

## **London Sexual Health Strategic Framework**

### **1. Introduction**

The London Sexual Health Framework (2009) aims to improve the Sexual Health of Londoners. It updates on the 2004 Framework with a range of Standards and Sexual Health indicators that can be used by PCTs. This should provide a robust Framework for commissioning, promoting partnership, ongoing integration of sexual health services, getting better access for Londoners and opportunities for innovative services that provide better value for money and efficiency. The NHS London's Operating Framework guidance for 2010-11 asks PCTs to implement this Sexual Health Framework.

### **2. Background**

The Framework was developed by over 80 multi-agency stakeholders including sexual health clinicians, commissioners and providers across London. It takes account of best practice approaches to prevention and patient care and policy changes.

Being sexually healthy means having the choice to enjoy an active sexual life, with the knowledge, self-esteem and assertiveness to negotiate sex with minimum risk of unintended pregnancy, sexually transmitted infections, abuse or violence. Sexual health services should promote sexual health, prevent sexual ill health, and diagnose, support, treat and manage people without prejudice or judgement.

Quality is a guiding principle for the NHS, encompassing safety, effectiveness and patient experience. For sexual health, there is an urgent need to commission high quality, evidence-based care; so that Londoners have access to prevention, promotion and treatment services that will enable them to move from some of the poorest levels of sexual health in England to amongst the best.

This Framework enables Sexual Health Commissioners and Providers to improve productivity and reduce costs while improving sexual health outcomes and indicators. It advises the NHS in London of commissioning requirements and economies of scale through collaborative commissioning to support PCTs as they address the need for cost effective ways of addressing service needs and improving service outcomes.

### 3. Vision

The vision for the NHS in London is to ***“To promote, support and improve sexual health by commissioning and delivering quality services that are comprehensive, coordinated, consistent, innovative, accessible and personalised to meet the full range of sexual health needs, without prejudice or judgement”***.

The vision for sexual health is encompassed in the objectives set out in the 2004 London Sexual Health Framework, and which still remain relevant:

- ***To improve London’s public health through the promotion of good sexual health and the prevention of ill health;***
- ***To improve access to London’s sexual health & HIV care services;***
- ***To improve the patient experience of people using sexual health services in London.***

## 4. The policy context

Strategic development of sexual health services in London is framed by a range of principles, policies and partners that guide and support the vision and objectives for improving sexual health and providing high quality services. These support sexual health as a priority for London (see Appendix 3)

## 5. Sexual Health Need in London

**London has the highest prevalence of sexual ill health in the UK. This impacts on overall population health, the extent of health inequalities, and the financial investment needed by London's health commissioners** (Primary Care Trusts and Practice Based Commissioners), London Councils and Children's Trusts. Needs, health outcomes and the effectiveness of service delivery vary across London. The "Sex and our city" report (2008) is London's first Sexual health needs assessment and service map that gives a comprehensive analysis of Sexual Health indicators and services. A range of the key indicators from this report are outlined in the next section. More detail can be found in the original report (see [www.londonsexualhealth.org](http://www.londonsexualhealth.org)).

### 5.1 Teenage conceptions

**In London in 2007 there were 5686 pregnancies in young women under the age of 18. The under 18 conception rate was 45.6 per thousand.** The reduction from the 1998 baseline remains at 10.7%, equal to the national reduction and substantially above the 50% target. **The rate of teenage pregnancy varies dramatically**, from 15.7 (43 pregnancies) in Richmond upon Thames to 76.2 (292 pregnancies) in Southwark. Generally outer London boroughs are making less progress with reducing the rate than inner London boroughs. **The percentage of under 18 conceptions ending in an abortion continues to increase (63% in London, 51% in England in 2007).** The under 16 conception rate is declining. In 2005-07 it was 8.7 per thousand (3207 conceptions) down from 9.6 per thousand in 2002-2004 against an England rate of 7.9 per thousand in 2005-2007.

### 5.2 Abortions

**There were 48,679 abortions for London residents in 2008, with 3128 (6%) for women under the age of 18 and 17,589 (36%) for women aged between 18 and 24.**

The majority of abortions (84% in 2008) are NHS funded and mostly carried out in the independent sector. In 2008, 76% were carried out at less than 10 weeks gestation.

**The percentage of abortions at less than 10 weeks gestation exceeded the national target (70%) but the variation across London suggests that the percentage could still increase.** The proportion of abortions performed at less than 10 weeks gestation varied from 63% in Newham to 85% in both Harrow and Havering in 2008.

**Seven of the 31 PCTs did not reach the target of 70% of abortions taking place before 10 weeks gestation.** Collecting more information on the proportion of these early abortions that are carried out using medical methods would help needs assessment and service development. **Reducing the number of repeat abortions remains a big challenge. 31% of abortions in London in 2008 were the second**

**or subsequent abortion for the woman concerned**, varying from 24% in Kensington and Chelsea to 38% in Barking and Dagenham.

### **5.3 Contraception**

**In 2007-2008 there were 541,000 attendances at community contraceptive clinics** in London, a slight reduction from 547,000 in 2006-2007. **Around three-quarters of consultations for contraception nationally are known to take place in general practice.** It is unlikely that this figure is very different in London; so community clinics remain important for access. 21% of women attending community clinics in London for their first appointment in the year were recorded as choosing long acting reversible methods of contraception (LARC) (KT31 returns 2007-2008). **The LARC prescribing rate in general practice varied from 0.5 to more than 3.6 per 1000 women aged 15 – 44** (Prescription Pricing Authority 2007-2008).

### **5.4 HIV**

**In 2008, 3098 people were newly diagnosed with HIV in London and around 25,000 needed HIV care.** Of these, almost half are men who have sex with men (MSM), and one third are from Black African backgrounds. **It is estimated that 27% of people with HIV have not yet been diagnosed; so an estimated 35,000 people in London are thought to be HIV positive.** HIV prevalence is highest in inner London. Lambeth has the highest diagnosed prevalence with 1 in 100 adults living with HIV. **Thirty-three per cent of people living with HIV were diagnosed late** in the course of the infection, that is, when the count of CD4 cells was below 200 cells per mm<sup>3</sup>. The range of late diagnoses varies from 19% to 48% between Primary Care Trusts, with late diagnosis being more common in outer London, particularly the North East and the South West. **Late diagnosis of HIV infection results in significantly increased morbidity and early mortality, as well as the risk of unknowingly transmitting infection, all of which are preventable.**

### **5.5 Sexually Transmitted Infections (STIs)**

**The diagnosis of most STIs is increasing. Episodes of syphilis in men in London have increased by over 1000% in the last ten years**, from 62 in 1999 to 731 in 2008. **Gonorrhoea rates in London are the highest in England**, with 4097 episodes in men and 1758 in women, but these levels have decreased over the last ten years, by 18% for men and 11% for women. 70% of new episodes of syphilis and 39% of new episodes of gonorrhoea occurred in men who have sex with men. **Episodes of Chlamydia have increased by 110% in men and 59% in women** since 1999; for genital herpes by 39% for both men and women; and for genital warts by 16% for men and 15% for women.

### **5.6 National Chlamydia Screening Programme**

The National Chlamydia Screening Programme (NCSP) is a control and prevention programme targeted at the highest risk group for Chlamydia infection in England; young people under 25 who are sexually active. Chlamydia infection is frequently asymptomatic, and treating it can reduce the risk of pelvic inflammatory disease and ectopic pregnancy.

**Chlamydia screening levels in London in 2008-2009 were 18.1%, above the England average of 15.9%. There was substantial variation between PCTs on the numbers of people in the target group screened;** from 6.7% in Westminster to 35.8% in Lambeth, with 10% of PCTs below the 15% target level. Of those tested 6.4% were positive.

### **5.7 Attendances at Genito-Urinary Medicine (GUM) Clinics**

All patients attending GUM services should be offered an appointment to be seen within 48 hours of contacting a service (NHS Operating Framework standard). For London GUM providers, the latest data (August 2009) shows that there over 45,000 attendances recorded, of which 32,528 were first attendances, almost all of whom were offered appointments within 48 hours and 89% of whom were seen within this time.

### **5.8 Antenatal Screening**

The “Infectious Diseases in Pregnancy Screening Programme” was introduced in 2003 to consolidate and establish standards for antenatal screening that had been in place for many years.

Appropriate measures in pregnancy for HIV positive women can reduce the risk of mother to child transmission from around 25% to around 1%.

**Screening levels for London in 2007 for Hepatitis B were 95.9% uptake with 1.18% positive (positivity levels were more than three times higher than any other SHA); for HIV 94.6% uptake with 0.32% positive (positivity levels twice that of the next highest SHA); for Syphilis 95.7% uptake with 0.43% positive (positivity levels nearly three times the next highest SHA); and for Rubella 96.2% uptake with 4.1% susceptible (the second highest susceptibility level for SHAs).**

## **6. Standards**

Five overarching standards have been identified as the basis for commissioning improved sexual health and sexual health services in London to deliver the vision set out in section 3. The details for all the Standards are attached in Appendix One.

### **Standard One**

PCTs should commission a comprehensive range of Sexual Health services that deliver improved health and wellbeing outcomes and measures meeting individual needs and showing service quality and effectiveness.

**Standard Two**

Sexual health services involve users in their design and delivery and regularly measure the experiences of service users.

**Standard Three**

Commissioners and providers work together to identify innovative approaches to promotion, prevention, and care that will increase and improve health and wellbeing outcomes.

**Standard Four**

Commissioners within each of the London sectors will work collaboratively and develop and fund Networks within a consistent London Framework, agreeing standards for quality and productivity across the sector.

**Standard Five**

Sexual health providers will develop integrated services across primary, community and secondary care using London Sexual Health tariffs to enable equity of access to integrated Sexual Health services. This will be under a Clinical Director providing leadership to the network of service providers, and with particular responsibility for clinical governance and training.

## Appendix 1. London Sexual Health Strategic Framework

### Standards for commissioners and providers to improve sexual health outcomes and performance

**Table 1: Standard One:** PCTs should commission a comprehensive range of Sexual Health services that deliver improved health and wellbeing outcomes and measures meeting individual needs and showing service quality and effectiveness.

National targets cover the reduction in the rate of teenage pregnancy, Chlamydia screening levels, and access to services for sexually transmitted infections. There should be clear pathways and accountability agreements which set out how commissioned services contribute to the achievement of health outcome targets.

Outcome indicators taking into account national, regional and local targets include:

1. Service	2. Commissioning Specification	3. Outcome	4. Indicator
<b>Sexual health and sexual health services information</b>	<p>Consideration need to be given to the style and approach to accurate and consistent information to promote sexual health and prevent sexual ill health, with a focus on self care and management using evidence including from social marketing to optimise the impact of available information. This includes building and maintaining healthy relationships, contraception, sexually transmitted infections, and related health issues such as alcohol and drug abuse.</p> <p>There needs to be effective signposting to services including primary, community and voluntary sector services for contraception and abortion, and services dealing with sexually transmitted infections, sexual assault and violence. This includes considering how information is accessed from printed material, the internet and text messaging.</p>	<b>Promoting good sexual health:</b> applying social marketing principles, and approaches relevant to different population segments, providing a range of approaches and materials that support people to be sexually healthy	<b>MEASURE: PCTs should have a Sexual Health Strategy that includes an annual Sexual Health Promotion Plan informed by a Sexual Health Needs Assessment, best practice e.g. Royal College of Public Health's World Class Commissioning of Health Promotion- (<a href="http://www.londonsexualhealth.org/uploads/RSPH%20-%20Reducing%20Inequality.pdf">http://www.londonsexualhealth.org/uploads/RSPH%20-%20Reducing%20Inequality.pdf</a>), evidence of analysis of STIs and local epidemiology and evaluation of social marketing approaches. The Sexual Health Promotion Strategy should be reviewed and updated every 3 years to meet changes in local needs.</b>
<b>Contraceptive advice and</b>	Access to the full range of contraceptive methods, including long acting methods. There should be	<b>Fewer teenage pregnancies:</b> addressing wider health determinants as well as service	<b>MEASURE: 50% reduction in the under 18 conception rate (births and abortions) by 2010 (from the 1998</b>

<b>products</b>	condom availability and the extent of no cost access, for example through 'C Card' schemes.  Emergency Contraception, both hormonal and intra-uterine, includes the extent of no cost access to care. Access to services that provide choice, are personalized and tailored to the needs of individuals and respect equality and diversity	provision, and including risk reduction, counselling, behaviour modification, and provision of post pregnancy contraception including long acting methods.	<b>baseline rate).</b> It is expected that this measure will be reviewed nationally as part of the Teenage Pregnancy Strategy led by the Department for Children, Schools and Families, and be revised to continue beyond 2010. Commissioners should consider whether more frequent reporting of live births and abortions could help to address progress on this measure
		<b>Increased access to long acting methods of contraception:</b> encouraging and enabling use while taking account of the importance of patient choice, with local agreement on how increased use of long acting methods will be measured and agreeing a local target rate appropriate to the population age profile.	<b>MEASURE: 100 or more females per 1000 females of reproductive age per year are prescribed intrauterine, implantable or injectable contraceptives by the end of 2011-2012.</b>  PCTs should commission providers to move to SHRAD and GUMCAD databases by April 2011.
		<b>Easy access to emergency contraception:</b> Including arrangements for free emergency hormonal contraception in pharmacies at least for young people (age range at a minimum of under 19 years old), and counselling about the different methods and their effectiveness.	<b>MEASURE: There should be 90% access to EHC within 72 hrs of request.</b>
<b>Abortion services</b>	Pregnancy testing, where tests are available and the extent of no cost access to tests. Care pathways need to include referral routes and post-abortion contraception, ensure choice of abortion provider and that clients are not subject to geographical restrictions or limited to a specific number of NHS abortions  Arrangements to ensure an agreed minimum of NHS funded abortions are undertaken in the first ten weeks of pregnancy. Arrangements for access to late abortions from identified providers of these services, and a well publicized care pathway that prevents any delays in access. This should include	<b>Early abortions and effective post abortion contraception:</b> More than 70% of abortions should take place earlier than 10 weeks gestation, and where this target has been achieved further improvement should be agreed. Local arrangements for measuring post abortion contraception should be agreed with providers. A strategy to reduce repeat abortions should be agreed.	<b>MEASURE: Every London PCT to achieve 70% of abortions earlier than 10 weeks gestation. For those PCTs above this level, to maintain 2008 levels and increase by an agreed per cent per year.</b> <b>- All abortion services will be commissioned for LARC and all women who have abortions leave the service with one or more of the most effective methods of contraception (hormonal oral or injectable contraceptives, intrauterine devices or contraceptive implants)</b>

	universal HIV testing as recommended by the British HIV Association		
<b>Services to prevent, diagnose and treat Sexually Transmitted Infections</b>	Information and support to prevent acquiring a sexually transmitted infection, including access to free condoms and post exposure prophylaxis for HIV (PEPSE). Provision of Chlamydia screening for young people under 25, with minimum screening levels of 25%, in 2009-2010 and 35% of young people screened in 2010-2011. Maintain 48 hour access to GUM services.	<b>Access to Genito-Urinary Medicine Services:</b> Access to GUM services is an operational standard for the NHS.	<b>MEASURE: 98% of patients contacting the service are offered an appointment within 48 hours and 85% are seen within 48 hours.</b>
	Access to quick and easy testing for sexually transmitted infections including HIV. Point of care testing with rapid results for HIV when clinically appropriate should be available, supported by further testing as required for confirmation of results. Diagnosis and management of people with sexually transmitted infections, working to the new standards recommended by the British Association for Sexual Health and HIV (BASHH, 2010)	<b>Fewer Sexually Transmitted Infections:</b> achieved through sexual health promotion and speedy diagnosis to reduce spread between partners, making full use of up to date screening technology and provision for automated results, with a range of ways to access and make easy appointments.	<b>MEASURE: All PCTs commission access to PEPSE (Post Exposure Prophylaxis after Sexual Exposure), and require providers to report on provision.</b> - Other measures are to be negotiated locally, which could include access to condoms, sexual health promotion campaigns, partner notification rates, and time to results and treatment
		<b>Chlamydia Screening:</b> increasing the uptake of Chlamydia screening by those at highest risk, those under the age of 25.	<b>MEASURE: Achieve and maintain 35% uptake of Chlamydia screening of 15 – 24 year olds by 2010-2011.</b>
<b>Services for people with HIV and AIDS</b>	Shared care services for people with HIV and AIDS, built on the principle that HIV is a treatable medical condition and that the majority of those living with the virus remain fit and well on treatment. Provision of information on access to post exposure prophylaxis for sexual partners of people with HIV and AIDS. Counselling about HIV and AIDS, the impact on life and health, psychosexual counselling and training in self management for people with HIV. There should be sexual health screens, sexual health promotion for people living with HIV and discussion of sexual harm reduction strategies.	<b>Fewer late HIV diagnoses:</b> including testing in community contraceptive services and in primary care, with same day testing and results. Testing in acute settings should also be agreed where population prevalence is such for this to be appropriate (check level).	<b>MEASURE: Reduce the level of late diagnosis of HIV to 15%, of 2004-2005 baseline by the end of 2011-2012.</b>  NB This includes evidence of meeting BHIVA guidelines on HIV testing in commissioning plans.
		<b>Better care for clients who are HIV positive:</b> Quality of life has improved for people living with HIV with the use of effective antiretroviral therapy. High quality chronic disease management should be provided to promote individual wellbeing, with effective support and education to prevent onward transmission of infection and of unplanned pregnancy.	<b>MEASURE: All commissioners ensure access to HIV testing and referral to specialist HIV treatment and care services.</b> - All commissioners commission positive self-management programme and counselling for people living with HIV. - All people living with HIV are offered a sexual health screen at least once every twelve months, with information documented if a screen is not required or

			the offer is declined. Providers will demonstrate the care pathway for individuals living with HIV which includes this care, and the uptake level for the screen.
		<b>No undiagnosed antenatal patients</b> with HIV, Hepatitis B and Syphilis. Testing arrangements and systems in place to report any women undiagnosed at delivery and actions to address and prevent future occurrences. Antenatal screening for Rubella Antibody negative women should be promoted as part of the programme.	<b>MEASURE: 98% screening levels for Hepatitis B, HIV and Syphilis for all London PCTs.</b>
		<b>Prevention of Hepatitis B</b> in MSM with a programme to ensure that MSM who are not immune to Hepatitis B are immunised.	<b>MEASURE: 70% of men who have sex with men attending specialist sexual health services and not known to be immune to Hepatitis B receive Hepatitis B vaccine.</b>
<b>Services that meet other sexual health needs and Service Availability</b>	Information and referral pathways to specialist services supporting people who have experienced, or are at risk of, assault, rape and other sexual violence, including their long term follow up and support. Services for people who experience difficulty with sexual function, both physical and psychological	<b>Patient Experience of sexual and reproductive health services, including meeting other sexual health needs:</b> Commissioners should ensure that all those in London have access to integrated local specialist sexual health services that deliver a comprehensive range of services with a range of opening hours accessible for patients including evenings and weekends. PCTs should require providers to measure and improve people's experience of their sexual and reproductive health services.	<b>MEASURE: Providers undertake at least annual surveys of client experience and can show how they are engaging service users in addressing issues highlighted, service re-design and making year on year improvement.</b>
	Services that are accessible, and understand the needs of, particular client groups, including those with learning disabilities and physical and sensory impairment.		
	Minimum opening hours, including the distribution throughout the week, by each level and type of		

	<p>service, and at evenings and weekends. Maximum waiting times and locally agreed waiting times for all other sexual health services. Access arrangements for hard to reach groups and those at high risk of sexual ill health, taking account of focus group and patient experience data</p> <p>A wide range of both more traditional and more innovative services, including face to face consultations with a range of health professionals, and using modern technology especially the internet.</p>		
--	---	--	--

**Table 2: Summary Table of Standards Two, Three, Four, Five- with performance indicators**

National targets cover the reduction in the rate of teenage pregnancy, Chlamydia screening levels, and access to services for sexually transmitted infections. There should be clear pathways and accountability agreements which set out how commissioned services contribute to the achievement of health outcome targets. Outcome indicators taking into account national, regional and local targets include:

<p><b><u>Standard Two*</u></b>: Sexual health services involve users in their design and delivery and regularly measure the experiences of service users</p>	<p><b>INDICATOR</b>: PCT plan to deliver effective patient and public engagement in sexual health services (reviewed and updated annually).</p>
<p><b><u>Standard Three*</u></b>: Commissioners and providers work together to identify innovative approaches to promotion, prevention and care that will increase and improve health and wellbeing outcomes</p>	<p><b>INDICATOR</b>: Commissioners and providers should agree a systematic programme to analyze services against the QIPP elements in 2010-11.</p>
<p><b><u>Standard Four*</u></b>: Commissioners within each of the London sectors will work collaboratively and develop and fund Networks within a consistent London Framework, agreeing standards for quality and productivity across the sector</p>	<p><b>INDICATOR</b>: PCTs to evidence development and funding of networks to deliver clinically and cost effective interventions with high impact on health outcomes.</p>
<p><b><u>Standard Five*</u></b>: Sexual health providers will develop integrated services across primary, community and secondary care using London Sexual Health tariffs to enable equity of access to integrated Sexual Health services. This will be under a Clinical Director providing leadership to the network of service providers, and with particular responsibility for clinical governance and training</p>	<p><b>INDICATOR</b>: PCTs and providers to engage and implement London sexual health tariffs and develop sexual health workforce strategy</p>

\* Further details of these standards as described below

## Standards Two, Three, Four, Five, with Performance Indicators.

### **Standard Two: Sexual health services involve users in their design and delivery and regularly measure the experiences of service users**

Consideration of design and delivery of sexual health services has typically been focused around access and waiting times for appointments, and about the range of services offered and their availability in primary, community and secondary care. The London Sexual Health Programme has commissioned Thames Valley University to scope best practice in patient and public engagement in Sexual Health services. This will be published in 2010 to advise PCTs.

The focus of most studies has been about the sense of stigma or embarrassment experienced by clients, and how this might be overcome. There is some published work on, for example, the benefits of nurse-led drop in sexual health clinics in schools as an effective way of accessing hard to reach groups. There is little evidence that Commissioners or Sexual Health Services have addressed the requirement to deliver a 'patient-led NHS', or to respond to the guidance given in the *Recommendations for Standards in Sexual Health Services* (MedFASH/DH 2005) that commissioners and services:

- Promote active user involvement in the planning and organization of services. Develop their understanding of the various communities they serve
- Recognise and respond to social exclusion, discrimination, and power imbalances (such as those between genders or individuals) in a way that enhances access, and promotes effective use of services
- Ensure all staff involved in sexual health services is committed to non-discriminatory working practices and delivery of care.'

The Review of the National Strategy for Sexual Health and HIV (2008) noted the challenges posed in engaging users of sexual health services, who experience stigma associated with sexual ill-health and whose use of services is often transient. They note that '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. Although users of HIV services have a long tradition of involvement, the ability of individuals with HIV to live healthy and fully functional lives has seemed to result in 'a dwindling of enthusiasm for activities that focus on their illness'. The *Standards for the management of sexually transmitted infections* (BASHH/MedFASH 2010) make recommendations about patient and public engagement, and on collection and reporting of Patient-reported outcome measures.

Sector commissioners and service provider networks should agree a strategy to address the current lack of engagement, starting with simple initiatives such as User Forums. The involvement of Local Involvement Networks (LINKs) may be helpful. Commissioners and Providers should agree on actions to build user engagement routinely into service delivery, with the aim of engaging users throughout the commissioning cycle, including in needs assessment, tender specifications, quality and clinical governance, and contract monitoring and evaluation. As a first stage, they should draw on approaches such as developing and investing in programmes for training and mentoring for service users to contribute to service design and delivery and Conducting service user surveys and 'mystery shopper' exercises

INDICATOR: PCT plan to deliver effective patient and public engagement in sexual health services (reviewed and updated annually).

**Standard Three: Commissioners and providers work together to identify innovative approaches to promotion, prevention and care that will increase and improve health and wellbeing outcomes**

Sexual Health Services are well placed to take advantage of the opportunities for innovation across the spectrum of prevention, promotion and care delivery. Local needs assessment provides the starting position to quantify sexual health status and the consequent demand for services. Sexual health services should assess their capacity based on current delivery arrangements, and commissioners and providers should work together to identify ways of increasing capacity and using capacity more flexibly. Effective prevention and sexual health promotion have an immediate benefit on improved health, reduced service demand and provide savings in year. All forms of contraception reduce the risk of unplanned pregnancy, and the fertility and abortion rate. Using long acting contraceptive methods has a greater impact than the less reliable methods. Early access to investigation and treatment for sexually transmitted infections can reduce the risk of spreading infection more widely, provision of post exposure prophylaxis for HIV exposure reduces the risk of HIV infection, and earlier diagnosis of HIV increases the likelihood that those living with HIV can live full and active lives.

INDICATOR: Commissioners and providers should agree a systematic programme to analyze services against the QIPP elements in 2010-11.

**Standard Four: Commissioners within each of the London sectors will work collaboratively and develop and fund Networks within a consistent London Framework, agreeing standards for quality and productivity across the sector**

Sector and network approaches across London have been in place for several years, but their effectiveness varies. The introduction of the London sectors, initially for acute commissioning, provides an opportunity to align sexual health commissioning within this structure.

The *Sex and Our City* Report 'presents us with a challenging picture of significant variations in sexual health need and inconsistency in the provision of services to meet these across the City' (foreword). The Report shows that 'a lack of consistent use of commissioning best practice, in particular the development, implementation and monitoring of service specifications, would suggest that PCTs within London are not always maximizing value for money in terms of investment and outcomes'. Work in 2010-11 will prioritize areas where there will be more added value from working in sector and London levels. This includes areas of pan-London and or sector procurement.

PCTs should agree formal and robust joint commissioning and strategic leadership arrangements, including clear accountability. The London sectors should form the groupings for Commissioners to work together. Sector PCTs should work with the London Sexual Health Programme to consider what activities should be commissioned at pan-London, sector, PCT and practice based commissioning level. Discussion is already underway to agree pan-London arrangements for commissioning for Chlamydia screening and abortions.

PCTs should commission health promotion and prevention services such as the Pan-London HIV prevention programme, to maximize the potential to promote sexual health, working collaboratively and recognizing that Londoners cross borough boundaries both physically and virtually. Attention should be given to the range of websites funded by PCTs, their ease of access, and opportunities for them to be streamlined.

Priority should be given to commissioning sexual health interventions with the greatest potential for cost effectiveness and impact on health outcomes. These include long acting methods of contraception, Chlamydia screening, HIV testing and prompt access to contraception, GUM and abortion services. NICE guidance has set out the expectation for identification of people at high risk of sexually transmitted infections and repeat abortions and offering one to one behavioural interventions.

Commissioners should work with service providers to review the skills of the workforce and identify urgently the training and workforce development needs. There are many opportunities for efficiency savings and for increased adherence to prevention and treatment with a more highly skilled workforce, for example by increasing the number of people trained to provide long acting methods of contraception. More development of Patient Group Directions and training in their use across London would substantially increase access to care. The potential for skill development and increased service delivery in primary care should be addressed as a priority.

INDICATOR: PCTs to evidence development and funding of networks to deliver clinically and cost effective interventions with high impact on health outcomes.

**Standard Five: Sexual health providers will develop integrated services across primary, community and secondary care using London Sexual Health tariffs to enable equity of access to integrated Sexual Health services. This will be under a Clinical Director providing leadership to the network of service providers, and with particular responsibility for clinical governance and training**

Coordination and integration of sexual health services enhances service quality, user experience and health and wellbeing outcomes. It broadens the opportunities for health promotion, screening and prevention, reduces service duplication, helps to identify training needs and service gaps, improves continuity of care and maximizes the efficient use of resources.

Integration of services under a Clinical Director provides leadership to the range of providers and service tiers across the locality aligning the work to PCT polysystem plans to improve access and bring care closer to home. The Clinical Director role in establishing and monitoring standards for clinical governance is critical, and they should also lead workforce planning, training needs analysis, and ensure the availability of training programmes. Although the role has some similarities to that of Clinical Directors in Acute Services, the complexity of the range of service providers and service settings increases the challenge, and the time commitment will need to be specified and agreed in contract negotiations.

This will be a work priority of the London Sexual Health Programme in 2010-11 jointly with commissioners, providers and sexual Health Networks with a key focus on developing a London Sexual Health workforce strategy.

INDICATOR: PCTs and providers to engage and implement London sexual health tariffs and develop sexual health workforce strategy

## **Appendix 2. London Sexual Health Strategic Framework**

### **Selected References and Supporting Guidance**

Department of Health (2001) Better prevention, better services, better sexual health. The National Strategy for Sexual Health and HIV.

Department of Health (2003) Effective commissioning of sexual health and HIV services: a sexual health and HIV commissioning toolkit for Primary Care Trusts and local authorities.

Department of Health (2005) Recommended quality standards for sexual health training.

Department of Health (2005) You're Welcome quality criteria: Making health services young people friendly.

Department of Health (2007) World Class Commissioning: Competencies.

Department of Health (2007) Sexual health needs assessment (SHNA). A How to guide.

Department of Health (2008) High quality care for all: NHS Next Stage Review final report.

Department of Health (2008) The Operating Framework for 2009/10 for the NHS in England

Department of Health (2009) Moving Forward: Progress and priorities – working together for high-quality sexual health. Government response to the Independent Advisory Group's review of the National Strategy for Sexual Health and HIV

Department for children, schools and families, Department of Health (2009) Healthy lives, brighter futures – The strategy for children and young people's health.

Department for children, schools and families (2004) Enabling Young People to Access Contraception and Sexual Health Information and Advice

Department for children, schools and families (2006) Teenage Pregnancy Next Steps and Accelerating the Strategy Guidance

Department for children, schools and families (2007) Extended Schools: Improving Access to Sexual Health Advice Services

Department for children, schools and families (2007) Improving Access to Sexual Health Services for Young People in Further Education Settings

National Chlamydia Screening Programme: Guidance available at [www.chlamydia-screening.nhs.uk](http://www.chlamydia-screening.nhs.uk)

NHS Quality Improvement Scotland (2008) Standards – Sexual Health Services.

NHS London (2004) London Sexual Health Strategic Framework

NHS London (2007) A Framework for Action

Association of Chief Police Officers (ACPO) (2009) Sexual Assault Referral Centres, Getting Started

British Association for Sexual Health and HIV (BASHH), Medical Foundation for AIDS and Sexual Health (MedFASH) (2009) Standards for the management of sexually transmitted infections (STIs), Draft for consultation August 2009

British HIV Association, Royal College of Physicians, British Association for Sexual Health and HIV and British Infection Society (2007) Standards for HIV Clinical Care

Faculty of Family Planning and Reproductive Healthcare (2006) Service Standards for Sexual Health Services

Independent Advisory Group on Sexual Health and HIV (2009) The Time is Now, Achieving World Class Contraceptive and Abortion Services

Medical Foundation for AIDS and Sexual Health (MedFASH), for the Independent Advisory Group on Sexual Health and HIV (2008) Progress and priorities – working together for high quality sexual health, Review of the National Strategy for Sexual Health and HIV.

Medical Foundation for AIDS and Sexual Health (MedFASH), (2005) Recommended standards for sexual health services.

Teenage Pregnancy Independent Advisory Group (2009) Contraception and Sexual Health Services for Young People

## Appendix 3

### **3.1 Healthcare for London: A Framework for Action (2007)**

Published by Healthcare for London and led by Lord Darzi, it repeats and endorses the approach set out in the 2004 London Sexual Health Strategic Framework. These principles provide a guiding framework on which commissioning and service development should continue to be based. Namely:

*There should be a focus on redesigning services, for both prevention and treatment, to tackle the rising rates of sexually transmitted infections, based on:*

- *increasing the use of contraception;*
- *providing services around sexual healthcare pathways, including services for contraception and abortion, particularly for young people;*
- *improved sexually transmitted infection and genito-urinary medicine (GUM) services, addressing Chlamydia screening and HIV/AIDS. ;*
- *improving service access, for example, through seven-day-a-week access to GUM through London-wide rotation of opening times, and greater use of*

*outreach services for at-risk populations, such as sex workers and young people;*

- *increasing the availability and accessibility of information on sexual health and sexual health services. Messages need to be tailored and taken out to young people and at-risk groups. Information should be supplied in multiple locations such as community pharmacies, health centres, schools (PCTs should be supporting sexual health programmes in their local schools) and further education institutions. There also needs to be more imaginative ways of giving information, for example, on-line through the use of internet sites that are popular with young people*

### **3.2 NHS Next Stage Review: High Quality Care for All (2008)**

Lord Darzi's Report specifically included improving sexual health as one of the key goals for prevention. It requires every Primary Care Trust to work with partners to commission comprehensive wellbeing and prevention services, with services customized to meet the specific needs of their local populations.

### **3.4 World Class Commissioning**

The eleven world class commissioning competencies have strong relevance for sexual health services.

### **3.5 NHS Operating Framework**

The NHS Operating Framework guidance for 2010-11 prioritises Sexual Health with a focus on prevention and targets for Chlamydia screening, reducing teenage conceptions with increased uptake of contraception in particular long acting reversible contraception and maintaining the 48hr GUM access. Sexual Health services are strongly aligned with the Quality, Innovation, Productivity and Prevention agenda (QIPP) bringing together the criticality of access to quality services, with prevention of ill health and service innovation. Sexual and Reproductive Health care both treats and prevents poor sexual health, including reducing the onward transmission of sexually transmitted infections and the numbers of unplanned pregnancies and abortions.

### **3.6 Recent Guidance specific to Sexual Health**

Recent national guidance on Sexual Health is listed below and cited in Appendix 2.

- 3.6.1 The Review of the National and Sexual Health and HIV Strategy (2008) outlined the need for strengthened commissioning at Local, Regional and National levels. It asks for accelerated tariff development and use, integration of services across sexually transmitted infections and Sexual and Reproductive Health, enhancing the role of Sexual Health Networks and a strengthened focus for Prevention.

- 3.6.2 The formal DH response to the Review (2009) gives examples of work at local, Regional and National levels and ongoing work to develop a Commissioning Framework for Sexual Health using the World Class Commissioning competencies.
- 3.6.3 A national Prevention Framework is also being commissioned as are pilots to reduce undiagnosed HIV.
- 3.6.4 A revised National Service Guide - a resource for developing Sexual Assault Adult Referral Centres (SARC), (2009) has been issued jointly by the Home Office, Association of Chief Police Officers and DH. It outlines minimum elements of provision that are needed to operate as a SARC.
- 3.6.5 The British Association of Sexual Health and HIV (BASHH) and the Faculty of Sexual and Reproductive Health (SRH) have professional standards for delivery of STI and SRH services. The BASHH standards will be launched in early 2010.
- 3.6.6 The National Sexual Health and HIV, and Reducing Teenage Pregnancy strategies are due to end in 2010. DH and DCSF are having discussions about the strategic direction post-2010.