

Better prevention

Better services

Better sexual health

The national strategy for sexual health and HIV

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Foreword

The last thirty years has seen an unprecedented shift in this country in attitudes towards sex and sexuality. The reasons for these changes are complex and wide-ranging.

There have been success stories in the way new and emerging threats to sexual health have been tackled. The control of HIV in England through providing people with information about risks, open access to Genito-Urinary Medicine (GUM) clinics and measures such as needle exchange schemes have resulted in us having one of the lowest rates of HIV in Western Europe. The availability of a broad range of contraceptive methods provided free by the NHS has given many women and men the opportunity to plan their families.

Despite these advances, there can be no room for complacency, as there are serious challenges to be met. There are an increasing number of people living with HIV, the rates of sexually transmitted infections have increased significantly in recent years, and there is a high rate of unintended pregnancies. Evidence suggests that many people lack the information they want and need to make informed choices that will affect their sexual health. There is a clear relationship between sexual ill health, poverty and social exclusion. The quality of service provision remains varied across the country. For all these reasons it is time to re-examine traditional approaches to the way problems associated with sexual health are addressed.

This sexual health and HIV strategy has been drawn up with experts and service users across the country, in line with the principles set out in the NHS Plan. It is part of a nationwide programme of investment and reform, to modernise services around the needs of patients and service users, tackle inequalities, and ensure that the NHS works to prevent ill health as well as treating problems once they arise.



Yvette Cooper

Parliamentary Under Secretary of State for Public Health

July 2001

This strategy has been developed by involving a range of stakeholders including service users, members of target groups and professionals in the field. A list of members of the strategy steering group is at **appendix 1**.

The criteria for all national public consultations is set out in **appendix 2**.

We would welcome views on this document. Any comments should be sent to:

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by **21 December 2001** at the latest, please.

Summary

This is the first national Strategy for sexual health and HIV. It is a Strategy that will modernise sexual health and HIV services in this country. It addresses the rising prevalence of sexually transmitted infections (STIs) and of HIV.

The consequences of poor sexual health can be serious. Unintended pregnancies and STIs can have a long lasting impact on people's lives. The number of visits to genito-urinary medicine (GUM) clinics has doubled over the last decade and now stands at over a million a year.

There is a clear relationship between sexual ill health, poverty and social exclusion. There is an unequal impact of HIV on gay men and on certain minority ethnic groups. For too long there have been significant variations in the quality of sexual health services across the country. This is not acceptable. This is a Strategy that addresses the need to raise standards of services in line with the principles set out in the NHS Plan.

HIV remains a life-threatening condition. There is still no cure. The introduction of drug therapies has improved the lifespan of people infected with HIV. But this has presented fresh and difficult challenges for those involved in their treatment, support and care. This is a Strategy that acknowledges and addresses the complex issues associated with HIV.

This Strategy aims to:

- reduce the transmission of HIV and STIs;
- reduce the prevalence of undiagnosed HIV and STIs;
- reduce unintended pregnancy rates;
- improve health and social care for people living with HIV; and
- reduce the stigma associated with HIV and STIs.

All this adds up to a Strategy that proposes:

- providing clear information so that people can take informed decisions about preventing STIs, including HIV;
- ensuring there is a sound evidence base for effective local HIV/STI prevention;
- setting a target to reduce the number of newly acquired HIV infections;
- developing managed networks for HIV and sexual health services, with a broader role for those working in primary care settings and with providers collaborating to plan services jointly so that they deliver a more comprehensive service to patients;
- evaluating the benefits of more integrated sexual health services, including pilots of one-stop clinics, primary care youth services and primary care teams with a special interest in sexual health;

- beginning a programme of screening for Chlamydia for targeted groups in 2002;
- stressing the importance of open access to GUM services and, over time, improving access for urgent appointments;
- ensuring a range of contraceptive services are provided for those that need them;
- addressing the disparities that exist in abortion services across the country;
- increasing the offer of testing for HIV and setting a target to reduce the number of undiagnosed infections, thereby ensuring earlier access to treatment for those infected and limiting further transmission of the virus;
- increasing the offer of hepatitis B vaccine;
- setting standards for the treatment of STIs and for the treatment, support and social care of people living with HIV;
- setting priorities for future research to improve the evidence base of good practice in sexual health and HIV; and
- addressing the training and development needs of the workforce across the whole range of sexual health and HIV services.

The NHS Plan highlights the need for patients to have a real say in the NHS and sets out action that is needed to make that happen. Building on that, this Strategy emphasises that the planning and provision of services benefit from involving service users and their representatives. Voluntary organisations have a crucial role to play too, particularly in the HIV field. Commissioners will therefore develop effective partnerships with voluntary organisations, service users and their representatives.

The Strategy is ambitious and comprehensive, and it requires a ten-year commitment to deliver what it proposes. As a start we will invest an extra £47.5 million over the next two years to support a range of initiatives set out in this document. If the strategy succeeds it will have contributed to reducing health inequalities. It will have set in place modern, efficient and patient-centred services, accompanied by a reduction in the burden of sexual ill health and HIV.

This Strategy will be strengthened through public consultation on its proposals over the coming months. The final Strategy will demonstrate that the Government has listened to the views of service users, their representatives and the wider public, as well as other stakeholders such as service providers and health professionals.

1 Sexual health in England today – setting the scene

Sexual health is an important part of physical and mental health. Sexual health problems in England have grown in recent years. More HIV infections are being diagnosed and sexually transmitted infections are rising. England has the highest teenage birth rates in Western Europe.

Introduction

- 1.1 Our sexual health affects our physical and psychological wellbeing and is central to some of the most important and lasting relationships in our lives. It follows that protecting, supporting and restoring sexual health is important.
- 1.2 The Government's strategy for sexual health and HIV proposes a comprehensive and holistic model:

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

The problems

- 1.3 Rising infection rates, the arrival of the HIV epidemic in the 1980s, evidence of increased risk taking and – often – poor control of infections, have all helped to raise the level of concern among health professionals, the Government and the public. The most common conditions now are Chlamydia, non-specific urethritis and wart virus infections, but almost all sexually transmitted infections (STIs) are becoming more common.
- 1.4 The number of visits to Departments of genito-urinary medicine (GUM) in England has doubled over the last decade¹ and now stands at over a million a year [figure 1]. Diagnoses of genital Chlamydia also almost doubled during the 1990s, with a particularly marked increase in men and women aged under 20. Recent surveys of women indicate Chlamydia² infection rates of up to 12% and there are more reports of outbreaks of syphilis³. The number of HIV infections newly diagnosed in 2000 was the highest since reporting began [figure 2].

1 Trends in sexually transmitted infections in the United Kingdom, 1990 – 1999. New episodes seen at genito-urinary medicine clinics: PHLS (England, Wales & Northern Ireland), DHSS & PS (Northern Ireland) and the Scottish ISD(D)5 Collaborative Group (ISD, SCIEH and MSSVD): December 2000, ISBN 09001144 49 5

2 Stokes T, Screening for Chlamydia in general practice: Literature review and summary of the evidence; J of public Health Medicine 1997 19(2), 227-232

3 CDSC 'Increased transmission of syphilis in Brighton and Greater Manchester among men who have sex with men': Communicable Disease Report Weekly 27 October 2000: Vol. 10 (43) 383-6

New Attendances at GUM Clinics. England, 1960–1999

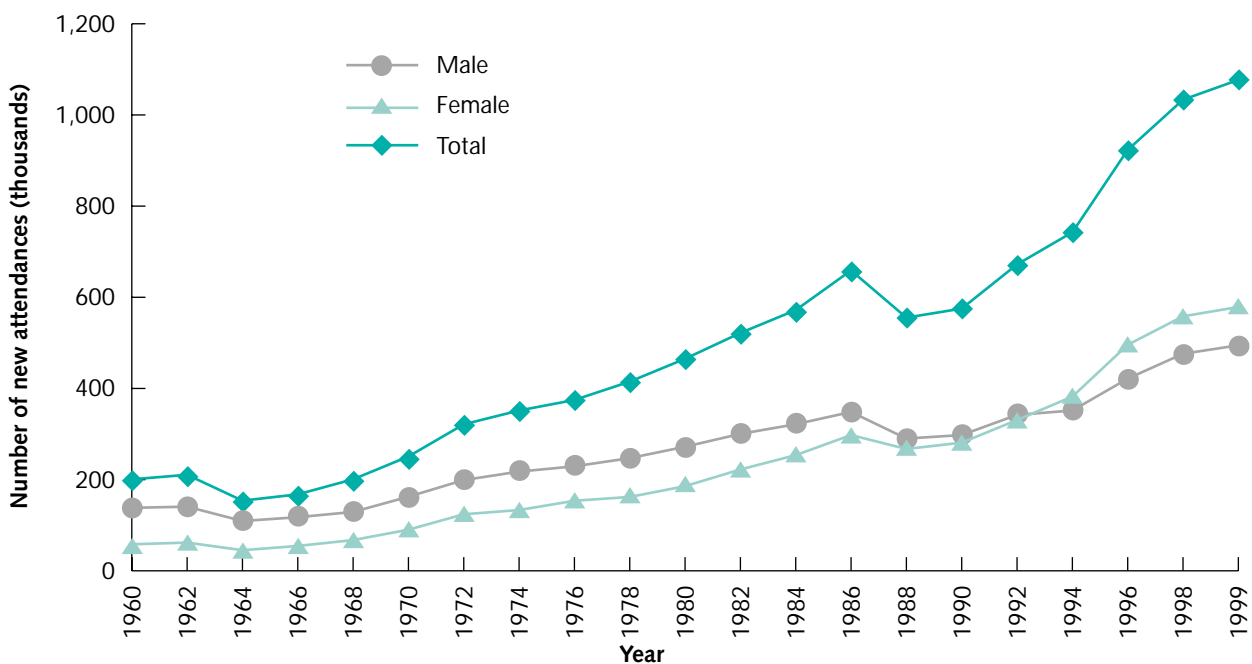


Figure 1

Number* of newly reported HIV infections in England by year of diagnosis (data to end March 2001)

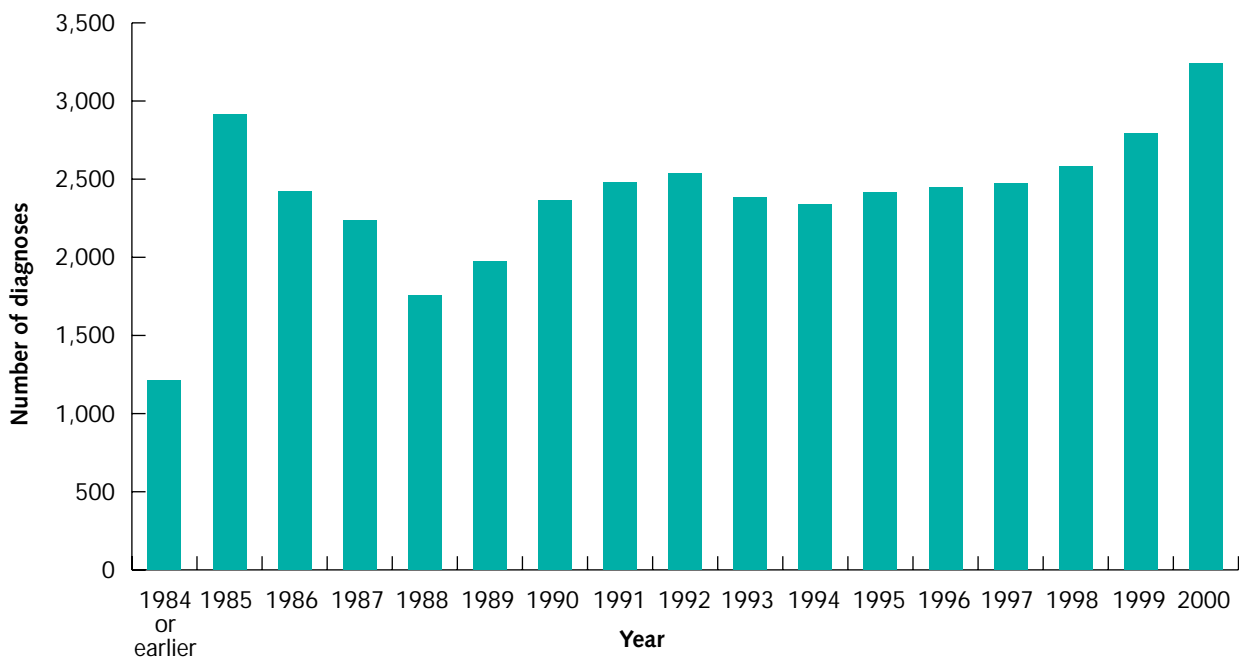


Figure 2

*Numbers, particularly for recent years, will rise as further reports are received. [Source: AIDS/HIV Quarterly Surveillance Tables]

1.5 Many sexual infections have long-term effects on health. Some genital wart infections are associated with cervical cancer, as is Chlamydia⁴. Left untreated, Chlamydia can result in pelvic inflammatory disease which can lead to ectopic pregnancy and infertility⁵.

4 Anttila T et al. Serotypes of Chlamydia trachomatis and risk of development of cervical squamous cell carcinoma. JAMA 2001; 285: 47-51

5 Stamm W, Guinan M, Johnson C et al. Effect of treatment regimens for Nesseria gonorrhoea on simultaneous infection with Chlamydia trachomatis. N Engl. J Med. 1984;310:545-9

Consequences of poor sexual health

- Pelvic inflammatory disease, which can cause ectopic pregnancies and infertility
- HIV
- Cervical and other genital cancers
- Hepatitis, chronic liver disease and liver cancer
- Recurrent genital herpes
- Bacterial vaginosis and premature delivery
- Unintended pregnancies and abortions
- Psychological consequences of sexual coercion and abuse
- Poor educational, social and economic opportunities for teenage mothers

International comparisons

- 1.6 England is not unique – other European countries have similar problems. France, the Netherlands, Sweden and Switzerland have all reported increases in gonorrhoea between 1995 and 1999⁶, particularly among men having sex with men. The same group has also suffered outbreaks of syphilis.
- 1.7 Despite the rise in newly diagnosed infections, HIV prevalence in England has stayed low compared with some other Western European countries. This reflects prompt action on a number of fronts: health promotion, needle exchange schemes and other harm minimisation initiatives, screening of blood and clinical interventions, the availability of open-access GUM clinics and careful surveillance and analysis of trends.

HIV

- 1.8 An estimated 30,000 people are living with HIV in the United Kingdom, of whom a third are undiagnosed. There is still no cure. There probably won't be a highly effective vaccine for at least five years. About 400 people a year die as a result of their HIV infection. The year 2000 saw the largest annual number of newly diagnosed HIV infections since the start of the epidemic, and for the second year running the number of new infections acquired through heterosexual sex outnumbered those acquired through homosexual sex. However, three quarters of these heterosexual infections were probably acquired abroad, which means that sex between men remains the major transmission route for HIV in this country. HIV prevalence by the end of 2003 is expected to be 40% higher than the 1999 level⁷.
- 1.9 Combination therapy has improved the lifespan of people living with HIV. Better survival rates combined with the growing numbers of new infections, mean that the number of people living with HIV is rising. Recently, there have been increasing concerns about resistant HIV strains and their sexual

⁶ Nicoll A, Hamers F F: Emerging trends in HIV, gonorrhoea and syphilis in Western Europe (in press/personal communication)

⁷ AIDS and HIV Infection in the United Kingdom: monthly report. CDR 2000, 10 (50), 453–4

transmission. All of these present some real challenges for long term clinical treatment, care and social support, as well as for prevention of further transmission.

- 1.10 HIV therapies are complex, expensive and extremely demanding on the patient. The human costs for people living with HIV are high. Many cannot work, and others can still suffer ill-informed prejudice and discrimination. Children with HIV have an especially difficult time – as well as the effects on their own health they may face losing one or both of their parents prematurely.

Sexual behaviour & knowledge

- 1.11 Studies suggest there has been an increase in risky sexual behaviour, and that there is still ignorance about the possible consequences. The average age at which people start having sex is now 17. Forty years ago it was 21 for women and 20 for men. Between a third and a half of teenagers do not use contraception at first intercourse⁸. Over a quarter of 14–15 year olds think that the contraceptive pill protects against infection⁹. In 1999 most people questioned in a national study did not know what Chlamydia was¹⁰.
- 1.12 A 1999 survey of gay men showed that 58% of those under 20 did not always use a condom¹¹. A recent study indicated that 44% of HIV positive men had anal sex with a new partner in the last month, of whom 40% reported no or inconsistent condom use¹².

Teenage pregnancy and unintended pregnancy

- 1.13 Sexual health is not just about disease. Ignorance and risky behaviour can also have profound social consequences.
- 1.14 Planning parenthood, understanding contraception and the age of first intercourse can all have an important impact on individuals and communities. England's teenage birth rates are the highest in Western Europe – treble those in France and six times those in the Netherlands.
- 1.15 In 1999 there were nearly 174,000 abortions performed in England and Wales. Abortion rates are highest for women in their twenties [figure 3].

8 Wellings K, Field J, Johnson AM, Wadsworth J. *Sexual behaviour in Britain, The National Study of Sexual Attitudes and Lifestyles*, Penguin 1994

9 Health Education Authority, *Young People and Health*, HEA 1999

10 Dawe F, Meltzer M. *Contraception and Sexual Health 1999: A report on using the ONS Omnibus survey produced on behalf of the Department of Health*. National Statistics ISBN 1 88774 4136

11 Sigma Research. *Vital Statistics Findings from the National Gay Men's Sex Survey 1999*, July 2000 ISBN 0872956521

12 Imrie J, Davis MD, Black S, Hart GJ, Davidson OR, Williams IG, Stephenson JM. "Meeting the sexual health needs of HIV-seropositive gay men in a pre-requisite to developing the next generation of prevention strategies". (Oral presentation) 14th Meeting of the International Society for Sexually Transmitted Diseases Research (ISSTD) and International Congress of Sexually Transmitted Infections, Berlin Germany. 24-27 June 2001

Abortion Rate per 1000 14–49 year olds, 1999



Figure 3

Inequality

- 1.16 Sexual ill health is not equally distributed among the population. The highest burden is borne by women, gay men, teenagers, young adults and black and minority ethnic groups^{13, 14}. The rates of gonorrhoea in some inner city black and minority ethnic groups are ten or eleven times higher than in whites¹⁵. HIV infection also has an unequal impact on some ethnic and other minority groups. Britain's African communities have been particularly badly affected by HIV/AIDS, with high rates among both adults and children¹⁶.
- 1.17 There is a strong link between social deprivation and STIs, abortions and teenage conceptions [see figure 4]. Unintended pregnancies increase the risk of poor social, economic and health prospects for both mother and child. Girls from the poorest backgrounds are ten times more likely to become teenage mothers than girls from wealthier backgrounds.

13 Lacey CJN, Merrick DW, Bersley et al. Analysis of the socio-demography of gonorrhoea in Leeds, 1989-93: *BMJ* June 14 1997; 314; 1718-9

14 Hughes G, Catchpole M, Rogers PA et al. Comparison of risk factors for sexually transmitted infections: results from a study of attenders at three genito-urinary medicine clinics in England: *Sex. Trans. Inf.* 2000; 76: 262-267

15 Low N, Daker-White G, Barlow D, Pozniak AL. Gonorrhoea in Inner London: results of a cross sectional study: *BMJ* 1997 June 14; 314 (7096): 1719-23

16 Communicable Disease Report, AIDS & HIV infection in the UK: monthly report; 26 April 2001: Vol. 11, No.17

Gonorrhoea rates per 1000 men and women, all ages, 1999

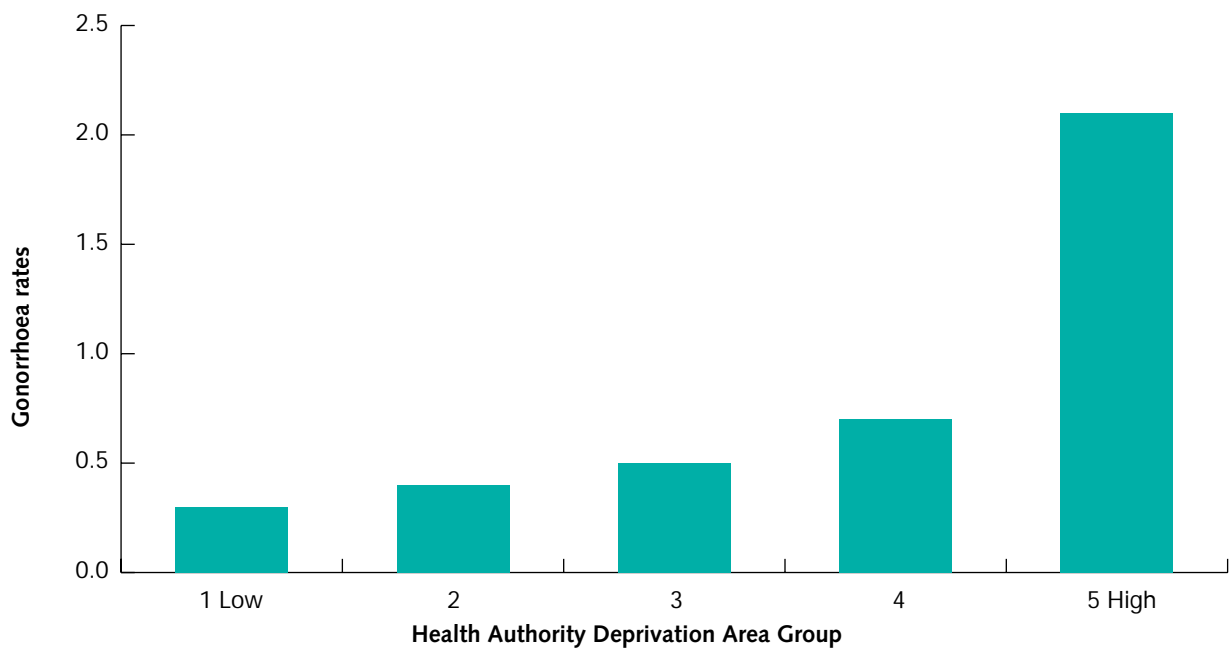


Figure 4

Inequity of current service provision

1.18 As well as the inequalities in sexual health itself, there are significant variations in the way sexual health services are provided [see figure 5], including health promotion and HIV prevention. This affects the quality and range of services as well as access to them. For example, the percentage of abortions funded by the NHS varies between 46% and 96% in different health authorities, and there is no evidence that this relates to variation in need.

Rates of First Contacts at Family Planning Clinics per 1000 women aged 20-24 years

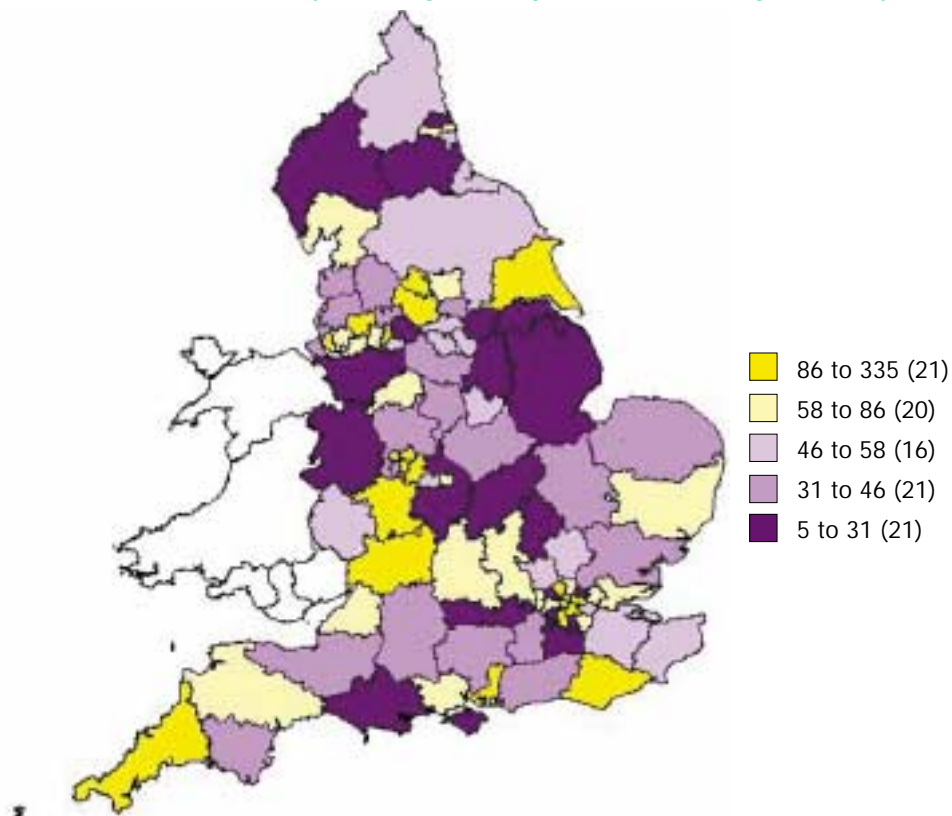


Figure 5

- 1.19 Pressure on sexual health services has led to unacceptable delays in accessing services. A recent survey of GUM clinics found delays of up to a week for urgent appointments and four weeks for routine appointments¹⁷. The effectiveness of joint working within and between organisations is also too variable.
- 1.20 These inequities are no longer tolerable. The NHS Plan signalled the Government's determination to tackle unjustified variations and raise standards permanently, and that applies to sexual health and HIV services as much as to any other.

Costs

- 1.21 Poor sexual health costs the country a lot of money. Preventing poor sexual health has significant potential not just for better health, but for the better use of finite resources. The prevention of unplanned pregnancy by NHS contraception services probably saves the NHS over £2.5 billion a year already. The average lifetime treatment costs for an HIV positive individual is calculated to be between £135,000 and £181,000¹⁸, and the monetary value of preventing a single onward transmission is estimated to be somewhere between £½ and 1 million in terms of individual health benefits and treatment costs. We can also reduce dramatically the costs associated with preventable infertility.

Conclusion

- 1.22 Improving sexual health in England will have major benefits for overall health and wellbeing, and for NHS resources. The NHS provides a comprehensive range of sexual health services – including GUM clinics, community family planning clinics and services in primary care – but too often they are fragmented, poorly advertised and too narrowly focused. Access is a problem in some parts of the country. In rural areas especially, long journeys and patchy provision often restrict access to services. Information on sexual health is often out of date or simply not available.
- 1.23 The problems are real, but they are not a cause for pessimism. For the first time, this strategy sets out a programme that begins to put things right. It strengthens programmes that prevent sexual health problems, and it sets out important new measures for improving people's understanding of the issues, for better planning of services and for better provision of treatment.

17 Djuretic T et al, Genito-urinary Medicine services in the United Kingdom are failing to meet the current demand (in press)

18 Beck EJ et al, for the NPMS-HHC Steering Group. "Reduced HIV disease progression and mortality due to CART in English NPMS-HCC clinics". 13th International AIDS Conference, Durban, South Africa, 9-14 July 2000: Poster TuPeC3331

2 Aims and principles

This strategy applies the values and principles of the NHS Plan to sexual health. It sets out to redesign services around the people who use them and aims to:

- improve services, information and support for all who need them;
- reduce inequalities in sexual health; and
- improve health, sexual health and well being.

Introduction

- 2.1 This strategy's fundamental aim is to improve England's sexual health. We need to foster a culture of positive sexual health by making sure that everyone gets the information they need – without stigma, fear or embarrassment – so that they can take informed decisions to prevent STIs, including HIV, and about services.
- 2.2 The strategy recognises that sexual health is important throughout life, and that people's needs for information and demands for services vary according to their age, way of life and sexual orientation.

Principles

- 2.3 The NHS Plan¹⁹ set out a sustained programme of investment and reform designed to deliver faster, better quality and more patient-centred care. This strategy takes the Plan's principles and applies them to sexual health and HIV services.
- 2.4 This means:
- ***Shaping services around patients, their families and their carers*** – the strategy focuses services more closely on people and gives patients' representatives and the public a bigger say in planning future developments.
 - ***Working with others*** – partnership at all levels is central to the strategy's success: between health and social care agencies, Government departments, prisons, voluntary organisations and private service providers as well as with patients and citizens.
 - ***Keeping people healthy and reducing health inequalities*** – the strategy sets out new ways to plan, fund and deliver sexual health promotion and HIV prevention services and tackle inequalities.

19 Department of Health: The NHS Plan, A plan for investment, a plan for reform: CM4818, Stationery Office July 2000: ISBN 0101481829

- ***Providing a comprehensive service*** – sexual health services can be patchy and poorly co-ordinated. The strategy describes effective models for services and sets new standards for fair access.
- ***Responding to the different needs of different populations*** – the strategy shows that services should meet the needs of local communities, and identifies where service developments are needed most.
- ***Continuously improving services*** – this strategy acknowledges the need for standards for sexual health and HIV services and for the agencies providing them. It sets out underpinning programmes of professional education, training, information and research to support continuous improvement in quality.
- ***Respecting confidentiality and providing open access to information about services, treatment and performance*** – the sensitivity of sexual health issues makes confidentiality and ease of access to information especially important.

2.5 Turning those principles into practice will mean:

- that everyone has better access to good services and information on sexual health;
- that services are focused on people;
- that key groups get the resources and developments they need;
- fewer undiagnosed infections;
- lower rates of unintended pregnancies;
- better health and social care for people living with HIV; and
- reducing the stigma associated with HIV and STIs.

3 Better prevention

National information campaigns.

Health Development Agency guidance on evidence-based prevention.

Clear targets and new reporting guidelines for local HIV prevention.

A national target for reducing the number of newly acquired HIV infections.

Introduction

- 3.1 Preventing poor sexual health depends on everyone having the information, skills and services that they need. Skilled professionals in health, education, social care and voluntary services play vital roles in HIV and STI prevention and raise awareness of sexual health and help people to get the information and services they need. In particular, their work has made a significant contribution to maintaining the low prevalence of HIV in England.
- 3.2 Attitudes to sex and sexuality have changed significantly and rapidly. In general, people – especially younger people – are more open about sex and more tolerant of homosexuality. Nevertheless, many still find the subject difficult to talk about or offensive, and discrimination persists.
- 3.3 Discrimination should never be tolerated. It should not be allowed to stop prevention messages getting across, nor to deter people from using testing services, or stop people accessing good quality information on sexual health relevant to their personal need.

Information for the public

- 3.4 Information on sexual health is often uncoordinated or poorly targeted. It is not consistently accessible and doesn't make enough use of new media and technology. There is a lack of accurate sexual health information relevant to young people (among others). Information on STIs, contraception and services is often out of date or not available at all. Even key groups often lack basic information about services – one survey found that a fifth of gay men didn't know that GUM clinics were open access²⁰.
- 3.5 Action giving young people better information has already started. The Teenage Pregnancy Strategy²¹, Sure Start Plus, the Healthy Schools initiative and the Department for Education and Skills' revised Sex and Relationship Education Guidance²² are all helping to expand young people's knowledge of and understanding of sexual health and relationships. In particular the schools guidance makes sure that secondary schools provide young people with information about different types of contraception, safe sex and how they can access local sources of further advice and treatment.

20 SIGMA Research Vital Statistics Findings from the National Gay Men's Sex Survey 1999, July 2000: ISBN 0872956521

21 Teenage Pregnancy, Report by the Social Exclusion Unit, ISBN: 0-10-143422

22 Sex and Relationship Education Guidance, ISBN 184185 144 2

3.6 The strategy builds on that by making better information available to people of all ages. It also reflects the five action areas of the Ottawa Charter for Health Promotion²³.

- **Building healthy public policy that promotes sexual health at local and national levels and addresses inequalities** – the strategy sets out a range of public health measures to reduce the spread of HIV and other STIs;
- **Creating environments that are supportive of sexual health** – the strategy emphasises the importance of sexual ill-health and the need to reduce stigma associated with HIV and STIs;
- **Developing personal and social skills regarding sex, sexuality and sexual health** – the better information and knowledge that the strategy encourages will help people to develop skills and make informed choices;
- **Ensuring that all services, which promote sexual health, build upon the evidence base and develop professionals' skills, knowledge and positive attitudes through education and training** – better professional education and training are central to the strategy, and it describes a programme of action for more evidence-based practice.
- **Strengthening community action in setting priorities, making decisions, planning strategies and implementing them to achieve better sexual health** – the strategy sets out targeted work aimed at reducing inequalities in sexual health and encourages more involvement of local people.

HIV prevention

3.7 Information on sexual health can help to prevent HIV, but there are aspects of HIV prevention, that need to be addressed specifically. The growing number of STIs is an indication of the level of unsafe sex and the potential for HIV transmission – especially among some higher risk groups²⁴. The number of HIV infections diagnosed in heterosexuals has risen, and African communities have been disproportionately affected. There is continuing transmission among gay men. There remains a low but steady rate of infection in injecting drug misusers.

3.8 Better treatment has reduced the death rate associated with HIV, but it is still a serious, lifelong and life-threatening infection. HIV prevention is, and must stay, a priority – especially for the higher risk groups. It remains important to diagnose and treat pregnant women to stop the virus transmitting from mother to child (see chapter 4).

3.9 England may have a relatively low HIV prevalence, but there are no grounds for complacency. The number of new diagnoses of HIV infection in 2000 is the highest on record. This is not necessarily all bad news as we may be reducing the pool of undiagnosed infection. Part of the increase appears to be due to implementation of the antenatal HIV screening policy, with more than double the number of HIV diagnosis reports giving “antenatal” as the reason for testing in 2000 compared with 1999. However, it is vital to maintain and strengthen prevention efforts.

23 Ottawa Charter for Health Promotion: WHO, Geneva 1986

24 CDSC 'Increased transmission of syphilis in Brighton and Greater Manchester among men': Communicable Disease Report Weekly, 27 October 2000: Vol. 10 (43) 3836

Objectives and targets

3.10 The key aims of HIV prevention are:

- to reduce the number of newly acquired HIV infections;
- to reduce the levels of unsafe sex (measured, for example, by rates of STIs including rectal gonorrhoea); and
- to raise awareness of services.

3.11 The strategy sets a national target for reducing newly acquired HIV infections and gonorrhoea infections. The target will help to assess the effectiveness of both national and local health promotion and sexual health service activities.

3.12 The target is *to reduce by 25% the number of newly acquired HIV infections and gonorrhoea infections by the end of 2007.*

3.13 To achieve these objectives the Department will:

- continue to give a high priority to HIV prevention for gay men that the Community HIV and AIDS Prevention strategy (CHAPS) currently delivers. *Making it Count* is the CHAPS collaborative framework for reducing HIV infection and should become the model for locally commissioned HIV prevention for gay men;
- develop, in collaboration with London health authorities, the National AIDS Trust and the African HIV Policy Network, a strategic framework for local commissioners and providers of HIV prevention for African communities;
- improve outreach services for people with undiagnosed HIV, particularly in targeted groups;
- set a target for reducing the number of people with undiagnosed HIV infection (see chapter 4);
- make sure HIV treatment and care services play a key role in HIV prevention by maintaining the sexual health of people living with HIV, diagnosing and treating STIs, reducing the transmission of HIV and providing information and advice (see chapter 4);
- make sure that services for people living with HIV help them to deal confidently with issues around disclosure, condom use and safer sex, so they can maintain their own health and reduce transmission. As a first step the Health Development Agency and Terrence Higgins Trust have produced a resource guide for professionals, on HIV and sexual health promotion for people with HIV;
- require health authorities to continue to provide needle exchange schemes for injecting drug misusers who are vulnerable to HIV and other blood borne viruses, and to promote the schemes in appropriate venues; and
- develop national information campaigns targeted at young injecting drug misusers and those who are already HIV positive and hepatitis B or hepatitis C infected. The Government's ten-year Drug Strategy and Second Annual Plan sets interim targets which support efforts to reduce the transmission of HIV and other blood borne viruses. The target for injecting drug misusers and needle sharing is to reduce the numbers in treatment who report injecting and numbers of those who report sharing by 2002.

3.14 The Department will also:

- Ensure that guidance on infection control measures in clinical settings is kept under review;
- support the Prison Service's strategy for preventing the spread of communicable diseases in prison, offering harm minimisation information and treatment of substance misusers and;
- take into account emerging findings on vaccines and microbicides (see chapter 6).

Role of mass media

3.15 Action to prevent sexual ill- health works best when it is multi-faceted. National information campaigns can provide a backdrop for more targeted local prevention work. Effective communications can inform and change attitudes and give people properly informed choice. An evaluation of safer sex campaigns in Holland showed attitudes and intentions towards safer sex were affected positively but that the effect was lost when the intervention ended²⁵.

3.16 To be effective information needs to be based on evidence and credible with target audiences. The evidence is that simply telling people not to engage in behaviours that put them at risk tends to be ineffective²⁶. Informed by a review of the research on how media campaigns can provide information to help people take informed decisions, the Department will develop a new information campaign for the general population in 2002 on preventing STIs (including HIV) and unintended pregnancies.

3.17 The Department will co-ordinate information campaigns for the population as a whole with initiatives like the Teenage Pregnancy Unit's campaign, and make sure they are properly evaluated. The Department will also ensure that professional groups know about new work in good time so that they can plan supporting local initiatives.

Evidence base

3.18 The evidence base for HIV and STI prevention is still dispersed and unsystematic. Although there is more agreement on the definition of success, what count as acceptable and effective interventions hasn't been agreed.²⁷

3.19 Effective commissioning of HIV/STI prevention needs up to date evidence of what and how different interventions work . The Department has commissioned the Health Development Agency to draw together the available evidence, assess what works and make clear recommendations on future approaches by the end of 2002. The Department will use that work to set the direction for local prevention activity.

25 Yzer MC, Siero FW, Buunk BP, Can public campaigns effectively change psychological determinants of safer sex? An evaluation of three Dutch campaigns. *Health Education Research*: 2000 June 15 (3): 339-52

26 Wellings K Assessing HIV/AIDS prevention: what do we know in Europe? General population. *Soz Praventivmed* 1994;39 suppl 1:S14-46

27 Hickson F et al, Making it Count , a collaborative planning framework to reduce the incidence of HIV infection during sex with men. Second edition, September 2000. Sigma Research

Co-ordinated provision of local sexual health information and HIV/STI prevention

- 3.20 Local co-ordination of sexual health information is vital and most effective when agencies work together in groups²⁸. Local planners and providers need to co-ordinate sexual health information and HIV/STI prevention, based on a local needs assessment as well as national priorities. Effective information gets to people where they are and addresses their specific concerns and needs, so people such as social workers and youth workers need to be involved.
- 3.21 Local multi-agency groups (see chapter 5) will co-ordinate sexual health information and prevention in line with the Health Improvement Programme. The groups must include representation from a specialist sexual health promotion/HIV prevention team and should make sure local activities are evidence based and are evaluated.

Sexual health information for specific groups

- 3.22 Some groups need targeted sexual health information and HIV/STI prevention because they are at higher risk, are particularly vulnerable or have particular access requirements. Strategies need to be developed to respond to the specific information and prevention needs of local populations. They should assess the needs of:
- young people, and especially those in, or leaving care;
 - black and minority ethnic groups;
 - gay and bisexual men;
 - injecting drug misusers;
 - adults and children living with HIV and other people affected by HIV;
 - sex workers; and
 - people in prisons and youth offending establishments.
- 3.23 In targeting these groups commissioners and providers need to work together to overcome the common barriers to accessing information and prevention services. These include stigma, discrimination, poverty and social exclusion, language, access problems, low awareness and concerns about confidentiality.
- 3.24 There is a range of service and health promotion initiatives that can help, including staff training on discrimination, outreach health promotion and targeting hard to reach or stigmatised groups.

28 Ingham R, Clements S, Gillibrand R. Factors affecting changes in rates of teenage conceptions 1991-1997. University of Southampton September 2000

Female genital mutilation

- 3.25 Female genital mutilation (FGM) – sometimes known as female circumcision – is illegal, unacceptable, and a violation of the human rights of the young girls (usually aged between four and ten) who suffer it. All procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs, whether for cultural or other non-therapeutic reasons, have been illegal in the UK since 1985.
- 3.26 Wherever there are people from cultures with a tradition of FGM there is a need to raise the awareness and skills of health, education and social services professionals. Local services need to support community initiatives aimed at stopping this practice. The Department will work with the FORWARD organisation to mobilise professionals from various disciplines to meet the needs of women and girls affected by FGM.

Helplines

- 3.27 The anonymity of telephone helplines can encourage people to seek help or advice on their sexual health. NHS Direct (0845 46 47) provides advice 24 hours a day including comprehensive information on local services and emergency contraception. The development of NHS Direct Online and NHS Direct information points in public places will also help people to find the information need. The Department will make sure that there are clear links between NHS Direct, specialist helplines and local providers, and that NHS Direct provides accurate information and advice. The Department will constantly review the helplines' decision support systems and ensure adequate training is available.
- 3.28 The National AIDS Helpline (0800 567123) and Contraceptive Education Service Helpline (0845 310 1334) deal with almost 300,000 telephone enquiries a year and provide confidential advice and information on all aspects of HIV, AIDS, STIs and contraception.
- 3.29 The Department will review the specifications for the National AIDS Helpline and the Contraceptive Education Service to make sure they respond to the needs of key groups and population as a whole. The review will include the outcome of an independent evaluation of both services, which will report in 2001, and involved consultation with health promotion agencies, health professionals, and voluntary groups including those representing people living with HIV.
- 3.30 The Department will develop wide ranging information provision, giving people choices in the way they can access information, including telephone lines, digital TV and the Internet as well as leaflets and posters where appropriate.
- 3.31 The Department will continue to support helplines providing services specifically for young people such as Sexwise (0800 282930).

Information and support for professionals

- 3.32 Everyone providing sexual health information and HIV prevention needs better access to up to date information²⁹. The Department will work with the Health Development Agency to develop and disseminate the information and evidence professionals need, including good examples of best practice (see paragraph 3.20).

29 SASH Consultation of the Sexual Health Strategy

- 3.33 The Government supports life-long learning and continuing professional development. Staff delivering sexual health promotion must have access to flexible, multi-professional education and training. Good training will help them to develop their interpersonal and communication skills and their cultural competence, values and attitudes as well as their clinical and technical ability. More action is set out in chapter 6.

The Department of Health is including sexual health information in its Practice Development toolkit available for all health visitors and school nurses. This helps to ensure a greater provision of sexual health information and HIV/STI prevention through services. Professionals consulted in the course of developing this strategy said this was a vital area for improvement if HIV and STI prevention was to be more effective.

- 3.34 Professionals across a range of services, including primary care, can play an important part in providing consistent and integrated information. The Department will set clear standards for sexual health information and HIV/STI prevention at all levels of service provision. These standards will help professionals to:

- give advice and support on safer sex practice;
- provide good information on sexual health services; and
- recognise relevant factors, such as alcohol use, drug misuse, homelessness, social exclusion and poor self-image.

- 3.35 People who work with vulnerable groups (for example, supporting children at risk, people with learning disabilities) need to help them develop the knowledge and skills to protect their sexual health. The Department will ensure provision of specific training for staff, in skills development, as part of the dissemination of the new guidance due out shortly on promoting health for looked after children.

Questions:

- Is the target proposed for reducing the number of newly acquired HIV infections the right one?
- Is there a better description than “safer sex” in the provision of information to people about preventing STIs, including HIV?
- What are the most effective interventions for HIV and STI prevention?
- How can the increasingly diverse range of communications media be best exploited for providing the public with the information they need?

Action and targets

The Government will:

Develop a new safer sex information campaign for the general population.

Ensure national helplines on HIV and safer sex are more responsive to people's information needs.

Use the work commissioned from the Health Development Agency to provide an evidence base for local HIV/STI prevention.

Exploit the wide range of media available for providing information on sexual health.

Set a target to reduce the number of newly acquired HIV infections.

Develop, with London health authorities and others, a strategic framework for HIV prevention for African communities.

Commissioners, service providers and health professionals should:

Focus sexual health promotion and HIV prevention on identified local need, set targets in line with national priorities and monitor progress as appropriate to local populations.

Support all staff to develop their skills through work-based and other dedicated education and training programmes, in line with national priorities.

Ensure prevention is integral to service delivery.

Co-ordinate local information campaigns with national information campaigns and ensure they meet good practice benchmarks.

Work towards achieving a target to reduce the number of newly acquired HIV infections.

4 Better services

Screening for chlamydia for targeted groups.

Strengthen the role of primary care in sexual health.

National standards for sexual health services.

Managed service networks.

Better access to services.

Pilot one-stop shops in sexual health.

Evaluate the role of GPs and primary care teams with a special interest in sexual health.

Target to reduce the number of undiagnosed HIV infections.

Target for hepatitis B vaccination.

Introduction

4.1 The main elements of a modern, comprehensive sexual health service are:

- contraceptive care and abortion;
- diagnosis and treatment of sexually transmitted infections and HIV;
- prevention of sexually transmitted infections and HIV; and
- services that address psychological and sexual problems.

4.2 Many branches of the NHS offer sexual health care, including general practice, community family planning, genito-urinary medicine and services aimed at specific groups such as young people. At their best these services provide comprehensive, accessible and confidential advice and care, and play a big part in promoting public health through prevention and information.

4.3 Despite that, sexual health services are patchy – availability, quality and choice vary around the country. Often there is too little co-ordination at local level, which can mean fragmented care and inconsistent advice. Reports of difficulties accessing services are becoming more common.

A new model of working

4.4 One of this strategy's most important aims is to develop sexual health services around patients' needs. Doing that successfully means:

- increasing uptake by providing a choice of easily available services;
- focusing services on local needs through effective commissioning;
- giving staff the education and training they need to work together and provide an integrated service;
- giving all service providers clear descriptions of their tasks, roles, skills and interrelationships;
- giving people better information about local services;
- reaching an understanding between commissioners and providers about the sexual health characteristics of the local community, including information on morbidity, services, resources and activity; and
- setting local targets for improvements in services.

4.5 Another of the strategy's aims is the development of managed service networks, allowing providers to collaborate and plan services jointly and so provide a more comprehensive service to patients. This is essential for HIV services. It will also strengthen service provision in areas like STIs, contraception and psychological and sexual problems. Paragraphs 4.60 and 4.62 describe the progress that has already been made towards networks in HIV services. A process for developing networks in other sexual health services will be ready by early 2002.

4.6 There should be three levels of service provision within any model for developing a comprehensive local service. Commissioners and providers in primary care, acute and community Trusts need to work together to set up a network that provides all three levels of services and meets the needs of their local population.

Level one

- | | |
|--------------------------------------|--|
| – sexual history and risk assessment | – contraceptive information and services |
| – STI testing for women | – assessment and referral of men with STI symptoms |
| – HIV testing and counselling | – cervical cytology screening and referral |
| – pregnancy testing and referral | – hepatitis B immunisation |

4.7 Patients' first point of contact is often their GP, who will assess their needs and decide whether to treat them in the practice or refer them to more specialist services. There are a number of elements of sexual health care that current good practice acknowledges should be available in every general practice setting. (These elements are set out in the box above.) However they are not provided everywhere at present. These will be consistently available in the future through the gradual development of primary health care

teams in Primary Care Trusts (PCTs) and Groups (PCGs) in terms of skills, access, standards and the improved availability of training and education.

- 4.8 All PCTs and PCGs should demonstrate the appropriate competence in providing sexual health care. Services should be provided by the appropriate staff, who could be doctors, primary care nurses or other staff with additional training. The role of nurses in this field is expanding. In addition developments in community pharmacy will enable pharmacists to enhance and increase the range of basic elements of sexual health care they offer. In some areas pilot schemes for the provision of emergency contraception, pregnancy testing and other aspects of sexual health have proved successful. The Department proposes to issue guidance on expanding NHS provision of emergency contraception in pharmacies.

Improving practice

Manchester, Salford & Trafford and Lambeth, Southwark & Lewisham Health Action Zones have developed innovative schemes where community pharmacists supply hormonal emergency contraception using a Patient Group Direction. Pharmacies are an important additional access route for emergency contraception, particularly at weekends and bank holidays when other services might not be available, and in these schemes they have worked with local GPs, family planning clinics, youth clinics and NHS Direct to agree clear standards derived from professional guidelines.

- 4.9 The availability and scope of the services that each primary care team offers must be well advertised. Where a primary care practice can't provide level one services, or has a moral objection to doing so, they must make that clear in practice information and make explicit alternative arrangements for their patients through other practices or community services.
- 4.10 Local commissioners will need to make arrangements with the providers of more specialist services to allow open access to these basic services for those not registered with a GP and those who choose not to consult their GP for sexual health services. To ensure consistent standards and appropriately integrated care, clinicians should develop and implement locally agreed protocols based on guidelines to be established nationally.

Level two

- | | |
|--|--|
| – intrauterine device insertion (IUD) | – contraceptive implant insertion |
| – testing and treating sexually transmitted infections | – partner notification |
| – vasectomy | – invasive sexually transmitted infection testing for men (until non-invasive tests are available) |

- 4.11 Not all the elements of general sexual health services can be provided easily or economically by every primary care team. To make services readily available everywhere, PCTs and PCGs need to identify and support primary care teams with a special interest in sexual health that can provide these services to a high standard, or make sure that they are available from other sources – for example local family planning and GUM clinics working in conjunction with general practices.

- 4.12 Each team needs the ability to assess and support people with complex sexual health care needs. Teams also need to act as an expert resource for local colleagues working at level one. Advertising and promoting these services will help people to know where they can get them, either directly or on the advice of their general practice. Examples of elements of level two services are set out in the box above.
- 4.13 GPs and nurses with a special interest in providing these services will need to undertake specific training to develop and maintain the skills required. In many circumstances, and increasingly given the new flexibilities in the GP contract such as Personal Medical Services (PMS), these services can be offered to people registered with other practices or unregistered with any practice.

Improving practice

South & West Bradford PCT has developed a network of specialist GPs who provide a variety of services to all patients in the PCG including minor general surgery, orthopaedics, plastic surgery, ophthalmology and diagnostic procedures. This model can be extended to embrace sexual health services. All the GPs undergo training with local consultants, and often both attend the same clinic, but with the GPs now seeing their own patients to increase throughput. They are not a substitute for consultants but they are a filter, helping to make sure that referrals to the specialist services are appropriate.

- 4.14 Services should be developed to meet local needs and should be tailored to fill gaps in existing service provision. So PCTs and PCGs will need to develop provision of the full range of level two services in collaboration with local existing open access community family planning and GUM services. With the development of PCTs, and services increasingly focusing on co-operation to meet local needs, there should be further integration of service organisation and delivery.

Level three

Level three clinician teams will take responsibility for sexual health services needs assessment, for supporting provider quality, for clinical governance requirements at all levels, and for providing specialist services. Services could include:

- outreach for sexually transmitted infection prevention
- outreach contraception services
- specialised infections management, including co-ordination of partner notification
- highly specialised contraception
- specialised HIV treatment and care

- 4.15 Specialist clinical teams will deliver the more specialist aspects of care that need to be provided across more than one PCG or PCT. They will have the focus and expertise necessary to serve people who have more complex, chronic or intensive needs.
- 4.16 Level three services include those for individual patients and those aimed at improving public health, and will be open access wherever possible. For individual patients they will provide specialist genito-urinary medicine, highly specialised contraception for people with complex medical conditions, specialised HIV services, local co-ordination and back up for sexual assault, termination of pregnancy services, and services for people with psychological and sexual problems.

- 4.17 Working more widely, specialist services will also take responsibility for outreach services for STIs or contraception. They will also support the planning and delivery of sexual health education in schools, colleges and prisons. As local services develop, these responsibilities could be devolved to level two.
- 4.18 Those responsible for services at level three should make sure that local guidelines are in place and that there is a framework for monitoring and improving practice. Clinicians in these specialist teams will have had higher training in one or more of the fields of sexual health and will act as an expert clinical resource for clinicians working at levels one or two. Nurses will have an expanding role at level three as specialists and consultants.
- 4.19 All three levels will form part of a service network, and each will have explicit responsibilities for different parts of the network. At the specialist level, for example, clinical teams will be responsible for supporting the clinical governance requirements at all levels, providing professional training, designing and updating care pathways and developing new services.
- 4.20 A whole range of professionals plays some part in sexual health services, but often they offer too narrow a service. This can mean that people have to make contact with several different services before they get all the care they need. For example, family planning clinics may provide an excellent contraception service but rarely offer comprehensive advice on avoiding, diagnosing or treating STIs.
- 4.21 The Department will set new standards to change that. We have begun to identify the range of care that can be provided in each setting, and that work will go forward in parallel with the setting of clinical guidelines. The Department will make sure this is backed up by clear referral pathways so that patients are referred on to the right service at the right time.
- 4.22 This service model is designed to deliver consistent, co-ordinated services across both primary care and the more specialist levels. It will take time to establish, but over the next few years we expect to see locally integrated services working together to provide comprehensive services. As a start we intend to identify a small number of demonstration projects that can provide a basis for wider rolling out of the model in future. The Department will also continue to evaluate the benefits of more integrated services by reviewing existing models and supporting new pilots, including the role of GPs and primary care teams with a special interest in sexual health.
- 4.23 The crucial role of sexual health services in prevention also needs to be recognised and strengthened, supported by staff training and best practice and linked closely to health promotion work taking place outside sexual health services.
- 4.24 In particular, condoms remain an important way of preventing unintended pregnancy, HIV and STIs, but there is evidence of a decline in their use among high risk groups³⁰. Information on preventing unintended pregnancy and STIs (including HIV) will continue to promote the use of condoms. Condoms should be provided within local sexual health services.

One-stop sexual health clinics

- 4.25 The Department will fund three one-stop sexual health services across the country to evaluate their impact on sexual health, and fund other pilot projects for primary care youth services in liaison with the Teenage Pregnancy Unit. These can inform plans for the overall shape of sexual health services. The Department will also consider piloting services within other settings, for example young offenders' institutions. If they are effective we will issue new guidance on appropriate service models.

³⁰ Increase in high-risk sexual behaviour among homosexual men, London 1996–1998: Cross sectional, questionnaire study. Dodds JP, Nardone A, Mercey DE, Johnson AM. *BMJ* 2000; 320: 1510–1

Chlamydia screening

- 4.26 The NHS Plan included a commitment to improving the prevention of ill health and providing screening programmes when they are effective. Chlamydia is a serious problem. Around 9% of sexually active young women are likely to be infected and around 70% of infections are asymptomatic³¹, so people do not know that they are infected. The consequences of untreated infection can be serious, and include pelvic inflammatory disease and subsequent infertility.
- 4.27 A pilot for Chlamydia screening finished in September 2000 and the results are being analysed. Although we need further work on re-infection rates and other aspects, the pilot has taught us a lot about introducing risk reduction programmes – for example, the importance of giving women good information and dealing promptly with positive cases.
- 4.28 The early indications are that these programmes are acceptable to both the public and professionals, and we plan to begin rolling out national screening for Chlamydia from 2002. To begin with this will be available to selected groups of young women such as all attending GUM clinics, women seeking termination of pregnancy or having their first cervical smear. A broader national programme will be implemented after experts have assessed the results of the pilot screening programme and the other relevant evidence.

Genito-urinary medicine services

- 4.29 A recent survey showed problems accessing some GUM services. This may add to the risk of complications and transmission of infection. The Department will work towards shorter waiting times for urgent appointments and increasing access.
- 4.30 The NHS also needs to improve the comprehensiveness and effectiveness of GUM services. The dramatic fall in levels of sexual infection in some European countries has been achieved through raised awareness, effective clinical services and thorough partner notification. The Department will develop the role, and increase the numbers, of health advisers in GUM services to improve access, provision of sexual health information and STI control.

Contraceptive services

- 4.31 The accessibility and range of contraceptive methods available, including NHS funded sterilisation, vary widely. General practice will continue to provide most NHS contraceptive care, but in 1999-2000 over a million women and 80,000 men attended community family planning clinics in England. These services, provided by community and hospital NHS Trusts, form a network of open-access services that complement primary care provision in a way that people clearly welcome and use. The Department will work towards ensuring local contraception provision includes sufficient open access to meet the level of need.

31 Summary and conclusions of CMO's Expert Advisory Group on Chlamydia trachomatis. Department of Health 1998

Abortion services

- 4.32 There are also wide variations in access to abortion services, and in the method of termination. In 1999 the percentage of NHS funded abortions ranged between 46% and 96% in different health authorities. A survey in the same year showed that women can wait up to four or five weeks in some parts of the country³². This can have particularly serious implications for pregnant teenagers, who tend to seek professional advice later than older women. The availability of medical abortion, which can be used early on in pregnancy and avoids the need for anaesthesia and surgery, also varies.
- 4.33 The Royal College of Obstetricians and Gynaecologists (RCOG) published guidelines in 2000 that included recommendations for women's access to abortion services. The earlier in pregnancy an abortion is performed, the lower the risk of complications. Services should therefore be developed to provide NHS funded abortions in line with the RCOG guidelines, ensuring that women who meet the legal requirements for an abortion are referred without delay. From 2005, commissioners should ensure that women who meet the legal requirements have access to an abortion within 3 weeks of the first appointment with the GP or other referring doctor (other than in exceptional cases, for example where a longer wait is clinically appropriate).
- 4.34 Commissioners and service providers should also ensure that information about local pregnancy counselling and termination services is readily available and widely publicised. Telephone helplines already function as effective access systems in some parts of the country.

Psychological and sexual problems

- 4.35 A wide range of practitioners provide psychological and sexual dysfunction services in the private, voluntary and NHS sectors. The Department will develop consistent standards of care to ensure that all those sectors manage their patients appropriately.
- 4.36 General practice and specialist sexual health services need to make patients feel that they can discuss problems with their sex lives. Services need to be able to assess patients and refer them on to specialist services when that is appropriate. We will encourage the development of training that allows a wide range of practitioners to recognise and assess sexual health problems like impotence. The Department will consider whether the development of standards in areas of significant sexual health morbidity, for example diabetes, should include good practice guidelines on the recognition, assessment and management of sexual health problems.

Female genital mutilation

- 4.37 Health professionals' contribution to the eradication of female genital mutilation (FGM) needs to include appropriate child protection measures (as the practice is traditionally performed on girls between the ages of 4 and 10). Women suffering from later damage to their health also need care and treatment.

³² Report on NHS Abortion Services; Abortion Law Reform Association. December 1999

Improving practice

The African Well Woman's Clinic at Guy's and St Thomas' Hospital Trust was set up in September 1997 to meet the needs of a growing population of women who have experienced FGM. It works within the antenatal clinic providing advice, support, counselling, information and appropriate referral to women with FGM. A specialist midwife provides outreach and education services as well as working on the labour ward. Outreach activity built knowledge of, and trust in, the service within local communities and women's groups and encouraged self-referral. The outreach also aims to raise awareness and facilitate referrals from GPs, maternity and gynaecology services and beyond. The clinic is part of a network of service providers including refugee outreach teams, child protection workers, translators, community organisers and educators who work together. They provide care for individual women who have undergone FGM and support for initiatives working towards the abandonment of FGM.

Access and information

- 4.38 The NHS Plan made better access to health services a priority. Quick and easy access is especially important for sexual health services and is clearly in the interest of the wider public health. This strategy sets out measures that strengthen open access GUM and community family planning services. The aim is for a single point of access to services to be developed by all PCTs by 2006.
- 4.39 Services will have to meet a number of new standards for access, including the effective advertising and signposting of services. There are already some good sources of information including NHS Direct, NHS walk-in centres, Sexwise, the Contraceptive Education Service, the National AIDS Helpline, National AIDS Manual (NAM), local information routes and information from other professionals or services. Nevertheless, many sexual health services are not well advertised and health professionals themselves are not always up to date with the location, timing and range of available sexual health services. People often have to spend too much time and effort searching for information they need quickly.
- 4.40 We will require all sexual health providers and commissioners to:
- keep NHS Direct up to date about local services;
 - produce a directory of services, building on the Teenage Pregnancy Strategy's local directories of services for teenagers;
 - provide concise information cards summarising local services and giving a contact number for detailed information;
 - make sure that general telephone directories, Yellow Pages and Thompsons list sexual health services under appropriate headings with cross referencing; and
 - consider advertising services directly to potential service users.
- 4.41 All services should review their location and opening hours to match their local population's needs, and will have to be able to show that users and potential users of services are involved in developing access policies.

Self care

- 4.42 People also need information and services to help them care for themselves. Sexual health services have a core role in providing information on prevention of HIV, STIs and unintended pregnancies. Services like NHS Direct, helplines and NHS walk-in centres also play a part and have a valuable role in improving access to sexual health services. These services should act as a foundation for the level one services described earlier in this chapter.
- 4.43 Commissioners and providers should agree the role of NHS walk-in centres locally, in the context of other local sexual health services. As a minimum, all walk-in centres should offer emergency contraception and respond to other urgent needs. They should provide initial advice and support, backed up by close networking with other local providers and clear protocols for referral to more specialist sexual health services.

Targeting sexual health and HIV services

- 4.44 Negative attitudes and expectations get in the way of access to services. Embarrassment, previous bad experiences and worries about confidentiality all create barriers between people and the services they need, while social exclusion, language, cultural difficulties and homophobia make those barriers harder to cross. There are obvious and particular access problems for prisoners.
- 4.45 Planners and providers must be aware of the difficulties that specific groups face in accessing services and ensure that services meet their needs. In doing that commissioners, working with providers, should:
- ensure that all staff working in sexual health and HIV are properly trained and supported so they can deliver respectful and non-discriminatory care;
 - understand and respond to local communities and their cultures by learning from, and supporting, community organisations and individuals;
 - develop services, in discussion with local service users and organisations, that maximise the take-up from the population groups at most risk; and
 - build networks with others inside and outside the NHS who serve the target populations.
- 4.46 In that context the Department will evaluate free condom schemes and consider options for improving access to condoms in liaison with the Teenage Pregnancy Unit, the Home Office and the Prison Service.
- 4.47 The Department will issue guidance by 2003 on specific action for developing services that meet the needs of targeted groups.

HIV testing

- 4.48 The Department will set out a programme for increasing the offer and uptake of testing for HIV. The objectives are to reduce undiagnosed HIV, ensure early access to treatment and limit further transmission.
- 4.49 The Department will work with voluntary and community organisations to make people more aware of the benefits of testing and of where testing, treatment and care are available. This will include promoting access to, and explaining the role of, local GUM services.

- 4.50 GPs can also make a significant contribution to reducing the number of people with undiagnosed HIV, especially for people who are reluctant to use GUM services. HIV testing has always been possible in primary care, although in practice its availability is variable. Training and education for non-specialist practitioners will help to promote and support HIV testing in primary care and general medical settings and strengthen referral routes to appropriate treatment and care.
- 4.51 In the past people have been put off by concerns about GPs providing medical reports to insurance companies. New General Medical Council guidance advises GPs to discuss the information required with patients before completing medical reports, and reminds them that patients are entitled to see the reports before they are disclosed to anyone else. Updated advice from the Association of British Insurers and the BMA makes it clear that only positive HIV tests will affect insurance.
- 4.52 The introduction of antenatal HIV screening meant that in 1999, 73% of pregnant women in Inner London had their infection diagnosed before delivery compared to only 50% in 1998. Data for the first part of 2000 also show significant improvements in outer London and the rest of England.

Improving practice

The Victoria Clinic has targeted gay and bisexual men as a group at high risk of STIs, and its initiatives have resulted in a significant rise in the number of men accessing services.

'Sorted' is a hepatitis B vaccination service. It is nurse-led and linked to a targeted health promotion campaign. The service increased its vaccine uptake from 13 in July to September 1999 to 148 in July to September 2000.

'Give me five minutes' is an HIV testing campaign, promoted by the London gay press and distributed in gay venues. It increased HIV tests taken in the clinic by young gay men by 98% in one year.

- 4.53 Increased antenatal HIV testing is the key factor contributing to a decrease in mother-to-infant HIV infections. The Department continues to support antenatal testing to achieve the National Objective of an 80% reduction by the end of 2002 in the number of children with HIV acquired from their mothers during pregnancy, birth or through breastfeeding.
- 4.54 The Department will also increase the provision of hepatitis B vaccine to the groups most at risk. Information campaigns encouraging the uptake of voluntary confidential HIV testing and hepatitis B vaccine will need a corresponding increase in service provision.
- 4.55 The Department will require GUM clinics to offer HIV testing to all attenders on first screening for STIs and to offer hepatitis B vaccine to those from high-risk groups, including sex workers, injecting drug misusers and gay men. This builds on the action already in hand through the Government's drug strategy to increase the availability of hepatitis B vaccine to injecting drug misusers.

HIV treatment and care services – managed networks

- 4.56 The HIV epidemic in England is not evenly distributed. Two thirds of HIV positive people live in London and most of the rest in and around other big cities, with a significant minority in rural areas. Most major treatment centres are located in London and the larger cities. The advent of anti-retroviral combination therapy means that most treatment and care can now be delivered on an outpatient basis, closer to where people live.

- 4.57 That treatment is complex and demanding and can have serious side effects. The rapid development of new treatments, with many people taking part in clinical trials, makes it essential for clinicians to keep up to date with emerging technology and developing knowledge on when to use therapy, and to monitor drug levels and resistance effectively. All this makes the medical management of HIV increasingly difficult.
- 4.58 Clinicians therefore need professional support to make sure they deliver high quality services. This means clinical partnerships, collaborative working and agreed service standards.
- 4.59 Managed networks are already developing for cancer and other complex conditions. They share patient care and give clinical supervision and support to practitioners in smaller units. The Department believes that extending the managed network approach to HIV will help to improve the quality of services and patients' access to them.
- 4.60 All HIV practitioners will be expected to work within a managed service network, which means that all HIV treatment and care should be given within the networks. Networks will decide how partnerships between larger and smaller units will work by clearly indicating roles and responsibilities. The networks will support non-specialist HIV services in primary care and provide a focus for local training and professional development. They will include the voluntary sector and user groups as well as a wide range of practitioners, and will build on the work started through London health authorities and the BMA Foundation for AIDS.
- 4.61 The successful implementation of the network approach relies on the development of nationally agreed guidelines on HIV treatment and care, together with locally agreed operational guidelines in the form of care pathways. Updated national HIV standards will be developed by 2002.
- 4.62 The BMA Foundation for AIDS guidelines (1999)³³ offer a template for constructing the set of new, updated guidelines. The updating process must be inclusive and involve a wide range of practitioners, commissioners and organisations, including the voluntary sector, as well as people living with HIV. We will also find ways of developing better and more consistent referral pathways between specialist HIV services and mainstream services such as mental health and neurological rehabilitation.
- 4.63 HIV treatment will continue to benefit from ongoing research and up to date technologies as it has done in the past with the introduction of HIV viral load tests and is now doing with resistance testing. We will encourage the developing technology in clinical decision support systems and computer links between clinical sites, making it easier to spread good practice and shared care within the networks.

Improving practice

To respond to the challenges that the rapid development and advancement in HIV treatment therapies present, the clinical directorate of HIV & GUM at the Chelsea and Westminster Hospital worked with Virco, a Belgian diagnostic and services company, to develop viral resistance testing to support patient services. This allowed the development of a comprehensive clinical and virological database, which will improve the quality of patient care and offer an invaluable resource for future research.

33 Standards for NHS hospital HIV services; Centre for Research on Drugs & Health Behaviour/BMA Foundation for AIDS (1999).

Adherence to drug regimes

4.64 A patient's adherence to their drug regime is crucial to the success of combination anti-retroviral therapies. These therapies require a very high level of adherence, which some patients can find difficult. One survey³⁴ found that about half the respondents who were on combination therapy had missed a dose in the last month. The Department will work with others in the field to improve adherence to drug therapies for people living with HIV.

Children with HIV

4.65 The relatively small number of children with HIV in England, most of them within London and the south east, means that paediatric HIV care is very specialised. We need to ensure consistent practice by developing managed service networks in paediatric HIV care.

4.66 These can build on the informal network arrangements that many paediatric units already have. Just like the treatment of adults, all the clinical care of children with HIV should take place within a clearly defined network. Children's networks should work closely with adult HIV services so that families affected by HIV can be treated together and children transferred smoothly on to adolescent and adult HIV services.

4.67 The Department will work towards developing paediatric networks by 2002.

Social care and support for those living with and affected by HIV

4.68 Treatment and health care for people living with HIV are obviously essential, but their overall quality of life cannot be neglected. Social care has its part to play, by:

- helping patients adhere to drug regimes;
- helping access to education, employment and leisure facilities;
- ensuring people have their needs assessed and met for welfare, benefits, housing, advocacy, interpretation, peer support, and other practical support for life in the community;
- supporting carers and families; and
- making sure that people living with HIV can benefit from wider initiatives that promote social inclusion.

4.69 To help deliver these principles, by 2002 the Department will set new, broad standards for delivering high quality social care and support for people living with and affected by HIV. The standards will reflect the need for partnership between the voluntary sector, people living with HIV, NHS bodies and other key organisations. They will draw on existing standards and criteria for inspection, and will be developed in consultation with the Social Services Inspectorate, local authority commissioners, service users and voluntary organisations.

³⁴ Taking Heart? Anderson W. and Wetherburn. P (1999); The Impact of combination therapies on the lives of people with HIV. Sigma Research

Planning and delivering HIV services – key principles

4.70 Those responsible for the planning and delivery of HIV services, including social care and support for people living with HIV, must be able to demonstrate the following principles:

- the involvement of people living with HIV;
- provision based on effective partnerships between the statutory and voluntary sectors;
- models of provision that are able to respond quickly to the changing health and social care needs of those living with HIV; and
- provision that respects individuals' rights, including the right to privacy.

The Department will also set new standards for involving service users in policy development and in the organisation and delivery of care. These will be in place by 2003.

HIV voluntary organisations

4.71 Right from the start of the HIV epidemic the voluntary sector has performed a key role in developing prevention initiatives and providing social care and support. The sector embraces a whole range of diverse organisations working in a constantly changing environment, and has generated some innovative and flexible services.

4.72 The evolution of the epidemic and the availability of combination anti-retroviral therapy mean that voluntary sector services continue to need to be reviewed. The pattern of provision has, for the most part, been an unplanned patchwork of arrangements not always reflecting users' needs or service priorities.

4.73 The Government wants to retain and re-energise the unique contributions of the voluntary sector and of people living with, or deeply affected by, HIV. The Department will work with service users, commissioners and providers to develop better strategic arrangements for commissioning voluntary sector services.

4.74 The challenge to the voluntary sector is to develop service provision and self-help that encourage user involvement in effective and efficient organisations. We want:

- focused investment in a sustainable and stable voluntary sector;
- contracts for clearly specified services;
- better integration of social care and clinical treatment;
- better knowledge among clients about the range of services that are available, so that uptake is improved; and
- culturally appropriate services that are responsive to high need groups.

Targets

- 4.75 We already have targets for reducing mother to baby transmission of HIV. Health authorities were asked to make sure that all pregnant women were offered and recommended HIV testing by the end of December 2000, and to set targets for uptake of testing which should reach 90% by the end of 2002. We expect that by then these targets will have resulted in an 80% reduction in the number of children with HIV acquired from their mothers during pregnancy, birth or through breastfeeding. On the evidence available so far, the targets are on course to be met.
- 4.76 This strategy sets other targets to increase the uptake of testing to help reduce undiagnosed HIV, and to increase the uptake of hepatitis B vaccine in groups more vulnerable to infection.
- 4.77 The target for reducing undiagnosed HIV is:
- *by the end of 2004, all GUM clinic attendees should be offered an HIV test on their first screening for sexually transmitted infections (and subsequently according to risk) with a view to:*
 - *increasing the uptake of the test by those offered it to 40% by the end of 2004 and to 60% by the end of 2007;*
 - *reducing by 50% the number of previously undiagnosed HIV infected people attending GUM clinics who remain unaware of their infection after their visit by the end of 2007.*
- 4.78 The targets for increasing uptake of hepatitis B vaccine are:
- *by the end of 2003, all homosexual and bisexual men attending GUM clinics should be offered hepatitis B immunisation at their first visit;*
 - *expected uptake of the first dose of the vaccine, in those not previously immunised, to reach 80% by the end of 2004 and 90% by the end of 2006;*
 - *expected uptake of the three doses of vaccine, in those not previously immunised, within one of the recommended regimens to reach 50% by the end of 2004 and 70% by the end of 2006.*

Standards

- 4.79 The sort of network approach described in this chapter requires shared standards of care between providers, and these standards should be defined, implemented and monitored locally and incorporated in clinical governance processes. Providers and commissioners of services should work together with local people to tailor existing guidance on good clinical practice for local use and to make sure it is implemented.
- 4.80 Providers and commissioners need to consider standards across the local network for both clinical services and information.

Clinical services

4.81 Standards could cover:

- open access;
- referrals between services (care pathways);
- the availability of a full range of clinically effective services;
- staff training, support, continuing professional development and lifelong learning; and
- service monitoring, audit and evaluation.

Information

4.82 Standards for information for service users (and potential users) might cover:

- information about the choice of services, including
 - which elements of clinical care are available
 - where and when services are provided, and pathways between them
 - access criteria for services;
- information accompanying treatment or care that helps patients to adhere to it; and
- information about other sexual health services, reflecting individual risk assessments.

Questions:

- Will the proposed new model of working for sexual health services succeed in reaching the goals listed in paragraph 4.4?
- What other service models for sexual health might it be appropriate for the Department to pilot?
- In line with the NHS Plan's principle of patient-centred care, how should services be developed that are sensitive to local communities and their cultures?
- Are the proposed key principles for planning and delivering HIV services the right ones?
- Is the challenge to voluntary organisations in paragraph 4.74 the right approach? How might more be made of the unique contribution the voluntary sector has to offer?
- What has to happen for people living with HIV, and service users generally, to feel more involved in policy making and service planning?
- Are the targets proposed for reducing undiagnosed HIV and for increasing the offer of hepatitis B vaccine the right ones?

Action and targets

The Department will ensure that:

- Pilots of primary care youth services, one-stop shops for sexual health and specialist GPs are funded and evaluated to inform future service planning
- The role of sexual health advisers is developed and numbers increased
- Service networks are established for HIV and for sexual health services, backed up by standards and guidelines
- Standards are set as part of promoting good practice, including improving information and access to sexual health services
- Broad standards are set for the delivery of social care and support for people living with and affected by HIV
- Chlamydia screening is rolled out nationally, initially for targeted groups

Commissioners and service providers should ensure that:

- Services are developed over time as defined in the three levels
- Services and information provision meet new standards
- Health service provision meets clinical governance requirements
- Services work within new managed networks and to standards and guidelines identified
- Actions identified in relation to the needs of targeted groups are met and reported upon
- High quality social care and support is provided in effective partnership with those living with HIV, voluntary organisations and other statutory organisations
- Services are developed to provide NHS funded abortions in line with RCOG guidelines

5 Better commissioning

Local multi-agency commissioning panels with identified lead commissioners.
Local targets linked to national priorities, based on local needs assessment, user and professional involvement and partnership working.
User and community involvement in service planning and commissioning.

Introduction

- 5.1 The effective implementation of this strategy hinges on good local planning and commissioning of services. Good planning helps to make sure that:
- medical, nursing and other health and social care staff can work together in new ways and across traditional boundaries;
 - HIV and STI prevention is more consistent and effective; and
 - both commissioners and providers broaden their focus and work in partnership.

Effective commissioning

- 5.2 The job of commissioning the various components of sexual health and HIV services is carried out currently at different levels and by different organisations. From April 2002 PCTs will be able to commission sexual health services. Specialised services for HIV treatment and care will need to be strategically planned at the appropriate level. (The definition of specialised HIV treatment and care will be published in autumn 2001.)
- 5.3 The Department will publish a good practice “tool kit” for commissioning the three levels of care described in chapter 4, and every commissioning organisation must be able to show that they have applied these principles of effective commissioning of sexual health and HIV services:
- using a multi-agency and multi-disciplinary steering group to develop and implement a local action plan;
 - understanding local needs and identifying priority population groups;
 - linking to the wider policy context;
 - working in partnership with other agencies and with users;
 - being centred transparently on community and patient;

- identifying current resources, including those that need development; and
- setting clear local targets for monitoring the development, implementation and outcomes of plans.

Local multi-agency commissioning groups

- 5.4 Local stakeholders, including all the organisations responsible for commissioning services, should agree a sexual health and HIV plan. A local multi-agency group should be set up to inform, implement and monitor this planning.
- 5.5 The size of the group will have to strike a balance between inclusiveness (of, for example, commissioning organisations like local authorities and PCTs as well as other stakeholders) and practicality. The group should be a function of existing primary care partnership groups where they have been established and build on local teenage pregnancy strategies. A lead commissioner should co-ordinate the group and the local action plan.
- 5.6 Assessments of the local need for services should:
- identify sexual health needs;
 - highlight gaps in services or high levels of need; and
 - take account of the wider, underlying determinants of health.
- 5.7 The groups should use improvements to data collection and information on service activity and good practice (see chapter 6) to inform planning for specific communities. They should also make sure that their plan relates to the wider policy context by reflecting the local Health Improvement Programmes and the views of local Modernisation Boards. Plans should highlight links with specific national and local initiatives. PCTs', local authorities' and health authorities' plans should also reflect the specialised commissioning plan for HIV treatment and care.

Working in partnership

- 5.8 Effective partnerships should be at the root of all commissioning of sexual health services. Commissioning plans should incorporate agreed aims and priorities, based on agreed local values and principles, which should reflect those set out nationally. There should be evidence of an effective process for involving stakeholders.
- 5.9 Partnerships should include voluntary organisations, service users and others who represent users and potential users. It can be difficult for some voluntary or community organisations to contribute because of limited staff and resources, but smaller organisations should be encouraged to collaborate to make their voices heard. We will support development programmes that help to build capacity in the voluntary sector.

Empowering patients and communities

- 5.10 The Government wants patients and the public to play a big part in reshaping services at local level. Patient Forums and the new Patient Advocate and Liaison Service will be a good source of input, but the local multi-agency groups should involve users in different ways to make sure they hear the full diversity of views. The groups should help their staff to develop the skills they need to take account of cultural complexities in their discussions with users.

Identifying resources

- 5.11 Commissioners should identify the current level of investment in sexual health services and HIV, the cost effectiveness of those services and any gaps in resources. Local planning will need to match capacity to need, priorities and targets and set out the resources necessary for meeting the targets.

Local targets

- 5.12 Local targets should be based on an assessment of need and an understanding of local services – but they should also fit with the aims and objectives of this strategy. This means that local targets should:
- tackle inequalities;
 - help to overcome local barriers to change;
 - be based on the service standards;
 - be measurable and achievable; and
 - reflect a clear process for involving those working in sexual health in setting the targets.

Targeted groups

- 5.13 The multi-agency groups should ensure that local strategies address the needs of targeted groups. The local needs assessment must identify groups that need targeted information or services as well as identifying barriers to access. Commissioning plans for HIV prevention must specifically address the groups that this strategy recognises as a priority.

Commissioning for services and prevention

- 5.14 Commissioners should reflect the aims of this strategy in their local plans. They should:
- reflect the three levels of services, concentrating on the interface between service levels to ensure smooth referrals;
 - make sure that there are clear open access arrangements, including for people who seek care from GUM services outside their own area;
 - identify action to meet the needs of targeted groups;

- include prevention of HIV and STIs in all service agreements and investment plans;
- give local people access to information on services in a variety of ways;
- lead the development of managed networks for HIV services and for sexual health services; and
- define and monitor service standards for providers.

5.15 HIV prevention plans should:

- show how resources will be used to target priority groups;
- set local targets;
- indicate the outcomes to be achieved; and
- describe the monitoring and evaluation process.

Commissioning social care services for people living with HIV

- 5.16 Commissioners of social care services for people living with HIV should base their planning on the same principles, including the involvement of users and good working partnerships between the statutory and voluntary sectors. The flexibility offered by the Health Act 1999 has created new opportunities to pool budgets and develop integrated provision and lead commissioning arrangements. Commissioners should exploit these mechanisms to build seamless social care services that can respond quickly to changing needs.
- 5.17 Social services departments should also consider the needs of people living with HIV in other relevant services, like those funded from the Carers Grant, and plan for services that encourage social inclusion.

Questions:

- Are the proposed principles for the effective commissioning of sexual health and HIV services the right ones?
- How easy will it be to set up multi-agency commissioning groups as a function of existing local partnership groups?

Action and targets

Commissioners should:

- Establish a local multi-agency group, involving local stakeholders and commissioning organisations, and identifying a lead commissioner. This should build on existing arrangements and the agreed local teenage pregnancy strategy.
- Ensure a multi-agency plan is developed, agreed and specified in the Health Improvement Programme.
- Work to reduce inequalities by ensuring local resources are targeted to high need groups as nationally specified and as identified in needs assessments.
- Work in partnership with the range of stakeholders.
- Ensure the diversity of user views is reflected in planning and monitoring by using a range of involvement mechanisms, including specifically involving people living with HIV.
- Set and monitor performance indicators for sexual health and HIV in line with national targets, using transparent mechanisms to evaluate the development, implementation and outcomes of plans.

6 Supporting change

Review of current information and data collation.
Improved evidence base.
Development of professional education and training.

Introduction

6.1 To help local services make the national strategy a reality, the Department will lead change in five key areas:

- information and data collection;
- evidence and research;
- professional education and training;
- workforce; and
- finance.

6.2 Each of these areas is essential to the strategy and each needs a programme of reform.

Information and data collection

6.3 Information systems in England already provide a range of sources relevant to sexual health and HIV. These are described in detail in “Sexual Health in England; a guide to national and local surveillance and monitoring data”³⁵. The systems include information on service provision, uptake of services, morbidity and conception. They also provide information on attitudes and behaviour through service reports and national surveys. Nevertheless significant gaps in information remain.

- 6.4 The Department will set up a formal review of current systems, working closely with the Association of Public Health Observatories, and develop some detailed proposals for making sure that information can meet identified needs. Work has already started and options for change will be published by the end of 2001. The proposals will aim to:
- maintain patient confidentiality;
 - improve the co-ordination of data collection;
 - capture information from new services such as NHS walk-in centres; and
 - improve information on behaviour and attitudes.
- 6.5 The Department will review Schedule 1 to the AIDS (Control) Act 1987, which asks health authorities to report annually on numbers of people with HIV and AIDS and say what services are in place or planned. The review should:
- streamline the cumbersome data exchanges between the Department and health authorities;
 - consider establishing regular reporting of local authorities' provision for people living with HIV;
 - strengthen research into the needs of people living with HIV; and
 - develop new ways of getting information to the people who are planning and evaluating local services.

Evidence base and research

- 6.6 There is a growing base of evidence and good practice in the field of sexual health and HIV – for example from the work of the Health Development Agency and SIGMA Research. Despite that, the evidence base is variable, and in some areas we still lack the knowledge we need to underpin our planning.
- 6.7 The Department's Policy Research Programme (PRP) aims to secure a robust research evidence base on important issues. The Department already allocates £1 million a year from the PRP to the Medical Research Council for AIDS epidemiological research, which in turn is supporting the National Sexual Attitudes and Lifestyles Survey. Future allocations of PRP funding will take account of research recommendations arising from this strategy.
- 6.8 Research priorities will be identified through consultation, to help target resources on where the information need is greatest and where studies can make the most difference. The broad areas where it appears that future research and evidence is needed are set out in the box below. The Department will consult and work with practitioners, planners and research organisations to establish priorities.

Potential research priorities

Prevention, information provision and determinants of risk

- links between drugs, sex and alcohol and the identification of effective interventions;
- better understanding of the sexual networks, health seeking behaviour and risk behaviour of targeted groups;
- the impact of combination therapies for HIV on behaviour, and the potential for complacency and unsafe sex in uninfected groups at risk and those already infected;
- the impact of ethnicity, deprivation, and other socio-economic factors in sexual health;
- best practice in condom promotion, including the most effective use of free condom distribution;
- effective microbicides and an affordable HIV vaccine, and how their use could be integrated into other HIV prevention and health promotion activities.

Interventions

- barriers preventing access to services, especially within targeted groups;
- a better understanding of why young men do not access services, and evaluation of innovative methods for engaging them in sexual and reproductive health interventions;
- effectiveness of new models of care for improving sexual health outcomes – for example the interface between PCTs and GUM services, one stop shops, integrated youth services
- improving partner notification within clinics and the community;
- evaluating and improving the uptake of sexual health screening services in non-specialist settings, especially for Chlamydia; and
- developing and evaluating surveillance mechanisms to meet new service configurations.

Professional education and training

- 6.9 Education and training for those who provide services is another underpinning element of this strategy, and needs to cover both generic and specialist skills. The Government is committed to personal development and training and making sure that staff are helped to keep their skills up to date. There will be increased and targeted investment in vocational training and in widening access to Individual Learning Accounts for staff without a professional qualification.
- 6.10 Everyone working in the field will need training to support implementation of this strategy. This will include people with a role in the delivery of HIV and STI prevention, education, and services – for example teachers, care workers, school nurses, youth and community workers, social workers, prison staff, and health visitors. It also includes people working with users in services that include sexual health issues – for example primary care, contraception, GUM, obstetrics and gynaecology, youth services and NHS walk-in centres. Many disciplines are involved including physicians, practice and clinic nurses, midwives, school nurses, health advisors, psychologists and youth clinic staff.

- 6.11 Training needs to cover core skills and issues such as awareness, attitudes, information, communication skills, sexuality, relationships and sexual health. Training to develop awareness of cultural differences is also important in understanding and meeting the needs of some black and minority ethnic groups.
- 6.12 As well as training staff in generic core skills, we need to equip specialist providers to deliver broader sexual health services. There are a number of important gaps in sexual health training and education, including inadequate, patchy or absent sexual health training in undergraduate curricula (doctor, nurse, and teacher) and a lack of specific courses such as STI management for GPs, even though this is now being addressed.

Training and development

Sexually Transmitted Infections Foundation course (run by the Medical Society for the Study of Venereal Diseases)

The course equips participants with the basic knowledge, skills and attitudes for the effective management of sexually transmitted infections. The content covers core STI knowledge and skills, and the target audience includes multidisciplinary GPs, family planning staff, school and practice nurses, health advisers and any secondary care clinician who may encounter patients with STIs. The course lasts two days and is based on the format of resuscitation council courses such as ALS/PALS.

Diploma of The Faculty of Family Planning

The aim of this course is to help participants develop the basic knowledge, skills and attitudes for the effective management of contraception and related issues. The target audience includes GPs and specialists in GUM, family planning and gynaecology.

- 6.13 The NHS Plan highlights the need to broaden the role and skills of the workforce. The growing role of nurses within the NHS generally is likely to be mirrored in sexual health practice. The development of nurse referral and prescribing, and of nurse specialists and nurse consultants, raises issues for their training and ongoing education. Another important group within sexual health services is sexual health advisers, who can play a pivotal role in partner management, information provision and liaison between community sexual health provision and GUM services. Their role within GUM needs to be strengthened and more clearly defined.
- 6.14 To help develop a skilled and confident workforce the Department will:
- work with those responsible for postgraduate medical education and training – for example the Specialist Training Authority and Joint Committee on Post Graduate Training for General Practice (both shortly to be replaced by the Medical Education Standards Board);
 - work in partnership with statutory and professional organisations and colleges to develop appropriate courses;
 - work with those developing initiatives under the umbrella of “modernising education and training”. This includes work on policy underpinning NHS Plan commitments such as a core curriculum for communication skills, common foundation learning and continuing professional development. The Department will also build on its work with the Quality Assurance Agency for Higher Education to streamline the quality assurance arrangements for all NHS funded non-medical professional education and on similar work for undergraduate medicine and dentistry;

- propose a process for developing national skill standards. This work will reflect and support the wider initiatives on core curricula and training set out in the NHS Plan and the Quality Strategy for Social Care. Professional organisations will be invited to help develop and respond to these standards in designing their courses; and
- identify a process for defining the roles and responsibilities of health advisers, including the development of a health advising qualification by 2005.

Human resources

- 6.15 Delivering this strategy will mean a considerable expansion and modernisation of services. The Department is looking at the way staffing is planned across the whole of health and social services. Increasingly, workforce plans need to look at how multi-professional teams can best provide patient centred services across traditional service and professional boundaries, and that is particularly relevant to sexual health services.
- 6.16 In April 2000 the Government published the national workforce planning review 'A Health Service of all the talents: developing the NHS workforce'³⁶ for consultation. Its recommendations include the establishment of Workforce Development Confederations to bring together NHS bodies, social services, GPs and other employers of health care staff to plan development and training. Confederations will replace education consortia and Local Medical Workforce Advisory Groups. Commissioners of sexual health services should ensure that their local confederation is aware of their training and workforce requirements.
- 6.17 Confederations will provide a comprehensive view of workforce requirements for all health professionals and:
- ensure coherence and that all staffing requirements are identified;
 - provide information supporting the central planning of numbers for basic professional training;
 - ensure that NHS funded education matches the priorities and commitments in the NHS Plan; and
 - provide a focus for developing local human resource strategies.
- 6.18 The Department's Taskforce charged with implementing the workforce aspects of the NHS Plan, and the new National Workforce Development Board that is developing proposals for future workforce requirements, will take into account the need to develop an appropriate skill mix in all sexual health services. Detailed workforce plans are expected by 2002.

Estate

- 6.19 The condition, accessibility, siting and opening hours of facilities can have a significant impact on people's willingness to attend. For example, 30% of GUM clinics operate three days a week or less. Modern and comfortable clinics are more attractive to potential users and less likely to reinforce any feelings of stigma associated with their use. The condition of facilities varies across the country and the Department will identify the need for modernisation within sexual health services and the options for delivering it.

³⁶ A health service of all the talents, developing the NHS workforce; Consultation document on the review of workforce planning. Department of Health 2000

Finance

- 6.20 As well as health authorities' general allocations and local authorities' Standard Spending Assessment, there are a number of dedicated funding streams for sexual health and HIV including:
- HIV/AIDS treatment and care special allocation;
 - HIV prevention special allocation;
 - national HIV/AIDS prevention and sexual health budget;
 - Teenage Pregnancy Local Implementation Fund;
 - Section 64 grants to voluntary organisations;
 - Supplementary Credit Approvals to local authorities; and
 - AIDS Support Grant.
- 6.21 In April 2002 the special allocation for HIV/AIDS treatment and care and for HIV prevention will be added to health authorities' main allocations. This reflects the need to bring HIV/AIDS services into the mainstream with other priority areas – in line with the NHS Plan – and will give health authorities more flexibility to meet local needs. To ensure that the current level of services is maintained, the Department will continue to monitor access to services, the standard and quality of the services provided and, if appropriate, the level of investment being made. These additions to general allocations will reflect the patterns of the epidemic rather than simple capitation shares. The Public Health Laboratory Service Survey of Prevalent HIV Diagnosed Infection data (SOPHID) will form part of the formula used by the Department to calculate the main allocations targets. These targets are used to inform the distribution of additional general funding to health authorities.
- 6.22 The AIDS Support Grant was established in 1988/89 so that social services departments could draw up strategic plans and provide care for people living with severe HIV disease and AIDS. That underlying aim is as valid as ever. It is less clear that the Grant, with its associated administration costs, is the best way of doing that. The Department will identify options for discussion.
- 6.23 The Department will also set new priorities for Section 64 funding to reflect better our aims for the HIV voluntary sector and the broader objectives of this strategy.

Performance management

- 6.24 The specific targets on HIV testing, the provision of hepatitis B vaccine and the transmission of HIV mean that sexual health will be included within the performance assessment framework. NHS performance indicators and reporting mechanisms will be agreed by Autumn 2001 and will cover a range of issues, including local outcomes and effectiveness, to ensure that the range of services at the three levels described in chapter 4 are available everywhere. The social services contribution to implementing this strategy will be assessed through joint NHS / Social Services in-year monitoring and through monitoring related to the AIDS Support Grant (pending the outcome of the review of the Grant outlined in paragraph 6.22).

Questions:

- Is the proposed list of potential research priorities the right one? What else should be in, and what should top the list?
- Are the proposed aims for the information systems that are needed to underpin this Strategy the right ones?
- How might the Department ensure that access to and quality of services are maintained after the special allocation for HIV/AIDS treatment and care is added to health authorities' main allocations in April 2002?
- How should HIV prevention resources be managed effectively so that the targets in this Strategy are reached?

7 Conclusion

- 7.1 This strategy is ambitious. It has been developed with the help of those working in the field, service users and members of targeted population groups, including young people. We have listened to all the views and information presented to us.
- 7.2 We believe this strategy provides a basis for developing sexual health services and prevention in a way that can really make a difference. We have set out a new model for services based on clear standards. This will improve access to information and services and end the inequities that have existed for too long.
- 7.3 We welcome comments on the proposals. Over the months ahead we will continue to develop work in the areas where we need more detail. The result of continuing work and the response to this strategy will enable us to set out a detailed programme of action. Some of the changes will take time to put in place and take effect, but our vision is of tangibly improved information, prevention and services for people of all ages and backgrounds.

Questions:

- Will implementing this Strategy deliver a reduction in the stigma associated with HIV and STIs? If not, what else needs to be addressed within the framework of this Strategy?
- Is this Strategy sufficiently far sighted to still be relevant to sexual health and HIV in 5 to 10 years time?

Appendix 1

Members of Sexual Health and HIV Strategy Integrated Steering Group

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The Department would also like to thank all those who have developed this Strategy through their contributions to the various sub-groups and working groups.

Appendix 2

The consultation criteria

The criteria for all UK national public consultations is set out in the Code of Practice for Written Consultation³⁷ published by the Cabinet Office. This requires that:

1. Timing of consultation should be built into the planning process for a policy (including legislation) or service from the start, so that it has the best prospect of improving the proposals concerned, and so that sufficient time is left for it at each stage.
2. It should be clear who is being consulted, about what questions, in what timescale and for what purpose.
3. A consultation document should be as simple and concise as possible. It should include a summary, in two pages at most, of the main questions it seeks views on. It should make it as easy as possible for readers to respond, make contact or complain.
4. Documents should be made widely available, with the fullest use of electronic means (though not to the exclusion of others), and effectively drawn to the attention of all interested groups and individuals.
5. Sufficient time should be allowed for considered responses from all groups with an interest. Twelve weeks should be the standard minimum period for a consultation.
6. Responses should be carefully and open-mindedly analysed, and the results made widely available, with an account of the views expressed, and reasons for decisions finally taken.
7. Departments should monitor and evaluate consultations, designating a consultation coordinator who will ensure the lessons are disseminated.

We confirm that these criteria have been, and will continue to be followed.

³⁷ Code of Practice on Written Consultation, Cabinet Office, November 2000



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