

## AGUM RESPONSE TO SEXUAL HEALTH STRATEGY

Many Clinicians and Departments have individually responded to the Sexual Health Strategy. The Sexual Health Strategy has been discussed both within clinics and at regional levels by members of the Association of Genitourinary Medicine. The Executive Committee have listened to various discussions and I have been sent copies of correspondence to the Department of Health and collated a response emphasising the important issues as appropriate

### 1 Sexual health In England today– setting the scene

We welcome this Chapter with its emphasis on the significant increases in the incidence of HIV and STI's and demonstrating the massive increases in attendance at GU Clinics.

The section on “**Sexual behaviour and knowledge**” emphasises that teenagers are having sex at an earlier age than ever before. This is not due to increased knowledge encouraging experimentation. It should be emphasised that countries that have a good education system related to sexual health have less of a problem than countries like England where the education is poor. The emphasis on inequity is important. The cost-section dramatically illustrates how important it is to prevent even a single case of HIV, both financially and in human cost.

### 2 Aims and principles

Principles are fine and set the scene nicely

### 3 Better prevention

**3.5: “Information for the public”** seems to suggest that young people are getting better information. Our perception on the ground is that that is not the case. The Strategy states that The Teenage Pregnancy Strategy, Sure Start Plus, the Healthy Schools initiative and the Department of Education and Skills' revised Sex and Relationship Education Guidance are all helping to expand young people's knowledge etc. etc. However, we think that some targets and emphasis ought to be put in this section so that schools have a definite obligation here rather than just hoping something happens.

The section on “**Objectives and targets**” states that prevention does need to be targeted at high-risk groups. We think that this section could be more specific about exactly how the Department is going to enforce/achieve these objectives. AGUM would like to see an effective mass-media campaign which will include press, radio and television.

“**Co-ordinated provision of local sexual health information and HIV/STI prevention**” is welcomed. We appreciate that co-ordination could certainly be better and this section needs stronger emphasis so that the current situation of fragmented, Family Planning Clinic, GUM, HIV does not continue. Co-ordination of management of those found to have CT in primary care and the local GUM services should be a standard of care.

#### **4 Better Services**

It has to be accepted that the current situation of massive demand for access to sexual health services is not being met. GUM clinics turn away significant number of patients as they simply cannot cope. Better management, more streamlined procedures, easier access to more definitive testing would all help but the Strategy suggests greater involvement of primary care in STI management.

There is a great willingness among GUM staff for this to work but there is some scepticism about the number of general practitioners who actually would want to be involved in anything more than minimal Level 1. There is also a significant worry that, to get general practitioners to do even Level 1, they would require significant financial incentives and this would simply be directing money away from the expert services who have the enthusiasm and staff but do not have the access. There is no doubt that there are ideal situations for Level 1 and Level 2 ie in more remote areas where there is little point in having a consultant driving 2 hours to a far-flung location and back again for a single clinic. This could easily be done by local practitioners with referral to the main centre for problem cases. However, within large urban areas the general practitioners seem even less keen to be involved and simply want to refer all the sexual health problems to the large nearby unit. The answer may lie in training practice nurses to perform at Level 1, with support from highly skilled Nurse practitioners from the local GUM clinics, who would facilitate appropriate management, as well as partner notification.

The section **(4.25)** on “**One-stop sexual health clinics**” does mention that there will be three pilot sites. Most physicians working in the area do not embrace the concept of a complete one-stop sexual health clinic, however, we do agree that services should be housed within the same or nearby unit and that the skill mix should be appropriate with personnel working in both settings. It is, however, not considered good medicine to get involved with every single aspect of an individual's sexual health at one clinic visit when, in fact, that individual needs to be referred to a more specialised clinic, even if that is at another time. For example a young person attending with chlamydia might later need insertion of an IUD and would need to be seen in a Family Planning and Reproductive Expert Clinic as opposed to the General run-of-the-mill GUM. Some units through the country already do provide family planning and GUM services within the one building and these seem to work well. We must recognise, however, that a large section of our clients do not require Level 3 or specialist services. Hence we should consider the provision of uncomplicated contraception to be made available from GUM services (most clinics have doctors and nurses with Family Planning certificates), and conversely, FPCs should be skilled up to screen for STDs.

The section **(4.26)** on “**Chlamydia Screening**” is welcomed. The pilot reports have shown that this needs to happen. The funding needs to be earmarked so that this happens quickly and the services can deal with the inevitable increased caseload.

The section **(4.29)** on “**Genito-urinary medicine services**” accepts that access is poor. There should be mention in here of increasing the staffing levels throughout GU clinics and not just the number of health advisors as specified in the Strategy. There should also be serious consideration for resources to modernise GUM clinics

to enable them to cope with the work load, and to support the Sexual Health Strategy – GUM modernisation paper refers.

Some consultants in GUM were disappointed to see the lack of emphasis on psychological and sexual problems. While AGUM realises that this issue has little economic impact on society, it certainly has a significant amount of distress for the patients involved and some more emphasis on these services should be made.

#### **“Access and information” (4.38)**

AGUM is working closely with NHS Direct and, hopefully, this will be a useful adjunct.

**“HIV testing”**: AGUM welcomes the drive to increase the number of people having testing and to reduce the obstacles to considering this a routine investigation. Our experience is that there are still difficulties with the Association of British Insurers and policies are still asking in an open – or covert way – about past HIV tests, even if they are negative. The Department of Health should deal with the Association of British Insurers directly and issue them explicit guidance. We welcome the increased antenatal HIV testing but it should really be an “opt-out” situation where, in many areas, it is an “opt-in”, and testing rates are disappointingly low.

#### **“HIV treatment and care services – managed networks” (4.56)**

AGUM welcomes the emphasis on developing networks. Treatments are now so complex that individual units have difficulty with the more complex cases and second and third line and salvage therapies. It is increasingly difficult for single-handed GUM consultants in DGH's to manage HIV care unless they are involved in a network. They must have easy access to expert opinion for more complex issues and know when to refer on and have a standard system for doing so. The establishment of managed networks should become a standard of care for HIV services.

In the **“Targets” section (4.75)** we welcomed the targets that suggest antenatal testing show rates of acceptance of 90% by the end of 2002. It is hoped that the Department of Health would encourage antenatal screening that operates on an “opt out” rather than an “opt in” system. This would reduce the workload and increase the number accepting testing. The targets for reducing undiagnosed HIV is achievable.

Of course, all this extra testing will increase the number of HIV infections diagnosed in the initial years. The target for Hepatitis B is also sensible and most clinics are already doing this.

At the end of that chapter there is a section on **“Action and Targets”** and although it suggests that chlamydia screening will be rolled out nationally it does say initially for targeted groups. We hope that this would eventually become routine practice i.e. screening of all sexually active young people.

## **5 Better commissioning**

This area is the one that caused most disquiet amongst GU personnel. It has long been known that GU medicine is regarded as a very low-key part of a Trust's service and funding has always been hard to come by as there are no stars attached to having an excellent, as opposed to a poor GU service. With the ring-fencing disappearing and the emphasis more on national service framework issues one could easily see that Primary Care Trusts will not have a great interest in the Sexual Health Strategy or commissioning first-class sexual health services. AGUM would hope that several Primary Care Trusts would come together and commission as a group rather than have a number of Primary Care Trusts selecting little bits of the strategy that they think individually important. Firm guidance from the Department of Health to Primary Care Trusts about the importance of commissioning sexual health services so as to not destabilise individual units is important.

## **6 Supporting Change**

A great deal of emphasis is placed on professional education and training and it would be expected that those who already work in the sexual health service will have to do a lot more training to increase the amount of sexual health awareness in primary care. Courses run by the MSSVD and the Diploma of Faculty of Family Planning are mentioned but there will be significant demand on staff in GU units and other sexual health services to provide education, training and backup. This is yet another argument for improving the staffing levels in these services so that they can not only maintain better access but continue to provide the education needed.

### **Summary**

AGUM welcomes the publication of The Sexual Health Strategy and the consultation process. The increased publicity and attention that will inevitably come from the launch of the Sexual Health Strategy should help services improve their profile nationally and locally. There is a marked lack of awareness in most Trusts and in Primary Care about sexual health issues. This focus can only be beneficial. There are genuine concerns about how interested Primary Care will be in taking on aspects of Levels 1 and 2 but there may be a surprising enthusiasm. AGUM is certainly committed to trying to keep services "open-access" or at least as accessible as possible and also to educate and train staff within other sexual health services and within Primary Care.

The commissioning process is seen as critical in the success or failure of the aims and ideals of the Sexual Health strategy. There is great uncertainty among staff working in the sexual health field about how this is going to work. It could result in fragmenting the current services unless there are tight guidelines around commissioning.