RAISING THE SEXUAL HEALTH STANDARD AMONG COMMISSIONERS

OPERATING PLANS ANALYSIS

EXECUTIVE SUMMARY

Following the launch of the BASHH Standards for the management of STIs at the start of this year, this document provides an overview of the sexual health content of the Operating Plans provided by Primary care Trusts. The report aims to support discussions about the implementation of the Standards to meet the sexual health needs of their communities between clinicians and their local sexual health commissioners, through a number of recommended discussion points:

Quality and Detail of Plans

- **Quality of Plans**: BASHH members should encourage PCTs, and SHAs to publish strategic and operational plans in sufficient detail as recommended in *Standards for the management of sexually transmitted infections* to allow clinicians, managers, policy makers and other stakeholders to review, compare, and objectively evaluate progress against local and national targets and objectives.

- **Data Reporting**: BASHH members could investigate whether Commissioners and other appropriate staff have a clear understanding of the core requirements for national data reporting and raise any deficiencies during their conversations with commissioners.

Sexual Health Services as key priority for PCTs

- **Sexual health services as priority**: BASHH members need to ensure that commissioners maintain the commitment especially in the face of increased financial pressure on the NHS and the demands of other clinical sectors.

- **Ensuring access to services**: BASHH members must ensure that patients can access the services they require regardless of local priority. HIV is an example where BASHH members could discuss a cross-PCT approach with commissioners and
could consider stressing the importance of efforts at all levels to reduce HIV diagnosis and promote prevention.

- **Chlamydia screening and STIs:** The National focus on Chlamydia screening must not mean that services for other STIs become marginalised. BASHH members need to ensure that their discussions with commissioners encompass gonorrhoea, HIV, syphilis and other STIs and could consider suggesting that sexual health commissioners establish specific targets for the leading STIs.

**Initiatives to reduce teenage pregnancy rates can bolster sexual health services**

- **Looking for synergies:** During discussions with commissioners BASHH members could consider looking for synergies between services. Our review of the sexual health plans did not find any evidence that a local emphasis on reducing the rate of teenage pregnancy resulted in relative neglect of STIs.

**Commissioning plans should reach marginalised groups**

- **Removing marginalisation:** It is essential that commissioning meets marginalised groups as it is often these that have the biggest need. Defining key groups and prospectively planning audits offers a paradigm that BASHH members could consider suggesting in their local discussions.

- **Pulling down barriers:** Consultation with patients for the improvement of services needs to extend beyond the most vocal local stakeholders and engage with marginalised groups. BASHH members could suggest that commissioners employ, as the standards documents suggest, “mystery shoppers to sample STI services, comments boxes in clinical settings and invitations to service users to participate in strategic focus groups and complete satisfaction questionnaires”.

- **Partnership working:** Partnership working can be successfully utilised to reach marginalised groups. Sexual health commissioners might welcome proposals from BASHH members for partnerships with other stakeholders, which help drive improvements in outcomes and services, while spreading the implications for budgets and other resources.

**A move to community based services**

- **Maintaining standards in the Community:** With many PCTs moving to provide level 1 services within the community, BASHH members should consider working with PCTs to evaluate the educational needs and other resource gaps to maintain quality services.
Hub-and spoke models: Hub and spoke service models can help services meet the vision articulated in *Standards for the management of sexually transmitted infections*. BASHH members could discuss piloting a hub-and-spoke or other appropriate models with local commissioners.

Utilising savings: Service reconfiguration can lead to significant cost savings. However, BASHH members must ensure that PCTs do not divert any savings generated by service reconfiguration to meet other priorities.

Using new opportunities to reach patients

Social media: Discussions between BASHH members and commissioners could explore potential pilot projects that aim to use social marketing and other approaches to engage with service users. Social marketing approaches may be especially valuable to reach currently disengaged or disenfranchised groups.

INTRODUCTION

Sexual transmitted infections (STI) impose considerable and growing clinical and societal burdens on the NHS and the UK more widely. According to the Health Protection Agency (HPA), the number of new and all other STI diagnoses in the UK rose by 53% and 74% respectively between 1999 and 2008. Syphilis (primary and secondary), Chlamydia and herpes (first attack) showed especially marked increases over this time: 1032%, 116% and 65% respectively. All three infections showed disproportionate increases among men who have sex with men: 2523%, 527% and 127% respectively.¹

Nevertheless, according to *Contraception and Sexual Heath, 2008/09*, 59% of men and 52% of women who were not in long-term, exclusive relationships had not altered their behaviour because of the risk of contracting HIV/AIDS and other STIs. This nihilism persisted despite increased awareness of STIs. For example, the proportion of men that recognised Chlamydia as an STI increased from 35% in 2000/01 to 88% in 2008/9, whilst the proportion increased from 65% to 93% among women. Nevertheless, only 30% of women reported being tested for Chlamydia.² Clearly, there is a need to translate increased awareness of STI and other sexual health issues into behavioural change in the community.

Against this background, providing world-class genito-urinary medicine (GUM) services is central to reducing the morbidity, mortality and expenditure arising from STIs across the UK.

¹ HPA Selected STI diagnoses made at GUM clinics in the UK: 1999-2008 Table 1
² Page 13 of report
However, according to the King’s Fund, the NHS now faces “the most significant financial challenge in its history”. Therefore, BASHH members will need to present compelling clinical and business cases to commissioners and other health service managers to maintain and, where appropriate, increase, funding of GUM services.

This document summarises the results of a review of sexual health plans published by primary care trusts (PCTs). The plans would not encompass recommendations in Standards for the management of sexually transmitted infections (STIs), which was published in January 2010. As such, the review offers a baseline against which BASHH can assess the publications’ impact.

BASHH believes that Standards for the management of sexually transmitted infections should form the basis for discussions between GUM clinicians and their managerial colleagues. The Standards support attempts by providers and commissioners to achieve safe, high-quality sexual health services across all aspects of STI management, including diagnosis, treatment and infection control. The Standards also offer several quantifiable targets that could form audit standards. As such, BASHH members can suggest that commissioners employ these targets to meet another standard in the guidance: that all providers of services managing STIs should participate annually in a regional or national audit, and complete an annual audit plan.

By examining current plans across PCTs, this report aims to further facilitate discussions between clinicians and their local sexual health commissioners and other managers about the most appropriate methods to meet GUM needs in their communities. BASHH also hopes that the report will stimulate members to share experiences and best practices so that the UK can develop the comprehensive and fully inclusive GUM services that patients and physicians deserve.

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3 The King’s Fund Budget Briefing 2010
**METHOD**

Munro and Forster Communications reviewed publicly available strategic and operational plans. BASHH members can access each plan through the links on the BASHH website. These links, which will be updated regularly, allow BASHH members to access local plans, those of other PCTs in their SHA, and across England.

**KEY FINDINGS**

**Quality of the sexual health plans**

Around 100 of the 121 PCTs in England included sexual health in the publicly available strategic and operational plans examined for this review. Most of those PCTs that offered sufficient detail to evaluate the plan seem to have a clear and realistic sexual health strategy. However, the plans differ markedly in the level of detail that each contains and their structure. Variations in detail, different timeframes and divergent aims between strategic and operational documents make direct comparisons of sexual health plans difficult. Therefore, such discordances mean that summaries of plans at a Strategic Health Authority (SHA) or national level are of little heuristic value in discussions with commissioners and other health care managers.

As a result, BASHH members could encourage PCTs, SHAs to publish strategic and operational plans in sufficient detail to allow clinicians, managers, policy makers and other stakeholders to review, compare, and objectively evaluate each health economy’s progress against local and national targets and objectives. For example, *Standards for the management of sexually transmitted infections* suggest that service specifications and contracts for commissioned providers of STI care should explicitly state expectations in relation to:

- access, type and levels of service commissioned
- location of services
- confidentiality, data collection and reporting
- partner notification
- participation in the local sexual health network for clinical governance

Inadequate detail, content and structure in the report often hinder readers’ ability evaluate whether ‘front-line’ services match the strategic vision or progress against the best-practice outlined in *Standards for the management of sexually transmitted infections*. For example,
our review of PCTs’ sexual health plans found insufficient evidence comment on progress on the following standards:

- Ensuring all staff delivering STI services successfully completed competency-based training, and fulfilled relevant update requirements
- Ensuring that a service provider takes a sexual history and makes a STI/HIV risk assessment for all individuals accessing services with STI concerns
- Offering HIV testing to all people having a first STI check and attaining uptake of 60%

Some PCTs may include these data in annual reports or other documents. Nevertheless, key information is less valuable if spread across numerous sources.

Therefore, BASHH members could suggest that annual reports and future operational and strategic plans cite progress against these standards. Improving the quality of local reporting would help meet the aim, articulated in *Standards for the management of sexually transmitted infections*, relating to the recording, collection, sharing and reporting of data. BASHH members could also ensure that commissioners and other appropriate staff have a clear understanding of the core requirements for national data reporting. Members could also work with commissioners and other stakeholders to ensure collection of the minimum data set and any supplementary local data that may be useful. BASHH members could investigate whether such systems are currently in place locally and raise any deficiencies during their conversations with commissioners.

Because of these deficiencies, we cannot conclude that no evidence of a service in a report is analogous to evidence of no service in the community. For example, Manchester’s 2009/2014 strategic commissioning plan focuses on teenage pregnancy. However, other evidence suggests that Manchester is actively improving GUM and STI services. For example, the FRESH clinics in Manchester cover HIV, Chlamydia and gonorrhoea testing among the under 25 year-olds. Furthermore, people screened for Chlamydia in Greater Manchester are also tested for Gonorrhoea. Therefore, any examples of sub-optimal performance cited in the report are not criticisms. Rather, these examples illustrate themes and issues. Indeed, BASHH welcomes the openness of those PCTs that admitted their weakness as well as their strengths and aspirations. BASHH believes that all PCTs should aspire to this level of transparency.

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4 North West Summary
5 [http://www.fresh4manchester.com/sti.htm](http://www.fresh4manchester.com/sti.htm)
6 [http://www.ruclear.co.uk/gonorrhoea/](http://www.ruclear.co.uk/gonorrhoea/)
Despite the inherent limitations, the quality and detail was adequate in a sufficient sample of sexual health plans to qualitatively evaluate GUM services across England. The review was also able to highlight common areas of interest and outstanding need.

**GUM is a key priority for PCTs**

The review of sexual health plans revealed that PCTs consistently regard GUM as a commissioning priority. For example:

- Brighton and Hove identified GUM “as a high commissioning priority” and promised “increased investment in the service”.  
- East Sussex Downs and Weald allocated additional investment of £1.03 million for sexual health services during 2009/10.
- West Kent PCT’s Strategic Commissioning Plan 2010-2015 includes £40 million to fund a redesign of GUM sexual health services.

The focus on sexual health and the increased investment noted in several sexual health plans is welcome. However, clinicians need to ensure that commissioners maintain this commitment especially in the face of increased financial pressure on the NHS and the demands of other clinical sectors.

Several sexual health plans also showed that PCTs had made promising progress towards optimum performance on certain ‘quality markers’. For example, the *Standards for the management of sexually transmitted infections* suggest that STI services should offer 98% of people an appointment, or walk-in, within 48 hours of contacting an STI provider.

- Barnsley attained the target of 100% 48-hour GUM access.
- Blackburn and Darwen met the target of offering 100% of people an appointment from July 2008. They also achieved the target of 85% seen by STI services.
- In Bury, all commissioned services offered 99.11% of patients an appointment within 48 hours in 2007/08.

As expected, sexual health plans varied between PCTs, in part, to reflect differences in local health needs, such as rates of pregnancy among teenagers, and the prevalence and incidence of HIV/AIDS. (Clearly, a high pregnancy rate among teenagers is a marker for high-risk sexual behaviour. As discussed later, several sexual health plans integrate STI and

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7 Page 144  
8 Page 147  
9 Page 155  
10 Yorks and Humber Summary  
11 Page 19  
12 Page 26
contraceptive services.) Such variations are, from a commissioning perspective, inevitable. Nevertheless, BASHH members must ensure that patients can access the services they require despite the infection being ascribed a low local priority.

For example, a recent report by the Independent Advisory Group on Sexual Health and HIV (Building on progress: Enhancing the response to HIV in England) notes that many PCTs do not regard HIV as a priority. Moreover, funding for HIV services is often difficult to access in many PCTs. The report adds that “there is not enough support for HIV prevention work at the local level, and there is an over-emphasis on national programmes”. With several notable exceptions – usually reflecting high rates of HIV locally – our review of sexual health plans supports this view.

In particular, the Independent Advisory Group on Sexual Health and HIV highlights that the late diagnosis of HIV disproportionately affects “individuals outside of London, of non-white ethnicity and of older age”. Indeed, Sheffield PCT commented that “Certain communities are disproportionately affected by STIs and HIV/AIDS. … This poses a considerable challenge for health and social services and indicates the need to target prevention activities appropriately.”

Against this background, the Independent Advisory Group notes that SHAs could facilitate collaboration across PCTs to provide effective regional services. BASHH members could discuss a cross-PCT approach with commissioners when appropriate. Furthermore, BASHH members could consider stressing the importance of “concerted efforts at all levels” to reduce HIV diagnosis and promote prevention. BASHH members, in collaboration with sexual health commissioners, could also develop plans to reach marginalised groups – an issue considered further later in this summary.

**Chlamydia screening is a major focus for PCTs**

Inevitably, most sexual health reports highlight their progress towards meeting the National Chlamydia Screening Programme (NCSP) targets. Currently, PCTs show considerable variation in the uptake rates for Chlamydia screening. According to the HPA, the proportion of 15-24 year olds screened for Chlamydia in 2008 ranged from 2.4% in Warwickshire and West Hertfordshire to 26.0% in Lewisham. Indeed, uptake can vary markedly even in
neighbouring PCTs. South Birmingham, which is in the same SHA as Warwickshire, \(^\text{14}\) screened 18.0% of 15-24 year old people for Chlamydia. \(^\text{15}\)

Indeed, several sexual health plans admitted that achieving the Chlamydia screening targets presents a challenge. Bradford and Airedale, for example, note that “The national Chlamydia screening target … remains a challenge”. \(^\text{16}\) BASHH members could consider identifying areas of local difficulties with sexual health commissioners and develop plans that address the issues.

In part because of the national focus on Chlamydia, sexual health plans placed less emphasis on other important STIs, such as gonorrhoea and syphilis. Nevertheless, some PCTs defined targets for gonorrhoea. For example, Bradford and Airedale aim to reduce the number of new cases of gonorrhoea to 18 per 100,000 by 2008/9. \(^\text{17}\) Sheffield set a target to reduce the number of new cases to 432 by 2008. \(^\text{18}\)

Despite commissioners’ inevitable preoccupation with Chlamydia, BASHH members must ensure services do not neglect opportunities to improve outcomes in other STIs. For example, clinicians could consider suggesting that sexual health commissioners establish specific targets for the leading STIs and ensure these are in the public domain. Increased transparency would improve accountability and offer benchmarks against which PCTs can assess their performance.

The recent publication of the BASHH / HPA *Guidance for gonorrhoea testing in England and Wales* potentially provides extra impetus to these discussions. The guidance notes that “identification of individuals with gonorrhoea, and testing to establish infection status, are important components of good sexual health”. The report recommends establishing care pathways that “ensure prompt and effective treatment of gonorrhoea and contact tracing in all settings”. In non-GUM settings, the report recommends “referral into specialist STI clinics … for appropriate treatment and partner notification, and to complete a full STI screen, including HIV testing”. BASHH members need to ensure that their discussions with commissioners encompass gonorrhoea, HIV, syphilis and other STIs.


\(^\text{15}\) [http://www.sexualhealthprofiles.hpaextranet.org.uk/performancemap/atlas.html](http://www.sexualhealthprofiles.hpaextranet.org.uk/performancemap/atlas.html)

\(^\text{16}\) Page 58

\(^\text{17}\) Page 59

\(^\text{18}\) Page 80
Initiatives to reduce teenage pregnancy rates can bolster GUM services

During their discussions with commissioners and other health service managers, BASHH members could consider looking for synergies between services. For example, our review of sexual health plans did not find any evidence that a local emphasis on reducing the rate of teenage pregnancy resulted in relative neglect of STIs. Indeed, in many cases, initiatives to reduce the pregnancy rate among teenagers bolstered the GUM agenda and several PCTs plan an integrated approach:

- Dudley PCT aims to provide “clinic sessions ... specifically targeted at young people where they can access Chlamydia screening and other STI testing as well as contraception”. 19
- Wolverhampton’s GUM and community contraceptive services are “moving toward a fully integrated service model”. The PCT plans to re-brand the service and enhance out-reach and in-reach services. Under a reciprocal agreement, GUM clinical sessions take place within the community contraceptive service and vice versa. 20
- Portsmouth City aims to commission an integrated GUM and contraceptive and sexual health (CASH) service from 2010/11. In preparation, Portsmouth City expanded CASH outreach partnerships with GUM to promote integrated working. 21
- Cumbria plans to develop and implement “a fully integrated sexual health service, that involves CASH young people’s services and level 1, 2 and 3 GUM and teenage pregnancy access.” 22

Commissioning plans should reach marginalised groups

As mentioned in the discussion of HIV/AIDS, BASHH members need to work closely with commissioners to develop services that reach local marginalised groups. As Rotherham’s plan notes: “certain groups and individuals experience greater barriers and therefore health inequalities”. Potentially marginalised groups identified by Rotherham include:

- lesbian, gay, bisexual and transgender people
- those with learning and other with disabilities
- people with HIV
- minority ethnic communities
- sex workers
- older people
- children excluded from school

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19 Page 94  
20 Page 103  
21 Page 177  
22 North-west summary
To better meet the needs of these groups, Rotherham’s “commissioning strategy will ensure that services are designed to meet the needs of the most vulnerable groups and we will monitor this by equity audit.” 23 Defining key groups and prospectively planning audits offers a paradigm that BASHH members could consider suggesting locally.

Against this background, *Standards for the management of sexually transmitted infections* note that stigma still surrounds STIs. Partly because of this stigma “achieving engagement with many populations ... is challenging”. Apart from the clinical imperative to reach marginalised groups – who are often those most in need of sexual health services - consultation with patients provides opportunities to design and develop responsive services. However, these consultations need to extend beyond the most vocal local stakeholders and engage with groups who do not always participate fully in discussions about health services. BASHH members could suggest that commissioners employ, as the standards documents suggests, “mystery shoppers to sample STI services, comments boxes in clinical settings and invitations to service users to participate in strategic focus groups and complete satisfaction questionnaires”. BASHH members could also suggest monitoring outcomes using equity audit. (See [http://www.dh.gov.uk/en/Publichealth/Healthinequalities/Bestpractice/DH_152](http://www.dh.gov.uk/en/Publichealth/Healthinequalities/Bestpractice/DH_152) for more on equity audits.)

Several sexual health plans highlight the importance of working with other stakeholders to reach marginalised groups. For example, over the next five years, the PCT on the Isle of Wight plans to work in partnership with several organisations including the police, the prison service, pharmacists, education and social services “to develop and deliver integrated approaches to promoting sexual health.” 24 Furthermore, North Lancashire’s plan envisages meeting Chlamydia screening targets by engaging with “core services” including “sexual health services, General Practice, Pharmacies, prisons and community nurses”. 25 Sexual health commissioners might welcome proposals from BASHH members for partnerships with other stakeholders, which help drive improvements in outcomes and services, while spreading the implications for budgets and other resources.

**A move to community based services**

*Standards for the management of sexually transmitted infections* calls for “open-access” services that are “available through self-referral, and all local health economies should

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23  Page 78
24  Page 188
25  Page 41
provide people with a choice of where to access care”. The *Standards* also suggest that every local health economy should commission: “a range of services for the management of STIs at Levels 1, 2 and 3”. The operational and strategic plans examined for this report suggest that many PCTs are progressing towards this goal. However, given future financial pressures BASHH members need to ensure local commissioners maintain the current inertia or do not delay plans for GUM service reconfiguration.

*Standards for the management of sexually transmitted infections* remarks that the “size and configuration” of local services depends “on the arrangement of local health services and on the flow of people”. However, in general, the services will probably “encompass large geographical areas incorporating a number of organisations and health economies”. The *Standards* add that the network should reflect “the sexual health economy” and involve all providers of sexual healthcare – not just those providers of STI management – as well as service users, local Health Protection Units (HPUs), NHS public health teams and commissioners”.

Against this background, many PCT sexual health plans envisage moving level 1 GUM services into the community. Calderdale, for instance, anticipates that 95% of general practice will provide high quality sexual health services by 2012. However, some plans highlight the need for additional training to optimise care of STIs in the community. To cite one example, the Heart of Birmingham PCT noted that “relatively few GP practices provide an excellent and comprehensive range of sexual health services for their registered population and young people tend not to access GPs for their sexual health needs”. BASHH members could consider working with PCTs to evaluate the educational needs and other resource gaps among the primary healthcare team that could compromise care as services shift to the community.

Nevertheless, increasing the proportion of STIs managed in the community should facilitate GUM services’ engagement with the wider stakeholder community through development of training, care pathways and clinical governance. Some sexual health plans also anticipate moving level 2 services into the community, which will further encourage seamless service integration. Brighton and Hove, for example, set a commissioning goal of “increasing access to level 2 sexual health services in primary care”. More specifically, the PCT plans to divert “activity from outpatient GUM clinics into a community setting – 320 appointments in
2008/2009, increasing to 600 in subsequent years”. Similarly, Derby City plan to develop level 1 and 2 sexual health services in the community and ensure plurality of providers. The approach will focus on “areas of greatest need in terms of deprivation, thus addressing inequalities and reducing teenage conception rates”.

No national blueprint emerged as a best-practice model for integrating the three service levels. However, a hub-and-spoke seemed popular. Devon and Torbay, East and North Hertfordshire and West Hertfordshire, and Surrey (among others) advocated this model. For example, according to the model proposed by Devon and Torbay, the PCT will deliver level 1 services in various community settings. Level 2 services will also offer all services provided by level 1. Level 3 will also offer all level 2 services. Critically, all three levels form a ‘managed clinical network’, which fosters interdependency, allows services to support each other, and facilitates effective management.

A hub-and-spoke model delivered using a managed network could help reduce the fragmentation of services admitted by some PCTs. Rotherham, for example, “has a number of sexual health services many of which though offering services of a high quality are not joined up as effectively as they could be”.

A hub-and-spoke model could also help services meet the vision articulated in Standards for the management of sexually transmitted infections. This document suggests that all services managing STIs should link to other services, including the local specialist GUM provider. Furthermore, “clear clinical care pathways between services” should be “explicit, agreed and utilised by all STI providers”. The level 3 specialist GUM provider should provide leadership for STI management within the network. BASHH members could discuss piloting a hub-and-spoke or other appropriate models with local commissioners as well as other managerial and clinical colleagues.

The impact that moving level 1 and level 2 services into the community will have on patient pathways – such as the number of referrals to level 3 as well as the funding and other implications – awaits further evaluation. However, West Kent’s service reconfiguration assumes that earlier identification and treatment of STI combined with the improved
pathways will reduce the costs of acute care by 10%. Furthermore, earlier identification and treatment allows repatriation of specialist activity, which West Kent estimates will reduce costs by 50%. Such estimates could help BASHH members develop business cases for consideration by sexual health commissioners. However, BASHH members may need to ensure the PCT does not divert any savings generated by service reconfiguration to meet other priorities.

Based on the sexual health plans examined for this review, there is little evidence that independent sector providers represent a major player in providing GUM services. Clinicenta run centres in North London. Hillingdon PCT also engaged Clinicenta to provide new sexual health services that target people less than 25 years old. The PCT also envisages “new community sexual health services by Clinicenta in the south Hillingdon and satellite clinic in the north with Hillingdon Hospital as the hub.” However, clinicians may need to remain cognizant of such initiatives, which could become more common in the future. The implications for service quality and budgets remain unclear.

**Using new opportunities to reach patients**

The *Standards for the management of sexually transmitted infections* advocate developing patient-reported outcome measures to capture clinical outcomes and patient experience. Furthermore, the growth of new media offers PCTs a plethora of opportunities to reach current and potential users. Nevertheless, *Contraception and Sexual Health, 2008/09* found that television programmes and advertisements were the most commonly mentioned source of information about STIs (31% and 24% respectively) followed by newspapers, magazines or books (16%). Despite several excellent sites run by PCTs, the Internet rarely provided the main source of information about STIs, even among young people (5% of 16-24 year olds). Such insights allow PCTs to develop social marketing and other campaigns to reach current and potential service users.

Indeed, the sexual health plans revealed considerable innovation in this area by some PCTs, especially in terms of social marketing. For example:

- Derby City plans to use social marketing and media campaign to meet Chlamydia screening targets.  

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35 Page 155
36 http://clinicenta.com/patients-relatives-a-friends-sexual-health-how-to-use-the-services.html
37 Page 169
38 Page 170
39 Table 6.4
40 Page 111
• Luton aims to “actively promote” home testing for Chlamydia through a web site, a text messaging service and other social marketing elements. ⁴¹

• Berkshire West aims to “improve Social Marketing of sexual health messages to young people and branding of young peoples’ services, through the recruitment of a Social Marketing Manager”. ⁴²

• Southampton’s GUM Service reduced “face-to-face follow ups through introducing a texting service”. ⁴³

Discussions between BASHH members and commissioners could explore potential pilot projects that aim to use social marketing and other approaches to engage with service users. Social marketing approaches may be especially valuable to reach currently disengaged or disenfranchised groups.
CONCLUSION

Addressing the public sector deficit will leave no part of the NHS untouched. While the PCT’s sexual health plans differ in structure, emphasis and detail, there is a consensus that sexual health is a key commissioning priority. Therefore, BASHH believe that it is imperative that members engage with their local sexual health commissioners to ensure that GUM maintains, and where necessary expands, funding, the financial pressures notwithstanding.

The survey of sexual health plans revealed considerable grounds for optimism. Overall, the plans reveal a commitment to improve sexual health services among PCTs and there are numerous examples of best practice and innovation in the sexual health plans. BASHH suspects that many more examples of excellence remain unreported in the plans. BASHH members should do all they can to publicise their successes, innovations and insights. Clinicians and other stakeholders must avoid developing services in isolation. There is a need to share best practice between PCTs and among BASHH members. We hope that in addition to offering some insights that could facilitate discussions with commissioners this report will begin the process of sharing insights.