Definition of Sexual Health

Sexual health is an important part of physical and mental health. It is a key part of our identity as human beings together with the fundamental human rights to privacy, a family life, and living free from discrimination. Essential elements of good sexual health are equitable relationships and sexual fulfilment with access to information and services to avoid the risk of unintended pregnancy, illness or disease.¹

¹ The National Strategy for Sexual Health and HIV, Department of Health, July 2001
The national strategy for sexual health and HIV was published in July 2001, and, as we approach the half way point in this 10 year strategy, we will reflect on progress. Interestingly, the landscape surrounding sexual and reproductive healthcare has changed enormously since the strategy was drawn up. Many of the recommendations from our last annual report have been realised.

We have seen the promise of unprecedented investment in the provision of sexual health services resulting from the Government’s White Paper, Choosing Health. Three hundred million pounds has been earmarked for improving genitourinary medicine (GUM) and contraceptive services, implementing the accelerated roll out of the Chlamydia Screening Programme, and a new sexual health media campaign. An extra £15 million was announced in July 2005 specifically for the improvement of infrastructure for genitourinary units. Local Delivery Plans (LDPs), which provide a tool for effective performance management, now include targets around 48 hour access to genitourinary services, detection rates of, and the provision of screening, as well as reducing conception rates in under-18s. The Healthcare Commission has included performance indicators around GUM, contraception and abortion that support the LDPs, which means we now have for the first time a set of targets for Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs) to actively deliver on for sexual health.

We have an opportunity to change things for the better and radically improve services. This is exciting, but also places very real challenges at the doorstep of Primary Care Trusts and Strategic Health Authorities who need to meet the Local Delivery Plan targets.

How will they do this, and what happens if they don’t? The new MedFASH standards on sexual health² set out the parameters. It is essential that the extra investment by Government is used by PCTs to improve their sexual health services. We have had disturbing reports that the money is not reaching its intended target, and this must be addressed. The IAG is currently considering the potential significance of the changes of Commissioning a Patient-Led NHS³ both for service provision and performance management. We hope it will offer significant opportunities to strengthen areas where sexual health services are weak as PCTs are reduced in number.

The Government’s extra investment also has thrown into relief issues that have been rumbling throughout the services since the IAG’s inception two years ago; issues around modernisation, integration of services, staffing and training. This includes increasing and developing the role of nurses, and nurse practitioners as well as developing career infrastructure and improving staffing for contraception and GUM clinics.

The review of contraception services and the £40 million pledged to improve those services means that they, too, will be a very important consideration in the forthcoming year.

This annual report is both a look back at a busy and constructive year, but more importantly a look forward at some of the issues the IAG will be addressing next year. These issues are complicated and often controversial, but we believe it is our duty to debate them. The various threats to patient confidentiality, addressing what will help curb STI rates among the ‘at risk’ groups, and also looking at how we can educate all about what good sexual health actually means, and how it can be achieved, are high on our list.

The remit of the IAG is to address the health issues that fall under the aegis of sexual health – contraception, abortion, psycho-sexual services and the detection and treatment of STIs and HIV – and we wish to help integrate them into mainstream health care, as part of an holistic approach.

We welcome four new members to the IAG this year, Dr Kate Guthrie, Helen Ward, Debbie Preston and Kierra Box.

I would also like to take this opportunity to thank Cathy Hamlyn, Head of Sexual Health and Substance Misuse at the Department of Health. Her guidance and advice to the IAG has been of the highest quality, and we will miss her, both as a valued colleague and friend, and wish her the best in her new role.

Baroness Gould of Potternewton
Chair, IAG on Sexual Health and HIV
October 2005

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2 MedFASH, Recommended Standards for Sexual Health Services, 16 March 2005, gateway ref 4455
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Choosing Health White Paper funding allocation of £300 million to improve sexual health services, and an extra £15 million announced in July to fund improvements in GUM infrastructure.

Of the £300 million, £50 million to be spent on an awareness-raising campaign on sexual health.

Four Local Delivery Plan targets specific to sexual health services.

- Access to GUM clinics within 48 hours.
- Decrease in rates of diagnosis of gonorrhoea.
- Percentage of people aged between 15-24 accepting chlamydia screening.
- Under 18 conception rates.

The commissioning of the National Review of Genitourinary Medicine Services.

The audit of contraceptive services.

The inception of the medical abortion pilot.

The publication of the MedFASH standards for Sexual Health Services.

The publication of the Recommended Quality Standards for sexual health training – Striving for Excellence in Sexual Health Training.

The Government has been asked to consider calls for the abolition or reduction of VAT on contraceptives from a number of key organisations, including the IAG, retailers and the voluntary sector, given the significant benefits which would be realised for the country’s sexual health overall, and that the Exchequer is likely to gain and not lose from such a move.

The Choosing Health White Paper commitment to improve local delivery on sexual health, followed up in the Delivery plan (published in March 2005) to develop national support teams including one on sexual health.

The maintaining of the AIDS Support Grant.

The steady progress in reducing teenage pregnancy rates.

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4 MedFASH, Recommended Standards for Sexual Health Services, 16 March 2005, gateway ref 4455

6 The Independent Advisory Group on Sexual Health and HIV
The Independent Advisory Group on Sexual Health and HIV (IAG) has produced its 2004/05 annual review against a background of profound change in the NHS.

The IAG wholeheartedly supports the Government in its drive to improve and modernise services. However, within the upheaval engendered by the restructuring of Strategic Health Authorities and Primary Care Trusts, and the evolving role of general practice, the IAG feels it is vital to keep genitourinary medicine, contraceptive services, and the provision of sexual health services overall, at the forefront of policy initiatives around service provision.

A key growth area for the future must be contraceptive services. Whilst we welcome the steps taken in the Choosing Health White Paper, contraceptive services are a very important element of sexual health. There is much more to be done.

Key themes emerge within this report: access to services, monitoring of results (from tracking how funding is spent to commissioning research that identifies effective interventions), and a suggested review of progress so far against the 10 year strategy produced in 2001.

The document is divided into four sections:

• Delivering improved services, with a focus on what exists at the moment, and how it can be improved.
• Developing new services, with a focus on modernisation and a review of current changes underway in the NHS.
• Professional skills, with a focus on career development and training.
• Sexual health and wellbeing in the 21st century, with a focus on the normalisation of sexual health issues within our social, legal and educational framework.

A full list of recommendations can be found at the back of the document.

The IAG will be contributing to the Health Outside Hospitals listening exercise and the consultation on Youth Matters, and the developing work on parenting to ensure that sexual health has its proper place in these important new initiatives.
Delivering Improved Services

What is happening in Primary Care Trusts?

The IAG on Sexual Health and HIV frequently comments on the issues affecting service provision within PCTs, and part of our work this year has been to investigate what PCTs are doing to meet Government targets. The IAG contacted sexual health leads directly for their feedback on what was happening in their local PCTs in terms of providing and funding various services to support sexual health.

One hundred and seventeen responses (out of a potential 302) were received – approximately a third of the entire sample – probably representing those most interested in sexual health issues. The number of responses is disappointing and too small to be representative of all PCTs. However, certain issues were highlighted that the IAG believe warrant further investigation.

Namely:

PCT sexual health leads have a patchy understanding of exactly what contraceptive services local GPs are providing.

For example, while 111 sexual health leads could report that there was a community family planning or contraceptive service in their area, over 30 sexual health leads didn’t know how many GPs were signed up to deliver contraceptive services. This indicates that the audit trail for GPs providing these services might not be clear to the sexual health leads in PCTs.

The survey shows that the introduction of a Local Delivery Plan target seems effective in helping prioritise sexual health.

111 respondents were aware that a review of GUM services had been commissioned.

104 respondents indicated that their PCT was in the process of examining how it was going to achieve the 48 hour target for GUM appointments by 2008.

Finally, and as a footnote – but an important one – 81 respondents noted that ‘concern had been expressed’ within their PCT about the costs of providing long term drug therapy for those with HIV.

We explore many of these issues later in the annual report, but believe that a regular monitoring of commissioning activity would be useful.

The IAG also would like to highlight its concerns about the role of sexual health leads in PCTs – many are too junior to be able to contribute at a senior level and play sexual health into the main agenda at a level of PCT discussion which really counts.
Ensuring Service Improvement as a Result of Extra Funding

A key concern for the IAG is that the investment provided for GUM and contraceptive services reaches its target. In terms of GU medicine alone, failure in funding and the resulting improvements would jeopardise the 48-hour access target meaning that STIs will continue to increase.

The IAG recognises that innovation in service delivery also needs to be considered. The money for GUM services does not necessarily have to be delivered through GUM clinics.

The lack of pump priming and the disparate timing in the reporting of the various audits of services with the allocation of funds to PCTs is a concern. For example the Contraceptive Audit is due to report in December 2005 (the IAG believes this date to be an optimistic target given the complexity of the task), but the first tranche of funding for contraceptive services is delivered to PCTs on 1 April 2006. For these reasons, there is not much time to plan the distribution of money.

The responsibility for ensuring that funds are invested as allocated by Government will lie both with SHAs and PCTs.

The Government believes that the proof that funding has reached its target is the improvement and successful delivery of services. The IAG believes that the Government must take some steps to ensure the funding does reach its allocated service. The IAG also asks what repercussions will be faced by PCTs that fail to fund and improve services? There needs to be closer working together at level 3 (specialist services) to ensure that the money is not squandered and is deployed as effectively as possible. This refers both to NHS monies and local authority funding.

As part of its Annual Health Check 2005/06 on basic service provision, the Healthcare Commission has in place performance indicators for Primary Care Trusts around access to contraception, GUM, termination of pregnancy and teenage conception rates. The IAG would welcome an opportunity to work with the Healthcare Commission on developing these recommendations further.

Recommendations

The Government to focus on how to ensure delivery of the LDP targets. Part of this is ensuring the funds reach the intended services.

The Department of Health to be aware that momentum must be maintained during service reconfiguration, including those changes outlined in Commissioning a Patient-Led NHS, which may serve to distract senior staff (including those responsible for commissioning and clinicians), from achieving targets. This is a major concern for public health.

SHAs to monitor PCTs to identify their current spend and planned investment in sexual health, and ensure that PCTs deploy the extra funding effectively in delivering services and achieving improvements.

The IAG would like to see the Healthcare Commission consider what monitoring can be put in place at a local level, for example, tangible evidence of the impact of extra monies including response from patients, collation of local statistics on performance and outcomes.

The Government to determine what sanctions should be incurred against PCTs that fail to reach their targets on sexual health services.

Modernisation

The IAG on Sexual Health and HIV recognises that Primary Care Trusts and Strategic Health Authorities are managing a process of change initiated by the Sexual Health and HIV Strategy and galvanised by the extra funding provided by the Government. This is challenging. The improvements proposed in the Choosing Health White Paper will take time to come about, but the IAG is extremely concerned that the enhancements do occur as intended, and that those responsible for commissioning services do so to meet the varied needs of their community. This is particularly pertinent with the proposed changes to the commissioning of services outlined in Commissioning a Patient-Led NHS and the reconfiguration of SHAs and PCTs.

There is increasing anxiety about the disinvestment in specialist (level 3) services under the supposition that primary care can do it all. The Sexual Health Strategy promoted partnership working at all levels. If anything, primary care (levels 1 and 2) should be enhanced but in no way replace or take funding from specialist services.

Part of the modernisation reflects the ‘normalisation’ of sexual health, moving it out of a metaphorical (and sometimes literal) portakabin and into mainstream healthcare. Another part of the normalisation of sexual health discussed later in this report is moving sexual health into mainstream education and law.

One of the hoped for benefits of the normalisation of sexual health is people presenting for regular STI and HIV screening, and an increased demand for a uniformly high standard of contraceptive services.

The Sexual Health and HIV Strategy and Implementation Plan

The Sexual Health and HIV Strategy is a 10 year strategy developed before major funding became available – and the funding has precipitated some change. The IAG believes that the time is right for a benchmarking exercise to ascertain what has been achieved in the Strategy and Implementation Plan, what is still outstanding, and how the Implementation Plan should be updated and amended for the remaining five years.

Recommendations

The Government and the Department of Health to review, update and amend the Sexual Health Implementation Plan as necessary. Examples of good practice would come out of this exercise, as well as information about how many PCTs have undertaken the required work.

The Government and the Department of Health to use the performance monitoring information generated by the National Review of GUM Services and the Contraceptive Audit when formulating the revised Implementation Plan.
Local Delivery Plans

The inclusion of targets for sexual health services in Local Delivery Plans, and the publication of the MedFASH standards this year, started the process of setting benchmarks for Primary Care Trusts.

The IAG welcomes the NHS Local Delivery Plans data monitoring lines. This section of the Annual Review concerns itself with three of the four monitoring lines:

- The percentage of patients attending GUM clinics who are offered an appointment to be seen within 48 hours of contacting the service, aiming to reach 100% by 2008.
- A drop in the number of new diagnoses of gonorrhoea per 100,000 population.
- The percentage of people aged 15 to 24 accepting chlamydia screening from 2006.

The fourth monitoring line – under 18 conception rates – forms the basis of the work done by the Independent Advisory Group on Teenage Pregnancy. However, we do address issues around sexual health and education in schools later in the document, as well as contraception, abortion and patient confidentiality.

Access to GUM Clinics Within 48 Hours

Those working in GUM were encouraged by the announcement of additional sexual health spending, including £130 million for GUM services announced alongside the Choosing Health consultation, and an extra £15 million announced in July to be spent on GUM infrastructure.

A recent review of literature in the Health Economics of Sexual Health indicates that good access to STI services with very short or no waiting time is "outstandingly cost effective".

At the moment, GUM services remain under extreme pressure related to the continued increases in new STI and HIV cases. Increasing screening effectively will mean an inevitable increase in activity initially. Pressure will further increase once the planned Sexual Health Media Campaign starts to take effect, although there have been some months to start gearing up services and we recognise that the new Sexual Health Media Campaign is likely to focus strongly on prevention in its first phase.

A national GUM service review is currently underway. The purpose of the review is to undertake a multidisciplinary assessment of each GUM service in England highlighting factors both facilitating and obstructing their ability to offer a prompt and high quality service. The review will offer recommendations for service improvements arising from the assessment of GUM clinics, PCTs, and SHAs. The findings from this survey and its recommendations will be given to the Department of Health.

The GUM review results will be very important to the strategic planning of expenditure in order to meet the target of 48 hour access.

At the moment, poor access times persist:

- Service capacity growth is far exceeded by patient demand.
- 48-hour goal by April 2008 remains very challenging.
- There is geographical variability – worse outside London, especially in the North.
- Good, innovative, effective, evidence-based practice is not being taken up by other services.

We are aware of some PCTs who have threatened to try and inhibit self-referral of patients to GUM clinics. The IAG believes that access within 48 hours is a laudable target, and the gold standard must be open access for absolutely all GUM services, where individuals can visit a clinic without appointment, and be seen that day. This should be a priority within the lifetime of the current 10 year strategy.

**Recommendation**

The IAG believes that for better overall effectiveness in sexual health the Department of Health must agree a new LDP line for the effective delivery of easy access to contraceptive services, and PCTs should also be assessed on their ability to offer a full range of contraceptive services.
Recommendations

PCTs and SHAs to ensure that the option for open access to GUM services is available and maintained in all clinics, specialising in GUM or otherwise.

The Department of Health to develop proposals for real-time monitoring of access during 2005/06, and planned improvement in IT support to allow real-time monitoring to take place in consultation with the Sexual Health Minimum Dataset.

The Health Protection Agency (HPA) survey of access times should now be performed quarterly.

PCTs and SHAs should act swiftly and within a specific timeframe on the results of the GUM review.

Tackling Increased Rates of STIs (with reference to PSA on Gonorrhoea)

The decreased level of incidence of gonorrhoea of 13% in women and 10% in men reported in the 2004 STI data9 is encouraging but there is no room for complacency as overall figures show an increase in HIV, syphilis and chlamydia.

Patient demand, both in terms of overall numbers and case complexity, continues to increase.

There is an upsurge in resource-intensive HIV cases, syphilis is becoming endemic in larger towns and cities, and there are very large increases in other workload statistics. The IAG is concerned that the decrease in gonorrhoea may not represent the full picture, as access difficulties and failure of other treatment services to report cases could mean some cases going unreported. There appears to be no movement on gathering data from General Practice.

Tracking the diagnosis of all STIs must be a priority, and diagnosis of STIs should be reported from all settings, not just GUM clinics. The completion of the Minimum Sexual Health Dataset is essential for accurate surveillance. At the moment all information on STI rates is gleaned from GUM clinics, and the information would be more comprehensive if General Practice and community services were included in the reporting mechanisms.

Recommendation

The Department of Health to ensure that the rapid completion and implementation of the Sexual Health Minimum Dataset is a high priority for the roll out of better IT systems for the NHS. There should be a full buy-in by all services within the NHS who are relevant, especially primary care.

9 HPA data on STIs, published 30 June 2005
Chlamydia Screening

The IAG welcomes the accelerated chlamydia screening programme which means it will be operational across England by March 2007. We are pleased that NAATs testing is now used in laboratories testing for chlamydia.

We are extremely interested to see the results of the free chlamydia screening offered over-the-counter at Boots the Chemist, as we see this as a very innovative and exciting development.

However, what is the provision of primary care engagement for those who go to the chemist for a test and are symptomatic or test positive for chlamydia? The IAG believes that innovative practices need to continue, and be fully evaluated.

The IAG would also like to reiterate that General Practitioners, Community Clinics and Practice Nurses should not be overlooked in the provision of chlamydia screening for young people. Recent analysis of attending behaviour by young people – including young men – in the NHS shows that 69% of men under 25 years of age, and 90% of women in the same age group had been to the General Practice in the last 12 months. For example, part of registration with a new General Practitioner (GP registration) is to provide a urine sample, and it might be an option to expand the test to include Chlamydia screening as a matter of course. This will involve the Government considering how best to support this service within the new general practice contract (nGMS).

While young people are most at risk of contracting chlamydia, the needs of older women (35+) should not be ignored. Traditionally, older women tend not to be considered ‘at risk’ of contracting STIs. However, a change in circumstances that results in sexual partner change (for example, divorce, separation or being widowed) means that health care professionals should be aware that some older women are vulnerable to contracting STIs. Providing screening for older women for chlamydia has been identified as an “averagely cost effective” intervention in a recent review of literature.

The IAG is keen to see what the protocols are for the operational management of the Chlamydia Screening Programme when it transfers to the HPA. We understand that the Department of Health is contracting out responsibility for the chlamydia Screening Programme as they believe the HPA is well placed to help accelerate delivery, drawing on their experience from other national screening programmes.

Recommendations

In order to increase screening coverage to get past the threshold required to make a programme effective in reducing prevalence, the Government to include an enhanced service or equivalent in the nGMS contract to incentivise General Practitioners to do more screening. If nothing happens nationally then PCTs may (or may not) introduce local schemes which will introduce disparity within the programme.

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10 Government Response to the Health Select Committee’s Third Report of Session 2004-2005 p.11
11 Averagely cost-effective Interventions compared with current NHS expenditure - £100 to £1,000 per Quality Adjusted Life Year. Payne, N and O’Brien, R. Health Economics of Sexual Health, a Guide for Commissioning and Planning, September 2005, DH
Reproductive Health

This section reviews some of the current issues around contraceptive services, and the importance that access to good quality contraceptive services can have in protecting women from unintended pregnancy. Emphasis must be placed on maintaining and improving current services.

Contraception and Family Planning Services

The IAG believes that it will be difficult to measure how effective the deployment of the £40 million pounds allotted for contraceptive services is because of changes in commissioning structure outlined in *Commissioning a Patient-led NHS*\(^\text{12}\), the lack of a Local Delivery Plan monitoring line on contraception, and delay on the publication of the contraceptive audit results.

The IAG is extremely concerned that so far there has been little focused work on access to contraception, which, in the light of the proposed change in commissioning, is very worrying. How can we bridge the gap between the only target in place (reduction in teenage pregnancy rates) and the daily experience of so many women of all ages (especially some of the most vulnerable) whose access to friendly, supportive and clinically adequate contraception is so limited?

The IAG is also worried that the first tranche (£20 million) of the £40 million will go straight to the PCTs’ bottom line in April 2006/07 before SHAs and PCTs – let alone those involved in practice based commissioning – have an opportunity to plan their services based on the national information from the audit – which at the moment is due to be completed in December 2005, although the IAG believes there will be delay on this date.

The Department of Health maintains that the very act of undertaking the audit will provide each SHA and PCT with the information to review and improve its services locally. However, the introduction of practice based commissioning and the timetable for PCTs to divest themselves of provider functions means there is an added upheaval about who will be commissioning services, and from where. This is particularly important when commissioning community based contraceptive services.

There is little performance management (other than a new performance indicator in the Healthcare Commission’s Annual Health Check) in place to monitor local contraceptive service provision, and very little information about current service provision which increases the danger that funding won’t reach its intended target.

The IAG also observes that the nGMS contract has poor performance indicators relating to the quality of contraception and training requirements to deliver it. This must be addressed in order for practice based commissioning to provide a high quality comprehensive contraceptive service.

As a minimum, contraceptive services should meet the following standards:

- All professionals providing contraceptive advice including General Practitioners and Practice Nurses should be adequately trained to do so. The IAG recommend the MedFASH\(^\text{13}\) standards be used as a benchmark for best practice.
- A full range of methods for women in each PCT area should be easily accessible.
- Services should be available in a variety of settings at times that are convenient to users, as dictated by the users.

There are powerful economic arguments for funding wide availability to good quality contraception. Research commissioned by *fpa* indicates that by changing the supply of contraceptives to better reflect women’s preferences and increasing availability of different long acting methods of contraception, the number of unintended pregnancies would fall and costs incurred by abortion and maternity services would be cut by £500 million over 15 years, resulting in an annual saving of around £33 million.\(^\text{14}\) For every £1 spent there is a corresponding saving of over £10.\(^\text{15}\)

Eighty per cent of contraception is provided by general practice and 20% is supplied by family planning, outreach clinics and community gynaecology. The IAG is concerned that the 20% of specialist services are not overlooked.

The increased accessibility provided by community contraceptive services is especially important for women who are at high risk of unintended pregnancy. Ensuring access for the more vulnerable and marginalised groups has been made possible by these services. The training and support needs of primary care staff in implementing standards in contraceptive service provision is in serious danger of erosion if not strategically thought through.

The IAG is very concerned about evidence indicating disinvestment in community contraceptive services by some PCTs. How will the Government ensure that the contraceptive needs of women are met? How will this be addressed by practice based commissioning?

The majority of community contraceptive services were transferred from Community Trusts to PCTs less than three years ago, and have not in general had the opportunity to do more than re-establish the basic functions (HR, payroll, and pharmacy). Many do not yet have proper service specifications or Service Level Agreements (SLAs) or contracts for the work they undertake.

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\(^{13}\) MedFASH, Recommended Standards for Sexual Health Services, 16 March 2005, gateway ref 4455


14 • • • The Independent Advisory Group on Sexual Health and HIV
We are concerned that the proposed changes will result in a loss of provision which will be felt by the women currently using community contraceptive services. There were 2.6 million visits made by 1.2 million women to community contraceptive clinics in 2003/04.

Care will need to be taken if these community services are to survive another re-organisation, and the IAG believes some strategic thinking is necessary to consider alternative ways forward.

The IAG requests regular updates from the Contraceptive Expert Advisory Group, and would like regular written updates to be circulated at each IAG meeting.

The Government has been asked to consider calls for the abolition or reduction of VAT on contraceptives from a number of key organisations, including the IAG, retailers and the voluntary sector, given the significant benefits which would be realised for the country’s sexual health overall, and that the Exchequer is likely to gain and not lose from such a move.

**Recommendations**

The Department of Health to put in place a Local Delivery Plan monitoring line that reflects the Healthcare Commission’s indicator on reproductive health. Services should offer a full range of contraception methods that are available so that the most appropriate methods can be chosen according to individual circumstances. The proportion of women choosing the IUD, IUS and implant will give an indicator of the range of methods provided by each service. PCTs and SHAs should monitor GP activity in terms of uptake of these methods in conjunction with KT31 returns.

That the Government carefully consider the implications of practice based commissioning for community contraception services.

The Department of Health to ensure appropriate and proper costings for all the elements of care provided by community contraceptive services.

The Department of Health use the contraception element of the MedFASH standards and FFPRHC standards on record keeping and workload as a benchmark of best practice for all services providing contraception, including General Practice.

The IAG to receive regular written updates from the Contraceptive Expert Advisory Group.

The Government to consider the proposed abolition or reduction of VAT on condoms.

**Abortion**

Access for women to early abortion remains a priority.

Abortion at an early stage of the pregnancy is less risky for women, and allows them increased choice in abortion method. One of the key issues is getting women to services in time to have an early abortion.

The IAG welcomes the Department of Health funded medical abortion pilot which explores what healthcare settings, other than a hospital, might be safe and appropriate for providing an early medical abortion service. This should help improve access for women. However, medical abortions formed only 19% of total abortions in 2003 in England and Wales.

As well as being the best option in terms of quality of care, an average reduction in delay of 10 days from referral to termination would increase the proportion of all abortions carried out under 10 weeks to 71% which would represent a current annual saving (at the current profile of methods) of £645,000.

This annual saving could increase to £17.5 million with a moderate change in the profile of methods used over the short term – within as little as 1 to 2 years – and, with a significant change in the profile of methods used over the medium term (up to 5 years), could produce an annual saving of £30 million.

While the choice of method of termination is a clinical decision, where possible, women should continue to be offered choice in methods of termination – whether it is a medical or surgical termination of pregnancy. Both should be available.

**Recommendations**

The Government to ensure that both medical and surgical abortion, by local as well as general anaesthetic, is available throughout England and Wales.

That early abortion remains a priority for all PCTs.

That the Healthcare Commission maintains its rating on early abortion given the signs of success we have already seen.

That PCTs strive for an average reduction in waiting time from three weeks to two weeks from first appointment to termination.

PCTs to facilitate early confirmation of pregnancy by availability in all GP surgeries of on the spot pregnancy tests.

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16 MedFASH, Recommended Standards for Sexual Health Services, 16 March 2005, gateway ref 4455
17 FFPRHC service standards for record keeping, April 2004, FFPRHC service standards for workload in contraception, March 2004
Developing New Services

The work towards modernising all services relating to sexual health is necessary. The potential for change is great. Within that change, it is important the needs of the community are met.

The adage, ‘there is no such thing as a difficult to reach group – there are only difficult to reach services’ should be borne in mind during the current reconfiguration of the NHS.

Evidence of Service Modernisation

There is extensive evidence of service modernisation which the IAG applauds, for example:

Using new technology:

- Use of technology has resulted in rapidly falling follow-up clinic attendances for new patients as people are receiving results by phone or text.
- Changes in approach to patient management, for example home treatment of genital warts.
- New diagnostic test introduction – more sensitive, higher patient acceptability of sampling procedures, rapid (same-day) testing.

Better processes and systems:

- Triage systems mean that urgent cases are seen quickly.
- The development of multidisciplinary clinician teams – nurse practitioners, nurse consultants – allow for more patients to be seen.
- Nurse-led clinics.

The Role of General Practice

The proposals in Commissioning a Patient-Led NHS²⁰ indicate that General Practices now will be leading on the commissioning of services, which will have an as yet unknown but potentially profound impact on the role of general practitioners and practice nurses, as well as on the provision of services overall. This is something that the IAG would like to review in some detail. We have already expressed our early concerns about the commissioning lines for community contraceptive clinics.

IAG members also report that in some PCTs the data is not yet available to support practice based commissioning (i.e. patient numbers, demographics, attendances, diagnoses, source of referrals). Without this basic information, it is impossible to commission new services sensibly.

It is also clear that in many instances, funding for General Practices’ time and exact levels of support from PCTs has not yet been clarified.

Recommendations

The open-access nature (>75% patients attending without prior GP referral) is a cornerstone of sexual health services, meets the ideals of a patient-led service and should be fully supported by the Department of Health within the new commissioning arrangements.

Good practice has a crucial role to play in providing comprehensive sexual health services within primary care. The IAG hopes that the Department of Health will support an outcome of the current GMS and Enhanced Services review that will reflect this.

Networks

There are several formally established clinically managed networks in place, including the Greater Manchester Sexual Health Network, Cheshire and Merseyside and the Southwest London Network. There are a number of less formal, but nonetheless effective, networks developing around the country.

The IAG is pleased to see that these networks are in the process of being developed, and waits with interest for the MedFASH publication in Autumn 2005 of a practical guide to the development of sexual health and HIV networks, which includes material from a conference on Sexual Health Service Networks held in May 2005.

Working with the Voluntary Sector

The IAG welcomes the important role of the voluntary sector in providing expert advice and consultation to Government and, increasingly, services for sexual health. The IAG believes this is an opportunity for the voluntary sector to increase its scope of service provision, providing standards can be met and monitored, and this should be considered as a valuable pool of expertise.

Monitoring Change

This is a time when we need to know what works in the prevention of sexually transmitted infections, in fertility control, and to encourage positive sexual health. Research can help Government to deliver on the goals of the Sexual Health Strategy and Choosing Health, and to ignore this would be to lose a major opportunity for progress.

In last year's report we noted how research on sexual and reproductive health had not been accorded the same degree of attention as service provision. We are pleased to note progress in this area, notably:

- The annual £1 million allocated by the Department of Health to the Medical Research Council (MRC) to support research was given a boost by the MRC of a further £700 thousand. This meant that in this year's funding round eight new research proposals were supported.

- Our call for the Department of Health and the MRC to undertake a review of support for and studies in sexual health has been heeded, and a scoping review is to be commissioned which will outline the current research situation in the UK.

However, despite unprecedented investment in sexual health service provision, research remains the ‘poor relation’.


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Recommendations

The DH/MRC Scoping Review – to be completed by Spring 2006 – will give a good picture of total UK spend on research on sexual health. The Government should act quickly on its recommendations with regard to specific gaps in our research knowledge.

In the light of the review the Government should also consider the adequacy of current levels of research support, given the scale of the UK’s sexual health and HIV problems.
Enhancing Personal Skills

A Multi-Agency Approach

We now have a major framework setting out recommended quality standards for all training related to sexual health called Striving for Excellence in Sexual Health Training. All training should reflect these standards.

Recommendation

All training at both local and national levels should include multi-agency approaches. These should offer opportunities for practitioner and planner from health, education, social work, youth work and the voluntary/community sector to receive training and on occasion train together. The National Sexual Health Training Group recommend that all training is delivered in the context of the quality standards.

Nurses’ Career Structure and Role

The Government’s strategy to improve sexual health is putting nurses at the forefront of service provision.

The holistic view means that nurses need to be aware of sexual health issues and integrate them into everyday patient care. For example, a male patient on medication for high blood pressure attends the practice nurse for a check up appointment. He has concerns that since starting the medication he cannot maintain an erection during intercourse, but through embarrassment, cannot ask about this issue. The nurse needs to be confident and competent to initiate discussions regarding issues over his sexual health. This requires intrinsic ability and sensitivity, coupled with good training. While this may seem a simplistic example – there may be cases where GPs must be involved in the conversation (although sometimes they don’t know how to deal with the situation) – it does highlight the need for training to ensure that all health practitioners are aware of sexual health issues.

Training and Development for Nurses

The IAG welcomes the improvements in training, and believes an enhanced career structure should be available to nurses who work in sexual health.

The IAG believes that all pre-and post-registration nurses should have access to sexual health modules during their programme of training, and the opportunity of clinical placements in sexual health.

The Sexual Health Competencies 2004, overseen by the RCN, is an integrated career and competency framework for sexual and reproductive health nursing which allows nurses to develop their practice to an advanced level. Its creation is very welcome.

The development of standards highlights the need for pre- and post-registration training opportunities for nurses to be developed and maintained. This will require collaborative working with the Council of Deans and the Nursing and Midwifery Council (NMC) with the intention of getting sexual health integrated into all pre-registration nursing curricula.

The IAG also welcomes the HIV nursing competencies currently being developed by the National HIV Nurses Association, and the GUNA (Genitourinary Nurses Association) database of all courses relevant to sexual health nursing due to be launched in Autumn 2005.

The IAG is aware that there is often a gap between nurse competence and actual performance caused mainly by factors such as personal attitude, workload, time pressures and a lack of resources. Therefore we welcome the competency framework as, beyond training, there needs to be assessment of progress based on performance. This will ensure continued support as well as raise standards.
**Recommendations**

The College of Deans and the Nursing and Midwifery Council (NMC) to ensure that all pre-registration student nurses have access to sexual health during their programme of training and the opportunity of clinical placements in sexual health. Nurses must be able to address the sexual health needs of the client group regardless of the speciality they choose to work in.

PCTs and SHAs to ensure that nurses working in primary care are able to access training in sexual health to meet the needs of their population.

That a course on contraception, with a format similar to the Sexually Transmitted Infection Foundation (STIF) course, is available to nurses and doctors. Discussion is taking place with the Faculty of Family Planning and Reproductive Health to look at this possibility, and the Department of Health to review the outcome.

PCTs and Trusts to ensure assessment of progress is based on performance within the clinical setting, as well as nursing qualifications.

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**Leadership Development**

It is essential to have leadership development programmes in place for nurses. Currently, there are twelve nurse consultants in Sexual Health, and one of the nurse consultants is in process of developing a Department of Health forum with the intention of working strategically to develop leadership locally and nationally in sexual health services. The remit of the forum, which is yet to be determined, should include sharing innovative and creative practice, providing mentoring, coaching and inspiration to sexual health nurses to encourage and grow the leaders of the future.

**Recommendations**

That leadership development of nurses in sexual health is fostered and encouraged by PCTs.

Professional nursing bodies to ensure that more nurse consultant posts be available within the sexual health field in order to retain highly skilled specialist nurses, whose contribution is integral to the successful delivery of the Government’s Sexual Health Strategy and White Paper commitments.

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**Distance Learning Skills Course**

The IAG also welcomes the creation of the distance learning skills course, which is offered to post-registration students by the RCN. To date over 1,000 students have accessed the programme emphasising the need for such training. This programme is ongoing and very popular. The course is the beginning of a nurse’s career in the field, or could be a knowledge base for others not in sexual health but who may have questions about sexual health issues in their job, for example, Accident and Emergency.

**Recommendation**

Educational establishments to ensure that more distance learning courses are developed in sexual health as they allow nurses to develop knowledge and training in the field, without having to take time off work to attend lengthy courses.

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**Abortion and the Role of Nurses**

Nurses have a valuable role to play in supporting women undergoing abortion. However, one of the requirements of the Abortion Act 1967 (and as amended in 1990), is that a pregnancy may only be terminated by a registered medical practitioner. For medical abortion, the medical practitioner is not required to perform personally each and every action that is needed for the treatment, but must personally decide upon and initiate the process of medical induction and take responsibility throughout. In some areas of abortion care nurses are already playing a leading role in providing abortion care. However, in others there is scope within the current legal framework for local services to further develop the nurses’ role, especially in medical abortion. This could go some way in reducing the waiting times for women.

**Recommendation**

PCTs and SHAs to develop nurses’ roles appropriately in the provision of medical abortion.
Training for All Practitioners in Community Gynaecology

As with all areas of sexual health, staffing is a major concern for contraceptive and abortion services. The IAG particularly welcomes the increased training and involvement of the role of nurses in community based contraceptive services, and the development of a formal career structure in community gynaecology for both doctors and nurses.

Additionally, the IAG believes that funded training posts for the future leaders of community gynaecology is a priority to ensure the leaders in sexual and reproductive health services are put in place for future service provision and training.

Recommendations

An increase in centrally funded training posts for subspeciality training in Sexual and Reproductive Health (Royal College of Obstetricians and Gynaecology collaboratively with the Faculty of Family Planning and Reproductive Healthcare) if we are to be able to provide services of any quality and safety. Consultants are needed to work as part of a team to plan strategic direction and organise and deliver training programmes for all three levels of the strategy.

Address the Royal College of Obstetrics and Gynaecology’s current training requirements for consultants in sexual and reproductive health. At the moment there is a structured modular training package for staff grades and associate specialists run by the Faculty of Family Planning, but this is not funded by the Deaneries.

Training for All Practitioners in Genitourinary Medicine

Recommendations

PCTs to ensure the continued expansion of Sexually Transmitted Infections Foundation (STIF) courses throughout the UK to introduce an equitable supply of training opportunities, in basic knowledge, skills and attitudes for medical and nursing practitioners in primary care.

New competency based practical training in GUM has been developed and is targeted at clinicians working in primary care – PCTs to have a training budget so that training requirements do not reduce patient throughput.

PCTs to develop and coordinate a local multidisciplinary action plan to deliver a common clinical governance framework which is essential to ensure uniformly high clinical standards for services provided within hospital, community-clinics, and non-clinical settings, including monitoring by an appropriate body.

PCTs to ensure training, support and audit is undertaken for all new non-GUM settings where diagnosis and treatment of STIs is undertaken.

Educational establishments and stakeholders to establish better joint working and planning of sexual health education – e.g. RCGP, BASHH, FFPRHC & RCN, and universities and educators.
Good sexual health is not widely promoted in society. Changing sexual mores and an often aggressive presentation of sexuality in the media means that understanding what good sexual health is, and the behaviours to achieve it, is a challenge.

The prevalence and demographic of certain diseases, like HIV, is changing, and the response of public health services should be reviewed to accommodate this change.

Given this environment, it is important that good quality targeted information is available to all. The IAG hopes the new Sexual Health Media Campaign will go some way in improving basic awareness of the issues around good sexual health, but believes that the more targeted and personal the information is at an early age, the more effective it is. Therefore, good sex and relationships education in schools is vital.

The Sexual Health Media Campaign

The Government-funded Sexual Health Media Campaign is welcomed in principle by the IAG. This high profile campaign targets younger men and women focusing on the risks of unprotected sex and the benefits of using condoms to avoid the risks of contracting STIs.

The IAG also welcomes the large amount of stakeholder involvement offered by the Department of Health to ensure that the most effective campaign possible is developed.

At the time of going to print, the campaign content and delivery mechanisms remain under wraps. However the IAG would like to encourage the Government to consider the widely reported benefits of health promotion at a local level, as this is often an extremely effective way to deliver targeted messages. The IAG would also like to urge the Department of Health to put in place robust and effective monitoring mechanisms to evaluate the efficacy of the campaign.

Recommendations

PCTs to be involved in local level delivery of the Sexual Health Media Campaign.

The Department of Health to ensure robust and effective monitoring mechanisms are in place to monitor how effective the campaign is.
The IAG on Sexual Health and HIV and the IAG on Teenage Pregnancy held a joint meeting on 17 May 2005 to examine the development of Personal, Social and Health Education (PSHE) and Sex and Relationships Education (SRE) in schools.

Both IAGs agree that good quality PSHE and SRE should form part of the National Curriculum as a vital way of ensuring children are aware, informed and empowered to make decisions relating to their wellbeing in terms of sexual health.

A number of proposals arose from the meeting concerning PSHE and SRE that focused on issues of leadership at all levels – from the development of strong policy supporting PSHE, right down to the delivery of PSHE in schools by appropriately trained staff.

The recently published evaluation of the Teenage Pregnancy Strategy includes the view that “the status, and thereby the quality, of SRE could be improved by making high quality PSHE mandatory within the National Curriculum”.21

The IAGs discussed the possible reworking of PSHE in how it is described, organised, and laid out in the curriculum, using terminology to be understood by all.

The IAGs were also concerned that non-specialist teachers were teaching PSHE, and in the case of SRE, this was of a significantly poorer quality than that delivered by trained specialist staff.

Recommendations

That the Government review the non-mandatory aspects of the delivery of PSHE for effectiveness, and consider if making them statutory would help.

Leadership from Government down to support the delivery of sexual health information to all children and young people through the PSHE modules.

The Government and the DFEs to review and rationalise the various education initiatives currently contributing to the PHSE and SRE agenda.

The Government to ensure the use of specialist trained and accredited teachers who wish to deliver SRE.

Confidentiality is vital in encouraging young people to use sexual health services. We are keen to ensure that young people are not discouraged from seeking help by policy developments in other areas which could challenge young people’s right to confidentiality. At the same time, we believe, in line with the Government’s guidance, that particularly in the case of abortion every effort should be made to persuade the young person to involve a parent and where this is not possible another family member or trusted adult to ensure they do get the best possible support. This approach both ensures that the maximum number of young people who need such services will come forward, and at the same time they receive appropriate support and aftercare from a responsible adult.

We are concerned that many young people, particularly those aged under 16, are still unaware of their right to confidential sexual health advice and treatment. The recent evaluation of the Teenage Pregnancy Strategy22 found that 32% of young women and 45% of young men didn’t know that young women can get a prescription for contraception without their parents’ knowledge, and this figure did not change between 2000 and 2004. We therefore think it is crucial to ensure young people are able to access confidential and trusted services to seek the advice they need because delays in seeking advice can lead to increases in unprotected sex, teenage pregnancy and STIs.

This confusion is likely to have been intensified by reports of ongoing challenges to under-16s’ right to consent to treatment without parental involvement. The forthcoming Judicial Review of the Department of Health’s best practice guidance on contraception, sexual and reproductive health for under-16s has been widely reported in the media, as have the concerns of some parents over the availability of emergency contraception for young people under 16.

21 Teenage Pregnancy Strategy Evaluation, Summary. Published 3 June, 2005
22 Ibid
We are extremely concerned that these developments could result in many sexually active young people being deterred from seeking sexual health advice at all, thereby compromising their health and wellbeing.

The IAG believes that it is only in certain and rare circumstances that confidentiality should be breached, for example when a young person is at risk of serious harm. The IAG believes that staff responsible for working with young people must be fully trained in protocols for dealing with issues around confidentiality and child protection to ensure these issues are dealt with effectively.

Recommendations

The Government to ensure that young people’s right, whatever their age, to confidential sexual health services must be maintained.

Policies and protocols on confidentiality for children and young people and child protection guidelines for those who are at risk of significant harm should form part of training for all professionals in the sexual health field.

It is important for Government to continue to offer guidance on reproductive health and other sexual health services, and to spread best practice on how to support health professionals in assessing whether young people are at risk and developing successful strategies in supporting young people in involving their parent or other family members.

The Increasing Rate of Infection of HIV, the Changing Profile of Those Who are Contracting HIV and the Increase in Funding to Support Diagnosis of STIs and HIV Warrants a Re-evaluation of the Strategy in Dealing with the Spread of the Disease. The IAG Anticipate Working on These Issues in the Next Year.

The global epidemic of AIDS affects England, the UK as a whole, and Europe. At the 2005 G8 summit, the British Government signed up to the concept of universal access for HIV treatment. And yet, the issue around charging for HIV treatment for those who have an uncertain immigration status and those refused asylum in England is current, and has huge implications.

Increased rates of heterosexual transmission and the resulting rise in women presenting with HIV means increased pressure on services in terms of providing care for children, and other social and community services.

Numbers of new HIV diagnoses made among women in England that have probably been acquired through heterosexual contact have risen from 1,205 in 2000 to 2,402 in 2004 (+76%), and as further reports are received the 2004 figure is expected to rise. Between 2000 and 2004, women have accounted for nearly two thirds (10,304/16,174) of HIV diagnoses acquired through heterosexual contact. Nearly a fifth (1,908/10,304) of these women were diagnosed during antenatal care.

The majority of HIV infections diagnosed in heterosexual women in England were acquired in high HIV prevalence regions, particularly Africa, although there has also been a small but steady rise in infections acquired in the UK.

Programmes to meet the sexual health needs of HIV positive gay men have received inadequate attention. The recent link between increases in syphilis and LGV (Lymphogranuloma Venereum) and a minority of men who report a high number of sexual partners reinforces the need for new initiatives and interventions. Urgent action is required to develop programmes designed to prevent the onward transmission of HIV and, in those already affected, to avoid co-infection with other life threatening diseases e.g. Hepatitis C.

The IAG is pleased that the AIDS Support Grant remains ring-fenced for the time being. However, members continue to be concerned that the grant has not increased in real terms since 2001/02. Lack of increase in the grant and uncertainty over its future has created difficulties for both the voluntary sector and local authorities in terms of the planning and delivery of services for people with HIV as a result of the patterns of the changes in the epidemic.
The IAG recommends that there is a strong involvement of those who are HIV positive advising on prevention messages – especially in black and minority ethnic groups.

Issues around education about HIV are extremely important, and range from good quality PSHE, to health promotion at a national level, and, perhaps even more importantly, health promotion at a local level targeting specific communities at risk of HIV as well as ensuring a broad understanding of the risks of HIV to new generations.

Easy access to testing for those who think they may be HIV positive is crucial.

The IAG welcomes efforts to normalise HIV, and those with HIV status, and all that this does in terms of reducing stigma and discrimination. However, and as with all areas of sexual health, we are concerned that the removal of ring-fencing of HIV-specific funds for the health service means that in some areas adequate funding is not being allocated to address the continuing challenges for people living with HIV. There is also the need to develop new approaches and services for them.

The IAG has a number of other pressing issues to consider in the next working year including:

- Charging for treatment for those with uncertain legal status.
- Role of post exposure prophylaxis.
- Education and local health promotion.
- Testing all pregnant women, including those who have a termination of pregnancy or miscarriage, for HIV.

Prosecution for Reckless Transmission of HIV

Offences against the Person Act 1861 – Section 20

The IAG is concerned about the use of criminal law to regulate public health, especially in areas of personal and sexual behaviour. At the moment, cases before the courts have concerned reckless transmission of HIV between male/female and male/male sexual partnerships in England, Scotland and Wales. The prosecutions in England and Wales have been based on the Offences Against the Person Act 1861, Section 20, which relates to recklessly causing grievous bodily harm.

These prosecutions for transmission of HIV have very serious consequences for key public health interventions such as testing for their HIV status, patient confidentiality and partner notification. The IAG believes that an inappropriate use of the law could well discourage people from testing and finding out about their HIV status; in addition, it could well undermine trust in the confidentiality of discussions with health professionals – the result being people living with HIV will be far less likely to ask for support to practise safer sex and less likely to provide details of sexual partners who may have been exposed to the risk of infection.
Recommendations

That all stakeholders in this debate participate in the consultation underway by the Crown Prosecution Service in drawing up guidelines which will regulate and restrict prosecutions from the transmission of STIs, including HIV.

That the Chief Medical Officer work with the Crown Prosecution Service to encourage a speedy process in establishing guidelines without prejudicing their quality, indicating the need to include public health as part of the consideration of what the public interest is in these cases.

The Home Office to ensure that investigations arising from any complaint from an individual bringing a case that falls under the description of reckless transmission should be carried out by police officers who have had not only training on HIV, but how to deal sensitively with sexual offences.

The Department of Health should:

a. Review the impact of the current prosecutions on the Sexual Health Strategy and share conclusions with the CPS consultation and with all professionals engaged in the Strategy’s implementation, and

b. Make generally available to health professionals an explanation of recent prosecutions and the implications for all aspects of health service delivery and conduct.

Sexual Health Leads should be briefed on this matter, by the Department of Health so they can provide guidance to local services.

Professional associations affected by the current approach should be encouraged by the Department of Health, if they have not already done so, to consider their position and ensure advice is available to their members as appropriate.

Sexual Activity in Particular Institutions

Prisons

As a particularly vulnerable group, prisoners’ sexual health needs are an issue that should be considered. These needs may range from diagnosis of an STI, an unintended pregnancy, to starting a programme of vaccinations, for example, for Hepatitis B vaccine, and then being moved to another institution before the course is completed.

Sexual activity may not be legal in prisons, but it is accepted as widespread and the risks must be addressed. Currently, many prisoners are refused access to condoms that could protect them from HIV and other sexually transmitted infections.

Recommendations

That PCTs consider and prioritise issues around sexual health in prisons.

The IAG believes that PCTs should ensure that condoms are freely available to all prisoners that might be vulnerable to contracting HIV or other STIs, and that access to information and advice, with confidentiality guaranteed, is available.

Schools

The quality of sexual health in schools varies greatly. The IAG has evidence that school nurses in some extended schools are unable to dispense emergency contraception to their pupils. This particularly affects some boarding schools, where pupils may have difficulty in accessing contraception from any other source.

Recommendations

The IAG would like to see PCTs taking a proactive role in ensuring that sexual health is delivered to the whole of its population including extended services within schools as part of the extended schools programme.
List of Recommendations

Delivering Improved Services
pp 8-15

Ensuring Service Improvement as a Result of Extra Funding
The Government to focus on how to ensure delivery of the LDP targets. Part of this is ensuring the funds reach the intended services.

The Department of Health to be aware that momentum must be maintained during service reconfiguration, including those changes outlined in Commissioning a Patient-Led NHS, which may serve to distract senior staff (including those responsible for commissioning and clinicians), from achieving targets. This is a major concern for public health.

SHAs to monitor PCTs to identify their current spend and planned investment in sexual health, and ensure that PCTs deploy the extra funding effectively in delivering services and achieving improvements.

The IAG would like to see the Healthcare Commission consider what monitoring can be put in place at a local level, for example, tangible evidence of the impact of extra monies including response from patients, collation of local statistics on performance and outcomes.

The Government to determine what sanctions should be incurred against PCTs that fail to reach their targets on sexual health services.

The Sexual Health Strategy and Implementation Plan
The Government and the Department of Health to review, update and amend the Sexual Health Implementation Plan as necessary. Examples of good practice would come out of this exercise, as well as information about how many PCTs have undertaken the required work.

The Government and the Department of Health to use the performance monitoring information generated by the National Review of GUM Services and the Contraceptive Audit when formulating the revised Implementation Plan.

Local Delivery Plans
The IAG believes that for better overall effectiveness in sexual health the Department of Health must agree a new LDP line for the effective delivery of easy access to contraceptive services, and PCTs should also be assessed on their ability to offer a full range of contraceptive services.

Access to GUM clinics within 48 hours
PCTs and SHAs to ensure that the option for open access to GUM services is available and maintained in all clinics, specialising in GUM or otherwise.

The Department of Health to develop proposals for real-time monitoring of access during 2005/06, and planned improvement in IT support to allow real-time monitoring to take place in consultation with the Sexual Health Minimum Dataset.

The HPA survey of access times should now be performed quarterly.

PCTs and SHAs should act swiftly and within a specific timeframe on the results of the GUM review.

Tackling increased rates of STIs (with reference to PSA on Gonorrhoea)
The Department of Health to ensure that the rapid completion and implementation of the Sexual Health Minimum Dataset is a high priority for the roll out of better IT systems for the NHS. There should be a full buy-in by all services within the NHS who are relevant, especially primary care.

Chlamydia Screening
In order to increase screening coverage to get past the threshold required to make a programme effective in reducing prevalence, the Government to include an enhanced service or equivalent in the nGMS contract to incentivise General Practitioners to do more screening. If nothing happens nationally then PCTs may (or may not) introduce local schemes which will introduce disparity within the programme.

Reproductive Health
The Department of Health to put in place a Local Delivery Plan monitoring line that reflects the Healthcare Commission’s indicator on reproductive health. Services should offer a full range of contraception methods that are available so that the most appropriate methods can be chosen according to individual circumstances. The proportion of women choosing the IUD, IUS and implant will give an indicator of the range of methods provided by each service. PCTs and SHAs should monitor GP activity in terms of uptake of these methods in conjunction with KT31 returns.

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The Government to ensure that both medical and surgical abortion, by local as well as general anaesthetic, is available throughout England and Wales.

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That the Healthcare Commission maintains its rating on early abortion given the signs of success we have already seen.

That PCTs strive for an average reduction in waiting time from three weeks to two weeks from first appointment to termination.

PCTs to facilitate early confirmation of pregnancy by availability in all GP surgeries of on the spot pregnancy tests.

Developing New Services

pp 16-17

The Role of General Practice

The open-access nature (>75% patients attending without prior GP referral) is a cornerstone of sexual health services, meets the ideals of a patient-led service and should be fully supported by the Department of Health within the new commissioning arrangements.

Good practice has a crucial role to play in providing comprehensive sexual health services within primary care. The IAG hopes that the Department of Health will support an outcome of the current GMS and Enhanced Services review that will reflect this.

Monitoring Change

The DH/MRC Scoping Review – to be completed by Spring 2006 – will give a good picture of total UK spend on research on sexual health. The Government should act quickly on its recommendations with regard to specific gaps in our research knowledge.

In the light of the review the Government should also consider the adequacy of current levels of research support, given the scale of the UK’s sexual health and HIV problems.

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pp 18-20

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All training at both local and national levels should include multi-agency approaches. These should offer opportunities for practitioner and planner from health, education, social work, youth work and the voluntary/community sector to receive training and on occasion train together. The National Sexual Health Training Group to recommend that all training is delivered in the context of the quality standards.

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The College of Deans and the Nursing and Midwifery Council (NMC) to ensure that all pre-registration student nurses have access to sexual health during their programme of training and the opportunity of clinical placements in sexual health. Nurses must be able to address the sexual health needs of the client group regardless of the speciality they choose to work in.

PCTs and SHAs to ensure that nurses working in primary care are able to access training in sexual health to meet the needs of their population.

That a course on contraception, with a format similar to the Sexually Transmitted Infection Foundation (STIF) course, is available to nurses and doctors. Discussion is taking place with the Faculty of Family Planning and Reproductive Health to look at this possibility, and the Department of Health to review the outcome.

PCTs and SHAs to ensure assessment of progress is based on performance within the clinical setting, as well as nursing qualifications.
Distance Learning Skills Course

Educational establishments to ensure that more distance learning courses are developed in sexual health as they allow nurses to develop knowledge and training in the field, without having to take time off work to attend lengthy courses.

Leadership Development

That leadership development of nurses in sexual health is fostered and encouraged by PCTs.

Professional nursing bodies to ensure that more nurse consultant posts be available within the sexual health field in order to retain highly skilled specialist nurses, whose contribution is integral to the successful delivery of the Government’s Sexual Health Strategy and White Paper commitments.

Abortion and the role of nurses

PCTs and SHAs to develop nurses’ roles appropriately in the provision of medical abortion.

Training for All Practitioners in Community Gynaecology

An increase in centrally funded training posts for subspeciality training in Sexual and Reproductive Health (Royal College of Obstetricians and Gynaecologists collaboratively with the Faculty of Family Planning and Reproductive Healthcare) if we are to be able to provide services of any quality and safety. Consultants are needed to work as part of a team to plan strategic direction and organise and deliver training programmes for all three levels of the strategy.

Address the Royal College of Obstetrics and Gynaecology’s current training requirements for consultants in sexual and reproductive health. At the moment there is a structured modular training package for staff grades and associate specialists run by the Faculty of Family Planning, but this is not funded by the Deaneries.

Training for All Practitioners in Genitourinary Medicine

PCTs to ensure the continued expansion of Sexually Transmitted Infections Foundation (STIF) courses throughout the UK to introduce an equitable supply of training opportunities, in basic knowledge, skills and attitudes for medical and nursing practitioners in primary care.

New competency based practical training in GUM has been developed and is targeted at clinicians working in primary care – PCTs to have a training budget so that training requirements do not reduce patient throughput.

PCTs to develop and coordinate a local multi-disciplinary action plan to deliver a common clinical governance framework which is essential to ensure uniformly high clinical standards for services provided within hospital, community-clinics, and non-clinical settings, including monitoring by an appropriate body.

PCTs to ensure training, support and audit is undertaken for all new non-GUM settings where diagnosis and treatment of STIs is undertaken.

Educational establishments and stakeholders to establish better joint working and planning of sexual health education – e.g. RCGP. BASHH, FFPRHC & RCN, and universities and educators.

Promoting Sexual Health and Wellbeing in the 21st Century

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The Sexual Health Media Campaign

PCTs to be involved in local level delivery of the Sexual Health Media Campaign.

The Department of Health to ensure robust and effective monitoring mechanisms are in place to monitor how effective the campaign is.

Personal, Social and Health Education and Sex and Relationships Education

That the Government review the non-mandatory aspects of the delivery of PSHE for effectiveness, and consider if making them statutory would help.

Leadership from Government down to support the delivery of sexual health information to all children and young people through the PSHE modules.

The Government and the DFEs to review and rationalise the various education initiatives currently contributing to the PHSE and SRE agenda.

The Government to ensure the use of specialist trained and accredited teachers who wish to deliver SRE.
Confidentiality and Young People

The Government to ensure that young people’s right, whatever their age, to confidential sexual health services must be maintained.

Policies and protocols on confidentiality for children and young people and child protection guidelines for those who are at risk of significant harm should form part of training for all professionals in the sexual health field.

It is important for Government to continue to offer guidance on reproductive health and other sexual health services, and to spread best practice on how to support health professionals in assessing whether young people are at risk and developing successful strategies in supporting young people in involving their parent or other family members.

Prosecution for Reckless Transmission of HIV

That all stakeholders in this debate participate in the consultation underway by the Crown Prosecution Service in drawing up guidelines which will regulate and restrict prosecutions from the transmission of STIs, including HIV.

That the Chief Medical Officer work with the Crown Prosecution Service to encourage a speedy process in establishing guidelines without prejudicing their quality, indicating the need to include public health as part of the consideration of what the public interest is in these cases.

The Home Office to ensure that investigations arising from any complaint from an individual bringing a case that falls under the description of reckless transmission should be carried out by police officers who have had not only training on HIV, but how to deal sensitively with sexual offences.

The Department of Health should:

a. Review the impact of the current prosecutions on the Sexual Health Strategy and share conclusions with the CPS consultation and with all professionals engaged in the Strategy’s implementation, and

b. Make generally available to health professionals an explanation of recent prosecutions and the implications for all aspects of health service delivery and conduct.

Sexual Health Leads should be briefed on this matter, by the Department of Health so they can provide guidance to local services.

Professional associations affected by the current approach should be encouraged by the Department of Health, if they have not already done so, to consider their position and ensure advice is available to their members as appropriate.

Sexual Activity in Particular Institutions

Prisons

That PCTs consider and prioritise issues around sexual health in prisons.

The IAG believes that PCTs should ensure that condoms are freely available to all prisoners that might be vulnerable to contracting HIV or other STIs, and that access to information and advice, with confidentiality guaranteed, is available.

Schools

The IAG would like to see PCTs taking a proactive role in ensuring that sexual health is delivered to the whole of its population including extended services within schools as part of the extended schools programme.
IAG Activities in 2004/05

2004

September 4    IAG Quarterly meeting
December 10   IAG Quarterly meeting

2005

January    Special IAG meeting to discuss Choosing Health White Paper
January    Research sub-group meeting
March 17   IAG Quarterly meeting
May       Special Joint IAG Meeting: Sexual Health IAG/Teenage Pregnancy IAG
June      Sub group meeting with TP IAG on BME groups
June      Sub group on nursing and midwifery in sexual health
June 14   IAG Quarterly Meeting
July      Special IAG Meeting with Public Health Minister, Caroline Flint
July      IAG sub group meeting on Health Care Assistants and Smear Tests
July      IAG sub group meeting on criminalisation of HIV
Sept 21   IAG Quarterly Meeting

The Chair held regular meetings with the respective Secretaries of State for Health, John Reid and, post-election, Patricia Hewitt, and with Public Health Ministers, Melanie Johnson, and post-election, Caroline Flint, as well as several meetings with Education Minister, Lord Adonis.

She meets regularly with special advisors, and also civil servants working as part of the Sexual Health team at the Department of Health.

The Chair also met with Russian delegates from the Duma.

The Chair also undertook an extensive programme of visits including Manchester, Liverpool, Hull, Newcastle, Southport, Ormskirk, and Mansfield, spent a day with Terrence Higgins Trust, Positively Women, and the RCN to meet the Sexual Health Forum, and participated in a number of other meetings and conferences.
List of IAG members

Chair
Baroness Joyce Gould

Joint Vice Chairs
Anne Weyman, OBE Chief Executive, fpa
Derek Bodell Consultant, former Chief Executive, National AIDS Trust

Strategy and Implementation Special Adviser
Professor Michael Adler CBE Professor of Genitourinary Medicine, Royal Free and University College Medical School.

Senior Health Promotion Expert
Jo Adams Consultant, former director of the Centre for HIV and Sexual Health

Public Health Expert
Helen Ward Senior Clinical Lecturer in Public Health and Honorary Consultant in Genitourinary Medicine at Imperial College London. On secondment as a consultant epidemiologist at the Centre for Infections, Health Protection Agency.

General Practitioners
Dr William Ford-Young GP, Macclesfield, lead on Sexual Health and HIV for Eastern Cheshire PCT
Dr Surinder Singh GP, and clinical lecturer in General Practice at the Royal Free and University College Medical School

Consultants in Family Planning/Community Gynaecology
Dr Connie Smith, MBE Co-director, Westside Contraceptive Services
Dr Sunanda Gupta Clinical and Professional Lead in Family Planning and Reproductive Healthcare, Waltham Forest PCT

Consultants in Genitourinary Medicine
Dr Patrick French Consultant in Genitourinary Medicine, Camden PCT; Honorary Senior Lecturer at the Royal Free University College Medical School
Professor George Kinghorn Consultant in Genitourinary Medicine, Clinical Director for Communicable Diseases, Sheffield Teaching Hospitals NHS Foundation Trust, Honorary Professor of Genitourinary Medicine, University of Sheffield

Nurses
Kathy French Sexual Health Advisor to the RCN
Lesley Greenhalgh Lecturer in Adult Nursing, University of Salford
Debbie Preston Practice Nurse, General Practice Surgery in Blackpool, Lancashire

Sexual Health Adviser
Heather Wilson Senior Health Advisor, Barnet Hospital

Abortion Providers
Ian Jones former Chief Executive, BPAS
Dr Kate Guthrie Consultant Gynaecologist/Consultant in Sexual and Reproductive Health and Clinical Director of the Sexual and Reproductive Health Care Partnership for Hull and East Yorkshire

Primary Care Trust - Chief Executive
Joanne Forrest Chief Executive, North Liverpool PCT

Strategic Health Authority Director
Dr Sheila Adam Director of Public Health, North East London Strategic Health Authority

Social Services Manager
Stephen Slack Director of the Centre for HIV and Sexual Health

User and Self Help Group Representatives
Christopher Woolls Director, Staffordshire Buddies

Voluntary Sector
Jan Barlow Chief Executive, Brook Advisory Services
Nicholas Partridge, OBE Chief Executive, Terrence Higgins Trust
Evelyn Asante-Mensah Chief Executive, Black Health Agency
Elisabeth Crafer Chief Executive, Positively Women

Adviser on Black and Minority Ethnic Communities
Max Sesay Chief Executive, African HIV Policy Network
Laura Serrant-Green Lecturer, Adult Health, University of Nottingham

Researcher
Professor Graham Hart Associate Director MRC Social & Public Health Sciences Unit

Young Persons Representative
Kierra Box Student