



# Improving Sexual Health

## Optimising the Strategic Health Authority contribution

### 1. Introduction

- 1.1 England is facing a major challenge. HIV and sexually transmitted infections are at record levels, teenage pregnancy rates are amongst the highest in Europe, and pregnancy termination rates vary dramatically. Yet, at the same time, England's public health and sexual health service response is faltering, with worsening access to Genito Urinary Medicine (GUM) services, and huge variation in access to contraception services.
- 1.2 In 2001, the Govt established a national sexual health and HIV strategy to address England's sexual health. However, an unforeseen consequence of the 2003/2006 NHS Planning & Priorities Framework has been that many NHS organisations have found it difficult to focus upon sexual health and HIV when faced with competing targets in other areas. Consequently barely a third of Strategic Health Authorities (SHAs) include sexual health within their Local Delivery Plans (LDPs), and only two thirds of Primary Care Trusts (PCTs) have undertaken a local sexual health needs assessment.
- 1.3 The consequences of this lack of up front investment are being seen in rapidly increasing NHS expenditure on HIV, rising rates of sexually transmitted infections, with the costs of HIV care increasing by about £50million each year and with increasing costs in relation to sexually transmitted infections (STIs).
- 1.4 Established in 2002, SHAs have a vitally important role in improving the nation's sexual health, having as they do, the responsibility in England for the performance of the local NHS. As they mature, SHAs have an increasingly crucial local leadership role

working with colleagues in PCTs and NHS Trusts. This briefing, prepared for SHA sexual health and HIV leads, sets out the key aspects of this and the work which should be undertaken to discharge this role. The priority attached to this work locally will obviously vary, relative to need, but there is no SHA which does not have some work to do in this area.

### 2. Why sexual health is important for Strategic Health Authorities

- 2.1 Improving sexual health is important for SHAs because of the impact on the delivery of broader NHS priorities, and because of the consequences and economic costs of poor sexual health.
- 2.2 **Delivering broader NHS priorities** – poor sexual health services struggling to meet growing need will impact on SHAs' ability to meet broader NHS policy objectives. The following are of particular importance:
  - **Choosing Health: improving public health** – the recent focus upon public health provides an opportunity and an expectation for the improvement of sexual health within SHA areas.
  - **Improving the patient experience** – the NHS has begun to make real progress in improving patient experiences in some areas such as cancer and cardiovascular services. However, this progress now needs to be extended to sexual health, through increasing resources to address lack of capacity, and increasing efficiency through evaluating and redesigning services, thereby eliminating

lengthy waits for GUM services and unequal access to contraception services. Additionally, there is more to be done to increase patient and public involvement within sexual health services.

- **Expanding service access** – the NHS has, in general, made huge progress in expanding service access, but less so within the sexual health field. Waiting times must be reduced by increasing capacity so that people can get rapid access to diagnosis and treatment.
- **Improving chronic disease management** – HIV is becoming a chronic disease as life expectancy grows due to effective treatments. As such, services must be enabled to meet the 'chronic disease management' needs of people with HIV.
- **Patient choice** – choice backed up with payment by results potentially ushers in diversity of access, choice of opening hours and of providers, and influence over care and support, so empowering people to choose the best service for themselves. However many services are currently unable to work in this way, for example in some areas the only choice which currently exists is between services with waiting times of six weeks or over. Investment and support is needed to avoid inequity and ensure that choice does not occur at the expense of quality standards.

2.3 **Consequences** – there are economic, social and human consequences of the burgeoning levels of unmet sexual health and HIV need:

- **Economic costs are increasing**, with the lifetime cost of NHS HIV treatment increasing by nearly £ 1 billion each year. This, in turn, means that the annual NHS HIV treatment bill is growing by about £50million each year. This cost burden is such that the ability of NHS services to invest in prevention and expansion of service access in order to get ahead of growing levels of need is seriously compromised. There is also a growth in NHS costs of treating increasing numbers of people with STIs and related complications. Work undertaken by DH has suggested that by

prevention of these and unplanned pregnancy there will be net savings.

- **Social costs are increasing** as a large part of sexual health need is focused in communities already experiencing health inequality. Teenage pregnancy and HIV further compound this inequality. Black and minority ethnic communities, young people and other vulnerable groups are disproportionately affected.
- **Human costs are also increasing**, with unplanned pregnancy, unnecessary ill health and avoidable death being amongst them.

### 3. The role of Strategic Health Authorities

3.1 SHAs have three distinct roles:

- Creating a strategic framework
- Establishing performance agreements and performance management
- Building capacity and supporting performance improvement in both service commissioning and provision

3.2 Implicit in the discharge of these roles is an expectation that SHAs will perform a leadership role within the local health economy, and will also influence the development of NHS work at a national level.

3.3 This means that SHAs are well placed to play an important role in improving sexual health and ensuring a strengthening of the public service response. Proposals for how this might be achieved are set out below.

### 4. Creating a strategic framework

4.1 Whilst the responsibility for developing local service strategy lies with PCTs there is much which SHAs can and should do to support this work.

4.2 **Strategic focus** – SHAs have an important role in influencing local strategic priorities, thereby providing an opportunity to ensure that sexual health and HIV needs are met. Establishing the local consequences of poor sexual health and the impact on the achievement of national policy objectives is an important step in achieving this.

- 4.3 **Planning mechanisms** – SHAs have an important contribution to make in ensuring a mechanism exists for planning the local development of sexual health and HIV services. In line with good practice this should include commissioners, statutory and voluntary providers, as well as means of involving people using services.
- 4.4 **Board level influence** – ensuring Board level attention to sexual health and HIV as a strategically important issue is a valuable way of making progress. SHA Board members have a valuable role to play in this through both formal and informal contact with PCT and NHS Trust Board members.
- 4.5 **Public health focus** – given the importance of sexual health as a public health issue, establishing this as a focus for local public health networks should be a priority. This should be underpinned by ensuring strong links with the Health Protection Agency's surveillance work, ensuring full access to, and usage of local data to inform local work, assess services and develop strategy. There should also be local SHA supported and PCT led needs assessment work to establish key areas of need and means of meeting these.
- 4.6 **Information availability** – work should take place with PCTs to establish a means of collecting a standard data set to inform strategic development. This should comprise public health information, including HIV/STI surveillance data, and teenage pregnancy rates, and also service uptake and access information, including GUM waiting times, levels of pregnancy terminations, and provision of contraception services. It will be important to ensure confidentiality issues are fully taken into account in developing work in this area.
- 4.7 **Liaison and influence** – in some areas patterns of service uptake mean that collaborative working is necessary across SHA boundaries. This will be most likely in relation to HIV & STI treatment, where quality and access considerations may distort service usage. SHAs have an important role in ensuring cross boundary planning and commissioning occurs. Additionally, SHAs have an important role in influencing Local Authorities to play their full part in helping tackle the causes and consequences of poor sexual health and high HIV need. A nominated and identified SHA lead should have responsibility for this.

## 5. Managing performance

- 5.1 Performance management is at the heart of the SHA role, and SHAs have full responsibility for ensuring the local health economy performs well. Local performance on sexual health is likely to come under greater scrutiny. There are a number of steps which SHAs can take to underpin performance management work in this area and clinical governance arrangements.
- 5.2 **Local Delivery Plans (LDPs)** – incorporating sexual health and HIV within SHA LDPs is one of the most valuable steps which should be taken by an SHA, signalling a clear intention that local work must be undertaken. Working with PCTs to ensure their commitment is also reflected in PCT LDPs is equally important in encouraging financial investment and service redesign support, and for ensuring a baseline against which local performance can be assessed and managed.
- 5.3 **Performance measures & balanced scorecard** – incorporating within the SHA balanced scorecard a limited number of key measures of sexual health and HIV performance is an important step in ensuring local scrutiny of work. This should draw upon the standard data set measures suggested at Para 4.6 above. It could include a 48 hour maximum waiting time for access to GUM & STI/HIV testing services, a measure of the proportion of terminations undertaken within 10 weeks of gestation, and a maximum waiting time from HIV diagnosis to first appointment in specialist services.
- 5.4 **Performance management** – sexual health and HIV should be given greater attention in SHA performance management discussions with PCTs and NHS Trusts. In so doing, this provides a valuable lever for performance enhancement, and for raising the importance of this at a senior level within local NHS organisations.

## 6. Building capacity & supporting performance improvement

- 6.1 Although the focus on delivery is at PCT and NHS Trust level there is much which SHAs can do to ensure they have the capacity and support to maximise their performance. An important element of this is in building and supporting PCT commissioning capacity.

- 6.2 **Commissioner development** – changes within the NHS in recent years has meant that in some local areas there is a need to improve the quality of sexual health commissioning. SHAs should ensure that PCTs are supported to have the necessary range of commissioning for sexual health.
- 6.3 **Sexual health leads** – most SHAs will have at least five or six PCT sexual health leads in their area. This provides an opportunity for SHAs to support joint working between them. To simplify joint working, one PCT should ordinarily be identified as having a lead responsibility across the others in order to oversee planning and commissioning work and avoid duplication of activity. This PCT, and indeed all the local PCT leads should be fully supported by the SHA.
- 6.4 **Service redesign** and service networks – SHAs are well placed to establish sexual health and HIV services as a priority for service redesign by SHA staff with modernisation/service redesign expertise. Working across a number of local PCTs is a valuable way of optimising the impact of this redesign work. Integral to this is the development of managed service networks. SHAs have an important role in supporting their development with attention paid to clinical governance arrangements of these networks.
- 6.5 **Investment** – although service redesign is important, it is equally important that there are sufficient resources within the local health economy to achieve sexual health and HIV service standards. SHAs have a role to play in overseeing the pattern of local investment. In addition, as part of the implementation of the National Sexual Health and HIV strategy, DH has made available pump priming investment monies. SHAs have an important role in ensuring that these monies are used in the most appropriate way at a local level.
- 6.6 **Workforce development** – the incorporation of Workforce Development Confederations (WDC) within SHAs enables WDC support for capacity and workforce planning work. It also enables support for work developing staff roles within sexual health services, for staff training and skills development, and for

providing strategic support for recruitment of where labour shortages exist.

- 6.7 **Health Act 1999 flexibilities** – the flexibilities contained within Section 31 of the Health Act 1999 have potential for enhancing the planning and delivery of sexual health services. SHAs have an important role in supporting joint health and social service working, and in supporting local agencies to maximise their use of these where they add value.

## 7. Improving sexual health – further information

- 7.1 A number of policy and practice guidance reports have been published over the past three years, and these can prove invaluable in overseeing the delivery and development of sexual health and HIV work. Of particular relevance are:

- National Sexual Health & HIV Strategy, DH, 2001, and Action Plan, DH, 2002
- Commissioning Toolkit, DH, 2003
- Health promotion Toolkit, DH, 2003
- Recommended Standards for NHS HIV Services, Medfash, 2003
- Clinical effectiveness guidelines, BASHH, 2002, [www.bashh.org/guidelines/ceguidelines](http://www.bashh.org/guidelines/ceguidelines)
- Policy guidance on developing HIV primary care services, THT, 2002 [www.tht.org.uk](http://www.tht.org.uk)
- Policy Guidance on integrating HIV health and social care services, THT 2002
- Practice Guidance on Involving People with HIV and Other Long Term Conditions, in Planning and Developing Services, THT, 2002
- Practice Guidance for Primary Care Trusts on Meeting the Prevention Needs of Local Communities at Risk of HIV Transmission, THT, 2002
- fpa policies on abortion, contraception, sexually transmitted infections (STIs) and teenage pregnancy, fpa 2004, [www.fpa.org.uk/news/policy/download](http://www.fpa.org.uk/news/policy/download)

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