007 to set sexual health objectives, which were agreed by the Local Medical Committee (LMC). The objectives included:

- setting up a young people's service offering access and quality advice
- providing a full range of services, including emergency hormonal contraception, free pregnancy testing, condom distribution, long-acting reversible contraception and chlamydia testing.

A mapping exercise has been conducted by the PCT to establish the current level of training of primary care clinicians and identify further training requirements. Service quality, access and demonstrable increase in service uptake will be monitored by the Programme Manager in Public Health.

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## Stronger commissioning of services and interventions across health and local government that will achieve better sexual health and reduce inequalities

5.29 It is essential that further action is taken to increase the level and quality of sexual health services provided by general practice, if the current policy shift towards delivery of care closer to home is to be realised. General practice is an important gateway to sexual health services, as well as being a major provider in its own right of contraception. It undertakes the diagnosis and treatment of a substantial number of STIs, makes referrals for abortion, is often the setting where psychosexual problems are raised, and has significant potential for sexual health promotion. Yet the full engagement of GPs in sexual health provision is extremely variable, as is PCTs' knowledge of what services are provided by general practices in their area<sup>274</sup>, despite their strategic role in commissioning services. General practice often sits outside local partnerships, but it needs to be brought in as an equal player if it is to play a significant role in delivering local sexual health strategies.

5.30 Dedicated services for young people, including innovative approaches to reach young people who do not access mainstream services, should be integrated with wider sexual health provision, and embedded and sustained as part of standard PCT commissioning in the future. There is greatly improved awareness at local level about what young people want from sexual health services as well as quality criteria for effective practice<sup>275</sup>, and a significant increase has been seen in the number of dedicated young people's services, often supported by teenage pregnancy funding. Ongoing and sustained investment is needed if we are to make headway with improving the sexual health and well-being of young people – the age group most affected by sexual ill-health. However, investment in services for young people should not be at the expense of investment in the range of services needed by all age groups and sectors of the population.

5.31 Workforce planning, education and training must be linked to service developments and changing models of care. It is essential that there is a more co-ordinated national and regional approach to the current and future needs of the workforce, as well as local investment and planning,

in order to create a sexual health workforce that is 'fit for purpose'. This means, among other things: maintaining an adequate supply of highly skilled medical staff to ensure high-quality governance and training and specialised care for complex cases; exploring the potential for a common medical training programme across GUM and contraception to facilitate further integration of service provision; increasing the pool of dual-trained health professionals at all levels to deliver integrated services; improving sexual health skills in general practice; increasing the supply of sexual health nurses to enable the expansion of nurse-delivered services in community and primary care settings; and developing the role of healthcare assistants to enable the delivery of specialist, community and outreach services. It also means ensuring basic sexual health skills for the wider workforce, clinical (eg. midwives, health visitors and the new Family Nurse Partnership roles) and non-clinical (eg. health trainers, youth workers).

### RECOMMENDATIONS FOR IMPLEMENTATION

#### LOCAL LEVEL

- Ensure sexual health and HIV services are included in **local service reconfiguration** work, particularly in relation to plans for primary care centres/polyclinics and shifting care closer to home
- **Specify local standards** in accordance with national standards (such as those from MedFASH<sup>276</sup>) and ensure the performance of all those providing sexual health and HIV services is monitored for adherence to these
- Ensure **SLAs** for all providers are explicit about what they are commissioned to provide, with funding relating to activity and outcomes
- Establish and maintain managed **sexual health networks** to support a planned, needs-based approach to sexual health provision; develop integrated care pathways and assure clinical and service governance. Networks should cover *all* NHS, social services and community/third sector provision and encompass new approaches to the delivery of sexual health and the further integration of contraception, abortion, STI and possibly other (such as psychosexual) services where appropriate. They should support the spread of evidence-based best practice and ensure the equitable delivery of services within their borders
- Audit sexual health services provided by **general practices** and maximise use of contractual and other financial incentives and resources, such as LESs, practice based commissioning, or PMS

contracts, to encourage practices to provide a wider range of services (eg. chlamydia screening, HIV and STI testing, LARC)

- Identify long-term **education and training needs** in relation to sexual health (and ensure they are included in local sexual health strategies); allocate specific funding for this, including the costs of cover when training takes place.

### REGIONAL LEVEL

- Ensure PCTs develop a **'fit for purpose' workforce supply**, including education and training and workforce planning, to support service demand and delivery
- **Promote the establishment and maintenance of sexual health and HIV service networks** across PCT boundaries to contribute to commissioning, avoid fragmentation across competitive healthcare providers, share functions, and work towards equity of provision and quality of care.

### NATIONAL LEVEL

- Attach core **competencies** to the three-level **sexual health service model** and update it to keep pace with developments, outlining increased opportunities for self-management, the widening of community-based provision (via primary care, pharmacies, the third sector and enhancement of community contraception), and the need to better utilise the role of GUM and specialised contraceptive and abortion services in improving clinical networking and governance, training, quality control and audit

- Ensure learning from the national evaluation of one-stop-shop models of sexual health provision is widely disseminated to provide greater clarity about the meaning of an **integrated approach**, and give guidance and advice on how locally integrated services (which are person-centred and responsive to patient choice) can benefit service users. Showcase examples of different models and levels of service integration that have been developed, to support local choices about integration; help implement any local service redesign
- Take immediate action to ensure key sexual health indicators are included in the future development of the **Quality and Outcomes Framework** (QOF). Consider what **other levers** can be used to promote a minimum level of sexual healthcare in *all* general practices and to further incentivise those practices with a special interest
- Work in conjunction with key professional bodies and training providers to provide a **strategic overview** of the education and training needs of the sexual health workforce (both specialist and generic). Highlight current gaps and identify action plans to meet current and future service needs.

## Getting there: sexual health in 2010 and beyond

### Opportunities and levers

5.32 Focusing effort on the action areas and recommendations outlined above will take us a step further towards realising the strategic vision first put in place by the national sexual health and HIV Strategy back in 2001. Tables 9a-d give an idea of what we are working towards during the remaining lifetime of the Strategy and beyond, point to the wide range of levers and drivers that now exist to get us there and identify the key stakeholders in that process. The implementation of the Strategy has taken place at a time of great change but has also given rise to a wealth of opportunities as the focus shifts more towards improving patient choice and experience; services that are personal and based on individual need; more investment in promoting health and well-being; and stronger commissioning of services and interventions across health and local government that will achieve better sexual health and reduce inequalities.

See Tables 9 a-d.

Table 9a | Where do we want to get to, and what does it look like?

- PSHE Education to be statutory part of curriculum
- Nationally funded and co-ordinated prevention campaigns with clear links to local activity
- Increased investment in sexual health promotion and HIV prevention at local level
- Reduced stigma surrounding HIV, abortion and other aspects of sexual ill-health
- Well developed and supported self-management and long-term condition programmes
- Strengthened commissioning across new models of provision
- Strong public health base to support service planning and delivery
- Fully 'integrated' services, supported by pathways and networks and common governance framework
- Well-trained, flexible multidisciplinary workforce delivering optimum care through a variety of settings and models
- Choice and easy access for service users and high-quality services at every level
- Access to non-judgemental and non-discriminatory health and social care provision
- Managed sexual health networks covering all parts of the country and covering all NHS, social services and third/community sector organisations
- Strong, committed local champions across government, regions, PCTs, public health, local government, professional bodies and the community
- Stable services that can withstand external policy changes

**Table 9b | Key drivers and levers**

- NHS Next Stage Review
- Public health intelligence, joint appointments, inequalities drive, needs assessment
- World class commissioning/Health and well-being framework, LDP, JSNA, LAA
- Local Strategic Partnerships, sexual health and HIV networks
- NIS, Vital signs
- Developing evidence base, NICE, professional guidelines
- National Support Team
- Social marketing
- QOF, contracting mechanisms (LES, PMS)
- PbR/tariffs
- AIDS Support Grant
- Common Data Set for Sexual Health
- Every child matters, The children's plan, SRE review, Healthy Schools, well-being duty
- Expert Patients Programme, self management programmes, health trainers
- Teenage Pregnancy, Drugs and Alcohol Strategies
- LINKs, user involvement, Overview and Scrutiny Committees
- Independent Advisory Group on Sexual Health and HIV (SHIAG), Independent Advisory Group on Teenage Pregnancy (TPIAG), UK CMOs' Expert Advisory Group on AIDS (EAGA)
- Healthcare Commission

**Table 9c | Critical stakeholders**

- Public
- Service users
- PCTs, trusts
- Community/third sector
- Local authorities: education, community, children and adult social services departments/councillors
- SHAs and Government Offices
- Health Protection Agency (local, regional and national), Public Health Observatories
- Department of Health; Department of Communities and Local Government; Department for Children, Schools and Families; Home Office; Office of the Third Sector; Ministry of Justice
- Professional bodies
- Independent sector, pharmacies
- Schools and colleges

**Table 9d | Health outcomes**

- Reduction in numbers of unintended pregnancies and rates of repeat abortions (including among under-18s)
- Reduction in new HIV transmissions and in late-diagnosed HIV
- Reductions in the proportion of people with HIV remaining undiagnosed
- Reduction in the rates of new STI diagnoses
- Increased Chlamydia testing and reduced chlamydia prevalence
- Improved sexual health and well-being

# SECTION 6

## Measuring further progress

### Development of indicators

6.1 A specific task identified for this review of the Strategy was to develop an agreed set of sexual health process and outcome indicators to measure progress at local and national levels.

6.2 The 2001 Strategy itself included a number of targets (later amended to goals and standards), and subsequent documents have added further indicators and targets, as outlined in Sections 2 and 3. The intention here is not to replicate the work of the DH, Healthcare Commission or HPA, but rather to build on their work and propose a limited number of indicators that will enable the SHIAG and other stakeholders to assess the implementation and impact of the Strategy at local and national levels.

6.3 With advice from a range of stakeholders, a small number of high-level indicators is proposed for national and local use. However, it is anticipated that indicators currently collected through national surveillance, such as STI and HIV data from the HPA and national fertility statistics, would continue to be available to give a more detailed picture. The indicator set should also be used at regional level, and supplemented by key indicators for which data are not available at PCT level.

6.4 Criteria for the selection of indicators include:

- linkage to key strategic priorities
- availability of data
- ability of indicator to detect change
- interpretability (ie. it is clear which direction of change indicates progress)
- applicability in all parts of the country
- collectability of data at PCT level

6.5 Following the proposed indicator set below, (Table 10) a short rationale is given for the selection of each indicator. (Where an indicator is selected from an existing national set, the same indicator wording has been used.)

### Rationale

#### Indicator 1: Rate of under-18 conceptions

6.6 Reducing under-18 conceptions is a key PSA target and a major objective of the Teenage Pregnancy Strategy. It is closely aligned with the objectives of the sexual health and HIV Strategy, and the rate of teenage conceptions is an important indicator for social exclusion and inequalities in sexual health. The data are routinely collected and reported, and this indicator provides an important part of the overall picture of sexual health.

**Table 10 | Proposed high-level indicator set**

<ol style="list-style-type: none"> <li>1. Rate of under-18 conceptions</li> <li>2. LARC:               <ol style="list-style-type: none"> <li>a) as percentage of all contraception prescribed in community contraceptive services and integrated sexual health services;</li> <li>b) rate of prescribing of each LARC method in general practice, per PCT</li> </ol> </li> <li>3. Percentage of abortions performed at less than 10 weeks gestation</li> <li>4. Repeat abortions within a defined timeframe (2 to 3 years) relative to baseline and in association with conception rate. (Would require safeguards against PCTs limiting abortion provision.)</li> <li>5. Percentage of the sexually active population aged 15-24 screened for chlamydia (to be replaced with a prevalence indicator when available)</li> <li>6. Guaranteed access to a GUM clinic within 48 hours of contacting a service (to be expanded to all sexual health services when data become available)</li> </ol>	<ol style="list-style-type: none"> <li>7. The number of new diagnoses of gonorrhoea and syphilis infections in GUM</li> <li>8. HIV testing:               <ol style="list-style-type: none"> <li>a) offer and uptake of tests in GUM;</li> <li>b) number of tests performed in GUM and other settings (excluding antenatal);</li> <li>c) percentage of women attending antenatal services who are screened for HIV</li> </ol> </li> <li>9. Proportion of HIV diagnoses where CD4 cell count is under 200 at time of diagnosis</li> <li>10. Proportion of those reporting sexual assault who are seen within specialist sexual assault services</li> <li>11. Uptake and coverage of HPV vaccination among target population</li> </ol> <p>To explore the impact of inequalities in sexual health, analysis of the above indicators should be undertaken by population characteristics where possible (deprivation, ethnicity, gender, age group, sexual orientation, prison).</p>
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**Indicator 2: LARC**

- a) as percentage of all contraception prescribed in community contraceptive services and integrated sexual health services;
- b) rate of prescribing of each LARC method in general practice, per PCT

6.7 A strategic priority is to ensure access to the full range of contraception is available to all, and that this applies to those seeking contraception from general practice as well as from community contraceptive services. LARC methods are highly effective and cost-effective<sup>277</sup>, yet access is currently patchy, especially in general practice. From a low starting point, an increase in the provision of LARC is a proxy measure for wider access to the range of methods, and should also lead to a reduction in rates of unintended pregnancy.

6.8 It is important to preserve patient choice, and there is a risk that setting a specific percentage target may result in pressure within services for inappropriate over-prescribing of LARC methods. For this reason, it is proposed that the percentage of LARC prescribed be measured against a baseline, to pick up a trend in improved access, and/or a regional or national benchmark for comparison with other PCTs. It will be important to keep this indicator under review, so that as prescribing rates increase, it is possible to identify when it ceases to be a good measure of access and patient choice.

6.9 This indicator would need to distinguish between depot medroxyprogesterone acetate (DMPA, brand name Depo Provera) and other LARC methods, as the latter require additional training for clinicians to insert them but may be more acceptable to users.

6.10 Data for this indicator can be collected from community contraceptive services through KT31 returns, and from general practice through prescribing data. The rapid development of IT infrastructure in community contraceptive services will assist with collection of these data.

**Indicator 3: Percentage of abortions performed at less than 10 weeks gestation**

6.11 Prompt access to abortion, enabling provision earlier in pregnancy, is both cost-effective and an indicator of service quality. The inclusion until recently of this indicator in the NHS performance management framework has led to very significant improvement, and it is now a strategic priority, in the context of the sexual health Strategy, to maintain and extend this improvement.

6.12 Therefore, although no longer part of the national performance management framework, it is recommended that this indicator is included within the proposed set of high-level indicators. The data for the indicator are readily available.

**Indicator 4: Repeat abortions within a defined timeframe (2 to 3 years) relative to baseline and in association with conception rate**

6.13 As long as access to abortion is not restricted, repeat abortion within a relatively short space of time can be taken to indicate an inadequacy in relation to contraception, whether insufficient service access, sub-optimal service provision or ineffective individual use of contraceptive method. While the indicator above for conceptions relates specifically to under-18s, this indicator is for women of all ages. The data for this indicator are readily available.

6.14 There is a risk this indicator could perversely incentivise PCTs to restrict the provision of abortion, or of repeat abortion. Strong safeguards against this course of action are therefore required, particularly in view of the stigma attached to abortion.

**Indicator 5: Percentage of the sexually active population aged 15-24 screened for chlamydia, measured separately in GUM and non-GUM settings (to be replaced with a prevalence indicator when available)**

6.15 Chlamydia prevalence is included as a national priority for local delivery (tier 2) in *Vital signs*, and in the National Indicator Set, and this is an indicator which can be expected to drive improvement during 2008/11. Extension of chlamydia screening coverage sufficient to impact on population prevalence is a key action identified by the sexual health Strategy review. Chlamydia prevalence would therefore be a useful high-level indicator to include in this set.

6.16 There is debate about the degree to which the population screened mirrors the population as a whole, and therefore whether the prevalence of chlamydia in the former (the positivity rate) can be used as a proxy measure of that in the latter. It is suggested that methods of measuring prevalence should be piloted, and until an agreed method for measuring prevalence is found, the NHS Operating Framework be followed in using the existing indicator of screening/testing rates in 2008/9 (and possibly beyond).

6.17 The proposed indicator specifies separate monitoring for screening within and outside GUM, because significant improvements in coverage need



to be achieved in non-GUM settings, but the overall coverage of screening (and partner management) is what will determine the ability to reduce prevalence.

**Indicator 6: Guaranteed access to a GUM clinic within 48 hours of contacting a service (to be expanded to all sexual health services when data become available)**

6.18 This indicator is retained within the NHS Operating Framework, as an existing commitment for which central monitoring will be maintained. Prompt access to STI diagnosis and treatment is a fundamental priority for the sexual health Strategy, and it has been clear that the adoption of this indicator as a priority target for the NHS in 2006/7 and 2007/8 has acted as a catalyst for major improvements in access.

6.19 As an immediate high-level indicator, it is recommended that this be retained, particularly as data collection and reporting are now established. It will be important to apply this indicator as soon as possible to services outside GUM offering STI testing and treatment, to ensure equity in service provision and avoid any perverse incentive to shift care to settings without 48-hour access, and also to apply it to other sexual health services when data become available.

A strategic priority is to ensure access to the full range of contraception is available to all, and that this applies to those seeking contraception from general practice as well as from community contraceptive services.

**Indicator 7: The number of new diagnoses of gonorrhoea and syphilis infections in GUM**

6.20 The national Strategy aims to reduce the incidence of newly acquired gonorrhoea. Gonorrhoea was chosen as a marker for rates of unsafe sexual activity and, because easily treated and cured, may also be a measure of access to STI treatment. Recent statistics have demonstrated the limitation of this single indicator, with diverging trends for the population as a whole which are falling and gay men, for example, which were until very recently increasing. There is also a divergence between gonorrhoea and syphilis trends, and therefore it is important to include

more than one infection in the indicator set. Rates of infection show significant inequalities between population groups, with black Caribbeans, for example, significantly over-represented among new diagnoses of gonorrhoea.

6.21 Data collection from GUM clinics for this indicator is well established. The new dataset to be introduced in 2008, GUMCAD, will allow the breakdown of data from GUM, and potentially from Level 2 sexual health services, by PCT of residence as well as by a number of demographic factors, improving the utility of this indicator in monitoring inequalities and assessing progress with prevention. Consideration could also be given to developing indicators for infection rates within each PCT using a combination of GUMCAD data and microbiology reports.

**Indicator 8: HIV testing**

- a) offer and uptake of tests in GUM;
- b) number of tests performed in GUM and other settings (excluding antenatal);
- c) percentage of women attending antenatal services who are screened for HIV.

6.22 This Strategy review identifies an increase in HIV testing in a range of existing and new settings as a key action. GUM services have made significant progress in increasing offer and uptake in line with the original Strategy target, but the number of individuals leaving GUM services with their infection still undiagnosed, many having refused a test, remains a cause of concern. It is therefore important to monitor both offer and uptake. (It will also be important to retain the reporting on proportions remaining undiagnosed after attending GUM, but this is not an indicator that can be measured at PCT level.)

6.23 The Chief Medical Officer has identified an increase in HIV testing in non-HIV specialist settings as a priority. It is therefore proposed to gather laboratory testing data for this indicator. Theoretically, collection of data on all HIV tests from all significant HIV-testing laboratories should provide the opportunity to measure rates of community, GUM and inpatient HIV testing in each PCT. PCT of residence and source of test request would be needed (i.e. GUM, GP, hospital), with the ability to exclude tests done for antenatal screening.

6.24 Antenatal HIV screening has enabled interventions to prevent the majority of potential mother-to-child transmissions. However, there is considerable variation in screening rates between regions. Data are routinely available at regional

level, but the importance of this indicator justifies a requirement for all SHAs to make it available by PCT and LA.

**Indicator 9: Proportion of HIV diagnoses where CD4 cell count is under 200 at time of diagnosis**

6.25 A key strategic priority is to increase the proportion of HIV infections diagnosed and to reduce the proportion of these which are diagnosed late. This has benefits for individual and public health. The indicator proposed here would measure late diagnoses, and should show over time whether the trend is towards earlier diagnosis. To ensure that a reduction in this indicator does not just reflect more late infections remaining undiagnosed, it should be looked at in the context of the total numbers of HIV tests performed and the HPA's annual estimate of the proportion of all infections which remain undiagnosed.

6.26 Additional insight could be gained by separately analysing this indicator for gay men, black Africans and any other population groups where there are concerns (eg. by gender).

6.27 The HPA has been working on the methodology for this indicator, and London has recently adopted it. Although HIV prevalence is lower in other parts of the country, earlier diagnosis is still important. It is possible that some PCTs may have such a low number of new HIV diagnoses that this indicator would need to be measured in those areas at network or regional level. However, it is suggested that the London experience be used as a pilot, with national implementation to follow once any methodological problems have been ironed out.

6.28 There are many other indicators relating to HIV, for the population as a whole and particular population groups. To maintain a fuller picture, it is important that surveillance and monitoring continue in relation to new diagnoses and transmission routes, estimated prevalence, numbers attending treatment services, numbers on HAART, and mother to child transmissions, as well as process measures regarding numbers of tests and antenatal screening rates. As numbers on treatment increase every year, consideration should also be given to the development of other indicators to measure clinical outcomes for those on treatment.

**Indicator 10: Proportion of those reporting sexual assault seen within specialist sexual assault services**

6.29 A number of specialist Sexual Assault Referral Centres (SARCs) have been set up with joint funding

from the Home Office (HO) and local NHS. However, provision around the country remains very patchy, and there are major inequalities in access to such services following sexual assault. The Strategy review identifies sexual assault as a gap in the original Strategy which should be addressed, and the HO and Department of Health (DH) have made it a priority to increase specialist service provision, with the proposed objective of ensuring that, by the end of 2010/11, every victim of serious sexual assault in England (and Wales) should have access to a SARC (integrated or virtual) as part of a co-ordinated community response.

6.30 In 2008/09, the PSA 23 will address the need to develop a co-ordinated community response to interpersonal violence (IPV), including sexual and domestic violence. The joint HO and DH strategy for the further development of SARCs would need to form part of this response, and the proposed indicator forms part of the National Indicator Set.

**Indicator 11: Uptake and coverage of HPV vaccination among target population**

6.31 The new national HPV vaccination programme for girls aged 12-13 is due to commence in the autumn of 2008, and over time has the potential to radically bring down rates of cervical cancer. As a new programme, it will be important to measure its progress. While it might be argued that the primary outcome of vaccination is not directly related to the sexual health Strategy, uptake of the vaccine is likely to be affected by social attitudes to sexual activity among teenagers and specifically the attitudes of parents. One reason for suggesting this indicator is therefore its potential role as a proxy measure for changes in the social climate in relation to sex and sexual health.

**Inequalities – analysis of above indicators by population characteristics**

6.32 For all the above indicators, there may be trends within particular population groups going in the opposite direction or at different rates from the global trends, and it is known that some population groups are disproportionately affected by HIV and other aspects of sexual ill-health. It is therefore proposed that all the above indicators should be analysed, data permitting, by deprivation quintile, ethnicity, gender, age group and sexual orientation, to see if there are continuing or potentially increasing inequalities that might be hidden within a global trend.

6.33 Further work would be needed to develop this analysis (which may be too complex to include

in high-level national indicators). Recent work by the North West Public Health Observatory provides a good starting point, and a project underway at South West Public Health Observatory should provide further support.

6.34 Data are not currently recorded to assess the level of sexual health in prisons, notably incidence or prevalence of STIs and HIV. However, chlamydia screening in prisons has found high positivity rates, and as the prison population is drawn from communities disproportionately affected by sexual ill-health, it should be a priority target for the provision of prevention interventions and services. There is a need to measure the impact of these interventions using health outcome data, and to monitor trends in sexual health over time in this environment. The opportunity should therefore be grasped to use the new GUMCAD dataset to collect this new information and incorporate it into sexual health indicator sets.

#### **Further development of indicators**

6.35 The indicators proposed above are mostly already established, or the data to measure them are relatively easily available. However, with the development of new datasets (eg. GUMCAD) and the identification of new priority concerns (eg. links between sexual risk behaviour and alcohol) attention should also be given to the creation of new indicators, which may take some time to develop.

6.36 A large number of possible indicators was suggested and discussed by stakeholders during this Strategy review. Those listed below are particularly relevant to issues highlighted in this report and would need further work to develop. However, the list should not be taken to be exclusive: further scoping and refining of potential indicators in the wake of this report is recommended.

- i) STI re-infection rates, made possible by the new dataset, GUMCAD. This might serve as an indicator of the effectiveness of prevention within sexual health services, particularly partner notification, as well as the proportion of the population which may be repeatedly exposing themselves to risk.
- ii) Indicators to measure the links between negative sexual health outcomes and alcohol/drug misuse, as well as indicators to measure the provision of services jointly addressing these (eg. alcohol/drug misuse interventions within sexual health services).
- iii) The ratio of abortions to conceptions, as a measure of unintended pregnancy (and thus of contraceptive service access and quality). Variations in the ratio are clearly also related to health inequalities. In time, depending on further assessment, this indicator might complement or replace that for repeat abortions.
- iv) An expansion of Indicator 2 could be considered to encompass provision of LARC in abortion services, eg. the rate of prescribing of each LARC method as part of abortion care, per provider. This could usefully supplement data on LARC provision from the main contraception providers and be particularly relevant in the context of aiming to reduce repeat abortions. However, caution would need to be applied to ensure the existence of the indicator did not work as a disincentive to offer the full choice of methods post-abortion.
- v) At present, point of care tests (POCT) for HIV are becoming more widely used, although still a small proportion of all HIV tests performed. As numbers increase further, potential methods for measuring their use and outcomes should be explored, as current data collection does not provide such information.
- vi) HIV incidence, i.e. HIV infections likely to have been acquired within a recent time-frame (around 6 months) using the Serological Testing Algorithm for Recent HIV Seroconversion (STARHS) laboratory technique. If demographics and risk/exposure of those coming forward for testing can be effectively monitored, changes in the proportion and characteristics of recently infected cases may well closely reflect onward transmission of HIV, and would represent a natural indicator of health promotion. Local clinics would need to submit the relevant data, and numbers of diagnoses in some PCTs may be too low for universal monitoring at PCT level, but in time this indicator might be considered for use at national level.



## **Build on what has been achieved**

7.1 The review has documented the many constructive steps the Department of Health has taken to support improvements in sexual health since the publication of the national Strategy back in 2001. It is important to acknowledge the progress that has been made and to celebrate the opportunities the Strategy has provided to change things for the better and radically improve many services. There is significant skill and commitment among those working in the sexual health field, and a considerable amount of specialist and technical expertise resides with NHS Trusts, Primary Care Trusts (PCTs) and local authorities (LAs), and with third sector and community organisations. This needs to be harnessed by local leaders and used to sustain momentum and ensure the impact of the central drive which has guided developments in the past few years does not fade and that sexual health retains its place at the forefront of local public health policy.

## **Shift to local prioritisation and delivery**

7.2 As the NHS shifts further from central control, it falls increasingly on PCTs and LAs to ensure they know the sexual health and HIV needs of their local populations and are adequately addressing them, in terms of sexual health promotion, prevention and service provision. To this end, there needs to be clearer responsibility and accountability for delivering on the Strategy and continuing the agenda of improving sexual health and reducing inequalities. If local organisations and partnerships fail to prioritise sexual health now, they risk having to deal with the real human and financial consequences further down the line with more infections and unintended pregnancies, and higher treatment and social care costs.

7.3 The commissioning process is seen as increasingly important in the effective shaping and resourcing of local sexual health promotion and service provision in order to meet locally assessed need. It is through effective commissioning that progress will be made in implementing choice, integrating services and moving them closer to the community, and shifting from an illness to a

well-being focus. Commissioning also provides the best opportunity to improve quality (building transparent quality performance measures into the commissioning process) to ensure choice does not come at the expense of quality standards. Given the drive and emphasis on world class commissioning in the NHS, it is of some concern that sexual health services are currently in a fragile position, having lost many experienced commissioners in the throes of constant organisational upheaval and change. SHAs and regional partners have an important role to play in helping PCTs to build capacity and expertise for world class commissioning in sexual health and HIV.

## **Political leadership and continued national support for local delivery**

7.4 Given the scale of the problems facing local health and social care organisations, and the complexities and stigma that surround sexual health and HIV, it is essential that there continues to be strong and bold leadership at ministerial level, and through regions, to continue the impetus for improvement, support more intensive local effort and ensure certain standards in sexual health provision (eg. equity of access, quality, choice, performance management) are being met. There is a continuing need for national action on a number of fronts (see Section 5), including more co-ordinated workforce planning and more systematic dissemination of the evidence base to strengthen confidence about what works. In addition, while LAAs and *Vital signs* performance indicators provide the opportunity for locally agreed targets, national targets remain necessary in order to ensure that improvements are being made in tackling sexual health inequalities across the country and to better control the spread of infections which know no geographical boundaries.

## **Tackling the wider determinants of sexual health**

7.5 Addressing the impact of inequalities in sexual health continues to be a major challenge. More effective interdepartmental partnerships at national level to ensure consistent cross-government policy in tackling the wider determinants of sexual health are key to making progress in this area. The role

played by health and education has been more explicit in implementing elements of the Strategy but the impact and influence of other departments, eg. the Home Office and Department of Communities and Local Government, have been less consistently reflected to date. This needs to change.

7.6 At local level, inequalities will continue to be best tackled through multi-agency partnerships. Through these, and with support from regional level, action can be taken to tackle ‘upstream’ preventive challenges that require joint planning to enable people to make healthier choices. Such upstream actions can sit alongside specific ‘downstream’ solutions that respond to sexual health problems when they occur and require closer engagement with clinicians and service providers. There need to be bolder partnerships than have been seen to date, brought together by a shared understanding about why improving sexual health is a priority, clarity about what each partner can contribute and why it matters to life outcomes and the wider community.

#### Looking to the future

7.7 The report of the year-long NHS Next Stage Review (spearheaded by Health Minister Lord Darzi) has recently been published<sup>278</sup> and its implications for the future shape of healthcare are starting to become clearer. The place of sexual health and HIV in regional visions as they are further developed and implemented, and the way in which PCTs and LAs set out to improve sexual health as one of the six key goals identified for comprehensive well-being and prevention services, will be important determinants of progress in 2008 and beyond, towards the aims of the Strategy.

has changed significantly since then; work needs to begin now on a cross-government framework that seeks to identify sexual health and HIV priorities beyond 2011 and sets the strategic direction for the next decade. It may also be timely to consider how the strategic direction for the long-term health and social care of people living with HIV can best be addressed, in the context of changing policy frameworks and new workstreams for long-term condition management. As part of this process, consideration should be given to the need to adopt a more social model of sexual health; to give more equal weight to maximising sexual health and well-being as well as minimising sexual ill-health, and to strategically align health, education and social agendas much more closely.

A shared understanding about why improving sexual health is a priority, clarity about what each partner can contribute and why it matters to life outcomes and the wider community.

7.8 The 10-year national Strategy takes us through to 2011. There is much still to be done at national, regional and local levels to realise its vision of better prevention, better services and better commissioning. However, the operating environment



**APPENDIX 1****Strategy review methodology**

The review was informed by three distinct streams of work:

**1. Desk Research**

Relevant information on progress with the strategy and the changing landscape was gathered and analysed, including:

- epidemiology (STIs, HIV, conceptions, abortions, inequalities etc) in relation to targets
- progress and achievements in relation to sexual health and the Strategy implementation action plan (at national and local level)
- evidence on what works in relation to sexual health
- policy changes since 2001 – impact on provision of sexual health services, potential impact of current reviews, where sexual health could be linked in with other public health policy developments.

**2. Expert Review Groups**

A series of Expert Review Groups were held in November and December 2007, to look more closely at the areas of **Services, Commissioning** and **Prevention and Inequalities** to consider:

- significant changes since the strategy was first developed
- impact of these on progress
- policy changes and opportunities they present
- barriers to implementation
- how to ensure local delivery
- critical areas for action.

A further group on **Indicators** was convened early in 2008 to consider and develop a set of sexual health indicators that could be used to measure performance locally and nationally.

**3. Meetings with key stakeholders and sexual health service users**

**Stakeholder Meetings** were held in London, Leeds and Taunton during February 2008 to test and refine the emerging recommendations, help identify key levers for implementation of the strategy at national, regional and local level and source case studies and examples of innovative practice.

**Service User Meetings** were held in London, Leeds and Birmingham to provide a more personal perspective on experiences relevant to sexual health and well-being and to inform the emerging areas for action.

**Strategic meetings** were held with representatives of DH National Support Team for Sexual Health, Teenage Pregnancy Unit, NHS Next Stage Review team, Healthcare Commission, MRC Sexual Health and HIV Research Strategy Committee.

## APPENDIX 2

## Delivery against The national strategy for sexual health and HIV – implementation action plan

Implementation action plan	Government response
<b>Framework for delivery</b>	
<b>1. Local implementation</b> <ul style="list-style-type: none"> <li>Sexual Health/HIV lead</li> <li>Local partnership development</li> <li>Senior SHA leads</li> </ul>	<p>Primary Care Trust leads established and contact list maintained by Department of Health. Level of resource available and seniority of leads have varied considerably</p> <p>Local partnerships have developed in line with <i>Shifting the balance of power</i> agenda</p> <p>SHA Sexual Health leads established and meet bi-annually with DH</p>
<b>2. Improve commissioning</b> <ul style="list-style-type: none"> <li>Sexual Health Commissioning Toolkit</li> </ul>	<p><i>Effective commissioning of sexual health and HIV services: a sexual health and HIV commissioning toolkit for Primary Care Trusts and local authorities</i> Published in 2003 <a href="http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4073555">www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4073555</a></p>
<b>3. Monitor progress</b> <ul style="list-style-type: none"> <li>Local service mapping</li> <li>Performance indicator development</li> <li>AIDS Control Act: review of criteria</li> <li>Data review</li> </ul>	<p>Funding provided for every local area to undertake baseline mapping exercise. Summary report published on DH website</p> <p>Range of indicators have been developed since publication of Strategy:</p> <p><b>Healthcare Commission</b></p> <ul style="list-style-type: none"> <li>- Access to GUM</li> <li>- % of NHS-funded abortions under 9 weeks</li> <li>- Access to contraception and chlamydia screening</li> </ul> <p><b>LDPs</b></p> <ul style="list-style-type: none"> <li>- 100% of patients attending GUM services who are offered an appointment to be seen within 48 hours of contacting a service by March 2008</li> <li>- % of population aged 15-24 accepting a test/screen for chlamydia</li> <li>- Reduce teenage conceptions by 2010</li> <li>- Decrease in rates of new diagnoses of gonorrhoea</li> </ul> <p><b>Vital signs 2008/9 – 2010/11</b></p> <ul style="list-style-type: none"> <li>- Prevalence of chlamydia</li> <li>- Under-18 conception rate</li> </ul> <p><b>08/09 Operating Framework for the NHS (continuing commitments)</b></p> <ul style="list-style-type: none"> <li>- GUM 48-hour access</li> <li>- Rollout of chlamydia screening programme</li> </ul> <p>Superseded in the light of broader DH review of central data returns, and mainstreaming in 2002 of NHS HIV allocations</p> <p>Common Data Set for Sexual Health (CDSH) has received draft approval from Information Standards Board. Phased approach towards full implementation of CDSH, due to IT limitations. This involves work to include quality of existing data collections (eg. resident-based STI data; ethnicity data, sexual health data from general practices) New comprehensive GUM waiting-time data collection introduced to monitor 48-hour access target Revised dataset for community contraception services piloted</p>
<b>4. Monitor investment</b> <ul style="list-style-type: none"> <li>Collection of data on levels of NHS HIV investment</li> </ul>	<p>No regular routine monitoring has taken place. Since 2006/7 PCT and SHA estimated expenditure on HIV has been reported as part of NHS programme expenditure</p>
<b>5. Involving users in designing services</b> <ul style="list-style-type: none"> <li>Set up mechanisms to involve users</li> <li>Good practice resource</li> </ul>	<p>UK Coalition of People Living with HIV and AIDS consulted on DH policy prior to their closure in 2007. Increased focus on user involvement in national HIV health promotion contracts</p> <p>HIV user representation on Independent Advisory Group</p> <p>Advice on good practice in involving users included in Commissioning Toolkit</p>
<b>6. Independent Advisory Group on Sexual Health and HIV</b>	<p>Set up in 2003 to advise Government on implementation of Strategy. Members reappointed in 2007</p>
<b>Better prevention</b>	
<b>7. National information campaign</b> <ul style="list-style-type: none"> <li>Launch new campaign</li> <li>Review evidence on what works</li> </ul>	<p><i>Sex Lottery</i> campaign targeting young adults launched in 2002; <i>Condom EssentialWear</i> launched 2006</p> <p>Extensive desk research of evidence from programmes around the world completed and published (<a href="http://www.sexualhealthprofessional.org.uk">www.sexualhealthprofessional.org.uk</a>)</p> <p>Programme of partnership work with all UK condom manufacturers, key condom retailers and owners of brands relevant to target audience lifestyle is in train and yielding results in terms of the condom retailing environment</p>
<b>8. Disseminate evidence</b>	<p>Evidence briefings for HIV prevention, STI prevention and teenage pregnancy and parenthood published by the Health Development Agency in 2003/4</p> <p>NICE guidelines on Long-Acting Reversible Contraception published in 2005 NICE guidance on preventing STIs and under-18 conceptions published in 2007</p>

Implementation action plan	Government response
<p><b>9. Information and advice for the general public</b></p> <ul style="list-style-type: none"> <li>Develop health promotion toolkit</li> <li>Develop a computer resource for young adults</li> </ul>	<p><i>Effective sexual health promotion: a toolkit for Primary Care Trusts and others working in the field of promoting good sexual health and HIV prevention</i> Published 2003</p> <p>DIPEX sexual health interactive computer resource produced and available at <a href="http://www.dipex.org">www.dipex.org</a></p>
<p><b>10. Improve the quality of helplines</b></p>	<p>Independent evaluation informed re-tendering of Sexual Health Information Line and provision of Sexual Health Direct (formerly CES). This resulted in an expansion of helpline provision and around £1.9m (excluding the Sexual Health Information Line*) is provided each year. This includes Sexual Health Direct**, Brook, Black Health Agency and contribution to THT Direct.</p> <p>*funded as part of a contract which includes other helplines ** also includes non-helpline information services</p>
<p><b>11. Education about sex and relationships</b></p>	<p>A range of measures to improve the teaching of PSHE have been introduced, including:</p> <ul style="list-style-type: none"> <li>funding approximately 2,000 participants a year (both teachers and community nurses) to undertake the PSHE certification programme;</li> <li>making provision of high-quality PSHE a requirement for achievement of Healthy School status;</li> <li>issuing guidance to schools to help them better assess what pupils learn in PSHE; and</li> <li>the establishment of a PSHE subject association to provide support to PSHE teachers and to share best practice.</li> </ul> <p>Recent announcement in the Children's Plan to review the delivery of SRE in schools, involving young people fully in the process. That review will conclude in July 2008, and will form the basis for deciding how best to drive improvement in the quality of SRE.</p> <p>An audit toolkit to be published in 2008 for schools to use to canvass the opinions of students on the quality of their school's SRE programme, and to help shape their future provision</p>
<p><b>12. Prevention for groups at special risk</b></p> <ul style="list-style-type: none"> <li>New framework for African communities</li> <li>Continued support for CHAPS</li> <li>National campaign targeting young injecting drug users, and continued support for local needle exchange schemes</li> <li>Support for work in prisons and YOIs</li> <li>Access for asylum seekers to information and advice about sexual health</li> <li>Work with FORWARD</li> </ul>	<p><i>HIV and AIDS in African communities: a framework for better prevention and care (2005)</i> and <i>The knowledge, the will and the power: an action plan to meet the HIV prevention needs of Africans living in England (2008)</i> published by DH-funded National African HIV Prevention Programme (NAHIP) co-ordinated by African HIV Policy Network. Results of first-ever sexual health needs assessment questionnaire to be published by Sigma Research in 2008</p> <p>Additional investment to fund syphilis awareness and prevention in MSM, and to disseminate Making it Count model at local level</p> <p>As a result of substantial investment through the Pooled Drug Treatment Budget and local mainstream investment (£604m annually) there has been a rapid increase in the availability of effective drug treatment services, including harm reduction activity such as needle exchange schemes. The National Institute for Health and Clinical Excellence (NICE) has been asked to provide public health intervention guidance on the optimal provision of needle exchange schemes among injecting drug users, to be published in early 2009</p> <p>A self-directed 'Basic Awareness in Sexual Health' modular course for Prison Officers has been produced for dissemination on HP Prison Service intranet. A working group is currently in progress and devising a toolkit for improving sexual health within prisons</p> <p>Good practice guide, <i>Sexual health needs of asylum seekers and refugees</i> published in 2007 <a href="http://www.fpa.org.uk/community/refugees">www.fpa.org.uk/community/refugees</a></p> <p>Grant aid has been provided to Foundation for Women's Health, Research and Development (FORWARD) to work closely with health, education and child-protection agencies and the practising communities to reduce female genital mutilation</p>
<b>Better services</b>	
<p><b>13. Set standards</b></p> <ul style="list-style-type: none"> <li>Recommended service standards</li> <li>Details of effective managed service networks</li> </ul>	<p><i>Recommended Standards for NHS HIV Services (2003)</i> and <i>Recommended Standards for Sexual Health Services (2005)</i> have been published by MedFASH</p> <p>Children's HIV National Network Review 2005 provided good practice advice on development of paediatric HIV service networks outside London</p>
<p><b>14. Implement 3 levels of sexual health services</b></p> <ul style="list-style-type: none"> <li>SHAs to oversee implementation</li> </ul>	<p>Further guidance provided in Commissioning Toolkit</p> <p>SHAs have played differing roles in line with <i>Shifting the balance of power</i> and devolution of decision-making</p>
<p><b>15. Develop targeted sexual health services</b></p> <ul style="list-style-type: none"> <li>Publish HIV care framework and action plan for African communities</li> <li>Disseminate good practice on developing other targeted services</li> </ul>	<p>Care services framework included in <i>Framework for better prevention and care</i> for African communities</p> <p>Framework for management of sexual health in primary care, available on Primary Care Contracting website (<a href="http://www.pcc.nhs.uk">www.pcc.nhs.uk</a>), supports the development of targeted services to suit local need</p> <p>See also point 12 above</p>

Implementation action plan	Government response
<p><b>16. Improve Contraceptive Services</b></p> <ul style="list-style-type: none"> <li>• Advice on developing role of nurses and open access services</li> <li>• Evidence on effectiveness of free or low-cost condom schemes</li> <li>• Good practice guidance on pharmacy availability of emergency contraception under PGD</li> <li>• Clinical guidelines for use of LARC</li> </ul>	<p>Advice contained in Commissioning Toolkit. Further good practice commissioning guidance for reproductive health to be issued shortly</p> <p>Advice contained in Health Promotion Toolkit</p> <p>Advice contained in <i>Recommended standards for sexual health services (2005)</i>, supporting more detailed practice guidance from Royal Pharmaceutical Society of Great Britain (2004). Emergency Hormonal Contraception (EHC) now widely available from pharmacies under PGD or, since 2004, to buy without prescription.</p> <p>NICE clinical guideline on use of LARC published in 2005, includes care pathway, features and choices to discuss with women, practical details and associated cost economic arguments for their increased use.</p> <p>The <i>Findings of the baseline review of contraceptive services in England</i> was published in 2007 and has been fed into the best practice guidance for service commissioners and service providers of contraception and abortion services, currently being developed</p>
<p><b>17. Tackle inequalities in access to abortion</b></p> <ul style="list-style-type: none"> <li>• National standard of access within 3 weeks</li> <li>• Guidance on commissioning abortion services</li> <li>• Further support for implementation - audit of abortion waiting times</li> <li>- pilot early abortion procedures</li> <li>- work with Royal Colleges to develop training in this area</li> </ul>	<p>Healthcare Commission PCT indicator 2002/3-2006/7 Additional funding allocated to PCTs to support delivery of indicator</p> <p>Advice contained in Commissioning Toolkit</p> <p>Due to the complexities of collecting data on waiting times for abortions, agreement reached that gestation is a good proxy for waiting times and was used as the indicator for the Healthcare Commission</p> <p><i>Evaluation of early medical abortion (EMA) pilot sites report</i> published in May 2008</p> <p>This has been identified as a matter for the Royal College of Obstetricians and Gynaecologists and the deaneries to lead on.</p>
<p><b>18. Improve GUM services</b></p> <ul style="list-style-type: none"> <li>• Develop Health Advisors Role</li> <li>• Review GUM skill mix, working practices and workforce planning</li> <li>• Develop model to assess impact of waiting times on sexual health outcomes</li> <li>• Work towards shorter waiting times and increase access</li> <li>• Capital investment to modernise facilities</li> <li>• Hepatitis B vaccine to be offered to all gay and bisexual men attending GUM clinics</li> </ul>	<p><i>Sexual health advising – facilitating the next steps</i> guidance document, currently being written by the Society of Sexual Health Advisers and due to be published in 2008</p> <p>Undertaken as part of the MedFASH review of GUM services</p> <p>Consideration currently being given to monitoring impact of the 48-hour access target on STI rates and other outcomes</p> <p>MedFASH completed a national review of GUM services in 2007</p> <p>HPA audit of GUM services leading to development of GUM waiting time target</p> <p>National Support Team for Sexual Health established to support delivery of the target in the most challenged areas. <i>10 high-impact changes for GUM 48-hour access</i> guidance produced in collaboration with MedFASH</p> <p>DH-funded GUM development pilots to pump-prime new services in under-served areas</p> <p>Toolkit for measuring GUM demand and capacity to be published by DH in 2008</p> <p>Capital funding made available to improve GUM estate and modernise premises and facilities</p> <p>DH spent £1.5m to provide GUM clinics with free hepatitis B vaccine to help boost provision (2002-5). Uptake target for first dose set for 2006 was met by 2004. Uptake target for third dose uptake was not met (41% in 2006, compared to target of 70%). However, course adherence will be underestimated as many men will receive subsequent doses at different clinics. The surveillance system was not able to identify such cases</p>
<p><b>19. Roll out chlamydia screening</b></p> <ul style="list-style-type: none"> <li>• Phased rollout in 10 sites</li> <li>• Study into rates of re-infection</li> <li>• Effective technology</li> </ul>	<p>By 2004, NCSP was introduced in 26 sites. <i>Choosing health</i> made commitment to accelerate implementation of NCSP to cover the whole of England by 2007. Responsibility for operational management of NCSP was transferred to Health Protection Agency with a strengthened national and regional team. All PCTs in England are now screening</p> <p>Pilot pharmacy chlamydia screening evaluation commissioned with Boots the Chemist in 2005. Final report published end of 2007</p> <p>Study results published in 2007, with recommendations for screening intervals</p> <p>Pump-priming funding made available to support use of NAA testing. User requirements for near-patient testing technology have been revised. System has been developed and is expected to be validated and available for use by 2009</p>

Implementation action plan	Government response
<b>20. HIV and STI testing</b> <ul style="list-style-type: none"> <li>Increase offer and uptake of testing</li> </ul>	National standard on HIV testing in GUM clinics achieved CMO letter re improving detection of HIV in non-specialist settings Testing awareness promoted in campaign for African communities
<b>21. Develop one-stop shops</b> <ul style="list-style-type: none"> <li>Develop and evaluate three models</li> </ul>	<i>Evaluation of One-Stop Shop (OSS) models of sexual health provision</i> published 2008
<b>22. Clarify confidentiality arrangements</b>	Revised guidance on under-16s and confidentiality published in July 2004 DH consultation on confidentiality and STIs. Review report to be published shortly Input into Connecting for Health on sexual health, in particular a conference on sexual health was held in February 2007 Input into Association of British Insurers revised statement on HIV and dissemination to NHS and others
<b>23. Better support for people living with HIV</b> <ul style="list-style-type: none"> <li>Commission report on support needs of adults and children living with HIV and develop standards</li> <li>Good practice on skills development for people living with HIV</li> <li>Review AIDS Support Grant</li> </ul>	<i>Needs of people living with HIV: a guide</i> was published by NAT in 2004 Survey of young people with HIV (2001) and handbook for service providers (2006) published by Children and Young People HIV Network, NCB Addressed through national health promotion contracts ASG allocation is now based on 70% HIV caseload in a local authority area, and 30% women and children living with HIV in a local authority area
<b>24. Tackling stigma and discrimination</b> <ul style="list-style-type: none"> <li>Support for NATs Stigma campaign</li> <li>Practical guidance on tackling stigma within NHS and other organisations</li> <li>Detailed action plan in partnership with other government departments</li> </ul>	Funded NAT's pilot World AIDS Day HIV Prejudice campaign in 2002; and additional funding for national prevention campaigns for African communities and MSM to address stigma Guides for employers and trade unionists published by NAT <i>DH action plan: HIV-related stigma and discrimination</i> published 2005 and <i>Tackling HIV stigma and discrimination: response to consultation</i> published 2007 Funding for projects by National AIDS Trust, MedFASH and NAM to implement <i>Tackling stigma</i> , and additional funding for targeted HIV health promotion contracts with THT and African HIV Policy Network (AHPN)
<b>25. Workforce development</b> <ul style="list-style-type: none"> <li>Review workforce implications of Strategy</li> </ul>	<i>A competency framework for nurses working in the specialty of sexual and reproductive health across UK</i> was published in 2004 by RCN in partnership with stakeholder organisations <i>National HIV nursing competencies</i> were published by NHIVNA in 2007 Significant development in the nursing workforce in sexual health, with nurses now delivering Levels 1,2 and 3 sexual health services in a variety of acute and community settings. Number of nurse consultant posts has expanded and roles of health advisers and healthcare support workers also enhanced since the Strategy. <i>Manual for Sexual Health Advisers</i> published by Society of Sexual Health Advisers (SSHA) in 2004. <i>Competencies for providing more specialised sexually transmitted infection services within primary care</i> were published by DH in 2005, and an accompanying assessment toolkit in 2006.
<b>26. Training strategy</b> <ul style="list-style-type: none"> <li>Map availability of basic sexual health skills training to inform national sexual health training strategy</li> </ul>	<i>Recommended quality standards for sexual health training</i> was published in 2005 Genito-Urinary Nurses Association commissioned to provide educational database for sexual health education and course provision <a href="http://www.guna.org.uk">www.guna.org.uk</a> RCN developed an accredited Sexual Health Skills distance learning programme for nurses BASHH developed and rolled out the <i>Sexually Transmitted Infections Foundation (STIF)</i> course for primary care clinicians. The Diploma of the Faculty of Sexual and Reproductive Healthcare is currently being revised. A new RCGP Introductory Certificate in Sexual Health, for GPs and practice nurses, is in development, funded by the DH. Current working group exploring training requirements and availability of courses for health professionals providing contraceptive care within primary and community services
<b>27. Develop the evidence base</b>	MRC-DH Committee for the Epidemiological Studies of AIDS replaced by the Sexual Health and HIV Research Strategy Committee, and research commissioned to support the effective implementation of the Strategy. 28 research projects have been supported (see Appendix 4). See Evidence briefings above (Action point 8)



## APPENDIX 3

The national strategy for sexual health and HIV: investments since publication	
Investment	Cost
Initial investment announced with Strategy (2002/3 – 2003/4)	£47.5m
Sexual health budget and investment (2004/5)	£31m
Sexual health budget and investment (2005/6)	£20m
Sexual health budget (2006/7)	£17.936m
Sexual health budget (2007/8)	£17.400m
Sexual health modernisation – <i>Choosing health</i> (2005/6–2007/8)	£300m
Boosting Contraception Services – further funding available in 08/09 and 09/10	£26.8m 2008/9
Sexual health programme budget 2008/9	£17.421m
GUM capital investment (2004/5 – 2005/6)	£30m
AIDS Support Grant and capital investment (paid by DH to LAs)	£115m 2002–2008

Source: Department of Health

## APPENDIX 4

## Research funded by the DH and MRC Sexual Health and HIV Research Strategy Committee (SHHRC)

## 2003

- JA Cassell, University College London: *Effects of access problems on transmission of STIs in the UK*
- P Easterbrook, Kings College: *Impact of HIV among black Caribbeans in South London: A socio-demographic, behavioural and laboratory study*
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- C Ison, Health Protection Agency: *Antimicrobial resistance in Chlamydia trachomatis: is it a reality?*
- I N Clarke, University of Southampton: *Development of a high resolution genomic Single Nucleotide Typing (SNP) system for genitotropic C.trachomatis*



**APPENDIX 5****Glossary of abbreviations**

AHPN	African HIV Policy Network	NCB	National Children's Bureau
AIDS	Acquired immune deficiency syndrome	NCSP	National Chlamydia Screening Programme
APMS	Alternative Provider Medical Services	NHIVNA	National HIV Nurses Association
BASHH	British Association for Sexual Health and HIV	NHS	National Health Service
BBVs	Blood-borne viruses	NICE	National Institute for Health and Clinical Excellence
BHIVA	British HIV Association	NIHR	National Institute for Health Research
BIS	British Infection Society	NIS	National Indicator Set
BME	Black and minority ethnic	NST	National Support Team
CDSH	Common Data Set for Sexual Health	OSS	One Stop Shop
CHAPS	Community HIV and AIDS Prevention Strategy	QOF	Quality and Outcomes Framework
CHINN	Children's HIV National Network	PBC	Practice based commissioning
CMO	Chief Medical Officer	PbR	Payment by Results
DH	Department of Health	PCT	Primary Care Trust
DMPA	Depot medroxyprogesterone acetate	PCTMS	PCT Medical Services
EAGA	Expert Advisory Group on AIDS	PEP	Post-exposure prophylaxis
EHC	Emergency Hormonal Contraception	PGDs	Patient group directions
EMA	Early medical abortion	PHSE	Personal, social, health and economic
FE	Further Education	PMS	Personal Medical Services
FORWARD	Foundation for Women's Health, Research and Development	POCTs	Point of care tests
GO	Government Office	PSA	Public Service Agreement
GMS	General Medical Services	RCGP	Royal College of General Practitioners
GMSS	Gay Men's Sex Survey	RCOG	Royal College of Obstetricians and Gynaecologists
GP	General practitioner	RCN	Royal College of Nursing
GUM	Genitourinary Medicine	RCP	Royal College of Physicians
GUMAMM	Genitourinary Medicine Access Monthly Monitoring	RPHG	Regional Public Health Group
GUMCAD	Genitourinary Medicine Clinic Activity Dataset	SARC	Sexual Assault Referral Centre
HAART	Highly active antiretroviral therapy	SCG	Specialised Commissioning Group
HIV	Human immunodeficiency virus	SHA	Strategic Health Authority
HO	Home Office	SHHRSC	Sexual Health and HIV Research Strategy Committee
HPA	Health Protection Agency	SHIAG	Independent Advisory Group on Sexual Health and HIV
HPV	Human papillomavirus	SLA	Service level agreement
IDUs	Injecting drug users	SRE	Sex and relationships education
IPV	Interpersonal violence	SSHA	Society of Sexual Health Advisers
JSNA	Joint Strategic Needs Assessment	STARHS	Serological Testing Algorithm for Recent HIV Seroconversion
LA	Local authority	STI	Sexually transmitted infection
LAA	Local area agreement	STIF	Sexually Transmitted Infections Foundation
LARC	Long-acting reversible contraception	THT	Terrence Higgins Trust
LDP	Local Delivery Plan	TPIAG	Teenage Pregnancy Independent Advisory Group
LES	Local enhanced service	UWE	University of the West of England
LINKs	Local Involvement Networks	YOI	Young Offender Institution
LSPs	Local Strategic Partnerships		
MDT	Multidisciplinary team		
MedFASH	Medical Foundation for AIDS & Sexual Health		
MSM	Men who have sex with men		
MRC	Medical Research Council		
NAA	Nucleic acid amplification		
NAATs	Nucleic acid amplification technologies		
NAHIP	National African HIV Prevention Programme		
NAM	National AIDS Manual		
NAT	National AIDS Trust		



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It is important not to underestimate the effort and commitment needed across Government and throughout the NHS and local government to tackle the inequalities in sexual health, and sustain and continue broader improvements in this area.

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