MEDICAL FOUNDATION FOR AIDS & SEXUAL HEALTH
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Sexual health – worth thinking about

A paper to inform national strategic planning for sexual health and HIV in 2011 and beyond

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Written by
Ruth Lowbury
Chief Executive
Medical Foundation for AIDS & Sexual Health (MedFASH)

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1. Introduction

The DH consultative conference, *Sexual Health Worth Thinking About: Celebrate - Innovate – Influence*, to be held on 4 February 2010 will bring key players together to help shape the priorities for sexual health policy in the future. This paper has been prepared to identify some key issues for consideration at the conference and to inform the further development of strategic planning for sexual health and HIV in England in 2011 and beyond.

The paper is written from a national perspective but highlights issues which can be addressed at national and local level recognising that implementation of any strategy depends on local level prioritisation and action. Many national level actions would aim to stimulate and support action at local (and regional) level.

This paper should be read in conjunction with the following publications, on which it builds:

- *Progress and Priorities – working together for high quality sexual health. Review of the National Strategy for Sexual Health and HIV*[1] and
- *Moving Forward: progress and priorities - working together for high quality sexual health: Government response to the Independent Advisory Group's review of the Sexual Health and HIV Strategy*[2].

Sections 2 and 3 outline the history of the national sexual health strategy and some recent contextual developments. Section 4 discusses key strategic issues to inform planning and includes a number of consultative questions. Appendix A contains the 'framework for further action' from *Progress and Priorities*, while Appendix B brings together the consultative questions from Section 4.

2. The national strategy for sexual health and HIV and its implementation

The first ever national strategy for sexual health and HIV[3] published in 2001 set out a vision for sexual health in England, focusing on prevention and the provision of sexual health services, with additional recommendations for commissioning and research. Using a comprehensive and holistic model of sexual health, the strategy envisaged integrated service provision across the different elements of sexual healthcare.

In 2004, the Public Health White Paper, *Choosing Health*[4] , gave a boost to implementation of the strategy by identifying sexual health as a public health priority. It contained commitments to improving access (notably 48-hour access to GUM), modernising services and accelerating implementation of the National Chlamydia Screening Programme (NCSP). These were shortly afterwards reflected in PSA targets and supported by the announcement of additional capital and revenue funding. *Choosing Health* offered a modern vision of sexual health services delivered through a flexible multidisciplinary workforce in a range of settings, with a particular emphasis on delivery in the community.

With the ten-year term of the sexual health strategy soon to be completed, it is timely to consider the appropriate strategic direction for sexual health and HIV in 2011 and beyond.

A review of the strategy was undertaken by MedFASH for the Independent Advisory Group on Sexual Health and HIV (IAG) in 2008. The review report, *Progress and Priorities*[1], outlined the enormous changes in context, the key developments in sexual health and the major achievements since the strategy's publication. Highlighting outstanding challenges and noting that implementation of the strategy at local level had been variable to date, the review explored the levers and barriers to implementation. To accelerate further implementation of the strategy, the report made a series of recommendations for action at local, regional and national level in five priority areas:

- prioritising sexual health as a public health issue and sustaining high-level leadership at local, regional and national level
- building strategic partnerships
- commissioning for improved sexual health
- investing in prevention
- delivering modern sexual health services.

The Government's response to the strategy review was published in 2009[2]. This provided a summary of actions taken by the Government since the strategy's publication and a more detailed response to the review's national recommendations, setting out how their implementation was being taken forward. A range of actions by the DH and partners at national and regional level are underway.

More recently, the IAG has published two further reports which build on the strategy review, exploring current challenges and offering more detailed recommendations for achieving world class contraception and abortion services[5], and enhancing the response to HIV[6], respectively.

Other recent national outputs, developed by professional bodies through multi-agency partnership working, also aim to foster the integrated and holistic approach to sexual health recommended in the strategy and to ensure service quality. These include new national guidelines for HIV testing[7] and new standards for the management of sexually transmitted infections[8], both specifically addressing the role of providers other than the specialists traditionally involved.

3. Contextual developments since the sexual health strategy review

A number of developments since the publication of *Progress and Priorities* set the context for the consideration of strategic priorities in sexual health for 2010 and beyond.

3.1 Financial constraint

The current financially challenging environment is now a key factor shaping the development of the NHS. David Nicholson, Chief Executive of the NHS, flagged in his Annual Report 2009/10[9] that the NHS would need to achieve £15–20 billion of efficiency savings by the end of 2013/14 to reinvest within the service, so as to enable the continuation of quality improvements. Sexual health and HIV services will not be immune from these pressures.

Recent health policy documents have explicitly addressed the financial challenges. In doing this, they identify quality, innovation, productivity and prevention (QIPP) as key, linked aims.

These documents include:

- the letter from David Nicholson to NHS Chief Executives and Chairs, *Implementing the Next Stage Review visions: the quality and productivity challenge*[10]
- the NHS five-year plan, *NHS 2010-2015: from good to great. Preventive, people-centred, productive*[11]
- *The Operating Framework for the NHS in England 2010/11*[12].

In particular, the NHS Operating Framework for 2010/11 highlights four key principles identified by David Nicholson that should apply to tackling change. Noting that they have produced much greater local ownership of decision-making, the Operating Framework states that these should be prominent in tackling the challenges ahead in 2010/2011:

- **"Clinical ownership and leadership** – we must all continue to mobilise and empower clinicians across the system. Clinicians must be on board when decisions are taken
- **Co-production** – all parts of the system need to continue to work together on shaping and implementing change
- **Subsidiarity** – ensuring that decisions are taken at the right level of the system, which means as close to the patient at possible
- **System alignment** – achieving complex cultural changes, such as making quality our organising principle, which requires all the different parts of the system to pull in the same direction and to work with partners".

These principles offer both opportunities and challenges for sexual health and need to be considered and applied at every level of decision making.

3.2 QIPP and current NHS policy priorities

The focus on quality at the heart of the NHS, as recommended in Lord Darzi's NHS Next Stage Review[13], has been maintained across key subsequent policy documents, including those itemised above. Quality care is defined by Darzi as clinically effective, personal and safe.

Productivity is now placed as a priority alongside quality, and it is argued that improving the latter will improve the former. The NHS five-year plan states that to keep the NHS moving forward, "services must be more productive", recognising that this will mean change on an unprecedented scale and hard choices about resources and priorities. It describes more productive services as services which are better for people, by being more preventive and people-centred.

The key documents also call for a renewed focus on prevention, bringing benefits to both public health and the public purse by reducing the need for treatment services. The five-year plan states that "it would be wrong to respond to the challenge the NHS faces by reducing spending on prevention – as has been the case in the past" and that a "paradigm shift" is needed "away from 'diagnose and treat' towards 'predict and prevent'".

It is worth noting that in the area of sexual health, this distinction cannot be easily made, as diagnostic and treatment services (whether for STIs or providing contraception) are by their very nature preventive. If prevention is seen as a route to greater productivity, any assessment of the productivity and cost effectiveness of sexual health services therefore needs to take account not only of the service model and efficiency of individual care (eg how the delivery of STI diagnosis and treatment is managed), but also the savings made by preventing further transmission of infection and/or unintended pregnancies.

Current NHS policy is seeking a reforming system where changes will continue to be shaped locally by the dynamics of co-operation, competition and patient choice. Greater integration of services will enable the transformation of patient pathways so they are designed around individual needs and with more potential for self-management. Innovation will be rewarded, as a means to shape services that better meet the needs of users while increasing efficiency.

More power will be put in the hands of patients. The NHS Constitution now gives legally binding entitlements to patients and the public, as well as staff, so that they know exactly what they have the right to expect of the NHS. Payment for providers will start to be linked to patient satisfaction. This may prove particularly challenging in the field of sexual health, where the patient voice has traditionally been weak, partly due to stigma and desire for privacy.

The experiences of sexual health service users may not frequently be shared through mainstream patient and public engagement channels, such as LINks, PALS, or patient complaint systems.

> We need a relentless focus on three things …. Firstly, improving quality whilst improving productivity, using innovation and prevention to drive and connect them. Secondly, having local clinicians and managers working together across boundaries to spot the opportunities and manage the change. It is simply not possible to identify from the centre the kind of quality improvements that are necessary. And thirdly, to act now and for the long term. (*David Nicholson, NHS Chief Executive, Foreword to NHS Operating Framework 2010/11)*

3.3 Transforming community services

An enhanced role for community services is being taken forward, with the shifting of care out of acute services and closer to home, along with the entry into the NHS 'market' of new providers and contestability.

Detailed guidance on the separation of primary care trust (PCT) provider functions from PCTs as commissioning bodies was set out in January 2009 in *Transforming Community Services*[14]. By October 2009, commissioners were required to have developed a detailed plan for transforming community services and providers to have reviewed options for the most appropriate organisational form(s) to adopt. Options include integration with another NHS organisation (eg acute trust), establishment of a new organisation such as a community foundation trust or social enterprise organisation, becoming part of an independent or third sector provider organisation, or retaining PCT provider status with governance arrangements clearly separated from the PCT as commissioner.

A number of further documents followed *Transforming Community Services* (TCS) providing guidance on best practice and measuring service quality, including the TCS quality framework[15] and six transformational guides for different aspects of community service provision[16]. The standard NHS Contract for Community Services (updated January 2010)[17] will be used to support the roll-out and implementation of the TCS Programme. This includes a mandated specification for abortion services, requiring the provision of contraception and chlamydia screening.

The main sexual health providers in this sector are community sexual and reproductive health (SRH) services, the leading specialist providers of contraceptive care. The geographical coverage of these services is patchy, but where they exist they lead the way in offering the full range of contraceptive methods including long-acting reversible contraception (LARC) and have a key role in training other providers of contraceptive care, notably general practice. SRH services are currently the largest provider of screens for the National Chlamydia Screening Programme (NCSP) and many PCTs are commissioning them to undertake testing and management of a broader range of STIs.

Whatever the service models and organisational forms which develop, it will be important to ensure that the characteristics of SRH services which enable them to provide high quality preventive care responsive to the needs of those who choose to use them, and to offer clinical leadership to other contraceptive providers, are maintained and further improved.

Community contraceptive services play an essential role in reducing unintended pregnancy, preventing teenage conceptions and improving sexual health. Open access and extended opening hours make them accessible to those who might otherwise feel excluded. General practice remains the majority provider of contraception, but there is a growing role for community teams in providing training, overseeing clinical governance and reviewing care pathways. (*NHS Next Stage Review. Our vision for primary and community care. DH 2008*[18])

TCS is meant to help ensure that local services are commissioned and organised to meet the needs of the local population. It encourages an increasing diversity of providers and service models, bringing the potential benefits of greater patient choice and personalised care. However, there are fears that the implementation of TCS may destabilise these key sexual health services in the community. The sexual health strategy review in 2008 identified contraceptive services as an area needing greater attention, following a period of local disinvestment and decline. Although more recently the DH has established new funding streams to improve contraceptive provision, the picture remains patchy. Many service providers do not have the business experience or skills to easily review and identify appropriate organisational forms as envisaged in TCS, or to compete effectively with other new or established providers in the local health economy. Many still lack the basic IT which would enable them to collect the data required by commissioners and for national surveillance.

Since the publication of TCS, the Secretary of State's statement that the NHS would be a 'preferred provider' and the subsequent explanatory letter from David Nicholson[19] aim to ensure that existing providers are involved in service redesign and have the opportunity to improve and to meet commissioners' needs before opening up to new potential providers. Existing services will be tested on whether they provide best value and real quality. A revised *PCT Procurement Guide* and refined *Principles and Rules of Co-operation and Competition* are to follow. This may appear to strengthen the position of existing SRH services, or at least those which have remained within the NHS. However, the implementation of the policy is currently facing challenge, through a complaint on behalf of third sector providers to the Co-operation and Competition Panel, and there is likely to be uncertainty for some time. However this is resolved, it is likely there will remain a tension between the requirements in current policy for collaboration and competition respectively.

3.4 Reviews of the National Chlamydia Screening Programme (NCSP)

In 2009, the National Audit Office (NAO) undertook a Value for Money review of the NCSP. The report[20] highlights the challenges of introducing a nationally organised programme into today's locally managed NHS. Findings include the fact that testing rates in half of PCTs in 2008-09 had not reached the level required to impact on chlamydia prevalence, while the rates of treatment in those diagnosed positive, and of partner notification and treatment, were below the standards set for the Programme. Costs were geographically variable, indicating significant scope for efficiency savings, and regional or national delivery of some elements of the Programme would have proved more cost effective. The review recommended clarification of the Programme's success criteria and measures for evaluating its impact. The NAO review will be followed by a report with recommendations to the government from the Public Accounts Committee in January 2010.

In parallel with the NAO, a DH-commissioned assessment of the NCSP by Dr Ruth Hussey (Regional Director of Public Health, NHS North West)[21] concluded that the rate of screening in young people was a major achievement but there were several areas where the Programme could be improved and put onto a more sustainable, effective and efficient footing.

There is potential to apply the learning from the NCSP more generally to sexual health commissioning and service delivery, and – particularly with the Hussey review's recommendations about increasing the role of core services and how to improve collaboration - to use the further implementation and improvement of the NCSP as a lever to improve sexual health service delivery more widely.

3.5 Teenage Pregnancy Strategy

In December, responding to the Teenage Pregnancy Independent Advisory Group's sixth annual report, the Children's Minister and the Public Health Minister called on local authorities (LAs) and PCTs to continue prioritising the Teenage Pregnancy Strategy beyond December 2010 (the end-date of the original strategy). They put a particular focus on improving sex and relationships education (SRE) in and out of schools and supporting effective contraceptive use by under-18s.

The Prime Minister's Delivery Unit (PMDU) is currently undertaking a rapid review of teenage pregnancy delivery. The review has again focused on improving effective delivery of SRE and effective uptake of contraception to accelerate progress towards the 2010 target, as these are the actions with the strongest evidence of impact.

The NHS Operating Framework for 2010/11 highlights that levels of teenage pregnancy remain a key area of challenge and that delivery of well-publicised,

accessible and high quality contraception and sexual health services for young people is key to reducing the number of unintended pregnancies.

Such measures to inform and empower young people and to enable them to look after their sexual health provide the foundation for the range of further programmes and initiatives required for sexual health improvement across the population. It will be important to ensure the ongoing strategic directions for sexual health and teenage pregnancy are considered together to ensure shared priorities, synergy and maximum value for investment.

3.6 Sexual health inequalities

There are a range of complex drivers of sexual behaviour and influences determining poor sexual health. For some of these, including alcohol use and sexual violence, work is already underway by the DH. In addition, an *Equality Impact Assessment for National Sexual Health Policy*[22] has recently been published by the DH, analysing factors resulting in sexual health inequalities according to the six strands of age, disability, gender, race, religion/belief and sexual orientation, and identifying future actions to improve sexual health in some key population groups. It is expected that the Equalities Impact Assessment will contribute to the development of future sexual health strategy, and workshops are being held at the conference on 4 February to agree priorities around future work in all of these areas.

4. Key strategic issues to inform planning

Building on the recommendations of the sexual health strategy review, as set out in *Progress and Priorities – working together for high quality sexual health*, and the Government's response to these in *Moving Forward*, and taking account of the subsequent IAG reports, as well as the contextual developments outlined above, this section discusses a number of key issues to inform future strategic planning on sexual health and HIV.

4.1 Strategic vision and health outcomes

While focusing primarily on the implementation challenges, the 2008 strategy review broadly endorsed the original sexual health strategy's vision and priority health outcomes, reiterating its aims with a few additions and amendments, most significantly a greater focus on promoting positive sexual health and wellbeing and more explicit inclusion of care for women seeking abortion. These were included in a framework of further action required in relation to each strategic aim, attached for reference at Appendix A.

The changes which have taken place since the strategy review relate mostly to external factors affecting implementation, discussed below. However, the key health issues remain broadly unchanged and it would be reasonable, in developing a new strategic framework, to consider retaining a similar set of health outcomes. The focus of planning would then be primarily on the priorities and drivers for delivery and improvement.

Consultative questions

1) **To set the strategic direction for sexual health and HIV in 2011 and beyond, would it be more appropriate to develop:**
   - **a new long-term strategy for sexual health and HIV?**
   - **a three-year operational plan, retaining the broader vision of the original sexual health strategy and *Choosing Health*?**
   - **some other option?**

2) **Is the *framework for further action* at Appendix A still appropriate for 2011 and beyond?**

3) **Have there been any significant changes or developments in relation to sexual health and HIV which should affect strategic priorities?**

4) **Are there any issues within sexual health and HIV which would merit the development of a separate or additional strategic framework (eg long-term care for people with HIV)?**

4.2 Investment in prevention and wellbeing

> Every primary care trust will commission comprehensive wellbeing and prevention services, in partnership with local authorities, with the services offered personalised to meet the specific needs of their local populations. Our efforts must be focused on six key goals: …[one of which is] improving sexual health *(High Quality Care for All. DH 2008)*

For the individual, prevention is clearly better than cure (and even more desirable where there is only treatment but no cure, as with HIV for example). But in the case of STIs including HIV, prevention also brings clear benefits to the wider public health because each infection prevented also prevents the potential onward chain of transmission. In reproductive health, prevention of unintended pregnancy has benefits for the individual woman but also for her family and community. Significantly, particularly in the current straitened financial times, this combination of individual and public health benefit means that investment in effective prevention can be cost-saving. This is recognised in current government policy for the NHS, where prevention is identified as a priority alongside productivity.

As set out above, most sexual health services are in themselves preventive through the treatments (for infections or to prevent pregnancy) that they provide for individuals and their sexual partners. In relation to HIV, although there is no cure, action to reduce levels of undiagnosed infection and to achieve diagnosis earlier in the course of infection is also preventive by reducing viral load (and thus infectiousness) through treatment and providing knowledge and support to change behaviour. To maximise the effectiveness of treatment services, it is important that provision of prevention messages and support to enable individuals to protect themselves and their partners on an ongoing basis are also an integral part of care.

Prevention 'upstream', and the promotion of sexual health and wellbeing, are equally important, for example through PSHE education for all children and young people in school and other settings, social marketing for different population groups, and targeted behavioural interventions for those at highest risk.

However, in the face of pressing financial constraints and competing priorities, prevention and sexual health can both seem 'soft targets' for cost-cutting by cash-strapped PCTs needing short-term savings. Sexual health is not always acknowledged in mainstream public health discourse as a priority alongside other 'lifestyle' health issues. Likewise, with the stigma that persists in relation to sexual health problems and use of sexual health services, there is little public voice speaking out to protect sexual health services. It is therefore crucial to gather the evidence of cost-effectiveness/cost saving and disseminate this to NHS decision-makers to support the case for investment in sexual healthcare services and preventive interventions 'upstream'. In addition, to get maximum impact and value for investment, the embedding of sexual health within broader public health and wellbeing programmes, eg the Healthy Child and Healthy Schools Programmes, and the development of

interventions to target the linkages between risk behaviours, eg alcohol consumption and unprotected sex, should receive greater priority. Work on these issues is already underway nationally.

> In the past, prevention has been sidelined in times of challenge – we must not allow this to happen again. We must continue to prioritise prevention as the first area to be addressed. *(NHS Operating Framework 2010/11)*

Consultative questions

5) What are the strategic priorities for prevention and wellbeing? Which of the following would you prioritise? Are there any others?

a. Gather and disseminate the evidence base for cost saving and cost effectiveness of investment in prevention (including assessment of the preventive impact of treatment services) in the sexual health field, including HIV

b. Commission research to expand and update this evidence base

c. Embed sexual health in broader public health and wellbeing programmes

d. Overhaul and protect health promotion infrastructure to support implementation of preventive interventions, and ensure they are of high quality and evidence based

e. Identify how to move investment in sexual health 'upstream' to affect the determinants of sexual ill-health

f. Launch a programme to improve the timeliness of HIV diagnosis and the proportion of infections diagnosed, which would include raising public and professional awareness, increasing availability of testing for groups at highest risk, and engaging all relevant clinical, healthcare and other professionals in improving rates of testing and clinical diagnosis.

4.3 Commissioning and service redesign

> Success requires bold and thoughtful leadership; re-thinking how we work; challenging current practice and thinking outside of our own organisational and professional interests so that quality genuinely is our organising principle. This is not a time for rash, short-term decisions. The quality and productivity gains cannot be made by cutting how much we currently do or how many we employ. (*David Nicholson, NHS Chief Executive, Foreword to the NHS Operating Framework 2010/11)*

Levels of need for sexual health services can be expected to remain high or increase (eg the numbers needing HIV treatment and care), at least in the short to medium term. The case can, and should, be made for maintaining

current levels of investment in view of the preventive role of sexual health services, but it is prudent to assume there will be budget reductions in real terms, as there will across most if not all of the rest of the NHS.

While there will be wide geographical variation, a number of inefficiencies may be identified in the way sexual health services are commissioned and provided. There is frequent fragmentation, with little multi-PCT commissioning and even a lack of strategic overview across the different areas of sexual health commissioning within individual PCTs. Service networks are patchy, care pathways may be poorly or only partially developed, and linkages between services at local and regional level are variable. The lessons of the NCSP reviews regarding value for money are relevant to apply here. It will be important to analyse where savings can be made through efficiencies and service redesign, and to avoid piecemeal non-strategic cuts for the sake of short term cost savings, thus risking the quality of, or access to, sexual health services.

There has been considerable innovation and modernisation of sexual health services, driven by the sexual health strategy and especially *Choosing Health* with its associated targets. More recently, the NCSP has been driving the greater involvement of general practice and community healthcare providers in the provision of STI management. However, further innovation and significant system redesign is likely to be needed across sexual health and HIV care, in order to reconcile the expected levels of need and of resources available. A workshop is being held at the 4 February conference to explore these issues further.

Sexual health services have often in the past been delivered in 'silos', with service users attending different specialist services for contraception and STIs, abortion services not linked to ongoing contraceptive provision, and only limited sexual healthcare available in general practice despite this being the most frequently chosen first point of contact for those with sexual health concerns[23]. To improve both productivity and service user experience, a more integrated delivery chain is needed, especially as an increasing diversity of providers take on a role in sexual health. A workshop at the 4 February conference will look at service delivery and value for money models.

Service networks can provide integrated care pathways so that users have a seamless experience of care, are seen by services at a level appropriate to their needs and by staff with appropriate competence, while the wastage arising from duplication and the complications resulting from partial or sub-optimal care are avoided. They provide a framework for the development of shared protocols, audit and training, with clinical leadership from the specialist service(s) in the network empowered to lead transformational change across organisational boundaries. It will be important for commissioners to ensure that competition between providers, designed to stimulate the market, does not impede the collaboration required for the successful development and functioning of networks and the benefits they bring.

With the advent of new testing technologies, a more autonomous role for pharmacists and the recent development of more support for personalised care (eg health trainers), the range of service models and access points into sexual healthcare is increasing. Self management, such as home testing and postal testing, has the potential to cut costs and can be preferable for some individuals. In addition to testing, the scope for cheaper models for provision of treatment is also expanding, as pharmacy prescribing and over-the-counter (OTC) medication increase. Access to diagnostics and treatment via the internet is also part of the spectrum of choice available to users and this can be expected to grow, encompassing both NHS commissioned and commercial providers but also including access to services and products from overseas which are not subject to UK regulation or quality control.

As the HIV epidemic develops, many people are living healthy, independent lives on antiretroviral therapy, with fairly routine and straightforward monitoring and treatment. However, new issues are emerging related to ageing and co-morbidities among people with HIV, and the prevention and early diagnosis of these need to be encompassed within routine follow-up. In addition, challenges remain for those with significant psycho-social difficulties, who may also be more likely to start treatment late and have poor adherence. With the number of people infected increasing every year, there is a need to examine how resources can be most effectively deployed, for example through greater self-management using a Long Term Condition management model and pathways which include primary care involvement in the routine management of those whose care is straightforward. Alongside this, new models of care including psycho-social support and multi-specialty teamwork may also need to be developed to improve the quality of care for those with more complex needs.

The existence of tariffs for only some aspects of sexual health and HIV care was identified in *Progress and Priorities* as a barrier to integration and work is currently underway supported by the DH to develop new tariffs to fill the gaps (as outlined in *Moving Forward*). The challenge will be to ensure that the suite of new tariffs is used to commission integrated pathways of care and to incentivise innovation and productivity while maintaining open access, patient choice, consistent quality of care and appropriate arrangements for clinical governance. Commissioners will need to ensure there is clinical ownership and leadership, so that clinicians are on board when decisions are taken on using tariffs to support system re-alignment. By doing this, they can lay the foundations for ongoing collaboration and co-production after 2010/11 if, as stated in the *NHS Operating Framework 2010/11*, tariffs become the maximum price payable rather than the mandated price for a particular activity.

> To drive up both quality and productivity, and to improve care and outcomes for patients, it is vital that clinicians are actively engaged in determining the best clinical care pathway redesign processes that deliver improved outcomes. This applies equally to clinicians in primary, community and secondary care. PCTs must have clinical engagement embedded in their commissioning process. *(NHS Operating Framework 2010/11)*

It will be important to ensure that whatever models of care are developed in the context of financial constraint, they maintain the fundamental principles of sexual healthcare, adhere to quality standards and maintain choice for service users. Commissioners will be under great pressure to reduce costs and eliminate unnecessary expenditure. They need to be able to assess not only costs but value for money, taking account of the package of care provided by different service models, and its impact on prevention at population level as well as its safety, effectiveness and user satisfaction at individual level.

Consultative questions:

6) **What are the strategic priorities for commissioning and service re-design? Which of the following would you prioritise? Are there any others?**

   a. **Ensure local commissioners have an understanding of how to assess cost and value in sexual health and HIV care.**
   b. **Ensure commissioners are aware of how to achieve greater productivity while adhering to minimum criteria for high quality sexual health and HIV care.**
   c. **Encourage subsidiarity in sexual health decision-making, so that decisions are taken at the right level based on local needs assessment.**
   d. **Disseminate examples of effective commissioning across different footprints (multi-PCT) and of needs-based, whole system commissioning across all aspects of sexual health including primary care.**
   e. **Foster and support the development of sexual health networks in all parts of the country and use these to inform commissioning.**
   f. **Taking account of the impact of stigma, explore how the views and experiences of users and potential users of sexual health services can better be accessed and used to inform the re-shaping of service provision.**
   g. **Take forward ‘co-production’ in sexual health and HIV, with individuals taking greater ownership of their own health, and providers collaborating with commissioners to improve patient pathways and bring care closer to home.**

4.4 Workforce

To be efficient and streamlined while providing quality care, services rely on appropriately qualified staff and appropriate clinical leadership. The use of healthcare assistants can enable nurses to function at a higher level, making full use of their competencies, and this in turn enables doctors to provide more

complex medical care and specialists to focus on providing clinical leadership. This effective, non-wasteful deployment of human resources requires sustained investment in training and ongoing professional development at all levels, but this should be recognised as investment to save, through the achievement of greater productivity.

The role of nurses is pivotal for the further development of efficient and effective sexual health services. Nurse training in sexual health is fragmented, and, since the demise of the ENB, there is no shared competency framework for nurses providing STI and contraceptive care and no standard curriculum or qualifications for sexual health nursing nationwide. A number of organisations and areas have undertaken pieces of work to address this gap and the Department of Health is currently commissioning a short project to bring these together into an overall framework. This will be promoted to higher educational establishments to bring greater consistency and quality to nurse education and training. This work is important to create and maintain a workforce able to take forward the vision for high quality sexual healthcare and improved productivity through the streamlining and re-design of services.

A further priority should be to address the gaps where service development and health improvement are impeded because of the lack of sufficient numbers of trained healthcare workers. An example is the fitting of LARC methods, which are more effective and cost-effective than other methods of contraception[24] but are currently used by a relatively small minority of women and not fitted by many clinicians who prescribe other methods.

Since the sexual health strategy review which highlighted the particular medical workforce difficulties in contraceptive services, the creation of a new medical specialty and career structure has been agreed for Community Sexual and Reproductive Health. However, it will take time for the full impact of this on the workforce to be felt, and in the meantime, clinical leadership for the provision of contraception will be thinly spread, especially as long as the commissioning of specialist contraceptive provision across the country remains patchy.

There has been considerable collaboration in recent years between the principal medical specialties in sexual health as regards training, with efforts to ensure curricula and courses available are complementary. Electronic learning provides the opportunity for more flexible, learner-focused development alongside practical training and competency assessment. Further development of dual training for doctors and other clinical staff would support the development of greater integration of sexual health services. This will involve collaboration and joint working between different Colleges and specialties.

The largest provider of sexual healthcare, providing 80% of contraception, is general practice. Although sexual health is now more prominent within the GP postgraduate curriculum, and the development of a major e-learning module by the RCGP (as part of e-Learning for Health) is almost complete,

most GPs and practice nurses have had little dedicated training on sexual health. Access to a range of training is available for those with an interest, and this should increase the potential of general practice to take a more active role in providing sexual healthcare, perhaps commissioned as locally enhanced services. However, we are still far from the point where anyone presenting to general practice with a sexual health concern is able to receive care at Level 1, as defined in the sexual health strategy. Increased training and development opportunities, appropriate to general practice, are needed along with levers to encourage its take-up. Such levers are likely to need to include incentives for greater general practice involvement in sexual health, such as further QOF points at national and/or local level.

Like general practice, pharmacy is accessed by a large proportion of the population and its growing involvement in the provision of sexual healthcare has the potential to increase further, alongside the provision of health promotion advice and signposting to sexual health services. There is also a much wider non-sexual health workforce in contact with those at highest risk, such as youth workers, student welfare and probation staff, who can provide information and signposting to help people manage their sexual health and access services when needed. Consideration should be given as to how best to utilise the potential of this varied workforce and to ensure it receives appropriate training and support.

The sexual health commissioning workforce should also not be overlooked. Under World Class Commissioning[25], commissioners are the local leaders of the NHS. They need to be agents for transformational change and this is especially important in the current financial and policy context. However, the sexual health commissioning workforce is fragmented: a number of individuals within a single PCT may each be allocated, for a small part of their working time, to the commissioning of just one part of local sexual healthcare, and there may be insufficient coordination between them. Also many commissioners responsible for sexual health have limited experience of this area of healthcare. PCTs should be encouraged to consolidate their sexual health commissioning function in order to foster both a strategic overview across sexual health commissioning and a concentration of sexual health expertise. This might be at PCT level or for the commissioning of sexual health services on behalf of a PCT consortium.

The DH's forthcoming sexual health commissioning framework and toolkit[26] will provide wide-ranging information and guidance to improve sexual health commissioning. Additional analysis would also be helpful to identify how further to support improvement in the capacity and capability of the sexual health commissioning workforce.

> We need bold, capable commissioners if we are to meet our goals of improved health outcomes, reduced health inequalities, improved provider quality and increased productivity. *(NHS Operating Framework 2010/11)*

Consultative questions:

7) What are the strategic priorities relating to the workforce in sexual health and HIV? Which of the following would you prioritise? Are there any others?

   a. Develop a national workforce development strategy and local workforce plans for sexual health, with priorities to include:
      - **Standardisation of sexual health nurse training**
      - **Broadening the reach of training and incentivising improvement in general practice**
      - **Growing commissioning competencies for sexual health**
      - **Building the health promotion workforce and infrastructure**

   b. Embed sexual health in generic workforce development initiatives, eg public health workforce.

   c. Provide protection and/or incentives for investment in training of the sexual health workforce.

4.5 Leadership and levers

Through the *National Strategy for Sexual Health and HIV*, followed by *Choosing Health* and more recently the final report of the *NHS Next Stage Review*, sexual health has been identified in the last few years as a national public health priority. National targets and local indicators have provided levers for local implementation. However, this was not always the case, and sexual health was at times a 'Cinderella' area of healthcare, suffering from a lack of priority and investment. Decision-makers are not immune from the stigma attached to HIV and sexual health and this can militate against decisions to give it strategic priority. With decision-making now located primarily at local level, the risk of local de-prioritisation of sexual health is likely to be exacerbated by the current and forthcoming financial challenges facing PCTs.

Strong leadership is therefore crucial, at national, regional and local level. A new strategy or action plan with visible high level ownership by government, would be a manifestation of this. Cross-governmental shared ownership would support such a strategy/plan in addressing the broader social determinants of poor sexual health and applying the tools to combat these.

In the traditionally fragmented field of sexual health and HIV, the Independent Advisory Group on Sexual Health and HIV has fostered debate between leaders in the field, provided a focal point for knowledge and understanding of the key challenges, and facilitated consensus independent from Government on priorities for action to improve sexual health. The role of the IAG is particularly valuable because of the absence of significant patient and public

advocacy on sexual health, the range of different specialties and providers involved and the stigmatised nature of sexual health and HIV.

In some areas of strategic priority in healthcare, a national clinical leader ("czar") has been appointed to work within the DH. The 2009 IAG report on contraception and abortion[5] recommended improvements in information, commissioning and workforce development but added that "if, despite [these] improvements …, unwanted pregnancies continue at anything like their present level, more radical options for delivering contraceptive services in a wider range of settings should be considered. In that case, the Government should appoint a national lead (czar) to assess how experience in other countries, based on World Health Organisation standards, to widen access to contraception could be adapted in the UK, especially to meet the needs of those women whom present services are most likely to fail." The appointment of a national 'czar' might provide the leadership to drive innovation, quality improvement and system alignment in sexual health across the country.

At local level, a key lever for improving delivery would be the retention of sexual health in the top priorities for performance management. If it does remain, and sexual health indicators continue to be a part of national indicator sets (in the National Indicator Set and Vital Signs), there is a dilemma. Targets or indicators, when prioritised, have demonstrated their effectiveness in improving performance (eg GUM 48-hour access and teenage pregnancy). However, by focusing on a specific aspect of sexual health, they run the risk of distorting priorities and taking attention away from other areas of sexual health. As far as possible, a holistic view of sexual health should therefore be adopted in developing and using indicators, and performance management should seek to assess holistic sexual health improvement across a local health economy. This is challenging, and measurement may be difficult. Work is underway to develop a balanced scorecard for sexual health.

A further local lever for improving delivery is World Class Commissioning (WCC). However, as sexual health is unlikely to be in the top ten health outcomes chosen by most PCTs for the WCC assurance process[27], the drive for high quality commissioning of sexual health and HIV will depend on local leadership and prioritisation.

Consultative questions

8) Would it be helpful to appoint a sexual health 'czar'? If so, what would their role be?

9) Are indicators and performance management the key levers for implementation of sexual health strategy at local level? Are there others which should be developed or strengthened?

10) Do you have any other suggestions for strengthening leadership at local, regional or national level?

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Appendix A

Further action in relation to strategy aims

The table below revisits and updates the aims of the original sexual health strategy, adding an additional one of ‘improving sexual health and wellbeing’ to reflect current policy emphasis, and identifies the range of actions required in 2008 and beyond to move closer towards realising them.

The table is taken from *Progress and Priorities – working together for high quality sexual health. Review of the National Strategy for Sexual Health* (2008)[1]

Table 8 | Strategy aims – further action required	
Strategy aims	**Focus for further action**
Reduce unintended pregnancy rates and improve care for women seeking abortion	• Improve access to the full range of contraceptive methods and regularly audit services • Improve professional and public knowledge of the most effective methods of preventing pregnancy (focus on adults as well as teenagers) • Protect and develop community contraceptive services to ensure their training and clinical governance role and preserve patient choice (but not excluding moves towards integration) • Increase availability and uptake of LARC • Develop a best practice protocol for commissioning abortion services • Improve access to NHS-funded early medical and surgical abortion and 2nd trimester abortion • Implement strategies to reduce the number of repeat unwanted pregnancies (by ensuring comprehensive care pathways are in place that include provision of appropriate contraception as part of post-abortion and post-natal care) • Extend locations for abortion services to community-based settings • Build the evidence base around factors affecting uptake and continuation of contraception • Take a strategic, needs-based approach to workforce capacity to ensure the contraceptive provider network meets service requirements
Reduce transmission of HIV and STIs	• Invest in national and local prevention programmes which target those most at risk and those already infected to prevent acquisition and onward transmission • Invest in and disseminate research which improves understanding of the reasons for continuing transmission and barriers to prevention, to tailor prevention interventions • Build the evidence base for what works and ensure this informs prevention programmes • Improve HIV incidence data (using the Serological Testing Algorithm for Recent HIV Seroconversion - STARHS) to enable monitoring of prevention effectiveness *The actions in the box below will also help to achieve this aim*
Reduce prevalence of undiagnosed HIV and STIs	• Develop and implement strategies to increase HIV testing in a range of existing and new settings (eg. in medical settings as part of routine diagnostic procedures, in general practice for identified at risk populations, in non-healthcare settings delivered by community organisations) • Ensure maximum uptake of antenatal screening and equity across providers • Improve understanding among professionals and policy-makers of the barriers (cultural, attitudinal, regulatory) to HIV testing, particularly in communities most affected • Facilitate prompt testing and treatment for STIs (including partner notification) by maintaining 100% access within 48 hours to GUM services, and expanding range of other services providing STI testing and treatment within 48 hours • Improve professional and public awareness of STIs, especially those which are asymptomatic • Expand the chlamydia-screening programme to reduce population prevalence, with effective partner management as a central component and key providers (especially general practice) actively involved to maximise coverage
Improve health and social care for people living with HIV	• Reduce morbidity and mortality associated with HIV through early diagnosis, timely access to clinical care and appropriate support to facilitate uptake of and adherence to highly active antiretroviral therapy (HAART) • Improve the well-being of people living with HIV through measures to involve them in managing their sexual health and individual care and in planning and evaluating services • Ensure services are integrated and meet the long-term condition management and social care needs of people with HIV • Recognise the central role of people living with HIV in preventing transmission, and integrate prevention into services and support provided for this group
Reduce stigma associated with HIV and other aspects of sexual health	• Improve public understanding and promote positive attitudes through leadership, visibility of people affected by HIV and other sexual health conditions, and informed public information and media coverage • Strengthen understanding in the sexual health and wider workforce (health, education, social care) of the needs and experiences of people living with HIV, facing an unplanned or unwanted pregnancy, or using sexual health services, and ensure policies and practices are in line with action to eradicate stigma • Review legislation and other government polices which fuel and reinforce stigma, and promote legislation and regulations which prohibit discrimination • Ensure sexual health services are positive and affirming for young people, and those of all ages, supporting them to take responsibility to have safe, fulfilling, healthy and pleasurable sexual relationships
Improve sexual health and well-being	• Support people to acquire the knowledge, skills and values essential to stay healthy, and to maintain and improve sexual health and well-being at all life stages (through access to good-quality SRE, life-long learning programmes and awareness and information campaigns) • Widen access to and scope of sexual health provision across general practice, primary-care health centres/polyclinics, pharmacies, schools, Further Education (FE) colleges and other youth settings, community/third sector organisations and workplaces where appropriate • Utilise research and social marketing techniques to understand more clearly what lies at the root of sexual risk-taking behaviours, particularly in relation to use of alcohol and drugs, and develop appropriate interventions to tackle these links • Review evidence about wider social determinants of sexual health and ill-health, and the factors affecting inequalities in sexual health, to inform policy development, educational interventions and service planning • Recognise psychosexual health as an integral part of sexual health, and ensure equitable access to psychosexual and sexual dysfunction services of consistent quality by ensuring geographical equity in provision and development of appropriate links between services • Adopt a holistic approach to sexual health to meet the needs of those vulnerable to multiple negative health outcomes (such as those who have experienced sexual assault, abuse and violence, the homeless, people in prison, sex workers, drug users, some ethnic minority groups, people seeking asylum and other migrants)

Appendix B

Consultative questions

Strategic vision

1) To set the strategic direction for sexual health and HIV in 2011 and beyond, would it be more appropriate to develop:
   - a new long-term strategy for sexual health and HIV?
   - a three-year operational plan, retaining the broader vision of the original sexual health strategy and *Choosing Health*?
   - some other option?

2) Is the *framework for further action* at Appendix A still appropriate for 2011 and beyond ?

3) Have there been any significant changes or developments in relation to sexual health and HIV which should affect strategic priorities?

4) Are there any issues within sexual health and HIV which would merit the development of a separate or additional strategic framework (eg long-term care for people with HIV)?

Prevention and wellbeing

5) What are the strategic priorities for prevention and wellbeing? Which of the following would you prioritise? Are there any others?

   a. Gather and disseminate the evidence base for cost saving and cost effectiveness of investment in prevention (including assessment of the preventive impact of treatment services) in the sexual health field, including HIV
   b. Commission research to expand and update this evidence base
   c. Embed sexual health in broader public health and wellbeing programmes
   d. Overhaul and protect health promotion infrastructure to support implementation of preventive interventions, and ensure they are of high quality and evidence based
   e. Identify how to move investment in sexual health 'upstream' to affect the determinants of sexual ill-health
   f. Launch a programme to improve the timeliness of HIV diagnosis and the proportion of infections diagnosed, which would include raising public and professional awareness, increasing availability of testing for groups at highest risk, and engaging all relevant clinical, healthcare

and other professionals in improving rates of testing and clinical diagnosis.

Commissioning and service re-design

6) What are the strategic priorities for commissioning and service re-design? Which of the following would you prioritise? Are there any others?

   a. Ensure local commissioners have an understanding of how to assess cost and value in sexual health and HIV care.
   b. Ensure commissioners are aware of how to achieve greater productivity while adhering to minimum criteria for high quality sexual health and HIV care.
   c. Encourage subsidiarity in sexual health decision-making, so that decisions are taken at the right level based on local needs assessment.
   d. Disseminate examples of effective commissioning across different footprints (multi-PCT) and of needs-based, whole system commissioning across all aspects of sexual health including primary care.
   e. Foster and support the development of sexual health networks in all parts of the country and use these to inform commissioning.
   f. Taking account of the impact of stigma, explore how the views and experiences of users and potential users of sexual health services can better be accessed and used to inform the re-shaping of service provision.
   g. Take forward ‘co-production’ in sexual health and HIV, with individuals taking greater ownership of their own health, and providers collaborating with commissioners to improve patient pathways and bring care closer to home.

Workforce

7). What are the strategic priorities relating to the workforce in sexual health and HIV? Which of the following would you prioritise? Are there any others?

   a. Develop a national workforce development strategy and local workforce plans for sexual health, with priorities to include:
      - Standardisation of sexual health nurse training
      - Broadening the reach of training and incentivising improvement in general practice
      - Growing commissioning competencies for sexual health
      - Building the health promotion workforce and infrastructure

b. Embed sexual health in generic workforce development initiatives, eg public health workforce.
c. Provide protection and/or incentives for investment in training of the sexual health workforce.

Leadership and levers

8) Would it be helpful to appoint a sexual health ‘czar’? If so, what would their role be?

9) Are indicators and performance management the key levers for implementation of sexual health strategy at local level? Are there others which should be developed or strengthened?

10) Do you have any other suggestions for strengthening leadership at local, regional or national level?

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Medical Foundation for AIDS & Sexual Health (MedFASH)
BMA House, Tavistock Square, London, WC1H 9JP
Tel: 020 7383 6345
Email: enquiries@medfash.bma.org.uk
www.medfash.org.uk

Registered charity no: 296689