Department of Health

A Framework for Sexual Health Improvement in England

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A Framework for Sexual Health Improvement in England

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Contents

Foreword

Anna Soubry MP, Parliamentary Under Secretary of State for Public Health

Good sexual health is important to individuals, but it is a key public health issue as well. Excellent progress has been made in some areas in recent years – our rates of teenage pregnancy are at their lowest level since records began and, while there is still no cure for HIV, the high-quality treatment provided by the NHS means that, if diagnosed early, most people with HIV can expect a near-normal life expectancy.

We should celebrate these successes, but we also need to look at where improvements can and must be made. We need:

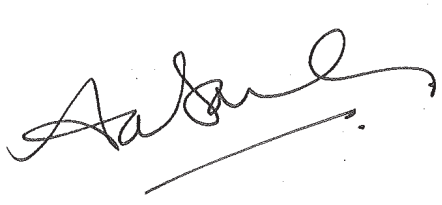
- a fall in the number of unwanted pregnancies, especially those that result in terminations;
- more people in high-risk groups being offered and accepting HIV tests;
- to ensure that people have access to free condoms and know how to prevent sexually transmitted infections;
- to continue to make progress in protecting our children from sexual abuse and exploitation;
- to continue to eradicate prejudice based on sexual orientation; and
- to help people to have the confidence and ability to say 'no' as well as 'yes'.

This document has been developed for commissioners and providers of sexual health services in order to:

- set out our ambitions for good sexual health; and
- provide a comprehensive package of evidence, interventions and actions to improve sexual health outcomes.

It is being published at a very important time, as the way in which public-health services are commissioned is about to change. From April 2013, local authorities will commission most sexual health services, but Clinical Commissioning Groups (CCGs) and the NHS Commissioning Board (NHS CB) will commission some sexual health services as well. These changes mean that commissioning will take place much closer to patients and communities, and this offers a real opportunity to take a fresh look at how services and interventions can meet people's needs. But these opportunities will only be realised if local authorities, CCGs and the NHS CB show leadership, commit to innovation and work together in the interests of their local population.

This document is designed to support the commissioning of sexual health services. It has been developed with help from key partners on our Sexual Health Forum, to whom we are very grateful. What matters, of course, is how far improvements are made, so we will review progress annually with colleagues in Public Health England and other experts to identify success and failure.



Executive summary

Sexual health matters to both individuals and communities.

The Government wants to improve sexual health, and our ambition is to improve the sexual health and wellbeing of the whole population. To do this, we must:

- reduce inequalities and improve sexual health outcomes;
- build an honest and open culture where everyone is able to make informed and responsible choices about relationships and sex; and
- recognise that sexual ill health can affect all parts of society – often when it is least expected.

We know that some elements of sexual health have already improved in recent years, but there are important issues that still need to be addressed. We need to:

- continue to tackle the stigma, discrimination and prejudice often associated with sexual health matters;
- continue to work to reduce the rate of sexually transmitted infections (STIs) using evidence-based preventative interventions and treatment initiatives;
- reduce unwanted pregnancies by ensuring that people have access to the full range of contraception, can obtain their chosen method quickly and easily and can take control to plan the number of and spacing between their children;
- support women with unwanted pregnancies to make informed decisions about their options as early as possible;
- continue to tackle HIV through prevention and increased access to testing to enable early diagnosis and treatment; and
- promote integration, quality, value for money and innovation in the development of sexual health interventions and services.

Sexual health needs vary according to factors such as age, gender, sexuality and ethnicity, and some groups are particularly at risk of poor sexual health. It is crucial that individuals are able to live their lives free from prejudice and discrimination. However, while individuals' needs may vary, there are certain core needs that are common to everyone. There is ample evidence that sexual health outcomes can be improved by:

- accurate, high-quality and timely information that helps people to make informed decisions about relationships, sex and sexual health[1];
- preventative interventions that build personal resilience and self-esteem and promote healthy choices[2];
- rapid access to confidential, open-access, integrated sexual health services in a range of settings, accessible at convenient times[3];
- early, accurate and effective diagnosis and treatment of STIs, including HIV, combined with the notification of partners who may be at risk[4]; and
- joined-up provision that enables seamless patient journeys across a range of sexual health and other services – this will include community gynaecology, antenatal and HIV treatment and care services in primary, secondary and community settings[5].

Effective commissioning of interventions and services is key to improving outcomes. Most sexual health services will be commissioned by local authorities, but Clinical Commissioning Groups (CCGs) and the NHS Commissioning Board (NHS CB) will also have a role.

These new commissioning arrangements allow each of the commissioning organisations to play to their strengths, but it will be vital for them to work closely together to ensure that the care and treatment people receive is of a high quality and is not fragmented. At the local level, the health and wellbeing board will bring organisations together and ensure that the care people receive is comprehensive, high quality and seamless.

We are publishing this document at this time to set out for commissioners and providers the Government's ambitions for good sexual health and to provide information about what is needed to deliver good sexual health services.

We have developed some key principles of best practice in sexual health commissioning, which will be of use to local authorities, the NHS CB and CCGs. These are:

- prioritising the prevention of poor sexual health;
- strong leadership and joined-up working;
- focusing on outcomes;

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1 Kirby D, *Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases*, National Campaign to Prevent Teen and Unplanned Pregnancy, 2007

2 Ibid

3 'Building the bypass – implications of improved access to sexual healthcare', Mercer C et al, *Sexually Transmitted Infections* 2012; 88: 9–15

4 Ibid

5 'Integration of STI and HIV prevention, care and treatment into family planning services: a review of the literature', Church K and Mayhew SH, *Studies in Family Planning* 2009; 40(3): 171–86

- addressing the wider determinants of sexual health;
- commissioning high-quality services, with clarity about accountability;
- meeting the needs of more vulnerable groups; and
- good-quality intelligence about services and outcomes for monitoring purposes.

Section 1: Why good sexual health matters

Introduction

While sexual relationships are essentially private matters, good sexual health is important to individuals and to society. It is therefore important to have the right support and services to promote good sexual health. This document has been developed to provide the information, evidence base and support tools (including links where appropriate) to enable everyone involved in sexual health to work collaboratively to ensure that accessible, high quality services and interventions are available.

Background

Sexual health covers the provision of advice and services around contraception, relationships, sexually transmitted infections (STIs) (including HIV) and abortion. Provision of sexual health services is complex and there is a wide range of providers, including general practice, community services, acute hospitals, pharmacies and the voluntary, charitable and independent sector. See Section 5 for more details.

From April 2013, the commissioning of sexual health services is changing. All commissioners and providers need to work together to improve sexual health services and to ensure good-quality services and good outcomes.

How commissioners implement and take forward work on sexual health at a local level will be influenced by the work of their health and wellbeing board. The boards will be assessing current and future local health and care needs through Joint Strategic Needs Assessments (JSNAs), and will develop Joint Health and Wellbeing Strategies (JHWSs) to meet the identified needs. These will inform local commissioning by the NHS CB, CCGs and the local authority. Local authorities will be required to commission open-access sexual health (STI and contraception) services that meet the needs of their local population.

In addition to this document, the Department of Health (DH) intends to publish guidance shortly to help local authorities to fulfil their required functions.

The past few decades have seen significant changes in relationships,and how people live their lives. People should have the freedom to make their own decisions about the types of relationships they want. Many different factors can influence relationships and safer sex, including:

- personal attitudes and beliefs;

- social norms;
- peer pressure;
- religious beliefs;
- culture;
- confidence and self-esteem;
- misuse of drugs and alcohol; and
- coercion and abuse.

The importance of improving sexual health is acknowledged by the inclusion of three indicators in the Public Health Outcomes Framework (PHOF). These indicators have been prioritised, as each represents an important area of public health that needs sustained and focused effort in order to improve outcomes. The indicators are:

- under-18 conceptions;
- chlamydia diagnoses (15–24-year-olds); and
- people presenting with HIV at a late stage of infection.

Significant progress has already been made in improving sexual health, including the following:

- Access to specialist genito-urinary medicine (GUM) services has improved by promoting rapid access to accessible services[6].
- Teenage pregnancy rates have fallen to their lowest levels since records began[7].
- The use of more effective long-acting methods of contraception has increased: 28% of community contraception-services users in 2011/12, up from 18% in 2003/04[8].
- High rates of coverage for antenatal screening for HIV, syphilis and hepatitis B have led to extremely low rates of mother-to-child transmission of HIV and congenital syphilis[9].
- Access to services has been improved through the expansion and integration of service delivery outside of specialist services, particularly in the community and general practice[10].

6 'Building the bypass – implications of improved access to sexual healthcare', Mercer C et al, *Sexually Transmitted Infections* 2012; 88: 9–15
7 Office for National Statistics, 2013
8 *NHS Contraceptive Services – England 2011*–12, NHS Information Centre for Health and Social Care, 2012
9 'Antenatal screening for infectious diseases in England: summary report for 2011', Health Protection Agency, *Health Protection Report* 2012; 6(36)
10 'Integration of STI and HIV prevention, care and treatment into family planning services: a review of the literature', Church K and Mayhew SH, *Studies in Family Planning* 2009; 40(3): 171–86

- Developments in diagnostic tests for STIs and HIV have increased screening outside of GUM clinics[11].
- More Sexual Assault Referral Centres for victims of sexual violence have opened throughout England[12].

The case for change

However, there is still work to be done. This is demonstrated by the following statistics:

- Up to 50% of pregnancies are unplanned; these have a major impact on individuals, families and wider society[13].
- In England during 2011, one person was diagnosed with HIV every 90 minutes[14].
- Almost half of adults newly diagnosed with HIV were diagnosed after the point at which they should have started treatment[15].
- Rates of infectious syphilis are at their highest since the 1950s[16].
- Gonorrhoea is becoming more difficult to treat, as it can quickly develop resistance to antibiotics[17].
- In 2011, 36% of women overall, rising to 49% in black and black British women, having an abortion had had one before[18].
- In 2011, just over half of women having an abortion had previously had a live or stillbirth, indicating that better support is needed to access contraception following childbirth[19].
- Estimates from the Crime Survey for England and Wales indicate that there are around 400,000 female victims of sexual offences each year and, of these, around 85,000 are victims of the most serious offences of rape or sexual assault by penetration[20].

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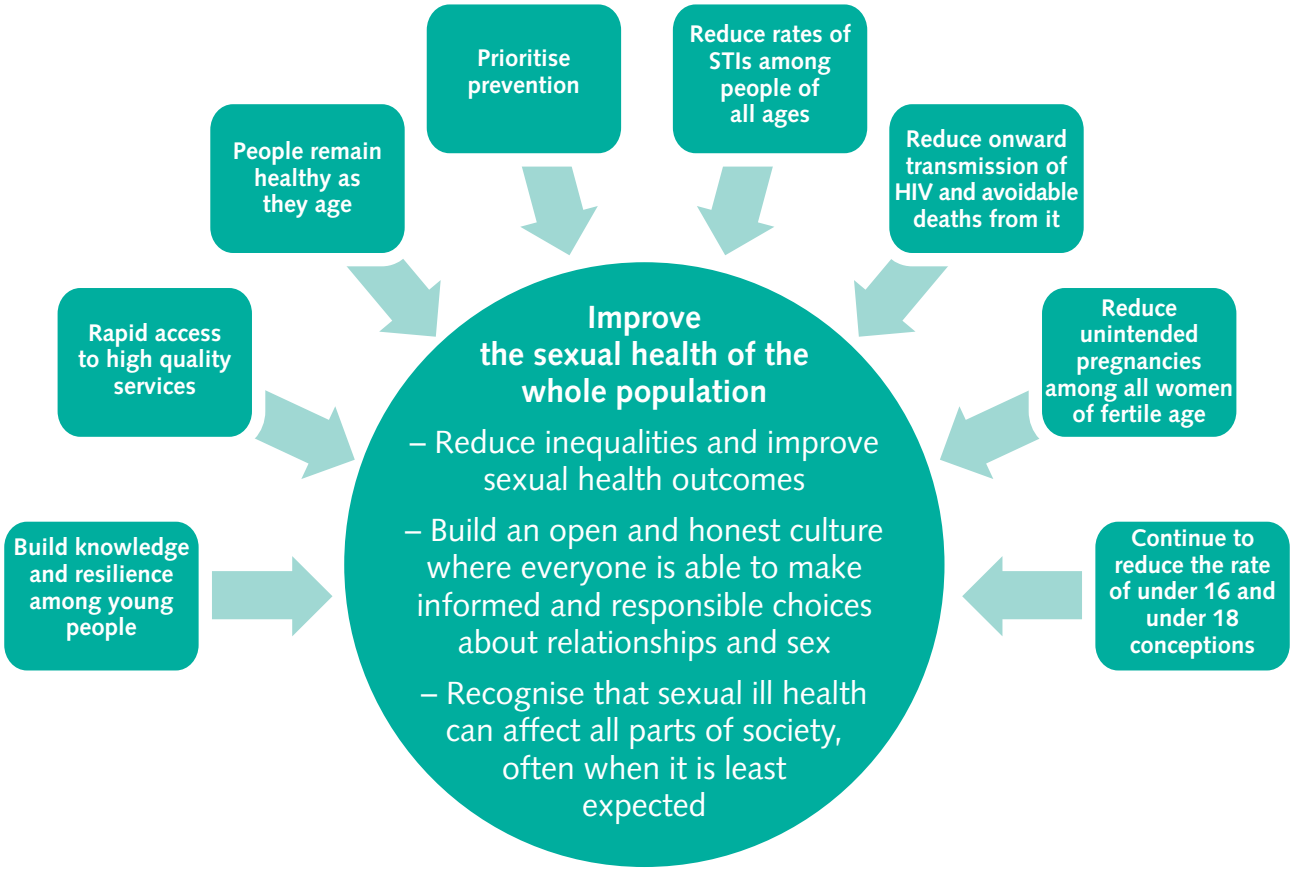
11 *Testing Times: HIV and other Sexually Transmitted Infections in the United Kingdom*, Health Protection Agency, 2007
12 Public health functions to be exercised by the NHS Commissioning Board: Service specification 30, sexual assault services, NHS Commissioning Board, 2012
13 'Effect of pregnancy planning and fertility treatment on cognitive outcomes in children at ages 3 and 5: longitudinal cohort study', Carson C et al, *BMJ* 2011; 343: d4473
14 *HIV in the United Kingdom: 2012 Report*, Health Protection Agency, 2012
15 Ibid
16 *Sexually transmitted infections in England, 2011*, Health Protection Agency
17 *GRASP 2011 Report: The Gonococcal Resistance to Antimicrobials Surveillance Programme*, Health Protection Agency, 2012
18 *Abortion Statistics, England and Wales*, Department of Health, 2011
19 Ibid
20 Based on a self-completion module of the Crime Survey for England and Wales using data from the 2009/10. 2010/11 and 2011/12 surveys combined

- In 2010, England was in the bottom third of 43 countries in the World Health Organization's European Region and North America for condom use among sexually active young people; previously, England was in the top ten[21].

Our ambition

Our ambition is to improve the sexual health of the whole population. Our key objectives are set out in Figure 1.

Figure 1: Key objectives



Working together to improve sexual health

Achieving good sexual health is complex, and there are variations in need for services and interventions for different individuals and groups. It is essential that there is collaboration and integration between a broad range of organisations, including commissioning organisations, in order to achieve desired outcomes.

21 Health Behaviour in School-Aged Children, World Health Organization, 2012

As previously mentioned, health and wellbeing boards will play a key role in ensuring that the care communities receive is seamless, through the process of developing the JSNAs and JHWSs.

The new commissioning arrangements, the new statutory duty to reduce inequalities and the creation of Public Health England present an opportunity to make a real difference to the future sexual health of the whole population. We will monitor progress through the PHOF indicators and a wider range of sexual health indicators proposed by Public Health England. Specific detail around new commissioning arrangements can be found in Section 5, *Improving outcomes through effective commissioning*, but the whole document sets out a range of information and actions to support good commissioning.

Moving forward, other opportunities also present themselves, for example:

- use of technology to support self-care, such as the 'My contraception' online tool developed by Brook and FPA[22] that helps people to choose which contraception method is right for them, and the Terrence Higgins Trust online resource 'myHIV'[23], which helps people to manage all aspects of their HIV;
- use of technology and social media in health promotion/education;
- continued development of effective treatments and products, including new methods of contraception, and the prevention of HIV, including 'Treatment as Prevention';
- making cost savings – evidence shows that spending on sexual health interventions and services is cost effective; and
- learning from and developing an evidence base of current effective practice.

22 http://www.fpa.org.uk/helpandadvice/mycontraceptiontool
23 http://www.myhiv.org.uk

Section 2: Sexual health across the life course

Introduction

We want people to stay healthy, to know how to protect their sexual health and to know how to access appropriate services and interventions when they need them. All individuals require age-appropriate education, information and support to help them make informed and responsible decisions. Most will also require access to services including provision of contraception and testing (and possibly treatment) for sexually transmitted infections (STIs) and HIV. It is crucial that the differing needs of men and women and of different groups in society are considered when planning services and interventions.

Most adults in England are sexually active. The 2010 Health Survey for England found the following:

- Of those aged 16 to 69, 92% of men and 94% of women reported that they had ever had sexual intercourse with someone of the opposite sex.
- Of those aged 16 to 69, 80% of men and 79% of women reported that they had had sexual intercourse with someone of the opposite sex in the past year.
- Men reported an average of 9.3 female sexual partners in their lives so far, while women reported an average of 4.7 male sexual partners.
- Overall, 80% of men and 86% of women reported that they had not had sex with someone of the opposite sex before the age of 16.
- The median age at first sex with someone of the opposite sex was 17 for both men and women.
- Of those aged 16 to 69, 1.6% of men and 1.8% of women reported that they had had sex with someone of the same sex in the past five years.

Different needs at different times

The diagram at Annex A sets out the different information, services and interventions needed as people move through their lives. Below, we discuss our sexual health ambitions for different age groups and what is needed to deliver these.

Sexual health up to age 16

AMBITION: Build knowledge and resilience among young people

- All children and young people receive good-quality sex and relationship education at home, at school and in the community.
- All children and young people know how to ask for help, and are able to access confidential advice and support about wellbeing, relationships and sexual health.
- All children and young people understand consent, sexual consent and issues around abusive relationships.
- Young people have the confidence and emotional resilience to understand the benefits of loving, healthy relationships and delaying sex.

Sex and relationship education

Both young people and parents want high-quality education about sex and relationships.

The provision of sex education is a statutory requirement for maintained secondary schools. What schools include in their sex-education programme is a matter for local determination; however, all schools must have regard to the Secretary of State for Education's *Sex and Relationship Education Guidance*[24]. The guidance ensures that pupils develop positive values and a strong moral framework that will guide their decisions, judgement and behaviour. It ensures that pupils are taught about the benefits of loving, healthy relationships and delaying sex, and also provides that pupils are aware of how to access confidential sexual health advice and support.

Academies do not have to teach sex education, but are required through their funding agreements to provide a broad and balanced curriculum. They are also required to have regard to the *Sex and Relationship Education Guidance* when providing sex education.

All schools delivering sex and relationship education are required to ensure that their pupils receive high-quality information on the importance of good sexual health.

Consent, confidentiality and safeguarding

All professionals working with children and young people should be aware of the law on consent. The Sexual Offences Act 2003 provides that the age of consent is 16, and that sexual activity involving children under 16 is unlawful. The age of consent also reflects the fact that children aged under 16 are vulnerable to exploitation and abuse. Most people wait until they are 16 or older before they have sex, and young people report that the legal framework helps them to resist pressure to have sex at an earlier age.

24 https://www.education.gov.uk/publications/eOrderingDownload/DfES-0116-2000%20SRE.pdf

The 2003 Act is designed to protect children – both boys and girls – not to punish them where it is wholly inappropriate. Guidance from the Crown Prosecution Service states that young people who are of a similar age should not be prosecuted or issued with a reprimand or final warning where sexual activity was mutually agreed and non-exploitative. However, the law says that children under 13 are particularly vulnerable, so to protect younger children any sexual activity with a child aged 12 or under will be subject to the maximum penalties – whatever the age of the perpetrator.

It was established in 1986[25] that health professionals can provide confidential medical advice, treatment and examination, including emergency contraception and abortion, to young people aged under 16. Health professionals have a duty to assess the young person's competence to discuss issues around consent, and in particular to encourage them to talk to their parents.

For the minority of young people aged under 16 who are sexually active, it is important that they have confidence to attend sexual health services and have early access to professional advice, support and treatment to prevent pregnancy and STIs. In addition, all sexual health service providers must be aware of child protection and safeguarding issues and take very seriously the possibility of abuse and/or exploitation.

Advice and guidance on child protection is available in *Working Together to Safeguard Children*[26] and *What to do if you're worried a child is being abused*[27]. All sexual health clinics should:

- have guidelines and referral pathways in place for risk assessment and management of child sexual abuse;
- use a standardised pro-forma for risk assessment for all aged under 16 years and those aged 17 to 18 where there is a cause for concern or learning difficulties; and
- be aware of local child protection procedures and work collaboratively under local safeguarding-children arrangements to ensure victims are identified and protected.

When teaching sex education in schools, the Secretary of State for Education's *Sex and Relationship Education Guidance* makes clear that pupils are to be taught how to avoid being exploited or pressured into unwanted or unprotected sex, and how the law applies to sexual relationships. Schools should, therefore, ensure that pupils learn about issues relating to sexual consent.

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25 *Victoria Gillick v West Norfolk and Wisbech Health Authority and Department of Health and Social Security* (1986) [1986] 1 AC 112 and *Sue Axon v Secretary of State for Health* (2006) [2006] EWHC 372 (admin)

26 Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children, Department for Education, 2006

27 What to do if you're worried a child is being abused, Department for Education, 2006

Sexualisation of children

Reg Bailey, Chief Executive of Mothers' Union, carried out an independent review, *Letting Children be Children*, looking at the pressures on children to grow up too quickly[28]. The review was prompted by the concerns of many parents who feel that their children are under increasing pressure to become consumers, and that the world their children live in is a more sexualised place than when they were growing up. The Government welcomed the review and the recommendations, which were primarily directed at businesses and media regulators. Ministers agreed to take stock of progress 18 months after the publication of *Letting Children be Children*. The stock-take of progress was announced on 17 October 2012 and the progress report will be published shortly.

Boys and young men

The needs of boys and young men are different to that of girls and this should be acknowledged. It is important that issues such as relationships, consent, contraception and infections are considered from a young man's perspective. An example of a tailored approach is in the box:

28 Bailey R, *Letting Children be Children: Report of an Independent Review of the Commercialisation and Sexualisation of Childhood*, Department for Education, 2011

Case study: The Playing Safely sport and sexual health programme

Harnessing the potential of professional sports clubs and players to inspire hard-to-reach young men is the hallmark of Playing Safely, an innovative sport and sexual health programme from Pennine Care NHS Foundation Trust.

Originating as a partnership with Oldham Athletic football club, Playing Safely is now in its fourth season of a contract with the Premier League to deliver a sexual-health awareness programme to players who are on a scholarship at the academies of Premier League football clubs.

Playing Safely uses a mixture of quizzes and other engaging sessions, utilising the natural competitive qualities of young men to address key sexual-health issues including maintaining respectful relationships, testicular cancer and self-checks, STIs, conception, contraception, and condom awareness. The programme offers chlamydia screening and has an uptake of over 90% with positivity rates in line with national average for the National Chlamydia Screening Programme (NCSP).

The Playing Safely project is also creating new partnerships with a range of elite sports bodies, including all the professional football leagues of England.

For further information on Playing Safely, contact:
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Building resilience

A wide range of factors has been shown to influence adolescent health outcomes. Many of these are 'deficit' factors, such as growing up in a single-parent family or living in a deprived area. However, these factors are clearly beyond the control of adolescents, and many resilient young people who grow up in difficult circumstances do have positive outcomes.

A more positive approach[29] is to identify the 'assets' that those resilient young people have, and to try and help at-risk young people to develop them. In this way, we can significantly improve their resilience – their ability to 'enjoy life, survive challenges, and maintain positive wellbeing and self-esteem'[30]. This also helps young people to challenge and change the taboos that are sometimes associated with sex and sexual health. Building resilience among

29 This methodology is known as lutogenesis and is based on the work by Aaron Antonovsky, a professor of medical sociology in the USA. The term describes an approach that focuses on factors supporting human health and wellbeing, rather than on factors that cause disease.

30 *Improving Young People's Lives*, Sustainable Development Commission, 2010

young people is a shared objective across government, in particular the Home Office in terms of civic disorder and crime, the Government Equalities Office in relation to body confidence, and the Department for Education in terms of teenage pregnancy.

DH is currently developing a new social marketing strategy for young people. The new strategy will address the range of risky activities that young people undertake by working to build resilience and self-esteem. The strategy will focus on changing behaviour by promoting and prompting conversation about health issues using a range of digital and mass-media channels, and the Government will work in partnership with a range of private sector and voluntary organisations.

School nurse development programme

A call to action for school nursing services was published in March 2012[31]. It sets out an ambition for the service model for school nursing services to meet both current and future needs. To support the programme a number of pathways have been developed for different public health services, and a sexual health pathway will be published later in 2013.

Young people aged 16–24

AMBITION: Improve sexual health outcomes for young adults

- All young people are able to make informed and responsible decisions, understand issues around consent and the benefits of stable relationships, and are aware of the risks of unprotected sex.
- Prevention is prioritised.
- All young people have rapid and easy access to appropriate sexual and reproductive health services.
- All young people's sexual-health needs – whatever their sexuality – are comprehensively met.

Most people become sexually active and start forming relationships between the ages of 16 and 24. Young people in these age groups have significantly higher rates of poor sexual health, including STIs and abortions, than older people. There is evidence that reducing the number of sexual partners and avoiding overlapping relationships can reduce the risk of STI acquisition[32].

31 *Getting it right for children, young people and families*, Department of Health, 2012
32 *Sexually transmitted infections in England, 2011*, Health Protection Agency

Chlamydia is the most prevalent STI in England and often has no symptoms. To address this, the NCSP aims to test all sexually active under-25s annually, or with each change of partner, as a routine part of primary care and sexual health consultations.

A significant proportion of STI diagnoses among gay and bisexual men continue to be in younger age groups: 34% of genital warts, 24% of gonorrhoea, 22% of genital herpes and chlamydia and 13% of syphilis cases diagnosed in 2011 were in those aged 15–24.

Following sustained action, pregnancies in young women aged under 18 are at their lowest rate since records began in 1969. This includes a reduction of 24% between 2007 and 2011 in the rate of abortions in women aged under 18. However, the abortion rate was highest, at 33 per 1,000, for women aged 20, the same as in 2010 and in 2001. This indicates that more work needs to be done in promoting effective contraception to prevent unwanted pregnancy.

In the consultation for *Positive for Youth*[33], the Government's youth strategy, young people said that taking the stigma out of asking for sexual health advice was seen as key to helping them take responsibility for making well-informed decisions. The Department for Education has also funded the development of *A framework of outcomes for young people*, signposting commissioners and providers to a wide range of support to help them to shift their focus from reducing negative outcomes to supporting the development of protective factors in young people.

The Government's mental health strategy also aims to strengthen young people's ability to take control of their lives and relationships, and to help to increase their emotional resilience[34].

33 *Positive for Youth: A new approach to cross-government policy for young people aged 13 to 19*, Department for Education, 2011

34 *No health without mental health: A cross-government mental health outcomes strategy for people of all ages*, Department of Health, 2011

People aged 25–49

AMBITION: All adults have access to high quality services and information

- Individuals understand the range of choices of contraception and where to access them.
- Individuals with children know where to access information and guidance on how to talk to their children about relationships and sex.
- Individuals with additional needs are identified and supported.
- Individuals and communities have information and support to access testing and earlier diagnosis and prevent the transmission of HIV and STIs.

At this stage of their lives, many people will be forming long-term relationships and may be thinking about starting to plan families. It is important that women are able to access the full range of contraception from a choice of providers in order to avoid unwanted pregnancy. Abortion statistics show that rates for those aged over 25 have increased over the past ten years and indicate that significant numbers of women aged over 25 have unwanted pregnancies. Restricting access to services by age can therefore be counterproductive and ultimately can increase costs. Some women with unintended and unplanned pregnancies will decide to proceed with their pregnancies. While many of these pregnancies will become wanted, the fact that the pregnancy was unplanned may cause financial, housing and relationship pressures, and have impacts on existing children. This is why provision of high-quality, effective and accessible contraception for women of all ages is crucial to support people to plan and space their families.

Increasingly, specialist gynaecological care is being provided by community sexual and reproductive health services integrated with contraceptive care to meet the needs of women throughout their reproductive life. This shift of care from hospital to the community is welcomed, and collaborative commissioning arrangements between commissioners should be considered so that this progressive approach to delivering specialist care in the community can be maintained.

While people in this age group do not experience the highest rates of STIs, those aged 25–49 are still at risk; 46% of all STIs diagnosed in genito-urinary medicine (GUM) clinics in 2011 were in this age group. This increased by 4% between 2009 and 2011.

The needs of specific groups, particularly gay and bisexual men and some black and ethnic minority groups who are at high risk of STI and HIV acquisition and unwanted pregnancy, must be considered and planned for within Joint Health and Wellbeing Strategies.

Older people aged over 50

AMBITION: People remain healthy as they age

- People of all ages understand the risks they face and how to protect themselves.
- Older people with diagnosed HIV can access any additional health and social care services they need.
- People with other physical health problems that affect their sexual health can get the support they need for sexual health problems.

As people get older, their need for sexual health services and interventions may reduce. Women will enter the menopause and increasingly not be at risk of pregnancy. However, older people's needs should not be overlooked. While STI rates in this age group only accounted for 3% of all STIs diagnosed in GUM clinics in 2011, they rose by 20% between 2009 and 2011.

Older age groups are more likely to be living with long-term health conditions that may cause sexual health problems. In particular, erectile dysfunction is associated with cardiovascular disease (CVD), diabetes, high blood pressure and a range of other conditions. Erectile dysfunction is recognised as a marker for underlying CVD and health professionals should be alert to this issue, which provides an early opportunity to treat the risks of CVD as well as addressing erectile dysfunction. There is also considerable evidence that cancer impacts on people's sexual health in a negative way, and cancer survivorship services need to reflect this.

Late diagnosis of HIV is more common in older age groups (half of those aged over 50) compared with younger age groups (one-third of those aged 16 to 19)[35]. The earlier that HIV is diagnosed, the sooner a person can get access to treatment and improve their individual prognosis while making changes necessary to prevent onward transmission (for example avoiding unprotected sex). The effectiveness of treatment for HIV means that more people will live well with HIV in old age. However, some will need other health and social care services associated with ageing, from a range of providers who will need to take account of the needs of an ageing population living with HIV and the need for shared care pathways.

35 Smith R et al, HIV Transmission and high rates of HIV diagnosis amongst adults aged 50 years and over. AIDS 2010, 24:000-000

Section 3: Sexual health influences and prevention

This section examines the attitudes, beliefs and behaviours that can influence sexual health outcomes, and the evidence base for actions to prevent sexual health problems. It highlights some key risk factors for poor sexual health and identifies vulnerable groups that may need access to more specialist services to meet their needs.

Influences on sexual health

There are a number of factors that can influence sexual health outcomes. These include the following:

- Personal beliefs, for example the degree of perceived risk of pregnancy or catching an STI or HIV. Most gay and bisexual men assume that prospective sexual partners do not have HIV, yet those with HIV assume the opposite.
- Personal understanding and perception of risk associated with certain sexual behaviours.
- Attitudes, for example the belief that condom use or male sterilisation can decrease sexual pleasure, or the common misconception that all hormonal contraceptives lead to weight gain.
- Social norms and peer pressure. For example, in surveys both parents and young people significantly overestimate the levels of sexual activity under the age of 16. Peer influence can be particularly strong when the relationship is between a dominant older youth and a younger, less confident individual.
- Self-esteem and confidence impact on the way people feel about their bodies; their attractiveness and their physical value can influence sexual health. People with low body confidence may be more likely to engage in risky behaviour, such as unprotected sex.
- Past behaviour, for example in using condoms or contraception.
- Relationships within families: young people who are able to have open and supportive conversations with their parents about sexual health matters are more likely to make better and informed choices about their sexual health and behaviour.
- Stigma and discrimination can prevent individuals from getting early diagnosis and treatment, disclosing to friends and family and getting the support they need.
- Behavioural willingness, for example if a person believes that someone who does not use contraception is attractive or gains 'status' through their behaviour, that person is at higher risk of adopting these practices.

- 'Informants'. These includes influences and places where people obtain information, including the media, the internet, school, friends and families.
- Religion can be a powerful influence on attitudes and behaviour, particularly around sexuality. Personal interpretations of faith and religious teaching can vary greatly.

The diagram at Annex B illustrates how different influences can impact on safer sex.

Prevention

The remainder of this section shows how we intend to meet the challenges resulting from these influences in order to seek to prevent sexual health problems.

AMBITION: Prioritise prevention

- Build a sexual health culture that prioritises prevention and supports behaviour change.
- Ensure that people are motivated to practise safer sex, including using contraception and condoms.
- Increased availability and uptake of testing to reduce transmission.
- Increase awareness of sexual health among local healthcare professionals and relevant non-health practitioners, particularly those working with vulnerable groups.

Sexual health promotion and prevention work aims to help people to make informed and responsible choices, with an emphasis on making healthy decisions. Effective health promotion addresses the prejudice, stigma and discrimination that can be linked to sexual ill health. However, service provision and treatment can also play key roles in prevention, in diagnosing STIs and HIV and preventing their onward transmission and in providing contraception to prevent unwanted pregnancies.

In order to improve sexual health outcomes, intervention programmes should be developed based on a robust evidence base and local needs. For example, the prevention of HIV and STIs should be targeted at those populations most at risk of infection; in England, this includes young people, gay and bisexual men and some black and ethnic minority groups. The prevalence of HIV among black African communities in England is estimated to be approximately 5%[36], and the rate of gonorrhoea is significantly higher among some black British populations than in the white British population[37].

In taking forward 'Every Contact Counts', there is an opportunity to appropriately raise issues related to sexual health, for example providing an HIV or chlamydia test as a part of

36 HIV in the United Kingdom; 2011 Report, Health Protection Agency, 2011
37 Gonorrhoea figures for 2011, Health Protection Agency, 2012

routine healthcare, regardless of whether a patient visits their GP, a sexual health clinic or other service. In addition, non-consensual sex and coercion, domestic and sexual abuse and violence can also be identified through these opportunities.

High-quality, accurate information can play a crucial part in helping people to understand how to improve their sexual health. However, information alone does not prompt people to change their attitudes and behaviour around condoms and contraception. There is evidence[38] to show that preventative interventions that focus on behaviour change and are based on behaviour-change theory have been effective in promoting sexual health. Effective behaviour change interventions:

- draw on a robust evidence base;
- are targeted at specific groups and take account of their specific influences and motivations to change;
- include provision of basic accurate information with clear messages;
- promote individual responsibility and focus on motivating the individual to change; and
- make use of 'changing contexts' models for 'nudging' people into healthier choices while recognising that such choices are influenced by complicated drivers of human action, including gender roles, inequality and norms around sexuality.[39]

Evidence also suggests that helping people to work through their own motivations and helping them to question and change their behaviour can form a key part of preventative interventions[40]. DH funds a national HIV prevention programme, HIV Prevention England, focused on gay and bisexual men and black African communities, which provides leadership, evidence-based interventions and information to support programmes commissioned by local areas. Further information and suggested actions for local areas are available at Annex C.

38 Downing J, Jones L, Cook P and Bellis M, *Prevention of sexually transmitted infections (STIs): a review of reviews into the effectiveness of non-clinical interventions*, Liverpool John Moores University Centre for Public Health, 2006

39 Dolan P et al, *Mindspace: Influencing behaviour through public policy*, Institute for Government, 2009

40 *One to one interventions to reduce the transmission of sexually transmitted infections (STIs) including HIV, and to reduce the rate of under 18 conceptions, especially among vulnerable and at risk groups*, National Institute for Health and Clinical Excellence, 2007

Embarrassment and stigma

Stigma is still associated with poor sexual health. Feelings of embarrassment or fear of being judged stop some people from getting information or from asking for early help. This can have a very real impact, for example:

- discrimination resulting from sexual health status can have an effect on quality of life and mental health[41];
- stigma linked to HIV can deter people from getting tested and taking their treatment[42];
- if STIs, including HIV, are not diagnosed and treated early, there is a greater risk of onward transmission to uninfected partners, and a greater risk that complications might occur;
- not using contraception significantly increases the risk of unintended pregnancy; and
- healthcare professionals feel embarrassed to offer an HIV (or STI) test, even if a patient is presenting with possible symptoms.

Use of alcohol and drugs

Research undertaken by North West Public Health Observatory[43] found that:

- there was an association between alcohol-attributable hospital admissions in both males and females with teenage pregnancy, even after controlling for the overriding and strong effect of deprivation (the same was true of the more common STIs);
- there is evidence that alcohol consumption and being drunk can result in lower inhibitions and poor judgements regarding sexual activity, vulnerability and risky sexual behaviour, such as not using contraception or condoms;
- alcohol consumption by young people leads to an increased likelihood that they will have sex at a younger age, and alcohol misuse is linked to a greater number of sexual partners and more regretted or coerced sex; and
- alcohol also increases the risk of sexual aggression, sexual violence and sexual victimisation of women.

Evidence suggests that gay and bisexual men who use particular illegal drugs (as well as alcohol) are more likely to engage in risky sex. A survey found that 51% of gay men had taken illegal drugs in the previous year, compared with 12% of men in the wider population[44].

41 'HIV-related stigma within communities of gay men: A literature review', Smit PJ et al, *AIDS Care* 2012; 24(3–4): 405–12

42 Ibid

43 Bellis M et al, *Contributions of Alcohol Use to Teenage Pregnancy*, North West Public Health Observatory, 2009

44 *Gay and Bisexual Men's Health Survey 2011*, Stonewall

Three pilot exercises are under way to assess the impact of delivering alcohol 'brief interventions' in sexual health clinics. Sexual health services can identify service users with potential alcohol problems. Most will benefit from some basic advice on how they can lower their risk of harm from drinking. For those who need more specialist support, referral pathways to alcohol services should be in place. Local areas should work in partnership in order to support as much integration across clinical pathways as possible, maximising the scope for early interventions and secondary prevention.

Vulnerable groups

Sexual and domestic violence and sexual exploitation and abuse can be issues for men, women and children. More than one-third (38%) of all rapes recorded by the police in England and Wales in 2010/11 were committed against children under 16 years of age[45], and 49% of gay and bisexual men have experienced at least one incident of domestic abuse from a family member or partner since the age of 16[46]. Service providers should be alert to these issues and be able to provide support and make onward referral for victims including to the police, social services and specialist health and third sector services. Evidence shows that such violence can severely affect the mental and sexual and reproductive health of victims.

Although routine enquiry about domestic violence in pregnancy has been undertaken for a number of years in antenatal settings, there has been less focus on screening in women having an abortion. Studies show an association between domestic violence and termination (and repeat termination) of pregnancy[47].

Female genital mutilation

Female genital mutilation (also referred to as FGM, female circumcision or cutting) is defined as all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons[48].

The Government has issued multi-agency practice guidelines on FGM[49] and it is a criminal offence under the Female Genital Mutilation Act 2003 to subject a girl or woman to FGM or to assist a non-UK person to carry out FGM overseas on a UK national or permanent resident. (The 2003 Act covers mutilation of the *labia majora*, *labia minora* or clitoris.) However, no offence is committed by a specified approved person who performs a surgical operation that is necessary on physical or mental health grounds or is for purposes connected with childbirth.

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45 Home Office

46 *Gay and Bisexual Men's Health Survey 2011*, Stonewall

47 'Abortion and domestic violence', Aston G and Bewley S, *The Obstetrician and Gynaecologist* 2009; 11:163–8

48 Classification of Female Genital Mutilation, World Health Organization, 1997

49 *Multi-Agency Practice Guidelines: Female Genital Mutilation*, HM Government, 2011

It is estimated that more than 66,000 women and girls living in Britain have experienced FGM. The procedure can have long-lasting physical and psychological effects, such as chronic pain, sexual difficulties and complications in pregnancy and childbirth and can increase the risk of HIV and other STIs. It is therefore very important that women and girls receive the right care within the NHS. Although some sexual health services can advise about FGM, in most cases women will need to be referred to a more specialised clinic, of which there are 15 in the NHS.

Prostitution

Some prostitutes are at higher risk of poor sexual health outcomes[50]. Prostitutes also experience vulnerabilities such as violence, rape and sexual assault, homelessness, and drug and alcohol problems that may impact on their sexual health needs[51]. There is a strong need for specialist services to be available because of the barriers prostitutes face in accessing mainstream services:

- The legal framework around prostitution makes some wary of disclosure to health professionals.
- They might fear stigma and judgemental attitudes.
- For some leading chaotic lives, particularly those affected by drug and alcohol abuse, accessing services with standard opening hours is challenging.
- Access to services, particularly for those who are being trafficked, coerced or 'pimped', might be controlled by others.

Specialist services should be able to meet all relevant needs, provide screening and treatment, contraception, vaccinations, health promotion and access to other support, including support for violence and abuse, and ways to leave prostitution. For young people aged under 16 who are identified at being at risk of sexual exploitation, including prostitution, an immediate referral should be made to children's social care services and to the police.

People with learning disabilities

The Human Rights Act states that every human being has a right to respect for private and family life. It is estimated that there are more than one million people living in England with a learning disability, but research has found that young people with learning disabilities do not have good access to sex and relationship education or information[52]. It is recommended that there be more accessible information and support for young people with learning

50 'Health needs and service use of parlour-based prostitutes compared with street-based prostitutes: a cross-sectional survey', Jeal N and Salisbury C, *BJOG: An International Journal of Obstetrics and Gynaecology*; 114(7): 875-81

51 *Sex Workers and Sexual Health: Projects responding to needs*, UK Network of Sexwork Projects, 2009

52 *Talking about sex and relationships: the views of young people with learning disabilities*, CHANGE, 2010

disabilities and for their parents. This needs to include information about sexuality, abuse and consent and practical information about contraception and safer sex where appropriate.

Victims of sexual assault

Sexual Assault and Referral Centres (SARCs) aim to promote recovery and health following a rape or sexual assault, whether or not the victim wishes to report it to the police. A SARC typically provides specialist clinical care and follow-up to victims of acute sexual violence, including sexual health screening and emergency contraception, usually in one place, regardless of gender, age, ethnicity or disability. In addition, victims can choose to undergo a forensic medical examination if they want.

The SARC concept is one of integrated, specialist clinical interventions and a range of assessment and support services through defined care pathways. This allows co-ordination with wider healthcare, social care and criminal justice processes to improve health and wellbeing, as well as criminal justice outcomes for victims of sexual assault as appropriate. Robust partnership working is therefore vital for the successful planning, commissioning and running of SARCs. From April 2013, the NHS CB will take over responsibility for commissioning the health aspects of SARC services as a public health service working with the police who commission forensic services, and local authorities who invest in specialist follow-up and other support.

Lesbian, gay, bisexual and trans people

Lesbian, gay, bisexual and trans (LGBT) people experience a number of health inequalities that are often unrecognised in health and social care settings. Research commissioned by Stonewall indicates that a high proportion of lesbian and bisexual women[53], and gay and bisexual men[54], have never been tested for STIs. A series of briefings[55] aims to show that LGBT people can be younger, older, bisexual, lesbians, gay men, trans, from black and minority ethnic communities and disabled, and to dispel assumptions that they form a homogeneous group.

Homeless people

Homeless people are at increased risk of STIs and unwanted pregnancies and can come under pressure to exchange sex for food, shelter, drugs and money. This makes it vital to address the health needs of this group.

The FPA Sleepin' Safe, Sexin' Safe project aims to increase and improve homeless young people's knowledge of sexual health, working in partnership with the youth homelessness charity Centrepoint and other youth homelessness organisations. Further information is at www.fpa.org.uk/communityprojects/youngpeople/sexual-health-choices-for-homeless-young-people

53 www.stonewall.org.uk/lesbianhealth
54 www.stonewall.org.uk/gaymenshealth
55 www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_078347

Section 4: Priority areas for sexual health improvement

Introduction

In addition to general prevention, there is a range of particular issues where focus is needed to improve outcomes; this chapter provides the ambitions and support information for those areas. A summary of key facts about each of the issues is at Annex C.

Sexually transmitted infections

AMBITION: Reduce rates of sexually transmitted infections (STIs) among people of all ages

- Individuals understand the different STIs and associated potential consequences.
- Individuals understand how to reduce the risk of transmission.
- Individuals understand where to get access to prompt, confidential STI testing and provision allows for prompt access to appropriate, high-quality services, including the notification of partners.
- Individuals attending for STI testing are also offered testing for HIV.

Services have seen significant reductions in waiting times and have modernised to increase capacity in order to see more people. Open access services in which people can be tested and treated for STIs quickly and confidentially encourage people to come forward for testing, treatment and partner notification, ensure that infections are diagnosed rapidly and prevent onward infection. Partner notification is an essential component of STI management and control, protecting patients from re-infection, partners from long-term consequences from untreated infection and the wider community from onward transmission[56].

There has been a recent emergence of outbreaks of less common (or previously rare) STIs such as gonorrhoea, syphilis and lymphogranuloma venereum, especially among young heterosexual adults (including adolescents) and gay and bisexual men. Public Health England has issued guidance on outbreak management[57].

56 'Partner notification for sexually transmitted infections in the modern world: a practitioner perspective on challenges and opportunities', Bell G and Potterat J, *Sexually Transmitted Infections* 2011; 87: ii34–ii36

57 See www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1214553002033

The best way for sexually active people of any age to avoid an STI is to use a condom when they have sex. It is important that young people should be able to access condoms easily and feel confident about carrying and using them. Many local areas have already developed 'C-Card' schemes. These allow C-Card holders to obtain free condoms from a range of outlets such as pharmacies, as well as more traditional providers such as GPs and clinics. Broader advice on sexual health is also offered as part of these schemes.

National Chlamydia Screening Programme

Rates of chlamydia are substantially higher in young adults than in any other age group. Launched in 2003, the National Chlamydia Screening Programme (NCSP) aims to test all sexually active people under the age of 25 annually or with each change of sexual partner as a routine part of primary care and sexual health consultations.

The NCSP currently delivers approximately two million chlamydia tests a year, diagnosing and treating about 150,000 infections annually[58]. Over time, the programme has raised awareness of chlamydia among young adults, engaged young men in protecting their sexual health and that of their partners and led the way for STI testing in the community, including in general practices and pharmacies. Recent research interpreted alongside existing evidence indicates that the NCSP may already be having an impact on the prevalence of chlamydia[59]. Taking the programme forward, there should be a focus on:

- retaining the NCSP identity – two recent surveys of young adults supported this and indicated that the words 'chlamydia' and 'screening' make it clear to them what is on offer through the programme, and make that offer acceptable;
- ensuring that the programme remains accessible to young people and screening large numbers of at-risk young adults (diagnosis of chlamydia is highlighted in the PHOF as an important indicator of ill health);
- integrating screening into wider sexual health service provision and increasing screening in primary care, particularly in general practice;
- restricting outreach screening to those young people with limited access to sexual health services, for example homeless young people, looked-after young people and those leaving care;
- expanding internet testing services, which are particularly attractive to young men; and
- promoting annual screening for young people (and additional testing on each change of partner), adherence to treatment and partner-notification professional guidelines.

58 *Sexually transmitted infections in England, 2011*, Health Protection Agency

59 'Screening and treating chlamydia trachomatis genital infection to prevent pelvic inflammatory disease: Interpretation of findings from randomized controlled trials', Gottlieb S, Xu F and Brunham R, *Sexually Transmitted Diseases* 2013; 40(2)

HIV

AMBITION: Reduce onward transmission of and avoidable deaths from HIV

- Individuals understand what HIV is and how to reduce the risk of transmission.
- Individuals understand how HIV is prevented.
- Individuals understand where to get prompt access to confidential HIV testing.
- Individuals diagnosed with HIV receive prompt referral into care, and high-quality care services are maintained.
- Individuals diagnosed with HIV receive early diagnosis and treatment of STIs.

Primary prevention

Prevention of HIV remains a priority, through evidence-based interventions including health promotion and support for sustained behavioural change including condom use. This is challenging, and interventions should include support for people with diagnosed HIV both to protect their sexual health (for example to avoid STIs) and reduce onward transmission. Recent research[60] shows that the number of HIV infections would be more than 400% greater if condom use by gay men had ceased entirely from 2000. A variety of primary prevention programmes, which take account of HIV prevalence, will be needed.

HIV Prevention England

HIV Prevention England (HPE) is the new national HIV prevention programme for England funded by DH and managed by the Terrence Higgins Trust supported by a team of sub-contractors. It is delivering a nationally co-ordinated programme of HIV prevention work with UK-based Africans and gay and bisexual men. HPE has established three goals:

- to increase HIV testing to reduce undiagnosed and late diagnosed HIV in both communities;
- to support sustained condom use and other behaviours that prevent HIV in both communities; and
- to tackle stigma within both communities and more widely.

60 'Increased HIV Incidence in Men Who Have Sex with Men Despite High Levels of ART-Induced Viral Suppression: Analysis of an Extensively Documented Epidemic', Phillips AN et al, *PLOS ONE* 2012; 8(2): e55312

HIV testing

The earlier HIV is diagnosed, the sooner a person can get access to treatment and improve their individual prognosis while making any changes necessary to prevent onward transmission.

In 2011, around half of adults newly diagnosed with HIV were diagnosed after the point at which treatment should have started (CD4 cell count ≤350 cells/µl). However, this varied by sexual orientation, ethnicity and age. For example, the proportion diagnosed late was lower in gay and bisexual men compared with heterosexual men and women. Older adults (aged 50 and over) were significantly more likely to be diagnosed late compared with younger adults[61].

Increasing the number of tests in non-specialist healthcare settings in line with existing good practice will play a key role in tackling HIV, particularly in local areas with a high prevalence of HIV[62]. Findings from pilot projects funded by DH on increasing HIV testing outside sexual health clinics indicated that offering an HIV test was feasible and acceptable to patients and staff[63]. This is particularly important in areas with a high prevalence of HIV – these are defined as areas with a diagnosed prevalence of more than two cases of HIV per 1,000 population; 58 local authorities meet this criteria[64].

Increasing the frequency of testing among groups at increased risk of HIV is also important. In 2011, the National Institute for Health and Clinical Excellence (NICE) published guidance on Increasing the uptake of HIV testing among black Africans in England[65] and among men who have sex with men[66]. A recent review also suggests that rapid testing in community settings, and intensive peer counselling where appropriate, can increase the uptake of HIV testing among gay and bisexual men[67].

Current legislation bans the sale of home testing kits for HIV. DH is reviewing the continuing need for this ban.

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61 *HIV in the United Kingdom: 2012 Report*, Health Protection Agency, 2012

62 *Evidence and resources to commission expanded HIV testing in priority medical services in high prevalence areas*, Health Protection Agency, 2012

63 *Time to Test for HIV: Expanding HIV testing in healthcare and community settings in England*, Health Protection Agency, 2011

64 *Evidence and resources to commission expanded HIV testing in priority medical services in high prevalence areas*, Health Protection Agency, 2012

65 *Increasing the uptake of HIV testing among black Africans in England* (PH33), National Institute for Health and Clinical Excellence, 2011

66 Ibid

67 'Promoting the uptake of HIV testing among men who have sex with men: systematic review of effectiveness and cost-effectiveness', Lorenc T et al, *Sexually Transmitted Infections* 2011; 87(4): 272–8

Primary HIV infection

More than half of people with HIV experience symptoms in the first few weeks following transmission of the infection. This symptomatic period, commonly known as primary HIV infection (PHI), usually lasts 2–3 weeks and is often the only sign of HIV infection before more advanced symptoms occur many years later. Common symptoms include malaise, fever, rash, headache and swollen lymph nodes. These symptoms are commonly missed both by infected individuals and by healthcare workers in genito-urinary medicine (GUM) clinics and primary care. A recent London study examining HIV prevalence in routine glandular fever screens submitted through primary care indicated that an HIV test was requested in only 12% of cases. However, the overall undiagnosed HIV prevalence in this patient group was 1.3% and 44% of these were recent infections (less than five months)[68].

During the PHI stage, individuals are highly infectious due to high viral load. In 2010 in the UK, an estimated 48% of new HIV infections among gay and bisexual men were acquired from undiagnosed men with PHI. Improving the diagnosis of recent HIV infection is therefore a real opportunity to reduce onward transmission of infection.

Effective strategies for the reduction of HIV transmission should include a combination of interventions, for example improving awareness and diagnosis of PHI; improving access to risk counselling and Treatment as Prevention; and enhanced partner notification using new technologies such as social media.

Treatment and care

HIV treatment is currently provided in accordance with guidelines produced by the British HIV Association (BHIVA), and treatment outcomes are excellent[69,70]. Currently, most treatment is provided in specialised service settings.

BHIVA recommends that treatment should begin when an individual's CD4 cell count is ≤350 cells/μl[71]. Consideration should also be given to starting treatment at higher cell counts in older persons, given the higher risk of disease progression for a given CD4 cell count. There is increasing evidence that people with suppressed or undetectable HIV viral loads, especially those on HIV treatment, are significantly less likely to transmit the virus to their partners than people who are not taking treatment. These guidelines now recommend that doctors should offer antiretroviral treatment as prevention to all patients with HIV in order to protect their partners from the risk of HIV infection – even if they have no immediate clinical need for treatment themselves.

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68 'Diagnosing HIV infection in patients presenting with glandular fever-like illness in primary care: are we missing primary HIV infection?' Hsu DT et al, *HIV Medicine* 2013; 14(1): 60–3

69 *HIV in the United Kingdom: 2012 Report*, Health Protection Agency, 2012

70 *Standards of Care for People Living with HIV 2013*, British HIV Association, 2012

71 'British HIV Association guidelines for the treatment of HIV-1-positive adults with antiretroviral therapy 2012', BHIVA Writing Group, *HIV Medicine* 2012; 13(2): 1–85

Local commissioners, working together, will be able to ensure that close links are made between services offering testing and other preventative interventions, and those offering treatment. They will also be able to consider innovative treatment pathways, such as a greater role for self-care, offering care outside specialised services in primary care and home delivery of treatment drugs. As people with HIV age, their wider health and social care needs are likely to increase and may be greater than other older people. Local services will need to plan for this as part of treatment and care pathways.

Contraception and unwanted pregnancy

AMBITION: Reduce unwanted pregnancies among all women of fertile age

- Increase knowledge and awareness of all methods of contraception among all groups in the local population.
- Increase access to all methods of contraception, including long-acting reversible contraception (LARC) methods and emergency hormonal contraception, for women of all ages and their partners.

Guidance from NICE has found that, while all methods of contraception are effective, LARC methods such as contraceptive injections, implants, the intra-uterine system or the intra-uterine device (IUD) are much more effective at preventing pregnancy than other hormonal methods, and are much more effective than condoms[72]. However, a condom should also always be used to protect against STIs.

Research[73] with young women having abortions and repeat abortions found that:

- some young people continue to have unprotected sex when they are fully aware of the possible consequences and when they do not want to become pregnant;
- there is a poor understanding of fertility among young women, and this contributes to inconsistent contraceptive use;
- some young people struggled to use their preferred methods of contraception effectively (principally condoms and the pill, which are user dependent);
- abortion was viewed as 'immoral' by many young women, and this view makes abortion decision making difficult and stressful – particularly when they are faced with the reality of an unplanned pregnancy; and

72 *Long-acting reversible contraception*, National Collaborating Centre for Women's and Children's Health, commissioned by the National Institute for Health and Clinical Excellence, 2005

73 Hoggart L and Phillips J, *Young People in London: Abortion and Repeat Abortion*, Policy Studies Institute, 2010

- if pregnant teenagers are strongly influenced by parents or a partner in their decision to terminate a pregnancy, this can sometimes lead to ambivalent feelings towards future contraception use and increase the risk of a further pregnancy.

There is increasing evidence that unplanned pregnancies have poorer pregnancy outcomes and that children born after unplanned pregnancies tend to have a more limited vocabulary and poorer non-verbal and spatial abilities. These differences are almost entirely explained by deprivation and inequalities[74]. A recent review by the Academy of Medical Royal Colleges and the National Collaborating Centre for Mental Health[75] concluded that unwanted pregnancy is associated with an increased risk of mental health problems. Women with pre-existing mental health problems should be actively supported to reduce the risk of unwanted pregnancies.

Highly visible, accessible contraception services that supply the full range of contraceptive methods can reduce unwanted pregnancy and better support people of all ages to have children when they are ready, and these will play a key role in improving outcomes.

Women should be encouraged and supported to use regular methods of contraception. However, emergency contraception is a safe and effective way of preventing unwanted pregnancy when regular methods have failed or have not been used. Emergency contraception can be purchased in pharmacies or supplied free of charge on prescription, and a new emergency contraception pill was licensed in 2009 that provides protection up to five days after unprotected sex. IUDs can also be used as emergency contraception, and health professionals should discuss with women which product is most suitable for their needs.

Abortion

For those women who request an abortion it is important that they have early access to services, as the earlier in pregnancy an abortion is performed the lower the risk of complications. The Abortion Act 1967 sets out the circumstances in which abortions can be carried out in Great Britain.

Unwanted pregnancy is experienced by women from all social backgrounds. The numbers of abortions increased slowly until 2008 and have remained relatively stable since then. However, repeat abortions have risen over the last decade and there was a further 2% increase in 2011, when 36% of all abortions were repeats. Abortion rates have fallen in younger age groups but are increasing in older women.

74 'Effect of pregnancy planning and fertility treatment on cognitive outcomes in children at ages 3 and 5: longitudinal cohort study', Carson C et al, *BMJ* 2011; 343: d4473

75 *Induced Abortion and Mental Health*, Academy of Royal Medical Colleges, 2011

Access to abortion has improved in recent years. In 2011, 96% of abortions carried out on residents of England and Wales were provided free on the NHS; of these, 91% were carried out before the thirteenth week of gestation[76].

Reducing repeat abortion and unwanted pregnancy after childbirth

There are complex reasons why women of all ages struggle to control their fertility. Referral pathways should be in place from abortion and maternity services to alcohol and drug services, mental health services and support services for domestic and sexual violence for those women who need them.

There is clear evidence that provision of contraception, particularly LARC methods, supplied or fitted by the abortion provider can reduce repeat abortions. Two recent studies[77] that followed women for around two years after they had an abortion demonstrated far lower return rates for repeat abortion for those women who chose a contraceptive implant or an intra-uterine method. Another study[78], which assessed the impact of 'fast-tracking' women having an abortion to the local family-planning clinic for intra-uterine contraception, found that half of the women never attended. This underlines the importance of the provision of contraception at abortion services.

However, LARC methods are not acceptable or suitable for all women, and it is important that women are allowed to make informed choices, with all the possible side effects and how these can be managed explained to them.

This is also an important issue for maternity services. Access to training and use of Patient Group Directions should be available for nurses in abortion clinics, community midwives, gynaecology nurses and other nurses to prescribe and fit all methods, including LARC.

Abortion counselling

AMBITION:

All women requesting an abortion should be offered the opportunity to discuss their options and choices with a trained counsellor.

There is evidence to suggest that NHS-funded abortion services provided by the independent sector offer all women the opportunity of seeing a trained counsellor, and that

76 *Abortion Statistics, England and Wales*, Department of Health, 2011

77 'Impact of long-acting reversible contraception on return for repeat abortion', Rose S and Lawton B, *American Journal of Obstetrics and Gynaecology* 2012; 206(1): 37.e16 'Effect of contraception provided at termination of pregnancy and incidence of subsequent termination of pregnancy', Cameron et al, *BJOG* 2012; 119(9):1074–80

78 'Assessment of a 'fast-track' referral service for intrauterine contraception following early medical abortion' Cameron ST et al, Journal of Family Planning and Reproductive Health Care; 38(3): 175–8

this offer is repeated at every stage of the care pathway. However, the situation in NHS hospitals that provide abortion is more variable, with some areas restricting access to counselling by age and, in some cases, no counselling being available at all.

Guidance from the Royal College of Obstetricians and Gynaecologists[79] recommends that healthcare staff caring for women requesting abortion should identify those who require more support in the decision-making process. The Care Quality Commission's *Essential Standards of Safety and Quality*[80] for providers of termination of pregnancy require that women know that 'they are able to discuss their choices and decisions with a trained counsellor' and 'where services are provided to children or people with a learning disability, the counsellor available has relevant expertise in discussing termination of pregnancy with them'.

Information exchange with a health professional will take place with all women, and this will involve some exploration of a woman's feelings and choices and can therefore often stray into counselling territory. Many health professionals report that part of their assessment involves a degree of counselling. However, some women will require more extensive support than health professionals without specific counselling training can provide. All providers should therefore ensure that there is access to appropriately trained counsellors for all women who accept the counselling offer. This can be provided face to face or remotely.

Our definition of 'trained counsellor' is an individual who has successfully completed and graduated from a minimum of a one-year full-time, or two-year part-time, counselling/psychotherapy qualification that included a supervised placement.

For those women who accept an offer of counselling, this must always be provided in line with the following principles:

- It should not impact on timely access to services by creating barriers or delays to access.
- Mandatory requirements for counselling should never be imposed.
- The counselling must be non-judgemental, and the counsellor must be willing to discuss the full range of options open to the woman.
- If the counsellor is not contracted/employed by an abortion service, rapid onward referral should be made if abortion is the chosen option.
- Counselling must always be impartial and put patients' needs first, irrespective of the contractor/employer of the counsellor.

79 *The Care of Women Requesting Induced Abortion*, Royal College of Obstetricians and Gynaecologists, 2011
80 Essential Standards of Quality and Safety, Care Quality Commission, 2010

The type and level of counselling offered should depend on the individual woman's needs. The focus of the intervention would depend on the presenting issue and the formulation of an approach agreed with the woman.

Counselling should be commissioned as an integral part of abortion service provision in line with the termination of pregnancy specification[81] produced by DH.

Post-abortion support and counselling

Every woman will experience different feelings and emotions after an abortion, and some will require additional support. While research indicates that having an abortion does not lead to long-term emotional or psychological problems, some women will benefit from counselling to discuss how they are feeling. Provision should be made for post-abortion counselling to be available, particularly within abortion services.

As highlighted earlier, care pathways should be in place for those women who need support from mental health, domestic or sexual violence, drugs and/or alcohol services.

Preventing teenage pregnancy

AMBITION: Continue to reduce the rate of under-16 and under-18 conceptions

- All young people receive appropriate information and education to enable them to make informed decisions.
- All young people have access to the full range of contraceptive methods and where to access them.

Continuing to reduce under-18 pregnancies is a high priority, as highlighted by the inclusion of this as an indicator in the Public Health Outcomes Framework. This is because[82]:

- of all young people not in education, training or employment, 15% are teenage mothers or pregnant teenagers;
- teenage parents are 20% more likely to have no qualifications at age 30;
- teenage mothers are 22% more likely to be living in poverty at 30, and much less likely to be employed or living with a partner; and
- teenage mothers have three times the rate of postnatal depression and a higher risk of poor mental health for three years after the birth.

81 http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_111203

82 *Teenage Pregnancy Strategy: Beyond 2010*, Department for Children, Schools and Families and the Department of Health, 2010

Outcomes are also worse for children:

- Children of teenage mothers have a 63% increased risk of being born into poverty and are more likely to have accidents and behavioural problems.
- The infant mortality rate for babies born to teenage mothers is 60% higher.
- Teenage mothers are three times more likely to smoke throughout their pregnancy and 50% less likely to breastfeed, with negative health consequences for the child.

While teenage conception may result from a number of causes or factors, the strongest empirical evidence for ways to prevent teenage conceptions is:

- high-quality education about relationships and sex[83]; and
- access to and correct use of effective contraception[84].

Over the past ten years, local areas have developed structures for translating this evidence into local delivery, with all partner agencies understanding their contribution.

It is for local authorities, working with health and other partners, to continue to take the lead in reducing teenage pregnancies. Local areas have been given the freedoms and flexibilities to do what fits to reduce teenage pregnancies in their area – by providing appropriate support to ensure that young people have ambitions and stay engaged with and reach high levels of educational attainment, so that all young people can have the best start in life.

Some local areas have undertaken successful early-intervention schemes to identify young people at risk of teenage pregnancy at an early age and provide them with more intensive support to address multiple risks and raise self-esteem.

There is a great deal of learning about what works on the Department for Education's website. Having clear and realistic goals around reductions in under-18 conceptions is vital, and the importance of local leadership and partnership working in translating evidence into local actions cannot be underestimated in delivering real improvements in outcomes for young people. Use of good local data to inform commissioning and interventions is essential. The Children's Improvement Board data profile should also be used to help local areas to review their own progress on children and young people's outcomes, and to provide support and challenge to local areas to further improve through sector-led improvements and peer support.

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83 Kirby D, *Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases*, National Campaign to Prevent Teen and Unplanned Pregnancy, 2007

84 'Explaining recent declines in adolescent pregnancy in the United States: the contribution of abstinence and improved contraceptive use', Santelli J, *American Journal of Public Health* 2007

Section 5: Improving outcomes through effective commissioning

It is estimated that, based on current spend, sexual health services will account for around one-quarter of the funds to be transferred to local authorities in April 2013 for their new public health responsibilities. Evidence demonstrates that spending on sexual health interventions and services is cost effective:

- For every £1 spent on contraception, £11 is saved in other healthcare costs[85].
- The provision of contraception saved the NHS £5.7 billion in healthcare costs that would have had to be paid if no contraception at all was provided[86].
- National Institute for Health and Clinical Excellence (NICE) Clinical Guideline CG30 demonstrated that (LARC) is more cost effective than condoms and the pill, and if more women chose to use these methods there would be cost savings[87].
- Early testing and diagnosis of HIV reduces treatment costs – £12,600 per annum per patient, compared with £23,442 with a later diagnosis[88].
- Early access to HIV treatment significantly reduces the risk of HIV transmission to an uninfected person[89].
- Work from the South West of England demonstrated that improvements in the rates of partner notification resulted in a reduced cost per chlamydia infection detected[90].

More work is needed to assess the impact that improving sexual health can have on wider local authority and other budgets. This should particularly focus on the impacts caused by reducing unwanted pregnancies and HIV transmission.

Commissioning arrangements from 1 April 2013

Figure 2 shows the commissioning arrangements that will apply from 1 April 2013.

85 McGuire A and Hughes D, *The economics of family planning services*, 1995
86 *Contraception Atlas*, Bayer HealthCare, 2011
87 *Long-acting reversible contraception: the effective and appropriate use of long-acting reversible contraception* (CG30), National Institute for Health and Clinical Excellence, 2005
88 'The Cost-Effectiveness of Early Access to HIV Services and starting cART in the UK', Beck EJ et al, *PLOS ONE*; 6(12): e27830
89 'British HIV Association guidelines for the treatment of HIV-1-positive adults with antiretroviral therapy 2012', BHIVA Writing Group, *HIV Medicine* 2012; 13(2): 1–85
90 Adams E and Turner K, SHORE Programme – Invest to save in the South West: Benchmarking current expenditure against sexual health, identifying local population needs and using local data in economic models, Office of Sexual Health, Taunton, 2012

Figure 2: From April 2013		
Local authorities will commission	**Clinical Commissioning Groups (CCGs) will commission**	**The NHS Commissioning Board will commission**
• Comprehensive sexual health services. These include: • contraception, including LESs (implants) and NESs (intra-uterine contraception) and all prescribing costs, but excluding contraception provided as an additional service under the GP contract; • sexually transmitted infection (STI) testing and treatment, chlamydia screening as part of the National Chlamydia Screening Programme (NCSP) and HIV testing; • sexual health aspects of psychosexual counselling; and • any sexual health specialist services, including young people's sexual health and teenage pregnancy services, outreach, HIV prevention and sexual health promotion, services in schools, colleges and pharmacies.	Most abortion services (but there will be a further consultation about the best commissioning arrangements in the longer term) Sterilisation Vasectomy Non-sexual health elements of psychosexual health services Gynaecology, including any use of contraception for non-contraceptive purposes.	Contraception provided as an additional service under the GP contract HIV treatment and care (including drug costs for post-exposure prophylaxis after sexual exposure) Promotion of opportunistic testing and treatment for STIs, and patient-requested testing by GPs Sexual health elements of prison health services Sexual Assault Referral Centres Cervical screening Specialist fetal medicine services

Because of the need to ensure universal provision of these essential services, local authorities will be mandated to provide comprehensive, open access STI testing and treatment services and contraception advice and services. Guidance will be published to help local authorities to fulfil the requirement to commission comprehensive, open access contraception and STI testing and treatment services.

Prescribed contraception and STI treatment are free of charge for the user. A key principle of sexual health services since their inception is that they have been confidential and open access a referral from a GP or other health professional is not required and services are not restricted by place of residency or age. There are strong public health reasons why the open access nature of these services should continue. Some people will choose to travel to services away from their area of residence, and this might be because a clinic is nearer to their workplace or is more convenient for another reason. However, others will choose to travel away from their home area because of a strong desire for anonymity and to reduce any risk of being seen attending a sexual health service. These needs may be driven by personal or cultural circumstances.

It will be vital for commissioners to work closely together to ensure that the care and treatment people receive is of a high quality and is not fragmented. Health and Wellbeing Boards will play a key role in ensuring that the services and care their communities receive is seamless. They will undertake Joint Strategic Needs Assessments (JSNAs) to identify the current and future health and social care needs of the local community as well as local assets. Based on this, they will develop Joint Health and Wellbeing Strategies (JHWSs) to agree their joint priorities for local action. Both JSNAs and JHWSs will inform CCG, NHS CB and local authority commissioning. Sexual health has a clear role to play in improving health and reducing health inequalities, and sexual health improvement should be considered as part of the process.

Key principles for best practice in commissioning

To help commissioners, we have developed six key principles of commissioning best practice. These are set out in Figure 3.

Figure 3: Key principles for best practice in commissioning

Prevention is prioritised

- Insights from behavioural science are used to help to develop interventions that motivate people to alter their behaviour. The prevention role of the wider non-health workforce is incorporated into commissioning.

Leadership and joined-up working

- The Director of Public Health, elected local authority members, other local authority officers, members of CCGs and local area teams of the NHS CB play a strong, strategic leadership role and identify sexual health locally as a key public health issue.
- They work in partnership with key players such as the local Healthwatch, local advocacy groups, voluntary and community sector organisations and businesses to develop a joint commitment to improving local sexual health.

Focus on outcomes

- Challenging but achievable outcomes measures are drawn up using robust data and needs assessment.
- The results, together with other robust evidence, are used to develop plans to improve local sexual health outcomes and reduce health inequalities.
- Progress against these and wider plans is monitored to ensure that improvements are on track.
- Monitoring secures value for money from services and interventions, and determines the relationship between commissioning and any improvement in outcomes.

Wider determinants of sexual health are addressed

- Strong links are made between sexual health and other key determinants of health and wellbeing, such as alcohol and drug misuse, smoking, obesity, mental health and violence (particularly violence against women and girls), contributing to a reduction in health inequalities.
- Services and interventions are developed and delivered to tackle these determinants in a joined-up way.

Figure 3: Key principles for best practice in commissioning

High-quality commissioning of services

- Interventions and services that meet the needs of all age groups are commissioned from high quality providers.
- Interventions and services are offered in a range of settings, with convenient opening times and appropriately trained staff, which meet professional best practice and other relevant guidance such as 'You're Welcome'. Public and patient feedback is used to ensure that services are meeting the needs of the local population.
- Staff working in sexual and reproductive health services should be trained to meet recognised national professional guidelines (for example, the British Association for Sexual Health and HIV (BASHH) and the Faculty of Sexual and Reproductive Healthcare (FSRH)).
- Robust care pathways are in place to ensure seamless onward referral that is acceptable to patients.
- Collaborative commissioning of a range of services to ensure that they are offered at sites that are convenient for users.
- Commissioners and providers promote innovation in service development.

The needs of more vulnerable groups are met

- Service provision is also targeted at groups with particular needs who may be vulnerable and at risk from poor sexual health, including young people, gay and bisexual men, some black and minority ethnic groups and people with learning disabilities.

National support for local commissioning

A standard public health contract has been published for use at local level. This will be supported by a model sexual health service specification which will be published shortly.

Public Health England

Public Health England (PHE) will formally take up its duties on 1 April 2013. PHE will play a key role in improving public health at both the national and local level, working closely with a broad range of both national and local stakeholders. PHE will have a strong health improvement capability. It will also provide specific support to local commissioners of public health services, including sexual health services.

PHE will have flexibility in relation to how it supports local authorities and CCGs, but it is likely that the support it is able to offer on sexual health will include:

- provision of evidence-based advice on how to improve sexual health;
- helping local areas to embed activity designed to reduce health inequalities into the commissioning of sexual health services;
- working with professional and other bodies to develop commissioning tools such as NICE standards, service specifications and standard contracts;

- taking the lead on workforce development and helping local areas to improve the capacity and capability of their sexual health workforces;
- helping local areas to develop plans to monitor outcomes and quality assure the sexual health services they offer;
- facilitating collaborative working, such as collaborative commissioning undertaken by a number of local areas, and helping to set up professional networks;
- providing costing and other tools to help local areas to provide effective and cost-efficient services and interventions; and
- commissioning national level social marketing and behaviour change campaigns, and helping areas to make links between their own locally based behaviour change work on improving sexual health into broader national level work.

PHE will also lead on health protection issues. They will ensure that local areas receive up-to-date sexual health surveillance data, and will work with local areas on managing any outbreaks, for example of syphilis.

PHE will develop its own methods of working with local areas to ensure that they have the information and support they need. However, there are also resources that are currently available to commissioners to ensure that strong services are in place from April 2013.

Sexual health service development

There have been major changes in the way that sexual health services are provided to the millions of people who use them each year, including service integration and innovation and provision of information and interventions designed to help people to adopt healthier sexual behaviours.

In the past, STI testing and treatment and contraception were provided in different settings. In many areas, these services have integrated so that people only need to visit one clinic for all their sexual health needs. This improves outcomes for patients and is more cost effective for service commissioners. Within integrated services, clinics can be organised to provide targeted sessions for different populations and age groups. Abortion providers are now offering a wider range of services, such as STI and HIV testing and contraception, to help meet the range of current and future sexual health needs. Sexual health services can also provide opportunities for the immunisation of groups at risk of hepatitis B infection, and for offering hepatitis C and hepatitis B testing to those in at-risk groups (for example by offering hepatitis C testing to gay and bisexual men with HIV, or to people who inject drugs). It is crucial that this joined-up approach continues.

General practice is the largest provider of sexual health services – particularly the provision of contraception – and is the most frequently chosen first point of contact for those with sexual health concerns. The NCSP has driven the greater involvement of general practice and community providers in STI management. With appropriate training, GPs can also play an important role in HIV testing and identifying those who are HIV positive, particularly in high-prevalence areas. However, many general practice staff have not had specific sexual health training and are often reluctant to raise or discuss issues due to a fear of causing offence, the sensitivity of the subject matter and constraints around time and expertise. Training, including e-learning courses, can support GPs and practice nurses in enhancing their skills and confidence in sexual health issues.

A recent study of GPs in Haringey evaluated the impact of an educational intervention (with no financial incentive) for GP practices. It found that:

- the intervention was associated with a substantial increase in the number of HIV tests done over a 19-month period;
- the number of HIV-positive diagnoses identified in Haringey general practices rose from an average of 9.5 per annum before training to a projected 22 per annum after training (on the basis of the last six months' data); and
- the highest increases in HIV testing were seen in the locality with the highest prevalence of HIV.

Encouragingly, increasing numbers of practices are providing a range of more specialist sexual health services, and we want to see this trend continue.

Pharmacists are also offering a wider range of provision, and services are being set up in non-traditional locations such as schools, colleges and youth clubs. This has helped to bring more vulnerable groups into contact with services. New technology, such as smartphone apps, is now being used to communicate with patients, deliver testing results and help patients to access information about sexual health. New technology can also support HIV patients through programmes such as 'myHIV'.

Many clinics are now using IT to collect information about patients and the services they have received, and to monitor outcomes. However, access to IT is still patchy – particularly in community clinics – which needs to be addressed to ensure that comprehensive and high-quality data is rapidly available at the local and national level. Good IT can also help with the development of fairer payment systems and to make services more cost effective.

Sexual health managed networks and collaborative commissioning have helped to ensure that clinical governance, professional guidelines and NICE quality standards are in place, and that services are commissioned around patient need and best value. They can provide a framework for the development of shared protocols, audit and training, with the network empowered to lead transformational change across organisational boundaries.

Commissioners and services need to continue to consider how they can integrate and innovate to offer better, more cost-effective services.

Clinical governance

It is essential that commissioners and providers have arrangements in place to ensure that people receive safe, high-quality sexual health services provided within robust clinical governance systems. DH will publish guidance for local authorities shortly.

Surveillance and keeping up to date with emerging challenges

It is essential that local areas use the surveillance data available to them in order to keep up to date with emerging challenges in sexual health and respond accordingly. High-quality information is key for the measurement of sexual health morbidity, to identify and target high-risk groups, for service planning, and to monitor and evaluate initiatives designed to improve sexual health. At present, there are a number of national data collections on sexual health, although the long-term plan is to integrate these as far as possible in order to develop a single data collection. Local areas can also collect their own data, tailored to their own needs and priorities.

There are a number of tools available that provide up-to-date surveillance information. For example, Public Health England has developed a local authority sexual health balanced scorecard. The scorecard brings together 20 indicators related to sexual health, which can be used to measure and compare differences between local authority areas. The PHE has also developed an index of sexual health deprivation, which combines information on HIV, other STIs, teenage pregnancy, abortion and reproductive health complications, including bringing cervical cancer into a single measure. The index ranks the sexual health of areas from the lowest to the highest.

Tariff development

DH has introduced a payment by results currency for adult HIV outpatient treatment (excluding the cost of drug therapies). The currency is based on a year of care patient pathway and will inform further tariff development work.

NHS London led on the development of a local tariff for integrated sexual health services. While these tariffs will not be mandatory for local authorities, they could be used to help local areas to:

- secure improvements in integration and innovation;
- obtain value for money and improvements in productivity; and
- further promote service integration.

Further work will be undertaken to support the future development of a system of tariff payments that local areas may choose to use.

Workforce development

The sexual health workforce is diverse and includes specialists and generalists. The former include specialist doctors and nurses in community and reproductive health and genito-urinary medicine and HIV. The latter include GPs, practice nurses, pharmacists, school teachers and college tutors. Safe, efficient, cost-effective and high quality care relies on the right mix of staff with the right mix of skills. Local areas should know of all the professionals who are part of their sexual health workforce, and that their skills are used to best effect. For example, using trained healthcare assistants for basic tasks can free up both nurses and clinical staff to undertake more complex clinical care.

Arrangements should be in place for continuing professional development, and staff should be supported to undertake appropriate training and development. Professional organisations such as BASHH, FSRH, the British HIV Association (BHIVA) and the Royal College of Nursing (RCN) can advise local areas on providing training for their staff. Non-specialist staff may need additional education and training; a recent study found that one in ten teachers did not know that chlamydia is an STI.[91]

Patient and public involvement

Patient and public involvement (PPI) comprises involving, consulting and listening to patients and the public in order to make services responsive to patients' needs, improve clinical outcomes and patient experience, add value to services and support good governance. PPI presents particular challenges for sexual and reproductive health services due to stigma and confidentiality issues. The London Sexual Health Programme has developed a website to provide a practical and useful 'toolkit' that can help to implement PPI in sexual health services[92].

Future developments

There is a range of service and technological developments that are likely to impact on service provision and interventions:

- The development of Point of Care Testing (POCT). POCT for STIs and HIV can shorten clinical pathways so that diagnoses and appropriate treatment will be available in a much quicker timeframe.

91 Westwood Jo and Mullan Barbara, Knowledge and attitudes of secondary school teachers regarding sexual health education in England, Sex Education, Volume 7, Number 2, 2007

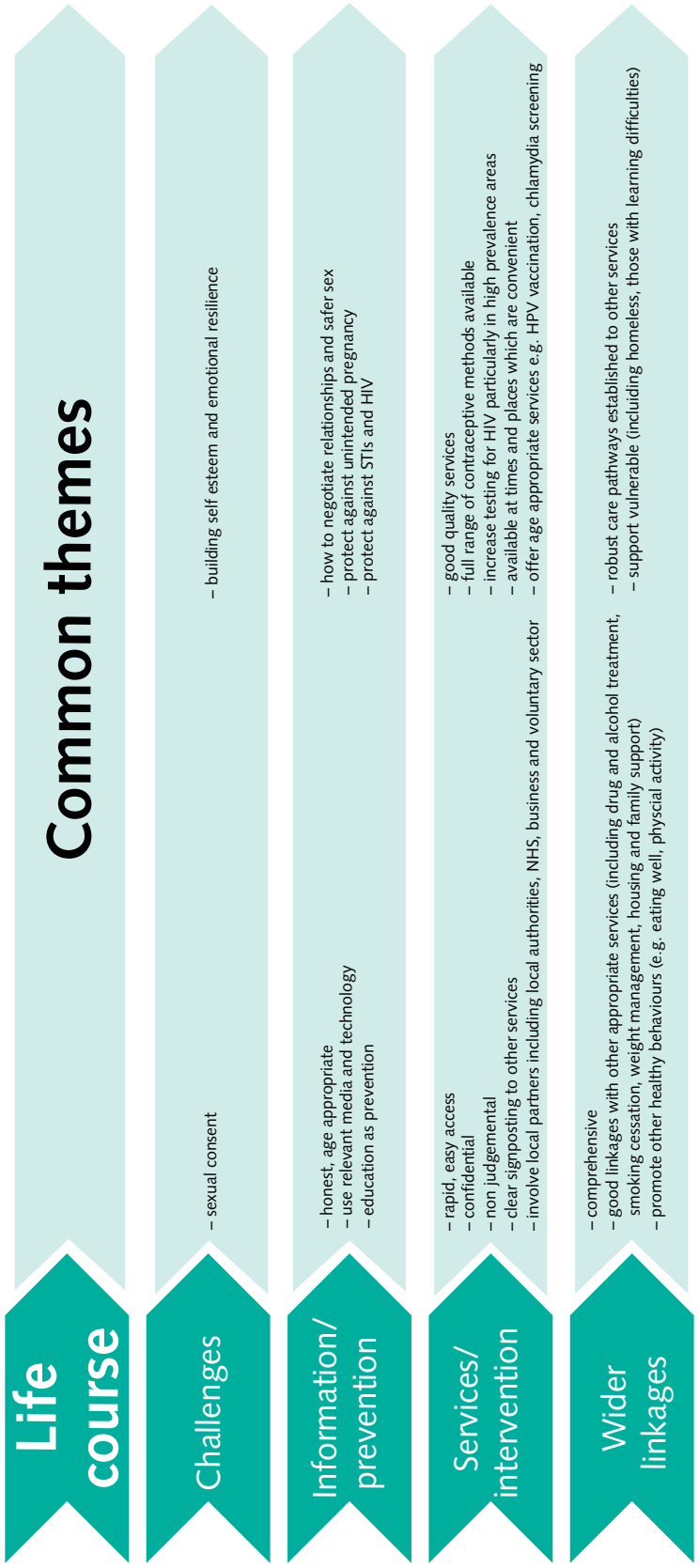
92 See www.londonsexualhealth.org/ppe-toolbox

- Pre-exposure prophylaxis (PrEP) can reduce HIV acquisition in HIV-negative individuals. PrEP represents an opportunity to strengthen HIV prevention delivered through clinics and in the community. There is a need for large-scale clinical trials to evaluate the possible public health impact of PrEP in the UK
- Advances in contraceptive products and devices.
- The development of mobile technology and smartphone apps that can test for some STIs.

Conclusion

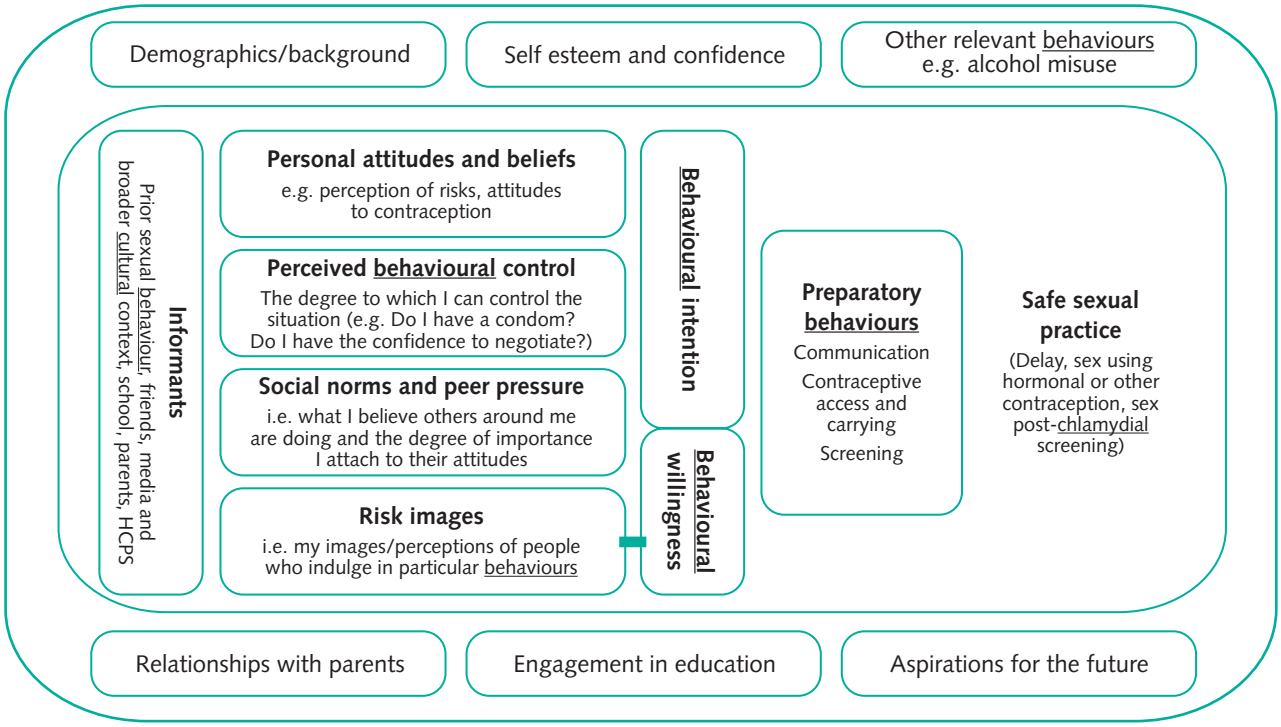
This document sets out the evidence base for improving sexual health and reducing inequalities. Individuals, commissioners, sexual health service providers and the voluntary sector all have roles to play; leadership and support will be available from PHE. Everyone needs to work together to achieve our ambition to improve sexual health and make a real difference to people's lives.

Annex A: Sexual health across the Life Course



Life course
To age 10
11-15
16-24
25-49
50+
Challenges
– naturally curious
– potential exposure to increasingly sexualised imagery
– sexual consent
– developing sexuality, self esteem, emotional resilience
– teenage pregnancy
– tackling sexual bullying
-puberty
– most sexually active
– highest number sexual partners
– STIs, unintended pregnancies
– forming long term relationships
– planning families
– promoting childrens health
– sexual dysfunction
– reticient to seek help
– newly forming relationships
– menopause
– sexual dysfunction
Information/ prevention
– role for parents and schools (including teachers and school nurses)
– use of technology advances
range of sources
– role for parents and schools
– protect against unintended pregnancies and STIs
– relationships and how to negotiate safer sex
– cover STIs, HIV and contraception
– help for parents to talk to their children about relationships and sex
– inform about risks faced
Services/ intervention
– support for parents, teachers, school nurses
– support parents, teachers, school nurses
– challenge misconceptions
–build resilience
– good quality (You're welcome)
– support for educational professionals
– full range of contraceptive methods
– testing for STIs and HIV
– take acount of particular needs
– available at times and in places which are convenient
Wider linkages
– other healthy behaviours (e.g. eating well, physical activity
– more intensive services for some children
– Smoking, alcohol, drug misuse
– support vulnerable (homeless, learning disabilities)
– Drug and alcohol treament, smoking cessation, weight management, housing and family support
– robust, care pathways

Annex B: Model of influences on safer sex practice



Annex C: Additional resources and suggested actions for local areas

Prevention

Latest data	• Evidence from the 'Got it Covered' campaign in 2009 showed that young people did not want to carry condoms for fear of being perceived as promiscuous. • In a recent study, around 20% of young people said that they had recently had unprotected sex with a new partner and only one-third said that they always used a condom. • A recent study showed that some women, particularly young women, did not have the correct perceptions about their own fertility, which meant that they were less likely to use contraception.
Target groups	• Everyone in the population – but particularly vulnerable groups such as young people, gay and bisexual men, homeless people, prostitutes and black populations
More information	• Terrence Higgins Trust • FPA • NHS Choices

Suggested action for local areas

Information/ education

- Ensure that information about local services is available in a range of formats, and is widely available from a range of outlets.
- Use local indicators to monitor and evaluate the success of any prevention initiatives.

Services/ intervention

- Interventions designed to prioritise prevention should be developed in line with the latest evidence, and firmly linked into the wider local public health prevention agenda, as well as linking with the provision of local services.
- Services should be commissioned against a robust assessment of local need. Services should be available at all times and in settings which are convenient for people and should offer rapid access.

Wider linkages

- Systems/networks ensure collaboration and intergration on promotion and prevention initiatives in line with up to date evidence and behavioural insight.
- Ensure that there are robust care pathways between sexual health services and all other relevant services, particularly alcohol and drug misuse services, and services for the victims of sexual exploitation, violence and assault.

Sexually Transmitted Infections

Key Facts

- Main preventable cause of infertility (particularly in women)
- Untreated STIs facilitate HIV transmission by increasing both HIV infectiousness and HIV susceptibility
- Certain types of human papillomavirus are linked with cervical and other oral and genital cancers
- Increasing numbers of STI outbreaks have emerged in recent years, including previously rare infections such as Lymphogranuloma venereum (LGV)
- Gonorrhoea is becoming more difficult to treat, as it can quickly develop resistance to antibiotics
- Most people with chlamydia do not have symptoms

Latest data

- There are over 400,000 diagnoses of STIs in England every year
- Young adults and gay and bisexual men are at greatest risk of getting an STI
- Diagnoses of infectious syphilis are now at their highest since the early 1950s
- LGV epidemic in gay and bisexual men since 2003
- Increase in cases of shigella, a gastrointestinal infection usually associated with travel abroad, acquired through sex between men in the UK

Target groups

- Young heterosexuals
- Gay and bisexual men
- People in areas of high deprivation
- Some black and minority ethnic populations

More information

- Public Health England, British Association for Sexual Health and HIV

HIV

Key Facts

- Remains a serious communicable disease for which there is no cure or vaccine
- The most deprived areas have the highest prevalence of HIV
- Most people living with HIV can now expect a near-normal life expectancy if diagnosed early and they take their treatment correctly
- Regular HIV testing and early diagnosis are key parts of HIV prevention
- Antenatal screening for HIV has resulted in very few babies (2%) being born with HIV

Latest data

- An estimated 96,500 people in the UK were living with HIV in 2011, of whom a quarter are unaware of their infection
- 6,280 new HIV diagnoses in the UK during 2011
- More than one in five people with diagnosed HIV in the UK are aged over 50 years
- Almost half of adults newly diagnosed with HIV were diagnosed after the point at which treatment should have started
- More than two million HIV tests performed annually in England

Target groups

- Gay and bisexual men
- Black African communities originating from sub-Saharan Africa
- Individuals living with HIV

More information

- British HIV Association
- Public Health England
- Terrence Higgins Trust
- Medical Foundation for AIDS and Sexual Health
- National AIDS Trust

Contraception and Unintended Pregnancy

Latest data

- Condoms and the pill remain the most popular methods of contraception
- Recent increase in women choosing long-acting reversible contraception
- Number of women using clinics to obtain their contraception has remained at about 1.1 million each year for the past ten years
- Number of men using clinics has increased from 92,000 in 2001/02 to 162,000 in 2010
- Around 50% of pregnancies are unplanned
- Abortions increased slowly until 2008 and remain stable
- Repeat abortions have risen over the past decade, with a further 2% increase in 2011 when 36% of all abortions were repeats
- Access to abortion has improved over recent years. In 2010, 96% of abortions carried out in England were provided free on the NHS and 91% were carried out before the thirteenth week of gestation

Target groups

- All women of reproductive age
- Black women are at the highest risk of repeat abortion

More information

- Faculty of Sexual and Reproductive Healthcare
- Royal College of Obstetricians and Gynaecologists
- FPA

Preventing Teenage Pregnancy

Key Facts

- Teenage pregnancy is associated with poverty, low aspirations and not being in education, employment or training
- Evidence of an association between alcohol use and teenage conception, regretted sex or forced sex
- Teenage parents are at greater risk of poor mental health
- Evidence suggests that, for effective prevention work, young people need a comprehensive programme of sex and relationships education, and access to young people-centred contraceptive and sexual health services

Latest data

- Substantial decreases in the rate of under-18 conceptions over the past decade
- In 2011, the rate fell to 30.7 per 1,000 women, the lowest level since records began
- Progress of local authorities varies. In 2011, those in the North East had the highest rate (38.4 per 1,000 women), and those in the South East had the lowest rate (26.1 per 1,000 women)
- Approximately half of conceptions among those aged under 18 will end in abortion

Target groups

- Young women and men aged under 18
- Parents of young people aged under 18

More information

- Department for Education
- Brook
- Faculty of Sexual and Reproductive Healthcare
- Sex Education Forum

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