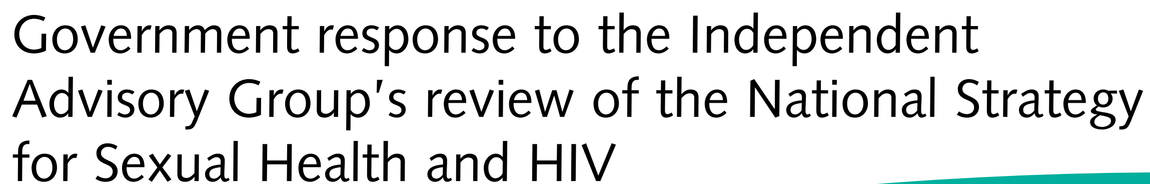
Department of Health

# 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 of Health

# 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

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# Ministerial foreword

Good sexual health is an important aspect of health and well-being and it is vital that people have the information, confidence and the means to make choices that are right for them. It helps people to develop positive relationships and enables them to protect themselves and their partners from infections and unintended pregnancy.

The Government published the first ever national strategy for sexual health and HIV in 2001, *Better prevention, Better services, Better sexual health: The national strategy for sexual health and HIV*, in recognition of the need to ensure that services are available that meet people's needs and to address rising levels of sexually transmitted infections (STIs) and unintended pregnancies. This groundbreaking approach set out to transform and modernise sexual health services in England and reduce STIs, HIV and unintended pregnancies.

Over the last eight years, a huge amount of work has gone into implementing this ambitious programme of work within government and across all levels of the NHS. We highlight some of the key achievements in the following pages. The Government's continuing commitment to improving sexual health was underlined in *High Quality Care for All*, which was published in 2008. It identified sexual health as being one of the six priority areas for primary care trusts to commission comprehensive well-being and prevention services to meet the needs of their local population.

The work that has been undertaken to date to implement the sexual health and HIV strategy has had a real impact on the lives of many people. They are now able to access clinics more quickly, and the range of services they receive has greatly improved. We need to make sure that these improvements are sustained and embedded to ensure that swifter progress is made and that rates of STIs and unintended pregnancies are reduced.

It is important to review progress and examine what more needs to be done, so we commissioned the Independent Advisory Group (IAG) for Sexual Health and HIV to review the implementation of the strategy. The IAG is to be congratulated on the high-quality and comprehensive report they produced in July 2008. The Government's response highlights how the Government will implement the national level recommendations over the next two years.

The current ten-year sexual health strategy ends in 2011. It is vital that we start shaping what we can do to further improve sexual health. At the beginning of 2010, I look forward to bringing together all the main players who can help us to make even more of a positive difference to people's lives.

Gillian Merron MP
Minister of State for Public Health

# 1. Introduction

## 1.1 The sexual health strategy

1. The first ever holistic strategy for sexual health, *Better prevention, better services, better sexual health – The national strategy for sexual health and HIV*, was published in July 2001. Following consultation, a detailed implementation action plan was published in the following year. A huge amount of work has been undertaken to take forward these actions as highlighted in Appendix 2 of *Progress and priorities – working together for high quality sexual health*.

## 1.2 Priority and targets for sexual health

2. Since the strategy was published, sexual health has been identified as a priority area for action in the NHS. Targets and indictors include the following:

   - A 50% reduction in the under-18 conception rate (births and abortions) by 2010 (from the 1998 baseline rate). This is one of five lead indicators used to measure progress on the Public Service Agreement increase the number of children and young people on the path to success (PSA14).
   - The NHS Operating Frameworks for 2008/09 and 2009/10 include a tier two Vital Signs indicator for reducing the prevalence of chlamydia. The target includes screening the following proportions of 15–24-year-olds for chlamydia: 17% in 2008/09, 25% in 2009/10 and 35% in 2010/11.
   - The 48-hour genito-urinary medicine (GUM) access target is included in the Operating Framework for 2009/10 as a standard to be maintained.

3. National Support Teams (NSTs) for sexual health, teenage pregnancy and response to sexual violence are continuing to support the most challenged primary care trusts (PCTs), especially on the chlamydia screening target, teenage pregnancy and contraception.

## 1.3 The strategy review and recommendations

4. In 2007, the Government commissioned the Independent Advisory Group (IAG) to undertake a review of progress in implementing the 2001 sexual health and HIV strategy.

5. The aim of the strategy review was to review the impact of the sexual health and HIV strategy, highlighting developments since publication and making recommendations for the future. In particular, the strategy review was commissioned to consider the following areas:
   - policy changes (for example, strengthened commissioning, health reform, shifting the balance of power)
   - structural changes (for example, devolution of decision making, NHS configuration)
   - service delivery changes (for example, plurality of service delivery, integration of services)
   - clinical changes (for example, development of the role of nurses and pharmacists, treatment practices).

6. The IAG subsequently commissioned the Medical Foundation for AIDS and Sexual Health (MedFASH) to work with them in developing the strategy review. Their comprehensive report entitled *Progress and priorities – working together for high quality sexual health* was published in July 2008. The report was welcomed by the Government, which noted that it provided a detailed and wide-ranging analysis of what has been achieved to date and what still needs to be done to make sure that people have the information and services that meet current and future needs.

7. The report highlights priority action in five key areas:
   - prioritising sexual health as a key public health issue and sustaining high-level leadership at local, regional and national level
   - building strategic partnerships
   - commissioning for improved sexual health
   - investing more in prevention
   - delivering modern sexual health services.

8. The report contains 70 cross-cutting recommendations for national (26 recommendations), regional (12 recommendations) and local

(32 recommendations) level action. The report recognises the progress that has been made in implementing the strategy to date but also highlights many of the challenges that have been faced in both changing sexual behaviour and improving service provision across all areas of sexual health. This response focuses on the recommendations made at national level. It is for strategic health authorities (SHAs) and PCTs to consider the implementation of the regional and local level recommendations, on a voluntary basis.

9. However, to support implementation at a regional level, the Department of Health (DH) worked with Keith Wilson at the Government Office for Yorkshire and The Humber to undertake a review of co-ordination of the various roles managing sexual health and teenage pregnancy at regional level. This review came up with a number of useful findings and we are working with regional colleagues to take forward implementation. In particular, we are working with South West SHA to pilot bringing together all staff working in different organisations (the SHA, Government Offices and Health Protection Agency (HPA)) into one team and under one manager to strengthen regional co-ordination and delivery. This work and emerging outcomes will be shared with other regional colleagues.

10. It should be highlighted that sexual health is a very broad area, which affects and impacts upon most of the population. While the original strategy was ambitious and set out a challenging programme of work to improve the sexual health of the population, those at highest risk of poor sexual health are often from specific population groups with varying needs. These groups include: young people; men who have sex with men (MSM); people from African communities; people living with HIV; sex workers; victims of trafficking; victims of sexual and domestic violence and abuse; and other marginalised or vulnerable groups. As recognised in *Progress and priorities*, it has been necessary to prioritise some of these groups in order to make progress and achieve results.

## 1.4 The future of sexual health

11. The current strategy ends in 2011 and consideration is already being given to what further action will be needed to continue to make improvements to sexual health. The outputs from the sexual health conference to be held early next year will form the basis for the Government's consideration as to the next steps.

# 2. Achievements since 2001

## 2.1 Sexually transmitted infections and HIV

12. We recognise that, overall, the number of sexually transmitted infections (STIs) has continued to increase since the strategy was published. However, the reasons for this are complex. We have seen major improvements in access to GUM services, alongside significant increases in capacity (there was a 28% increase in attendances in 2007/08 and a 14% increase in 2008/09). We are also seeing more people coming forward for screening than ever before; in England there was a 16% increase in the number of people screened for STIs in 2007. In 2006, 38% of those screened tested positive for an STI; in 2007, this reduced to 35%.

13. This means that more people are being tested and therefore having infections detected. It also means that more people than ever before are getting the information, tests and advice they need. Rapid treatment and detection cuts the risk of transmitting STIs. If this increased access is maintained, we believe it could have a significant impact on the control of STIs in the coming years. However, there is no room for complacency and the overall increase in infections again highlights the need, identified in the strategy, to continue to take urgent action to tackle STIs.

14. Since publication of the 2001 strategy, life expectancy and HIV treatment regimens continue to improve, and for many HIV is increasingly seen as a manageable long-term condition. We have also seen an increase in community-based HIV testing services, and increased uptake of voluntary HIV testing in both MSM and heterosexuals. However, although more HIV testing is taking place, around a quarter of people with HIV are unaware they have HIV. Increasing the offer and uptake of HIV testing and improving its detection in non-HIV specialist settings remains a priority.

15. Following publication of *Health Inequalities: Progress and Next Steps* in 2008, we are funding eight new projects, both within and outside London, aimed at piloting new approaches to HIV testing in a range of health and community-based settings. DH has committed to reducing the level of undiagnosed HIV by offering HIV testing outside traditional GUM settings, including community and primary care settings. DH has allocated £750,000

for this work in 2008/09, and the projects will be evaluated to see whether further work is needed.

16. We have sustained and increased our investment to £2.9m a year in our targeted HIV health promotion programmes for MSM and African communities, managed by the Terrence Higgins Trust and the African HIV Policy Network respectively. The Terrence Higgins Trust, through the CHAPS partnership, designs and delivers information, campaign and other materials specifically targeting MSM. The African HIV Policy Network, through the National African HIV Prevention Programme, develops and disseminates information and materials on HIV prevention, targeting people from African communities living in England.

17. To help those who are living with HIV, the AIDS Support Grant, provided to local authorities to support their HIV social care packages, has increased following the 2007 Comprehensive Spending Review from £16.5m in 2001/02 to £21.8m in 2009/10 and £25.5m in 2010/11.

18. We recognise that actual or perceived stigma and discrimination can have a detrimental effect on uptake of testing and other services. In May 2007, DH published *Tackling HIV stigma and discrimination*, setting out the action DH and other government departments are taking to reduce HIV-related stigma. This included funding for the National AIDS Trust, NAM Publications and MedFASH to deliver on priorities for action identified by the DH consultation. All of these projects have now been completed.

19. We have also funded work through the African HIV Policy Network to produce two linked toolkits to help Christian and Muslim faith leaders to address issues of stigma around HIV within their communities. Research has shown that the majority of Africans living in the UK are adherents of either the Christian or Muslim faiths, and that support from their faith leaders and communities is an important factor in combating the stigma they still suffer around HIV. These toolkits were launched in June 2009.

20. Since 1997 broader government action, including the legislative and policy developments on equalities, will have helped to address HIV-related stigma and create a social environment that is supportive of HIV health promotion. Examples include the repeal of Section 28, the equalisation of the age of consent, the introduction of civil partnerships and the amendments to the Disability Discrimination Act 2005, which now covers HIV from the point of diagnosis (rather than from the onset of AIDS).

## 2.2 Access to genito-urinary medicine

21. There has been considerable investment in and focus on supporting improvements to GUM clinics since the strategy was published. This includes investment to improve the quality of the buildings in which services are provided. *Progress and priorities* acknowledges that there have been vastly improved waiting times for GUM, and that DH should continue to build on this success and move forward with offering local services that meet the needs of the community. We are keen to improve access to sexual healthcare services by offering people more convenient options for getting screening and testing, including in non-healthcare community settings to relieve the burden on traditional more specialist services.

22. Between 2005/06 and 2007/08 there was a national Local Delivery Plan target that, by March 2008, all first attendees at GUM clinics should be offered an appointment to be seen within 48 hours of contacting the service. In March 2008 this target was delivered, with:
    - 99% of patients offered an appointment to be seen within 48 hours
    - 86% of patients seen within 48 hours.

23. The latest data shows that the target, on the whole, is being sustained (99.8% offered appointments and 87.8% seen within 48 hours in March 2009). As an existing standard, GUM access was, and continues to be, a Care Quality Commission indicator for both PCTs and acute trusts. Now that the target has been delivered, an 'operational standard' has been agreed of 98% of patients to be offered an appointment within 48 hours. This tolerance of 98% allows services a small amount of legitimate flexibility, while maintaining a challenging target. The sexual health NST continues to support areas in maintaining and improving access, while the DH Performance Delivery Team is continuing to performance manage organisations against these operating standards.

24. In addition, since April 2007 we have been using a new monitoring system to assess progress towards the target, with data collected directly from clinics on a monthly basis. This dataset, called the genito-urinary medicine access monthly monitoring (GUMAMM), can be used to monitor and assure equality of access on the basis of ethnicity, gender and age, patient choice and the patient's perspective on waiting times.

## 2.3 National Chlamydia Screening Programme

25. Genital chlamydia infection is the most commonly diagnosed STI among young people attending GUM clinics in England, accounting for 65% of all cases. Young people (aged between 16 and 24) represent only 12% of the population but account for nearly half of all people with STIs.

26. In 2003, the Government introduced the National Chlamydia Screening Programme (NCSP), and every PCT in England is now offering screening as part of the programme. Opportunistic screening is offered to all sexually active women and men, aged under 25 years, in a variety of health and non-healthcare settings, such as youth services, prisons and military bases. This opportunistic approach has been found to be effective in reaching those at highest risk.

27. The data for 2008/09 shows that PCTs have made significant progress since last year, with 15.9% of the target population tested. Since the programme was launched in 2003, we have seen the following:

    - Nearly 1.5 million (1,462,637) tests have been performed by the NCSP between 2003 and the end of March 2009, increasing from just over 17,000 in 2003/04 to nearly 760,000 (759,027) in 2008/09.
    - We have seen a positivity rate of 8.8% among screened women and 7.4% in screened men since the programme began. The highest positivity levels were found in women aged 16–19, men aged 20–24, those reporting behavioural risk factors and certain ethnic groups.
    - Those screened were mostly of white ethnicity (67%) and female (71%). The proportion of screens in men has increased year on year (7% in year 1; 33% in year 6).
    - Screening is occurring in an increasingly diverse range of settings, with the majority in community contraceptive and sexual health services (33%), general practice (15%) and educational settings (11%).

28. The NCSP gives immediate benefit to everyone who takes part and means that we are able to stop chlamydia in its tracks. Chlamydia can lead to problems that include infertility in women and can be carried unknowingly by men as well as women. By detecting it earlier we are making a real and measurable difference to the lives of young people. The rate of screening of young people is a major achievement and it is essential to continue to make progress and increase screening volumes so that we can consider moving to a more outcome-focused indicator on reducing chlamydia prevalence.

29. A review of the delivery of the programme has recently been completed by Dr Ruth Hussey, Regional Director of Public Health for NHS North West. We are now implementing the findings from the review.

30. With the programme now established and showing the ability to screen at increased levels, during 2009/10 DH will be introducing a public campaign encouraging young people to accept chlamydia screening when offered.

## 2.4 Public sexual health campaign

31. In November 2006 we launched the Condom Essential Wear campaign, which aims to normalise condom use among 18–24 year olds in order to protect against STIs. The campaign tracking has indicated very high levels of campaign awareness and message clarity. It has also indicated increased awareness of the need for condom usage during casual sex, and for protection against STIs. The tracking has also noted indications of increased condom usage, particularly among those aged 25 to 34 years, with a significant proportion attributing this directly to media influence. This dovetails with the public campaign work (*RUThinking?* and *Want respect? Use a condom*) undertaken by the Department for Children, Schools and Families (DCSF) and provides a continuous messaging programme for all age groups – from under 16 to adulthood.

32. Following the announcement of new money for contraception services, the campaign strategy has been reconsidered to incorporate not only condom normalisation and contraception but also support to the NCSP, now that screening levels have increased significantly. This review is looking at how messages that the target audience see as contradictory can be successfully combined. The new communication strategy will come into effect in late 2009. We anticipate that this will continue the progress made thus far by the previous sexual health and teenage pregnancy campaigns in reshaping the presentation of sex and relationships across society.

33. In addition, following demand identified by the NSTs, regional social marketing posts have been funded in each SHA area. Their role has been to support areas in developing social marketing strategies that effectively target those most at risk.

## 2.5 Contraception

34. As the IAG's report highlights, improving contraceptive services is key to delivering the strategy's aim of reducing unintended pregnancies. We are now implementing a comprehensive programme of work to support accelerated delivery in this area.

35. In February 2008 we announced an extra £26.8m investment for 2008/09 to improve women's access to contraception and help to reduce the number of teenage pregnancies.

36. Of this, £12.8m was allocated to PCTs in their main allocations. DH wrote to PCTs in June 2008, via the NHS publication *The week,* to note that the allocations included £12.8m to improve contraceptive services. PCT general allocations were further uplifted by 5.5% in 2009/10.

37. In 2008/09 £10m of this funding was allocated to SHAs, with a further £10m in 2009/10, to be used innovatively in those areas with high levels of teenage pregnancy and repeat abortion rates. Both the teenage pregnancy and sexual health NSTs have been assisting commissioners in how best to target these additional resources. We are aware that a number of excellent projects have already been funded using these additional funds, and we fully expect that these projects will help to build improved and sustainable contraceptive services in the future. It is particularly encouraging to see that many projects focus on the provision of long-acting reversible contraceptives (LARC), which have a higher rate of efficacy than other contraceptives such as the pill.

38. £2m was also allocated to develop contraceptive services in further education (FE) colleges. In 2009/10, the money is being used as follows:

    - £1.6m has been allocated to SHAs for them to support improvements in local sexual health services for young people in FE.
    - £0.4m will be used for initiatives that directly support the FE sector, including a focus on staff training, sexual health services for those with learning difficulties and improvements in STI screening.

39. A programme to support consistent implementation of You're Welcome has been put into place across the nine regions working through the Government Offices. At the end of March 2009, 68% of PCT areas had signed up to implement You're Welcome and work to its national priorities for 2009/10. These include general practice, health services in education settings, contraception and sexual health services and abortion service providers.

40. Ensuring that people receive accurate information about contraception is a key priority. Section 3.4 gives details of the contraception element of DH's forthcoming sexual health campaign. In addition, from 1 April 2009 GPs were incentivised through the Quality and Outcomes Framework (QOF) to give their patients improved advice on contraception, particularly on long-acting reversible methods of contraception.

## 2.6 Teenage pregnancy

41. Despite a small (2.6%) increase in the under-18 conception rate between 2006 and 2007, the 2007 rate is still 10.7% lower than it was in 1998 – the baseline year for the teenage pregnancy strategy. Within the overall reduction in under-18 conceptions, teenage births have fallen by almost a quarter, whereas teenage abortions have increased by 6.5%.

42. Progress across the country is mixed. While a fifth of local areas have achieved under-18 conception rate reductions of over 20% (twice the national average), a similar proportion of local areas have rates that are static or increasing. Additional support has been provided to areas with high and increasing rates, through Government Offices and the NST for teenage pregnancy.

43. The additional funding to improve access to contraception referred to in Section 3.5 is, in part, being used to develop contraceptive and sexual health services in places that young people can access easily, such as schools and FE colleges. A mapping survey conducted in 2007 by the Sex Education Forum shows that around three-quarters of colleges and 30% of secondary schools now provide some level of contraceptive and sexual health (CASH) provision – in some cases offering a broad CASH service providing advice, condoms, emergency contraception, pregnancy testing, STI screening and a range of contraception options, including LARC.

44. The Government's decision to make personal, social and health education (PSHE) statutory in all key stages, including sex and relationships education (SRE), will ensure that young people receive a more comprehensive SRE programme and a more consistent offer across all schools.

## 2.7 Abortion

45. The latest data for 2008 shows that we have made excellent progress in improving access to abortion services, with more abortions being performed at earlier stages in pregnancy than ever before: 90% of all abortions in 2008

were carried out at under 13 weeks and 73% at under ten weeks. What is more, an ever-increasing number were funded by the NHS: 91% in 2008 compared with 78% in 2002.

46. Many areas have made changes to their services to help reduce barriers to access, and this is reflected in the number of women able to have their abortions earlier. This shift has also allowed women more choice of the method of abortion: 38% of all abortions in 2008 were early-medical abortions, and this number continues to rise. That is why we are progressing our work to develop a protocol to allow the provision of early medical abortion in a community medical setting.

47. The need to link contraceptive and abortion services with a clear and short patient pathway is regarded as good clinical practice, and will be stressed in the good practice guidance for the commissioning and provision of contraceptive and abortion services that will be published later this year.

48. We have also taken steps to tackle repeat abortions by ensuring that, from 1 April 2009, the national contract for the provisions on NHS abortions includes a requirement for providers to supply women with post-abortion contraception and advice. DH is working with stakeholders to develop a standard service specification that will improve the delivery of abortion services (including contraception) and will reduce unacceptable local variations in the standard of service provided. This framework will be ready for use from April 2010.

## 2.8 Conclusion

49. These are just some of the actions that we have taken since the first sexual health strategy was published in 2001. The recommendations that the IAG has produced will further help and support progress towards achieving the strategy's aims.

50. In the following section we provide a more detailed response to the review's national recommendations and how we are taking forward implementation.

# 3. Response to national-level recommendations

Note: page numbers following the recommendations relate to the IAG's report, *Progress and priorities – working together for high quality sexual health*.

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

**Provide strong and effective leadership for sexual health and maintain it as a priority public health issue across government. (p50)**

**Adopt a more integrated, cross-governmental approach that 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. (p52 – under priority for action 2 – Build strategic partnerships).**

51. As already highlighted, the Government remains committed to improving sexual health and providing strong and effective leadership in this area. As well as setting national targets and indicators this commitment is demonstrated by inclusion of sexual health in *High Quality Care for All*. Sexual health and teenage pregnancy indicators feature in the National Indicator set. Teenage pregnancy is the second most popular indicator (chosen by 106 local areas) in the National Indicator set and is the fifth most popular indicator chosen by PCTs in terms of their commissioning priorities. This highlights the level of commitment at local level to making progress.

52. DH is currently taking forward a piece of work, as part of the delivery of *High Quality Care for All* to strengthen and link all aspects of the prevention agenda, including sexual health. While this work is at an early stage at present, we expect that the agenda it sets will allow strong links between practitioners at local level to be forged or re-forged, and that local people will benefit from this new approach.

53. To ensure that all the work we are undertaking to implement the strategy supports DH's duties towards equality, we are currently producing an equality impact assessment for sexual health work at the national level.

54. Governance for monitoring progress on sexual health and teenage pregnancy is through senior level boards within DH (Performance Committee) and DCSF (Youth Board). The Youth Board is responsible for ensuring delivery of the Government's youth PSA, 'to increase the number of children and young people on the path to success'. In doing so the Board:

- prioritises the strands and projects
- ensures that delivery plans for the strands and projects within the programme are developed, owned and implemented
- provides direction regarding issues/risks that are escalated and in turn escalate any issues to the Permanent Secretary's Group
- ensures that any strands and projects are appropriately resourced
- ensures that the appropriate links are made within the programme, with other PSAs and other government departments so that the programme continues to work effectively across government.

55. Departments with representation on the Youth Board include DCSF, DH, Cabinet Office, HM Treasury, including the Prime Minister's Delivery Unit, Ministry of Justice, Home Office, Department for Work and Pensions, Communities and Local Government, Department for Culture, Media and Sport and Department for Business, Innovation and Skills.

56. Other initiatives from within DH and other government departments that impact positively on sexual health, include the following.

## You're Welcome

57. A programme to support the consistent implementation of You're Welcome has been put into place across the nine regions working through the Government Offices. The funding has contributed to the delivery of:

- the first wave of services to be awarded the You're Welcome quality mark. Over half were contraceptive service providers plus one GP and an abortion service provider
- regional events showcasing You're Welcome application in all nine Government Office areas

- You're Welcome within GUM services, in consultation with the British Association for Sexual Health and HIV (BASHH).

58. At the end of March 2009, 68% of PCT areas had signed up to implement You're Welcome and work to the national priorities for You're Welcome 2009/10. These include general practice, health services in education settings, contraception and sexual health services and abortion service providers.

59. The inclusion of sexual health in Lord Darzi's *High Quality Care for All* was a clear call to action for senior leaders in the NHS, who have now produced plans to ensure that sexual health remains a top local priority.

60. On teenage pregnancy in particular, Ministers and other senior leaders work closely with areas facing the greatest challenges to help them to improve their performance, and DH plans to undertake further management support for NHS organisations.

## Cross-departmental work on HIV

61. DH works with other government departments and agencies to ensure issues relating to HIV are addressed. Examples include working with the Crown Prosecution Service, the Ministry of Justice and voluntary sector partners on the Crown Prosecution Service's policy statement and guidance to prosecutors on the intentional or reckless sexual transmission of infection, and working with the UK Border Agency on migrants with HIV.

62. DH also works with the Department for International Development, supporting them in implementing *Achieving Universal Access – the UK's Strategy for halting and reversing the spread of HIV in the developing world*. DH also participates in the European Commission's AIDS think tank, which that has provided opportunities to share with others our good practice on national HIV health promotion programmes for MSM and African communities.

## e-Learning for Healthcare

63. The DH e-Learning for Healthcare programme develops and delivers nationally quality assured e-learning material to support the professional and generic workforce's learning and development, and to improve multi-disciplinary team working.

64. e-Learning for Healthcare is currently working with the Faculty of Sexual and Reproductive Healthcare (FSRH) to develop materials which will allow the FSRH to offer some elements of its Diploma and Letters of Competence in Subdermal Implants and Intrauterine Contraceptives online. The comprehensive curriculum currently under development includes:

- contraception
- sexually transmitted infections
- planning a family
- early pregnancy assessment including referral for abortion
- recognising psychosexual problems
- providing care for young people
- the law relating to confidentiality, to sexual activity and to young people.

65. It is hoped that all of the modules will be available from January 2010.

66. e-Learning for Healthcare, BASHH and the Royal Colleges of Physicians are working together on a project for specialist training in sexual health and HIV. This project will deliver a comprehensive e-learning programme comprising all the knowledge components of the UK sexual health and HIV specialist medical training curriculum. The programme will be delivered in three levels (introductory, advanced and specialist), and will consist of approximately 200 e-learning sessions, each around 20 minutes in length. The training package is designed to provide the knowledge framework, which can then be supplemented by training in clinical settings. It is anticipated that doctors will be able to register for e-learning in sexual health and HIV during the academic year 2009/10.

## Cross-departmental work on sexual violence

67. DH is working closely with the Home Office to ensure delivery of a high quality and holistic service for victims of sexual violence, whatever their age, gender or social circumstance, including sex workers and those who are victims of trafficking. Victims should receive the help and support they need quickly in order to overcome the physical, sexual and mental health impacts. They should be safe and be able to access high-quality care and support – no matter where they live.

68. DH has recently established an NST on the response to sexual violence, with funding of £1.4m. Working with the Home Office, its role is to deliver on

the Home Secretary's commitment that each police force area should have a sexual assault referral centre (SARC) by 2011. The team works locally to bring together experts from the health service (including sexual health, children and young people, mental health, primary care and emergency medicine), SARCs, forensic services, the Crown Prosecution Service, the third sector and the police to advise on developing local service provision for victims of sexual violence.

69. As part of the current cross-government violence against women and girls strategy consultation, a health taskforce has been established to identify the role and the response of health services in preventing, identifying and supporting women and girls who are victims of violence and abuse, and to make recommendations on what more could be done to meet their physical, sexual and mental health needs.

## Links between alcohol and sexual health

70. Work has started to look at how the Government can better support research, interventions and prevention for sexual health and alcohol misuse in young people to reduce risk-taking behaviour. It will also consider the role of alcohol in sexual violence and abuse and the resulting impact on the victim's sexual health. A consultation meeting with researchers, academics and public health professionals took place on 5 May 2009. Work to implement the findings from the workshop will take place over the next year.

71. All of this activity demonstrates that cross-government working on sexual health is in place. Work has already started to map sexual health to other government priorities and this will be published by the end of the year.

**Case study: The Bridge Sexual Assault Referral Centre**

The Bridge SARC is located on the second floor of Bristol's Sexual Health Service. This location allows users of the SARC direct access to specialist sexual health services. Facilities available in the building include a contraceptive advice service, a pregnancy advice service, a sexual health screening service and HIV Post Exposure Prophylaxis after Sexual Exposure provision. Sexual health advisors, psychosexual counsellors and specialised GUM doctors are also available on site. The sexual health facility also offers a drop-in facility that generates referrals to The Bridge where victims are able to be seen immediately and can discuss the options that are available to them.

The pathways between all of the services allows for direct access to any of them and an information sharing policy ensures that all the victim's needs are met quickly and sensitively. Sexual Health services are an intrinsic part of the victim's care plans and contribute to the high standards of care that all of them receive.

There is also the capacity to hold case conferences and become part of shared learning. Regular teaching sessions and group meetings are also available to The Bridge staff, contributing to their learning and development, which is of clear benefit to victims.

**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/Government Offices, as appropriate. (p50)**

72. DH supports this recommendation and implementation has already commenced. In July 2008, the South West Public Health Observatory was commissioned to develop a balanced scorecard for sexual health.

73. This scorecard will be a voluntary aid that could be used to support the development and performance management of sexual health. It will be a source of information for public health, sexual health commissioning and performance management. It will act as a tool to enable service providers and commissioners to run reports, view and compare the latest data in a variety of formats, including PCT-level maps, tables and graphs. Some of these reports will be open access while others will have access restricted to service providers and commissioners. Composite sexual health indices that will enable rapid local assessments of sexual health are also in development.

74. The first phase of the scorecard will be available from the end of August 2009. It will focus on young people and the indicators recommended by the IAG in their review and will allow for the monitoring of the following:

    - proxy indicators of the joint DH/DCSF PSA target on teenage conceptions
    - outcomes of the deployment of contraception monies to SHAs.

**Strengthen national support to local services by extending the role of the NST to other areas of sexual health service provision (e.g. contraceptive and abortion services). (p50)**

75. The DH NST for sexual health has proven to be very beneficial in securing partnerships with PCTs and sustaining access to GUM services. However, the sexual health NST's visits in the past three years have also addressed broader issues and routinely include strategic planning and commissioning of a broad range of sexual health services, which includes chlamydia, contraception and abortion services. The intention has been to ensure that local sexual health epidemiological evidence is used by public health workers to inform commissioning intentions in line with the sexual health strategy.

76. In addition, the teenage pregnancy NST advises on contraception and sexual health services and abortion, both in terms of commissioning and service provision. Although the focus of their work is on young people, the whole range of sexual health services is considered.

77. Feedback from PCTs and sexual health services demonstrates that NST input is valued. Over the past 12 months the NSTs have taken on a remit to assist PCTs to deliver on chlamydia screening. In addition, they are supporting SHAs and PCTs to improve access to LARC. However, there remains scope for developing and refining this remit further and the sexual health NST will continue to use this approach to support delivery of the strategy over the next few years. In future, this will take into account progress against the balanced scorecard, as described above.

78. DH is determined to deliver a high quality and holistic service for all victims of sexual assault, which is why it has recently established a response to sexual violence NST. Working with the Home Office, its role is to deliver on the Home Secretary's commitment that each police force area should have a SARC by 2011 (see paragraph 68).

**Use the NST to share learning and disseminate good practice (e.g. develop the *10 High Impact Changes* publication approach taken for GUM 48-hour access, extending to chlamydia screening and contraceptive services). (p51)**

79. We agree that the NSTs for sexual health, teenage pregnancy and the response to sexual violence have a key role to play in sharing and disseminating good practice. Over the past three years, NSTs have developed and commissioned guides such as the *10 High Impact Changes: For Genitourinary Medicine 48-hour access* (2006); *Sexual Health Needs Assessment – a how to Guide (2007)*; *Genitourinary Medicine 48-hour Access: Getting to target and staying there (2008)*; *Quick wins and sustainable services: Hitting the target without missing the point. Commissioning chlamydia screening* (HPA 2008) and work is under way on further guidance.

80. In their work with individual PCTs, the NSTs undertake initial diagnostic assessments that help to identify both strengths and challenges. The NST then makes specific recommendations for improving commissioning and delivery systems. Follow-up support provides customised interventions to improve and sustain performance, such as a stakeholder workshop to develop and expand local chlamydia screening activity.

81. In addition, the NSTs regularly share good practice at local, regional, and national conferences. This work will continue and the NSTs will work to develop a database of good practice to be shared with the local areas.

82. The NST works closely with the NCSP team at the HPA who have an important role to play in disseminating good and emerging practice in delivering chlamydia screening. The NCSP encourages PCTs to evaluate new initiatives and to share learning. The NCSP is also commissioned to continue to develop relevant practice guidance, which is informed by evidence and local experience.

83. In addition to the NSTs, the DH sexual health policy team now includes a dedicated post working with SHAs to provide support, advice and guidance on effective use of the funding that has been allocated to them to work with PCTs in improving access to contraception. This intensive, 'hands-on' support has been welcomed by SHAs and should help to ensure that the projects initiated with these time-limited funds are sustained into the future.

**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. (p51)**

**Review the research funded by the DH/Medical Research Council Sexual Health and HIV Research Strategy Committee and through other funding streams (e.g. National Prevention Research Initiative), to identify continuing evidence gaps and establish effective mechanisms to foster evidence building and knowledge transfer. (p51)**

**Establish a central register of research and good practice not published elsewhere, with inclusion subject to selection criteria and peer review. (p51)**

**Build infrastructure and training to support independent clinical research in sexual health, particularly in areas where it is currently weak, notably contraception. (p51)**

84. We are pleased that the report recognises there is now a much improved evidence base in the UK for sexual health, but we recognise that more can be done.

85. We will give consideration to how we can work with others to enable strategic overview and planning of sexual health research – taking into account existing structures, partnerships and joint planning mechanisms.

86. DH will always consider funding good-quality research that supports our sexual health and HIV priorities. DH funds research and development through two main routes:

    - The National Institute for Health Research (NIHR) is a virtual institute specifically designed to deliver the Government's research strategy *Best Research for Best Health – a new national health research strategy*. It has a key role in supporting clinical and applied research and translating health research findings into health and economic benefits for the UK.

    - The DH Policy Research Programme (PRP) commissions research to provide the evidence base for policy development and evaluation of policy implementation in health and adult social care.

87. We recognise the importance of knowledge transfer, and we will explore how policy-makers can make best use of existing research evidence and

data, including how to disseminate research findings to commissioners and front-line providers. In so doing we will look at ways of engaging with and building on existing initiatives, such as the synthesis and spread of knowledge through NHS evidence.

88. We accept, as a general point, the importance of promoting the recruitment, retention and development of research staff across all health professions. The NIHR and its partners are funding programmes to build research capacity and facilitate research career pathways across a range of professions, including doctors, GPs, nurses, midwives and allied health professionals.

## 3.2 Priority for action 2: Build strategic partnerships

**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. (p52)**

89. We have already taken action to strengthen joint working with DCSF and the Teenage Pregnancy Unit to better integrate the sexual health and teenage pregnancy strategies. We have done this in a number of ways. The additional funding for contraception that has been allocated to SHAs and PCTs is being used to help to reduce teenage conceptions, but should also result in improved contraception services for women of all ages. As already highlighted, the sexual health policy team is working closely with SHAs to ensure that this funding is used as effectively as possible, especially in teenage pregnancy hotspots.

90. *Healthy lives, brighter futures*, the cross-government strategy for children and young people's health, has highlighted the inseparable nature of health, learning and achievement. We are using the interlinked frameworks of You're Welcome, the Healthy Further Education Programme and the National Healthy Schools Programme to encourage the development of high-quality services that are more responsive to young people's needs. The partnerships that are being built to develop locally appropriate services are involving young people in design, review and evaluation. This approach is helping to improve accessibility and acceptability of health information, advice, treatment and care for teenagers, including those in vulnerable groups.

91. We are also highlighting the need to ensure that organisations locally are working together to ensure that sexual health policy, in particular the

chlamydia screening programme, works in conjunction with the teenage pregnancy strategy to ensure that young people receive high-quality sexual health interventions, including contraceptive and relationship advice, however they access services or sexual health professionals. The work currently being undertaken on improving access to sexual health services in FE colleges, and in encouraging local organisations to meet the You're Welcome service standards, will be of particular relevance.

92. The work to integrate roles on sexual health, teenage pregnancy and chlamydia in the South West SHA (see section 1.3) will also support the integration of service delivery.

93. The work of the response to sexual violence NST includes building partnerships across all sectors working with young people to ensure they are able to identify and address the needs of young people who have been victims of sexual violence. It includes improving pathways and provision of services for young people who have been victims of sexual violence or coercive sex.

**Case study: Using theatre to educate teenagers in the East of England**

The East of England SHA's teenage pregnancy lead has helped fund a theatre production company to run workshops in schools in certain parts of the region. All of the workshops were well-evaluated by both staff and students, and additional funding has been provided to cover some of the post-production cost of turning the theatre play into a feature length film. The SHA has commissioned the workshop using this film to be held in every college in the region.

**Case study: Integrating media work within East Sussex PCT supported improvements in chlamydia screening rates**

East Sussex PCT has integrated its sexual health, teenage pregnancy and chlamydia media work and created a media steering group which delivers three sexual health campaigns a year. Working in this way, the budgets have been pooled and a marketing co-ordinator has been appointed to support the chlamydia work.

The campaigns run through schools, community settings and youth work and deliver three key messages about unwanted pregnancies, condom use and chlamydia screening. This approach has been multi-agency and has made use of youth workers, clinicians and support teams to deliver the key messages. The branding that has been developed is evidence-based and tested using the social marketing model.

The results have been very impressive and chlamydia screening performance went from 2% to 13% in the three-month period following the launch of the initial campaign in December 2008.

**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, 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. (p52)**

94. Following the Third Sector Funding and Investment Review, completed earlier last year, new third-sector funding arrangements aimed at increasing transparency and effectiveness have been introduced. The Section 64 General Scheme of Grants has been replaced by the Third Sector Investment Programme which, for 2009, has two new funding programmes.

95. The Innovation, Excellence and Service Development Fund seeks to support third-sector organisations to test and develop new, innovative approaches to improving health and well-being; promote and disseminate practice that is proven to achieve excellent outcomes; build the capacity and capability of third-sector organisations to develop sustainable and stable business models, including connecting with the health and social care commissioning and system management environment.

96. The fund also supports projects with the potential for national impact in line with DH objectives of better health and well-being and better care for all. Organisations can apply individually, or in partnership with others. The fund will support capacity building of third-sector organisations, enabling previous Section 64 core grant holders to develop their organisation through a more sustainable business model. We have planned for a budget of up to £6.4m in 2009/10 to support this fund.

97. The Third Sector Strategic Partner Programme represents a shift from historical relationships where the department has 'core' funded organisations to more strategically relevant investment in developing the capability of the third sector and supporting clear, co-ordinated communication from the sector to the department and vice versa.

98. The programme is a cross-cutting approach that will work across DH policy areas, through the partners, to build wider third-sector capability and understanding of the health and social care environment, to enable the sector to engage in a more informed way to utilise its full potential.

99. We have planned for a budget of up to £2m in 2009/10 to support this programme. We are considering how the programme will develop in 2010 and are in the process of identifying the specific gaps in terms of reach across and into the third sector through the existing cohort of strategic partners.

100. Since the launch of the sexual health strategy in 2001, DH has invested £11m in core and project support grants to 40 third-sector organisations in the sexual health and HIV field. As well as supporting the development of innovative approaches in encouraging increases in testing and better access to services (especially among black and minority ethnic groups), the funding has provided stability to a number of organisations which has enabled them to play a leading role in the delivery of the national strategy. In particular, DH has increased the funding provided to the Terrence Higgins Trust, fpa and the African HIV Policy Network to support the expansion of their national programmes of work in HIV prevention and sexual health.

**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. (p52)**

101. We agree that it is essential that we continue to work with relevant professional bodies to ensure strong leadership and achieve common aims

and objectives. Examples of how this work continues to be taken forward include the following:

- Work with BASHH on improving GUM services and maintaining the GUM access target is ongoing.
- We continue to work with the Royal College of Obstetricians and Gynaecologists (RCOG) on service development issues and have funded the College to review its evidence-based guideline *The Care of Women Requesting Induced Abortion*, and its guidance *Termination of Pregnancy for Fetal Abnormality*.
- We have worked closely with the Royal College of Nursing (RCN) and provided funding for a Sexual Health Skills course which is unique in the UK, reaching over 1,500 nurses in four years. The benefits to clinical practice, including towards the aims of the sexual health and teenage pregnancy strategies, have been witnessed through the assignments and evaluations of course participants. The course continues with RCN approval in a new e-learning format from the University of Greenwich, and is now part of a much wider programme in sexual health learning.
- We have provided funding for the Royal College of General Practitioners (RCGP) for the development of an e-learning tool for generalist clinicians and practice nurses already working in general practice that provides a basic grounding in sexual health issues. The structure is based on the highly successful RCGP Certificate in Management of Drug Misuse.
- We are also working in partnership with the FSRH to support their application for specialty status and address workforce issues.
- In particular, DH recognises that there is an urgent need to increase the numbers of sexual and reproductive health consultants and DH is working closely with the RCOG and the FSRH to address this. FSRH have recently successfully applied to the Postgraduate Medical Education and Training Board to establish a new Certificate of Completion of Training in Sexual and Reproductive Health. In effect, this will establish a new medical specialty and is a vital step forward to achieve a fit-for-purpose training programme and address current and future workforce needs in sexual and reproductive health and support delivery of Government policy and targets. The application was strongly supported by DH.

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

**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. (p54)**

**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 service level agreement contracts across all sexual health and HIV care pathways; key outcomes; best value investments ; national standards and best practice). (p54)**

**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 to complement national targets and give a more comprehensive picture of sexual health improvement at national and local levels. (p54)**

**Attach core competencies to the three-level sexual health service model and update it to keep pace with new 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. (p59 – under priority for action 5 – Deliver modern sexual health services)**

**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 re-design. (p59 – under priority for action 5 – Deliver modern sexual health services)**

102. *High Quality Care for All* has signalled a journey towards an improved NHS which is fair, personalised, effective and safe, and which is focused

relentlessly on improving the quality of care. Commissioning is seen to be one of the most important vehicles for delivering this agenda. Improving the way we commission health and care services will deliver better health for all, better care for all and better value for all, and will dramatically reduce health inequality.

103. To deliver the improvements signalled in *High Quality Care for All*, there is an urgent need to build capacity for commissioning in the NHS. To that end, DH and the NHS have jointly launched the world class commissioning programme, which aims to dramatically transform the way we commission health and care services in this country.

104. As part of this work DH is undertaking a major piece of work to develop a new sexual health commissioning framework and work on this started in early 2009. This framework will adopt the 11 world class commissioning competencies to guide the commissioning cycle. This will offer a pragmatic approach to needs assessment; procurement and contestability of services; and evaluation and performance management.

105. This work is being led by DH in collaboration with a range of stakeholders including local commissioners, the World Class Commissioning Team, the NST for sexual health and the HPA.

106. The framework will provide evidence-based guidance, support for PCTs to undertake sexual health population profiles and developing links to partner organisations, as well as providing local examples of commissioning documents, action plans, service specifications and public engagement strategies.

107. Stakeholders are contributing by drawing upon national knowledge and local experience that is aligned to the stages in the commissioning cycle including:

- health needs assessment
- understanding current capacity
- identifying gaps
- outlining change
- making a business case for change
- drawing up detailed service specifications
- procuring/contracting service providers

- implementing change
- monitoring and evaluating services.

108. The new sexual health commissioning framework will incorporate guidance on sexual health promotion and prevention. It will also be integrated with the abortion and contraception good practice guidance that is currently being produced by DH.

109. The framework will include service specifications for the three levels of sexual health services as recommended by the original strategy. Once this work is complete, we will consider further the recommendation about attaching core competencies to these service levels. The sexual health balanced scorecard, described above, will provide PCTs and other organisations with the ability to assess their own performance and analyse the outcomes for their population.

110. The national evaluation of Sexual Health One-Stop Shops is available on DH's website and a link has been circulated to all PCT and SHA sexual health leads. This was a comprehensive piece of work and provides valuable guidance to commissioners and service providers on the factors to consider regarding integrating services. Key findings from the review will also feature in the new commissioning framework, which will be published in September 2009.

**Case study: Collaborative commissioning of HIV prevention work in London**

London PCTs jointly commission targeted HIV prevention work with African communities, MSM and people living with HIV in the capital.

The programmes link to clinical settings and community-based organisations, both within PCTs and across the capital. Interrelated interventions are funded and planned as part of a programme of activity, designed to support clients with behaviour change, provide information and skills to negotiate or maintain safer sex and improve the health and social care for people living with HIV.

Collaborative commissioning is used to ensure value for money, avoid duplication and achieve equity of access across London for all London residents.

**Case study: Camberwell Sexual Health Centre provides integrated services**

In January 2009 the reproductive and sexual health (RSH) and GUM services at King's College Hospital NHS Foundation Trust merged to form a fully integrated sexual and reproductive health service. The new department provides the full range of contraception and STI testing and treatment services on an open-access, walk-in basis from the Camberwell Sexual Health Centre. It is supported by specialist RSH, GUM and HIV services provided from the Caldecot Centre.

By bringing the two workforces together and developing a team of healthcare professionals who are dual trained to deal with both contraception and STI work, they have developed a one-stop, holistic service. The clinic was the recipient of the 2008 *Health Service Journal* Award for Clinical Service Redesign.

**Case study: The South West London HIV and Sexual Health Clinical Services Network (SWAGNET)**

SWAGNET was established in 2002 as a joint initiative of adult HIV and GUM services provided at Kingston Hospital, Mayday Hospital, Queen Mary's Hospital, St George's Hospital and St Helier Hospital. In recent years SWAGNET has also welcomed the integration of reproductive services and other community providers of sexual health into the network and has geared up to provide an effective clinical governance and training structure for a more diverse range of providers.

The network, operating on a sector-wide basis, brings together a large number of people passionate about delivering excellent sexual health services. Communication and interaction is facilitated through monthly electronic newsletters, three full network meetings per year, an open-access website and taskforce groups as required.

SWAGNET provides a structure for sharing frustrations as well as achievements, ideas as well as protocols, support as well as healthy competition. The network brings together a varied wealth of expertise to support the local sexual health economy, providing clinical governance, ongoing training and career development, particularly relevant in periods of financial constraint.

See www.swagnet.nhs.uk/ for more information.

**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. (p54)**

111. *The NHS Plan*, in July 2000, introduced the Government's intention to link the allocation of funds to hospitals to the activity they undertake. Since then, payment by results (PbR) has been implemented incrementally both in terms of scope and financial impact. The aim of PbR is to provide a transparent, rules-based system for paying trusts. It will reward efficiency, support patient

choice and diversity and encourage activity for sustainable waiting time reductions.

112. We have attached a high priority to developing PbR tariffs for sexual health. However, given the range of sexual health services that are provided, this is a complex issue that has required time and resources to take forward. It has therefore been necessary to prioritise action in this area. Once work is completed on the HIV tariff, we will consider what refinements are needed to the current GUM and abortion tariffs and what DH's role might be in supporting work in this area.

113. Significant progress has been made on developing an HIV PbR outpatient tariff, which is being sponsored by the sexual health policy team. A care pathway is being piloted currently, and working groups have been meeting to address costings, data, clinical categories and commissioning issues. We hope to begin a shadow tariff among the ten pilot sites by the autumn of 2009.

114. Portsmouth City Teaching PCT (sponsored by NHS South Central), are another one of the PbR development sites, and are piloting the development of a national tariff for community contraception services. A project group has been established to look at the totality of service provided by the contraception and sexual health service and review how service activity can be counted and, therefore, priced. An IT system has been developed and is now operational to underpin the collection of robust data. There is ongoing monitoring of all CASH activity in shadow form to appropriate levels in order to test the new tariffs and see how these compare with the Service Level Agreements currently used by the service.

115. In addition, the London Sexual Health Programme is developing agreed tariffs for integrated sexual health services (including chlamydia screening) to be paid by PCTs to providers of sexual health services. This work will complement the contraceptive services development work undertaken by Portsmouth PCT described above. Work involves scoping patient-level data from five pilot sites to help commission appropriate costing. The sites involved in this work form part of innovative integrated sexual health services.

116. Finally, the NCSP is managing a project entitled the chlamydia screening costing review and tariff development. The project has three objectives:

- to develop estimates of budget allocation for chlamydia screening in the community at PCT level, based on examples of current best practice in PCTs
- to develop tariffs for work carried out by chlamydia screening providers in the community (including screening activity, laboratory investigations, management of positives and partner notification)
- to explore the various existing screening pathways and advise on the most cost-effective operational strategies.

117. The project is being supervised by the DH Sexual Health PbR Development Group and is being led by an NCSP programme manager and two health economics consultants. The project also involves close collaboration with the Portsmouth and London pilots, in order to ensure consistency between different sexual health tariff developments. Recommendations on the best allocation per screen at PCT level, indicative tariffs for providers and best operational strategies are expected to be made available in September 2009.

118. Due to the integrated nature of sexual health services, Portsmouth PCT, London Sexual Health Programme and the NCSP, which form the wider sexual health PbR tariff development group, meet regularly under the guidance of DH PbR development to ensure consistency across the different development work strands and to share learning accordingly.

**Provide interim advice to local organizations on how to maximise use of new datasets (GUMCAD, GUMAMM, revised KT31) and those currently available to assess need, track trends and monitor performance, and prioritise the roll-out of the Common Dataset for Sexual Health and HIV, ensuring there are adequate IT systems to support full implementation. (p54)**

119. The Common Dataset for sexual health aimed to collect comprehensive electronic information on all aspects of sexual health and related service provision from all main providers of sexual health services. Advice and guidance on the implementation of the new datasets has been issued via the Information Standards Board as these have been approved.

120. The Common Dataset being phased-in in three main stages:

**(1) Data collection of STI diagnoses and service provision from GUM clinic settings**

121. The initial phase has covered the rollout of two systems, GUMAMM and the GUM clinic activity dataset (GUMCAD). GUMAMM monitors waiting times

for patients attending GUM services stratified by provider and commissioning PCTs. GUMAMM is well-established and is currently producing monthly data updates. GUMCAD monitors all diagnoses made and services provided by GUM clinics, and includes information on patient risk factors and area of residence. A Dataset Change Notice was issued by the NHS Information Standards Board for Health and Social Care (ISB) in 2008 and implementation across all clinics in England is almost complete (166 of 207 (80.2%) have had the software installed as of 19 May 2009).

**(2) Data collection of STI diagnoses and service provision from other sexual health service providers and laboratories**

122. The next phase will broaden the scope of data collection on STI diagnoses and services to cover other sexual health service providers, such as community contraceptive services, CASH services, general practice and so on. GUMCAD is currently being piloted by 'Level 2' sexual health services and an application from the HPA to the ISB to broaden the scope of GUMCAD to cover these services is in progress.

123. Negotiations are also under way between the HPA and the NHS Information Centre for a regular data extract on STI service provision and diagnoses from all GPs across England through their new General Practice Extract Service, thereby covering a significant proportion of 'Level 1' providers of sexual health services.

124. Finally, better data is needed to estimate chlamydia testing coverage to enable the assessment of chlamydia control measures, especially the NCSP. Because chlamydia screening is offered by traditional NHS, third sector and non-NHS providers, the HPA is piloting a routine data extract on chlamydia testing activity from laboratories, and will apply to the ISB to make this a national data standard. Current data flows as part of the NCSP will be reviewed in light of these developments to minimise duplication of reporting pathways.

**(3) Conversion of the paper-based KT31 data collection on contraceptive service provision to an electronic reporting system.**

125. Detailed information on contraceptive services is currently collected on form KT31. A revised electronic version has recently been piloted by DH in community contraceptive services. The new dataset, if approved, will provide a record of activity and interventions within community services at PCT level. Commissioners will have access to data on their populations groups attending CASH and the service they have received. The revised KT31 is currently going through the ISBs approval process and the outcome of this will be

known later this year. In recognition of the fact that many services have little or no IT currently, DH has invested £1m in 2008/09 and will receive £2.5m in 2009/10 to pump-prime the procurement of IT systems in this area.

126. In the longer term, electronic data collection of GUMCAD and KT31 will be integrated as a single data flow in those services which are required to provide both STI and contraceptive-related data.

**Case study: Transforming local services through IT improvements in Portsmouth City PCT**

Portsmouth City PCT's CASH service used to manually collect its data until it secured funding from the PCT and support from DH to purchase a bespoke IT solution. The IT system, CASHclin, has been in use since May 2009 and provides a wide range of functions, including electronic patient records, diary management and monitoring of national KT31 data requirements, as well as improving the accuracy of data needed for future PbR initiatives. The new system has transformed the clinical consultations undertaken, releases administrative and clerical support time and enables the service to understand its business far more comprehensively.

## 3.4 Priority for action 4: Invest in prevention

**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 (e.g. 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. (p56)**

127. We plan to develop a prevention framework to promote better synergy across national programmes and help guide local health promotion and prevention. Such a framework will help identify strategic priorities for national and local action in a systematic and coherent manner. In scoping this work, we will consider existing frameworks, (such as for HIV, *Making it Count* and *The Knowledge, the Will and the Power*) and programmes of work, including social marketing, already undertaken by DH and other government departments. We will also consider existing links and where

these need strengthening or need making more explicit. We will also include other recognised resources such as National Institute for Health and Clinical Excellence guidelines. Crucial to the effectiveness of a framework and its contribution to positive sexual health outcomes for all, will be ensuring it is closely aligned to world class commissioning through the proposed sexual health commissioning framework.

128. With regards to HIV prevention, we already plan to set up a small reference group following DH's review of the national HIV health promotion programmes, in order to promote closer working and learning across the two national HIV programmes. The group will draw on strategic expertise both within and external to the two programmes.

129. DH is also investigating how preventative behaviours may be encouraged through social marketing interventions. This reflects the *High Quality Care for All* desire to see prevention 'on an industrial scale'. This programme is investigating how to build communications and negotiation skills that enable safer sex to be secured and how non-clinical settings can contribute to improving sexual health in their communities.

130. The initial target audience is vulnerable females whose self efficacy in this area currently compromises their ability to make their desire for safer sex a reality. Work with the equivalent male audiences is planned for the near future. We have developed and are in the process of implementing a social marketing pilot intervention activity in Lambeth PCT to help raise the self efficacy of vulnerable young women from Afro-Caribbean backgrounds. The aims of this work are to:

- increase their ability to negotiate safe and positive sexual encounters
- equip them with confidence, language, skills and information to practice effective condom usage. This project will focus on increased and improved condom usage among the target group. This will not prohibit a parallel purpose of encouraging effective use of contraception within the parameters of good sexual health project delivery. This will be promoted through appropriate information, support and signposting for the client group and their partners
- encourage behaviour change within the target audience through the positive social marketing exchange and modify sexually risky behaviour, thus reducing the incidence of STIs and unwanted pregnancies.

**Case study: Social marketing improves chlamydia screening rates in Norfolk and Waveney**

The Norfolk and Waveney Chlamydia Screening Programme's (NWCSP) National Social Marketing Demonstration Site is one of ten learning demonstration projects established with DH support. NWCSP offers free opportunistic chlamydia screening and treatment to sexually active young people under 25 years old at over 200 screening sites, including health and non-health settings. However, most of these sites are currently under-performing and return few if any screens.

Research with providers revealed various barriers to offering screening and, based on these insights, the chosen interventions focus on enhancing support and communication to screening sites; The interventions include: improved induction sessions for new sites; training to build providers' confidence and skills in introducing screening to young people; more systematic and targeted follow-up and support from the chlamydia screening office; promotional materials for pharmacies to publicise chlamydia screening; and register-based pop-up reminders to prompt GPs to offer screening to under-25-year-olds.

**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. (p56)**

131. We believe that *Tackling HIV stigma and discrimination,* published in 2007, is still relevant in setting out the rationale on why HIV-related stigma is unacceptable and should always be challenged. We have clearly stated why HIV stigma and discrimination must be challenged and reduced and broader legislative changes will help support that, especially the 2005 amendment to the Disability Discrimination Act 2005, which included HIV.

132. Government and its agencies have a role to play, which is why DH has funded work in this area, but there are many other players, including affected communities, faith groups, the media and others who have a valuable contribution to make or who are better placed to challenge at a local or community level. Rather than commit to a major review, DH will continue to work with our contractors for the national HIV health promotion

programmes to better integrate within the national programmes action to address community-based HIV stigma. We will continue to work with other government departments as appropriate to address issues or opportunities that may impact on HIV-related stigma. This will include the DCSF to consider opportunities to address HIV stigma in the context of compulsory SRE.

**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. (p56)**

**Investigate and disseminate evidence on the cost-effectiveness, or cost-saving, of local-level prevention initiatives. (p56)**

133. We agree that more could be done to collate and disseminate evidence on the impact of health promotion and prevention activities, including information on cost-effectiveness where this is available. Linked to the proposal on a prevention framework we will consider developing a web-based portal, or gateway, with accessible links to relevant research and evidence. Such a site would evolve over time to become a comprehensive yet easily accessible resource with up-to-date information to support effective interventions, which avoids duplication and identifies best practice and is clear on what sexual health outcomes are being changed. DH will discuss with stakeholders where a portal might be sited and how best to interact with different audiences, such as commissioners, providers, researchers.

**Make PSHE 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. (p56)**

134. On 23 October 2008, the Government published its response to the review of SRE in schools. This set out the Government's decision to make PSHE statutory and announced a review – led by Sir Alasdair Macdonald – on how best to translate this decision into a practical way forward.

135. Following a call for written evidence and meetings with key stakeholders, Sir Alasdair published his report on 27 April 2009. There were three key recommendations. First, that PSHE education should become part of the statutory national curriculum, in both primary and secondary phases. Second, that the existing right of parental withdrawal from SRE should be maintained. Where parents do choose to withdraw, schools should make it clear to them that in doing so they are taking responsibility for ensuring that their

child receives their entitlement to SRE through alternative means. This right of withdrawal does not extend to the existing statutory elements of the national curriculum requirements regarding sex education in science at key stages 1 to 4 and we recommend that this should continue to be the case. Furthermore, there should be no right of withdrawal from the whole or any other aspect of PSHE education. Finally, all initial teacher training courses should include some focus on PSHE education.

136. DCSF is now consulting on these recommendations, with a view to legislating to make PSHE statutory within a fifth Session Bill.

137. The Government response to the SRE review also accepted a wide range of further recommendations made by the SRE review steering group. The Government has agreed to develop new SRE guidance for schools. The aim is to consult on a draft in the autumn, with a view to the guidance being published in January 2010. In addition, the Government has accepted that more needs to be done to improve the skills and confidence of teachers and other professionals who input to schools' SRE programmes.

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

**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. (p59)**

138. We are pleased to say that from 1 April 2009, GPs have been given greater incentives, through the QOF, to provide sexual health advice, specifically on contraception and particularly on long acting methods. The 'points' can be received for producing a register of women who have been prescribed any method of contraception at least once in the last year, providing details of the percentage of women prescribed an oral or patch contraceptive method in the last year who have received information from the practice about LARCs in the previous 15 months, and providing details of the percentage of women prescribed emergency hormonal contraception at least once in the year by the practice who have received information from the practice about long acting reversible methods of contraception at the time of, or within one month of, the prescription.

139. Both GP and patient knowledge about all the methods of contraception and which will best suit an individual patient will be enhanced by two new web tools that are currently in preparation. The first, which is aimed at patients, is under development by the fpa and Brook, with the support of DH and other partners. This tool will take a three-step approach, which will engage women in a formal process of decision making about contraception and prepare them for a conversation with a partner, a healthcare professional, a parent or another source of support about the particular contraception that best meets their needs and their circumstances. The second, to be developed later this year, will be based on a tool for health professionals developed by the World Health Organization and will help health professionals, particularly GPs, to have a structured discussion with women about the types of contraception that will best suit their needs and lifestyles.

**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. (p59)**

140. The NHS is best placed to determine the workforce it needs to deliver a high-quality service for patients. DH is committed to supporting the NHS in this by ensuring information such as supply and demand of the sexual health workforce is understood throughout the NHS, and that workforce planning and education and training decisions reflect this.

141. *A High Quality Workforce: NHS Next Stage Review* outlined improvements for the workforce planning system, including a Centre for Workforce Intelligence and professional advisory boards to provide expert research, analysis and co-ordinated clinical advice to the NHS.

142. It is important that sexual health services are planned around patient pathways and that any strategic overview of training and education of the sexual health workforce considers training across the entire pathways, rather than concentrating on individual staff groups. This will help to ensure that the NHS has the right workforce with the right skills in the right place to deliver high-quality care for all patients.

143. To improve the quality and availability of forensic medical examinations for victims of sexual assault, DH is providing £75,000 to fund the start-up costs of a new Diploma in Forensic and Clinical Aspects of Sexual Assault. In addition to the help this will provide to victims, it should also increase the rate of successful prosecutions for rape and will reduce attrition rates.

The Health Task Force (see paragraph 69) will also look at the provision of forensic physicians within SARCs.

**Case study: Improving sexual health training in the West Midlands**

NHS West Midlands recently audited their regional CASH service training capacity with a view to increasing the numbers of health professionals with both the Diploma of the Faculty of Sexual and Reproductive Healthcare (DFSRH) and LARC-fitting qualifications. Following the review, additional training funds were identified, which also allow for the recruitment of a regional training administrator to co-ordinate the access to training. To support this investment PCTs will keep a register of staff with DFSRH or other relevant letters of competence and ensure skills are properly maintained and available, particularly within teenage pregnancy hotspots.

**Case study: London improves choices in contraception through staff training**

The London Sexual Health Needs Assessment (MedFASH, 2008), shows that there is a more than seven-fold variation in prescribing of LARC from general practice between PCTs. To address this, the London Sexual Health Programme carried out a training needs assessment in primary care so that women in London are offered a choice of contraception regardless of healthcare setting.

As a result, a training project called 'Improving Choices in Contraception through Training' was initiated that provides training for contraception, including LARC, to general practice staff in their own practice to national standards set by the FSRH.

Accredited trainers registered with the FSRH will provide in-practice training and assessment for doctors and nurses who wish to obtain, respectively, the basic level diploma or advanced Letters of Competence from the FSRH, or accreditation from the RCN. Doctors and nurses will undergo both theoretical and practical training before a final assessment of competency. In addition, support will be offered to surgeries in the form of posters and information booklets so that patients can be made aware of the opportunity to discuss different methods of contraception.

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# List of acronyms

| | |
|---|---|
| BASHH | British Association for Sexual Health and HIV |
| CASH | contraceptive and sexual health services |
| DCSF | Department for Children, Schools and Families |
| DH | Department of Health |
| DFSRH | Diploma of the Faculty of Sexual and Reproductive Healthcare |
| FE | further education |
| FSRH | Faculty of Sexual and Reproductive Healthcare |
| GP | general practitioner |
| GUM | genito-urinary medicine |
| GUMCAD | genito-urinary medicine clinic activity dataset |
| GUMAMM | genito-urinary medicine access monthly monitoring |
| HPA | Health Protection Agency |
| IAG | Independent Advisory Group |
| ISB | Information Standards Board for Health and Social Care |
| LARC | long-acting reversible contraception |
| MedFASH | Medical Foundation for AIDS and Sexual Health |
| MSM | men who have sex with men |
| NCSP | National Chlamydia Screening Programme |
| NHS | National Health Service |
| NIHR | National Institute for Health Research |
| NST | National Support Team |
| NWCSP | Norfolk and Waveney Chlamydia Screening Programme |
| PbR | payment by results |
| PSA | Public Service Agreement |
| PCT | primary care trust |

| | |
|---|---|
| PSHE | personal, social and health education |
| PRP | policy research programme |
| QOF | Quality and Outcomes Framework |
| RCGP | Royal College of General Practitioners |
| RCN | Royal College of Nursing |
| RCOG | Royal College of Obstetricians and Gynaecologists |
| RSH | reproductive and sexual health |
| SARC | sexual assault referral centre |
| SHA | strategic health authority |
| SRE | sex and relationships education |
| STI | sexually transmitted infection |
| SWAGNET | South West London HIV and Sexual Health Clinical Services Network |

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