



# *Effective Commissioning of Sexual Health and HIV Services*

A Sexual Health and HIV Commissioning  
Toolkit for Primary Care Trusts and Local  
Authorities

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*Department of Health*

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Toolkit for Primary Care Trusts and Local  
Authorities

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**READER INFORMATION**

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<b>Circulation list</b>	Ds of Social Services, Voluntary Organisations
<b>Description</b>	This document is intended for those for commissioning and providing sexual health and HIV services. It provides a summary of key aims, goals, standards and guidance on good commissioning practice for tasks, roles and responsibilities. It's intended to meet varying local circumstances and situations.
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<b>For recipient use</b>	

# How to use this Toolkit

This commissioning toolkit has been developed in response to the first national strategy for sexual health and HIV, and the implementation plan published by the Department of Health in June 2002. It represents a wide range of interests and views within sexual health and HIV services and aims to help and support Primary Care Trusts (PCTs) in exploring options for improving local services and the contribution they make to improving the sexual health of the population.

The toolkit has been designed for PCT commissioning leads and those responsible for leading on sexual health within PCTs, local authorities, and service providers in statutory, voluntary and community sector organisations. Strategic Health Authorities will also find this toolkit useful.

**The toolkit has four main sections (including eight appendices to support the contents of those sections):**

## **Section One – Introduction to the Commissioning Toolkit for Sexual Health and HIV Services:**

introduces the main aims and objectives of the strategy, and offers an overall purpose for the toolkit and context setting to support implementation. It explains why a toolkit for commissioning sexual health services will be helpful to PCTs particularly given the breadth of services that exist across a range of providers.

### ***Subsections include:***

- *Introduction*
- *National Strategy for Sexual Health and HIV*
- *Overall Purpose and Objectives of a Commissioning Toolkit*
- *Context Setting for the National Strategy for Sexual Health and HIV*
- *Why is a Toolkit needed for Commissioning Sexual Health and HIV Services?*

## **Section Two – Establishing a Framework for the Future Development of Sexual Health and HIV Services:**

acknowledges the variations of commissioning practice and skills, and provides a clear framework to support PCTs in commissioning practice, including good practice checklists and values which underpin service development and improvement.

### ***Subsections include:***

- *What is Commissioning for Sexual Health and HIV all about?*
- *Characteristics of Good Commissioning Practice*
- *Checklists for Commissioning*
- *Values*

### **Section Three – Developing Primary Care Trusts; Working towards better Sexual Health and HIV Services:**

offers a range of models for commissioning arrangements for PCT consideration, including an emphasis on the role of voluntary and community organisations and service user involvement in service planning and delivery. Section three also provides further information on funding arrangements and reviews currently underway, and includes a section on the role of the strategic health authority.

#### ***Subsections include:***

- *Developing lead commissioning consortia*
  - *Lead commissioning role*
  - *Criteria for effective commissioning consortia*
  - *Areas to be covered*
  - *Four key ways for local consortia arrangements*
  - *Use of consortia*
- *Role of the Voluntary and Community Sector Organisations (VCOs)*
- *Involving Service Users and other Communities*
  - *Obtaining patient views*
  - *New mechanisms for service user involvement*
  - *Incorporating patient views*
- *Increased Use of the Health Act and Section 31 partnerships*
- *AIDS Support Grant*
- *Funding Arrangements for HIV Treatment and Care 2002 – 03*
- *Asylum Seekers and Visitors from Overseas*
- *Role of the Strategic Health Authority*
- *AIDS Control Act*

### **Section Four – Service Policy Issues for PCTS:**

Offers detailed information on improving access to sexual health services, including considerations for PCTs in relation to the provision of levels one two and three as outlined in the national strategy. It provides best practice guidance for GP, primary care, contraceptive, GUM and HIV services, and a section on tackling inequalities in access to abortion. It discusses the role of health promotion and a brief summary of the evidence base for planning and practice. Section four also discusses the roles of nurses and health advisers and the implications for training and workforce issues which need further consideration at local and national level.

#### ***Subsections include:***

- *Introduction*
- *Framework for Improving Access to Sexual health Services*
  - *considerations for levels one, two and three*
  - *local networks*
  - *PCT considerations for developing sexual health services in primary care*
- *Recommended Minimum Elements for the Provision of Sexual Health and HIV Services*
- *GMS Contract*
- *Dental Services*
- *Prisons*
- *Best Practice Guidelines for Contraceptive Services*
  - *Elements of a best practice contraceptive service*
  - *Best practice guidelines for service provision for contraceptive services*

- *Best Practice Guidelines for GUM and HIV Services*
  - *Elements of a comprehensive GUM service*
  - *Best practice elements for GUM*
  - *Best practice elements for HIV*
- *Tackling Inequalities in Access to Abortion*
- *Health Promotion and HIV/STI Prevention*
- *Evidence Based Planning and Practice*
  - *HIV prevention evidence base*
  - *STI prevention evidence base*
- *Role of Nurses*
- *Role of Health Advisors*
- *Implications for Training and Workforce Issues*
- *Confidentiality*
- *What are the Key Challenges?*

It is recommended that the lead commissioners and sexual health leads use this toolkit to identify models which best fit their local situation and tailor a model for host consortia arrangements across their area. The checklists provide detailed guidance to assist PCTs on their current position with regard to commissioning and can be used in conjunction with the local baseline review data to monitor developments and improvements as required.

Whatever choices are made locally, sexual health commissioning and service improvements will be most effective where real partnerships are encouraged across all agencies with service users, professionals and organisations working together to effect change and modernisation.

## **APPENDICES**

These are included to provide further advice and information to PCT commissioners which will assist in developing sexual health and HIV services at local level.

- Appendix 1 Overview of Key Points in the National Strategy for Sexual Health and HIV
- Appendix 2 SW London Consortia Arrangements
- Appendix 3 Integration of the HIV/AIDS Service: South Downs Health NHS Trust Section 31 Partnership
- Appendix 4 Elements of Service for Levels One, Two and Three
- Appendix 5 Points that need Addressing when Commissioning Abortion Services from the NHS or Independent Sector
- Appendix 6 Sources of Help and Further Information for Professionals working in Sexual Health and HIV
- Appendix 7 Service Planning, Monitoring and Evaluation (including example of activity grid and ASTOR )
- Appendix 8 Example Clinical Governance Framework

# Section One

## Introduction

This document is intended for those responsible for commissioning and providing sexual health and HIV services in primary care trusts (PCTs) and local authorities. Strategic Health Authorities (StHAs) and service providers across the NHS, voluntary and community organisations will also find this toolkit of interest.

It provides a summary of recommended key aims, goals and standards for PCTs in relation to sexual health and HIV, and further guidance on good commissioning practice including checklists for local activity. Access to sexual health services particularly for disadvantaged groups and areas are referred to in the “Reducing Inequalities” section of “Improvement, Expansion and Reform: The Priorities and Planning Framework [PPF] for 2003–2006”. Although there are no specific targets in the PPF around sexual health services this is one of the few health areas that affects the majority of the population and is relevant through the greater part of people’s lives. The consequences of poor sexual health can have a long lasting and severe impact on people’s quality of life. Sexual health is also increasingly associated with poverty and social exclusion. It is therefore important that these issues are addressed and that quality services are in place. This document provides good practice guidance that sets out how best practice in this area can be achieved.

This guidance will be supplemented by a report setting out national examples of effective commissioning practice to be developed and published by the Department of Health (DH) in 2003.

The DH has commissioned work with key stakeholders across a range of statutory and voluntary agencies and organisations to develop and publish standards for service delivery across a range of HIV treatment, care and support services. The HIV and AIDS standards document will be available in early 2003. Further work has been commissioned for broader sexual health and sexually transmitted infections (STIs) standards (including partner notification) to be published in 2004. Details of effective managed service networks to support implementation of the standards and best practice guidance will be published in 2003.

A health promotion toolkit, a manual for health advising practice and a training strategy are also being developed and will be published shortly. This commissioning toolkit should therefore be used in conjunction with the standards documents and health promotion toolkit as they are published, as a means of providing best quality, appropriate sexual health services at local level to those who need them. All these documents will be available on the DH website.

### National Sexual Health and HIV Strategy

The first national strategy for sexual health and HIV was published for consultation in July 2001 (*See Appendix 1 for overview of strategy and implementation plan*). It was backed by investment of £47.5 million to support a range of initiatives set out in the strategy.

The Government is committed to improving sexual health and reducing health inequalities, and recognises the direct links between sexual ill health, poverty, poor housing, unemployment, discrimination and other forms of social exclusion.

The main aims of the strategy are to:

- reduce the transmission of HIV and STIs;
- reduce the prevalence of undiagnosed HIV and STIs;
- reduce unintended pregnancy rates;
- improve health and social care for people living with HIV; and
- reduce the stigma associated with HIV and STIs.

The strategy acknowledges the breadth of challenges for improving sexual health and HIV services, which include a diverse range of treatment, care and prevention methods, and are therefore complex to commission. Services are delivered by a wide range of different providers, to meet a breadth of needs, to different populations. The cost of individual cases can be high. Demands for comprehensive and integrated contraceptive/Genito-Urinary Medicine (GUM) services are rising. Technology is developing rapidly, and the new treatments and diagnostic methods are expensive and HIV treatment costs are increasing in high HIV prevalence areas.

The average life time treatment cost for an HIV positive individual is calculated at between £135,000 and £181,000. The monetary value of preventing a single onward transmission is estimated to be between £0.5 and £1million in terms of individual health benefits and treatment costs.

The prevention of unplanned pregnancy by NHS contraception services has been estimated to save the NHS over £2.5billion a year.

Preventing STIs such as chlamydia will dramatically reduce the costs associated with pelvic inflammatory disease and preventable infertility. Chlamydia trachomatis infection is the most common bacterial STI in the UK and the long term consequences of infection are especially detrimental to women. It is a well-established cause of pelvic inflammatory disease (PID), ectopic pregnancy and tubal – factor infertility. It is estimated that these complications cost the NHS at least £100 million annually (Chief Medical Officer's Expert Advisory Group). Much of this cost arises because early infection is largely asymptomatic and a large proportion of cases remain undiagnosed which leads to the later development of serious complications in untreated women.

Open access to contraceptive, GUM and HIV services remains a key priority for the treatment of communicable diseases. Therefore sexual health provision in GUM, HIV and contraception services must remain open access for service users and these services must cross boundaries between strategic health and local authorities and PCTs.

By reviewing and modernising contraceptive, abortion, GUM and HIV services, PCTs can make a significant impact on local health and well being. Even simple reforms to service provision can have immediate impact on sexual health outcomes, for example, increasing access to contraceptive training for practice nurses working from GP surgeries can increase access points for young people.

A baseline review of all sexual health and HIV services was commissioned by DH in December 2001, and will have assisted PCTs, lead commissioners and key stakeholders in identifying current strengths and weaknesses, assessing and identifying existing and unmet need, and identifying local variations in health outcomes and resource utilisation specifically for sexual health and HIV services. An analysis of these reviews will be published in early 2003.

This toolkit does **not** include a framework for commissioning the following services:

- substance misuse (drugs and alcohol)

- psychosexual counselling
- treatment, care and counselling for sexual dysfunction
- breast, testicular and prostate cancers
- female genital mutilation – support advice and information services
- infertility investigation and treatment
- menopause clinics
- preconceptual and pregnancy care, midwifery and obstetrics
- gynaecology, andrology, urology and endocrinology
- genetic counselling
- gender dysphoria and gender reassignment

These services interface with broader specialist and acute services, and with GP primary care.

## Overall Purpose and Objectives of a Commissioning Toolkit

This document has been developed in accordance with the principles set out in the NHS Plan, Shifting the Balance of Power (StBOP) and the Planning and Priorities Framework. It has been developed as a national resource to support PCT commissioners and service providers, providing strategic direction, frameworks and models for service delivery and checklists to enable key stakeholders and decision-makers achieve the main aims of the national strategy.

Aimed at PCTs who are now responsible for commissioning sexual health and HIV services, it is not intended to be a blue print as to how things must be done. Rather, it is intended to be used as recommended best practice guidance that can be useful and help make sense of local situations, recognising that there is 'no one size fits all'. It aims to enable processes and mechanisms, which will lead to improvements at local level.

### **The six key objectives of this document are to:**

- provide strategic direction
- help commissioners and providers negotiate formal agreements about service planning
- provide support to PCTs and StHAs while acknowledging that they are evolving and working within a changing environment with competing demands and priorities and limited resources
- help focus on target populations and prioritise according to needs and scope for health improvement
- where appropriate help local health economies agree achievable and measurable outputs and outcomes to self-assess progress
- facilitate the allocation of local funding within an evidence based framework.

Local action plans have already been developed in response to the national teenage pregnancy strategy, and consideration should be given to how service developments can be co-ordinated with new plans developed in response to this strategy.

## Context Setting for the National Strategy for Sexual Health and HIV

The NHS Plan (July 2000) added broad expectation for joint working, seeking to ensure that the NHS and its partners work to a set of national goals and principles.

### **More explicitly these include:**

- improved quality and access to primary care
- improved quality and access to secondary care
- narrowing the health inequalities gap between socio-economic groups with a particular focus on children
- improved efficiency of NHS services (measured by fair access, quality and responsiveness)
- increased and improved patient satisfaction with services
- improved life chances for looked after children.

### **Three key priorities for this agenda are:**

- to ensure policy making is more joined up and strategic
- to make sure that public service users, not providers, are the focus by matching services more closely to people's lives
- to deliver public services that are of high quality and are efficient.

Broader health inequalities are evidenced in areas of high deprivation, with sexual ill health linked to poverty and social exclusion. As sexual ill health and HIV disproportionately affects vulnerable communities, (including gay men and black and minority ethnic communities, particularly Africans), the above mentioned recommended standards should underpin the planning and delivery of interventions and services at local level to those communities.

These recommended standards also demonstrate the importance of genuinely joined up future planning so as to encompass the broad range of clinical, treatment, care and support services for people across social care and health, education, training and housing.

### **In summary, the modernisation of sexual health and HIV services is in line with other national policy priorities including:**

- the promotion of clinical quality and service improvements
- the development of multi disciplinary and multi-agency partnerships
- improved access to quality services for treatment, care, support and health promotion
- targeted health promotion interventions, including outreach and information
- a reduction in health inequalities
- bridging the gap between health and social care provision of services
- increased contribution from GPs and practice/school/community nurses and health advisers
- the development of more patient centred services with greater user and community participation in service planning and evaluation.

Commissioners and providers will need to stay abreast of national initiatives to improve the quality of health and social care where these may impact on sexual health services. These will include the national service frameworks where commissioners will need to ensure that their activities contribute to improving sexual health wherever possible. For example, it is anticipated that the forthcoming National Service Framework for Children will incorporate elements to address sexual health issues amongst young people. The National Service Framework for Diabetes also highlights the long term implications of the disease for sexual health (the management of erectile dysfunction).

## Why is a Toolkit needed for Commissioning Sexual Health and HIV Services?

**“PCTs will want to use their local commissioning discretion to reshape how local health care services are delivered to reduce waiting times, increase responsiveness and improve clinical outcomes. They will want to ensure a focus on prevention services as well as treatment, to forge local partnerships to more effectively address health inequalities and ensure an appropriate balance between investment in primary and community services as well as acute.”**  
(HSC 2002/007)

### Securing Service Delivery: Commissioning Freedoms of Primary Care Trusts

Feedback from the strategy consultation suggests variations in commissioning practice. Many service patterns are characterised by historical patterns of spending and may not have been updated by evidence from local needs assessments or epidemiology. Commissioners of sexual health and HIV services are at different levels in their development, particularly with recent reforms as a result of StBOP, and the move from former health authorities to PCT led commissioning.

PCTs will need to take active steps to manage increasing demand and the implementation of new technologies. Though a simple concept, this may prove to be a complex process to implement in practice, not least because of organisational change, but also because it requires new structures, new systems and changes of role across PCTs and clinical, support and prevention services. The commissioning process will also require the development of new relationships and new attitudes to decision making amongst those involved.

This toolkit has therefore been developed as a national resource for sexual health and HIV commissioners and service providers, recognising that some areas will have already established excellent commissioning principles, and others may currently be developing them.

## Section Two

# Establishing a Framework for the Future Development of Sexual Health and HIV Services

PCTs can consider a strategic approach to support progressive development for sexual health work at local level. This includes identifying clear stages in partnership relationships and major factors that will impact on the commissioning process.

Commissioners will need to pinpoint their local strengths and weaknesses and opportunities for change in service provision, and consider further approaches that can be useful in identifying expertise to enable this to happen locally. Some examples of key elements for consideration for commissioning are given below, derived from work undertaken by **fpa** on service commissioning. They include:

### commissioner culture and expertise

- the way in which the role of the commissioner has been developed, the clarity with which the commissioning processes are defined, and the skills held individually and organisationally

### needs assessment

- the foundation variable, (i.e. needs assessment is the most effective method to determine the sexual health needs of communities)

### strategic planning

- defines how the future of sexual health and HIV services will be configured, how they may differ from current arrangements and suggests clearly defined milestones toward key priorities

### user involvement

- beyond tokenistic consultation, it should mean the engagement between commissioners, service providers and users that will impact on the outcomes as well as shaping priorities and strategic planning. User involvement, to be effective, should be a thread running through the commissioning process, and as such should adopt a variety of methods to encourage participation and involvement from service users

### communication

- focuses on the exchange of information and dialogue between stakeholders and the use of and relationship with the media and other forms of information sharing with the public

### **primary care focus**

- recognises the major impact of ‘Shifting the Balance of Power’, and the move to primary care led commissioning where influence on the direction, quality and quantity of sexual health provision will be determined

### **resources**

- the allocated finance and staff resources from all sources which will drive the provision of relevant services, and which must be used creatively to add value and develop services in the right direction

### **collaborative working**

- which should reflect the range of stakeholder interests and recognises that much more will be achieved through partnership approaches and strategic and financial alliances

### **education and training**

- which needs to be provided to support successful implementation of the strategy’s action plan, support professionals and enhance understanding and expertise at local and national level

### **building relationships**

- including formal and informal mechanisms which strengthen effective relationships between commissioners, providers, users and communities

### **building local networks**

- identifying the local champions that will make most impact, and identifying the range of interventions and validating them.

To develop effective PCT commissioning, there are steps that can be taken to create the right climate for changes and/or improvements in current practice. This includes an understanding and definition of what commissioning actually is.

The following section outlines the characteristics of good commissioning practice and checklists for improving local services.

## **What is Commissioning for Sexual Health and HIV all about?**

Commissioning, purchasing and contracting are not the same activity, despite the terms often being used interchangeably.

**“The purpose of commissioning is to maximise the health of a population and minimise illness by purchasing health services and by influencing other organisations to create conditions which enhance people’s health.”**

*(Ouvriet, J Purchasing for Health – Oxford Uni Press 1995, p.18)*

Purchasing health services is a narrower activity, one that is concerned with buying the best value for money services to achieve the maximum health gain.

Contracting is simply the selection of a provider and the negotiation of an agreement to provide an appropriate quantity and quality of service of payment.

PCTs will approach the challenges according to their locally identified needs assessments and epidemiology, and will address them in different ways. However, whichever approach is taken, good commissioning requires:

- Relevant and appropriate information about local service provision
- Systematic choices within and between services
- Strong partnership arrangements with key stakeholders and providers across a range of agencies and organisations in the statutory and voluntary sector.

Although the definitions clearly delineate these activities, they are in fact linked processes. Key commissioning processes are therefore the set of activities that provide a tangible connection between the assessment of need within the target population, and the delivery of health outcomes.

## The Linked Process



These key processes are cyclical. Outputs and outcomes will ultimately inform the ongoing assessment of need. What is learnt from the process should also be identified and incorporated into day to day practice.

**The key commissioning processes for sexual health and HIV services will therefore include:**

- needs assessment
- consider developing local strategy plan based on of the national action plan
- local priority setting dependent on need and epidemiology
- local plans agreed across consortia and/or partnership boards
- specifications for service delivery with all service providers across treatment, care, prevention, health promotion and support
- service level agreements with the range of statutory and voluntary providers
- service monitoring and evaluation to ensure progress to recommended standards
- outputs and outcomes against success criteria outlined in service level agreements (SLAs)
- outputs and outcomes against the success criteria in local strategy and action plans.

*(Appendix 7 provides details of good practice for service planning, monitoring and evaluation, including examples of ASTORS and activity grids)*

## Characteristics of Good Commissioning Practice

For tighter and more effective responses and to encourage closer collaboration across agencies and organisations (to improve service delivery and to provide more seamless services), the following characteristics are considered good practice:

- agree formal Board level commitment to reviewing sexual health services
- develop a joint vision for the future planning and delivery of services
- establish the gap between the vision and current service provision by reviewing local services
- identify available resources
- develop and implement local needs assessment programme
- identify local needs against epidemiological data and establish information systems to collect better information that can inform future planning
- review local service provision
- identify gaps in provision
- identify areas for improvements and prioritise those service developments according to shared vision
- establish clear arrangements for joint commissioning within the area ensuring that any joint arrangements are linked to each partners mainstream activities and budget processes
- establish stakeholder arrangements
- promote effective links between key stakeholders (GUM, contraceptive services, young people's services etc) to ensure cohesion
- consider the development of health promotion strategies to promote the engagement of socially excluded groups and improve access where problems are apparent e.g. targeted services for gay men, or African communities disproportionately affected by HIV, or young people's services to

increase uptake of chlamydia screening, emergency hormonal contraception, and STI testing (see health promotion toolkit)

- develop more effective assessment, care planning and co-ordination arrangements to ensure that the services provided match the client's level of need
- promote more multi-disciplinary processes including single assessment and single points of access into the range of services, thus minimising the risk of 'revolving door' syndrome (i.e. services users being referred on unnecessarily)
- improve the quality of support available to those target groups most affected by sexual ill health, particularly those with complex or intermittent problems
- strengthen joint working arrangements and establish multi-disciplinary teams where possible
- review effectiveness of shared care arrangements, taking into account the strengths and weaknesses of different models, new funding flexibilities, and the views of key stakeholders and service users across the range of providers and users
- review current funding provision in acute NHS Trusts and PCTs and ensure that levels of expenditure accurately reflect user needs and support
- consider the development of consortia arrangements across strategic health authority and PCT areas where patient flow warrants it and where warranted by economic factors.

## Recommended Checklists for Commissioning

### Strengthening partnership working and commissioning

- set up inter-agency planning fora at local level to oversee the needs assessment and commissioning of sexual health and HIV services
- identify a lead person within the PCT responsible for liaising with the lead commissioner for Sexual Health. This could be one and the same person or a different person depending on whether host commissioning consortia are in place
- consider the establishment of host consortia arrangements across Strategic Health Authority areas
- ensure the use of Section 31 partnership arrangements are linked to provider partner mainstream activities and budget processes
- establish effective links between planning fora and other key strategic partnerships into the commissioning process, including service user views
- promote greater emphasis on long term planning and funding cycles to promote better continuity in local service development
- provide clarity around expectations and clear statements as to who is responsible and accountable for each work or service provision area
- accumulate evidence of effectiveness of interventions and programmes, and use ASTORS (see Appendix 7 for explanation of ASTOR) to develop appropriate outcome measures of impact (also see CHAPS and Making It Count framework, managed by Terence Higgins Trust)
- share good practice and evidence of effectiveness.

### **Promoting better care co-ordination and joint working**

- develop a shared understanding of local needs assessment and identify priorities of what needs to be done to improve care locally
- define the roles and responsibilities of the different services and identify who will take the lead in driving forward new care planning arrangements
- establish and agree clear criteria for referrals between services and how they will be dealt with. Include the criteria in Service Level Agreements (SLAs)
- set clear criteria and common procedures for assessment to reflect a multi-agency, disciplinary and integrated approach
- agree training and development needs arising from the introduction of new arrangements and how these will be addressed
- consider how users could be involved in developing those services.

### **Developing more flexible approaches**

- strengthen sexual health services across the range of providers to enable flexibility according to local needs identified by providers and users
- introduce shared guidelines, protocols and procedures with partners across the range of service providers.

### **Improving support to primary care**

- assess the elements included within the 3 levels for service delivery set out in the strategy, and identify local specialist and primary care providers of these levels
- introduce a local shared care policy (where relevant) agreed with clinical governance leads within acute trusts and PCTs
- introduce parallel care for patients with stable quasi chronic conditions
- take account of the views of GPs and other stakeholders including the Local Medical Committee (LMC) and PCT on the introduction of a shared care scheme
- consider further the role played by practice, community and school nurses and health visitors in supporting vulnerable patients, and ensure adequate training and support for nurses wanting to develop their sexual health promotion role
- identify wider training implications for primary care providers and consider resources available to support training needs.

## **Values**

PCTs should make explicit the values which underpin their local sexual health service provision and development and can encourage providers and users together to make effective interventions for sexual health gain. Explicitly stated values are considered important particularly for sexual health services as concerns about stigma and discrimination for people with HIV and other STIs, and/or women seeking abortions are widespread and affect access to relevant services. Anonymity and confidentiality are key indicators for successful access and uptake of services, and for respecting people's rights to dignity and privacy, so explicit values may improve confidence and consequently uptake of services.

Some values that PCTs may consider useful in developing with providers and users are as follows:

### **Equity**

People need access to services of quality, appropriate to their needs, regardless of race, gender, sexuality and religious and cultural beliefs. Services could offer opportunities for significant improvements in health, including reduction in diseases and disorders, and promote well being to all users, applying principles outlined in the health promotion toolkit. Commissioners and providers should recognise the interplay of other social and political factors in relation to sexual health.

### **Accessibility**

Services should be clearly advertised, welcoming and accessible to those who need to use them. They could encompass the needs of diverse communities, and make them accessible to meet those needs, including those for who English is not their first language.

### **Participation**

Services can encourage and enable users and carers to participate in the life of the community in which they live. Information on and referrals to other agencies, organisations and/or groups in the local area facilitate participation for service users. Where possible, user feedback can be fed into the commissioning process, via service providers.

### **High Quality and Best Value**

Services should be provided at high quality and at the best value within available resources.

### **Positive Image**

Services need to recognise that people seeking sexual health services may find it difficult to ask for assistance with some issues. They could ensure that the service views both itself and its service users in a positive light.

### **Effectiveness**

Services can be encouraged to look at evidence of effectiveness in relation to their service delivery, and ensure that this is monitored and evaluated as part of the service level agreement monitoring.

# Section Three

## Developing Primary Care Trusts – Working towards better Sexual Health Services

The principal commissioning responsibility for the successful implementation of the national strategy lies with PCTs, working in partnership with local authority commissioners and with support from Strategic Health Authorities. This section sets out guidelines for:

- the development of lead commissioning arrangements
- the development of commissioning structures
- the use of the Health Act (1999) flexibilities to develop joint health and social care commissioning and service delivery
- the involvement of voluntary and community organisations
- the involvement of service users
- national monitoring requirements
- maximising support from StHAs
- asylum seekers and overseas visitors.

### Developing Lead Commissioning Consortia

The national sexual health and HIV strategy recommends an approach to local commissioning of sexual health services summarised as follows:

- use of a multi agency and multi disciplinary steering group to develop and implement a local action plan in response to the strategy
- shared understanding of local needs and identification of priority populations
- linking local work to a wider policy context
- work in partnership with other agencies and service users
- development of a community and patient focus
- identification of current resources including those which need development
- establishment of local targets for monitoring the development, implementation and outcomes of plans.

In order to maximise limited resources, PCTs can consider developing local strategies based on the national implementation action plan. By integrating improvements in sexual health services within broader strategic objectives (e.g. local health improvement and modernisation initiatives, neighbourhood renewal programmes, new deal for communities initiatives, teenage pregnancy strategy action plans), PCTs can achieve even more.

A local consortium of PCTs working together will require a **lead commissioner** who can act on behalf of the consortia and ensure a seamless approach to the commissioning of local sexual health and HIV services.

*(see Appendix 2 for SW London Consortia arrangements)*

**Recommended Criteria for an effective commissioning consortia can include:**

- identification of a lead PCT and commissioner
- identification of a public health network of support across PCTs and with the medical director or director of public health at the StHA
- identification of the means to involve providers and users
- establishment of formal delegated responsibility from all PCT stakeholders
- delegated budgetary powers from PCTs to host commissioner
- development of a single commissioning plan for each consortia
- Chief Executive and Board level commitment across PCTs and StHAs.

**A lead-commissioning role will be necessary to:**

- co-ordinate the consortia's work and lead the development, implementation and monitoring of national and local action plans with a multi agency planning group, including NHS services, voluntary and community organisations, service users and community representatives, and specialist HIV/sexual health promotion representation. The group should also be responsible for monitoring implementation of its agreed plan
- establish, with the lead PCT, full and delegated authority from consortium members, including delegation of agreed budgets across all of the HIV and sexual health service areas
- manage the budgets on behalf of the consortia members
- develop processes to maintain consortium support across the range of work and ensure maximum participation from all partners
- develop a single commissioning plan for the consortium
- determine who will enter negotiation arrangements with service providers for SLAs, performance management and implementation
- clarify reporting arrangements for SLAs and contract monitoring.

## What areas can be covered by Commissioning Consortia?

Areas covered can be determined by how specialist services are currently commissioned.

**Further areas for consideration at local level may include:**

- ante natal HIV testing
- HIV prevention
- voluntary sector support and service delivery
- respite and palliative care

- community mental health services for people living with HIV (although further work may be required to disentangle open access services currently provided via some acute settings)
- contraceptive services
- community based GUM and family planning and integrated sexual health services
- specialist contraceptive services
- abortion services
- use of Personal Medical Services (PMS) resources to enhance the development of primary care.

It will be for local PCTs to agree whether the broader sexual health services will be included within local consortia arrangements.

## Four key ways for Local Consortia Arrangements

**There are four key ways this can work:**

- *formal consortium with pooled budgets and lead commissioning arrangements* – it can make sense for one PCT to undertake the commissioning for its neighbours. This is already common practice in some areas, but in areas of high local HIV prevalence the PCT with the highest prevalence and therefore highest needs may be best placed to take on this role and develop a formal consortium arrangement. It is an alternative form of “clubbing together”, but the group of PCTs involved have greater input to the commissioning decisions, with one taking the lead. It provides an opportunity to commission a range of services from a single point and provide a level of co-ordination which will benefit the service user and may be more effective and cost efficient
- *separate contracts with providers for treatment care and prevention, but shared risk around drug treatment costs* – concentrating a set amount of HIV treatment funding on drug treatment costs to ensure that the treatment funding is allocated to where the patients choose to attend for treatment
- *separate budgets with a co-ordinated approach to service developments, and agreements as to investment*
- *networking on local LDPs-delivery plans intentions, but PCTs act independently of each other and the only consortia arrangements are those which identify need and agree the allocation of resources.* This may happen where the PCT is large and covers a population with significant HIV need. Treatment and care for other sexual health services (e.g. contraceptive services, GUM) can be managed under consortia arrangements.

## Use of Consortia Arrangements

The use of these consortia arrangements can:

- enhance and maximise the commissioning power of PCTs
- maximise resource distribution
- share and minimise financial risks around HIV drug treatment costs, minimise transaction costs and simplify cross charging arrangements
- ensure provision of a range of care and elements from levels 1, 2 and 3 across geographical areas

- share and make best use of specialist staff and services for sexual health
- enable service users to be geographically mobile across PCT boundaries, and ensure open access and anonymity where required
- work together to safeguard service quality, range and access
- work together to minimise the need for multiple service negotiations and avoid unnecessary overheads and service duplication e.g. minimise the bureaucracy in contracting arrangements
- develop appropriate risk sharing arrangements for treatment and care costs
- explore the potential for a purchasing consortium for antiretroviral therapies and other drug treatments as appropriate
- develop a standard approach to cost pressures, data collection, monitoring and validation
- assess the adequacy of current epidemiological data, including future projections and commissioning additional data as required
- use baseline review data to map current configuration of inpatient and outpatient services, and develop mechanisms and processes for change, including the implementation of managed service networks.

A consortia approach is likely to benefit most areas and enhance service development through the use of flexible budget arrangements and shared resources.

## The role of Voluntary and Community (VCOs) Sector Organisations

The voluntary and community sector (VCOs) is diverse, encompassing many different types of organisations. Some are large, covering a range of activities, whilst others are small with specialist knowledge in just one area. VCOs have an important contribution to make to the modernisation of sexual health services. In many areas, they are well placed to achieve this because of:

- their in depth expertise and knowledge of sexual health and HIV
- their reputation with patients and consumers, and the confidence which they are held in by these groups
- their efficiency, as many voluntary organisations do not have the same level of overheads and infrastructure costs as larger NHS organisations, many make use of volunteers, and some raise money from charitable sources to support local services.

VCOs are particularly well placed to make a contribution in the following areas:

**Delivery of health promotion services** – VCOs with health promotion expertise have a role to play in the delivery of sexual health promotion and HIV prevention services. This role will particularly centre around the delivery of community based health promotion services which should be seen as an essential and complementary partner to clinic and surgery based services.

**Delivery of social care services** – many VCOs have significant levels of social care expertise, e.g., signposting, advice, information, and advocacy. These should be treated as important parts of local care networks. In addition, in some areas, VCOs may be able to help PCTs and social services departments take advantage of Health Act 1999 flexibilities, by providing a focus for pooled budgeting and integrated joint working.

**Delivery of clinical support services** – some VCOs have substantial expertise in the provision of clinical support services, for example, pre HIV test discussions and post test counselling, pregnancy counselling, focused counselling for people with HIV, treatments information and support, and sexual health and HIV health advocacy. Such services might be delivered under a healthy living or expert patient programme. Such services should be integrated with broader health provision in these areas.

**Delivery of peer support services** – many VCOs have substantial expertise in delivering peer support services to help people with HIV maximise their health and social well being.

**Support to the commissioning and planning process** – many VCOs have a lot of information about local needs and about the views of local patients and ‘at risk’ groups. To make best use of this information, these organisations should be involved in local commissioning and planning work.

**Support to statutory providers** – some VCOs are well placed to provide second tier support such as training, policy/practice development, and printed resources to enable patients and professionals to work together to maximise health outcomes.

To enable VCOs to optimise their contribution to the modernisation process, PCTs can consider the following:

**VCO involvement in commissioning and planning** – PCTs can establish the levels of local expertise in voluntary organisations and ensure this can be used to best effect in planning work, for example contributing to needs assessment work. VCOs can be involved in health improvement and modernisation teams and local multi agency planning teams on the same basis as statutory agencies, and may be encouraged and supported to do this.

**VCO involvement in service delivery** – PCTs can ensure a level playing field for statutory and voluntary organisations. Robust and transparent commissioning processes can be established to ensure VCOs have the same opportunities to tender for and deliver appropriate services as PCTs and NHS Trusts. Wherever possible, three year funding agreements could be considered, with constructive and supportive contract management to back this up. PCTs can also ensure that VCOs delivering services have access to local capacity building and work with local Workforce Development Confederations. Capacity building and support will be particularly important for small community based organisations such as African HIV community groups.

PCTs can, at the outset, undertake a stocktake of local VCO capacity and expertise. They can also make explicit any eligibility criteria for any funding or service developments, be clear on who key contacts are and be transparent about processes and timetables which may affect and/or involve VCOs.

## **Involving Service Users and other Communities**

**“The NHS of the 21st Century must be responsive to the needs of different groups and individuals within society; and challenge discrimination on the grounds of age, gender, ethnicity, religion, disability and sexuality. The NHS will treat patients as individuals, with respect for their dignity. Patients and citizens will have a greater say in the NHS and the provision of services will be centred on patient needs.”**

*(NHS Plan July 2000)*

Both documents, ‘Shifting the Balance of Power’ and the national strategy for sexual health and HIV, reflect a desire to achieve a cultural shift within sexual health and HIV services in relation to user

involvement. As such, PCTs may establish involvement mechanisms which enable users to make an effective contribution to:

- evaluating and improving the quality of existing sexual health and HIV services
- developing PCT & social services commissioning plans for sexual health and HIV
- developing managed care networks.

Achieving genuine and effective involvement is not easy, as many people using sexual health and HIV services are stigmatised, and suffer from marked health inequality. In addition, many people use sexual health services on a confidential, and time limited episodic basis, and this presents real challenges for achieving consumer involvement.

## **New Mechanisms for Service User and Community Involvement**

### **Patient Advice and Liaison Services (PALS)**

Every NHS Trust, including PCTs will have established one of these from April 2002. These are customer care services helping individuals with information, problem solving and referral to independent advocacy if necessary.

### **Patient Forums**

Following legislation in 2002, every NHS Trust (including PCTs) will have a patient forum, recruited from users and community groups. The forum will have an independent role, monitoring services and contributing to trust decisions from the patients' perspective. Patient forums should become integral to NHS decision-making processes.

### **Local Authority Scrutiny**

Following legislation in 2002, every local council will have a role in overseeing the decision making of the NHS, introducing an element of formal democracy to local health services. This will mean more involvement of local councillors as a point of influence for change in the NHS

PCTs may consider establishing a mechanism by which they will ensure that the views of patients can be obtained and taken into account in sexual health and HIV planning work.

To achieve this PCTs can aim to establish mechanisms for obtaining patient views on need and services, and the means of incorporating these within planning work. PCTs can ensure rigour in the collation of patient views, and transparency in the way these views are reflected in local planning and commissioning work.

**Obtaining patient views** – There are a number of ways of achieving this including:

- use of point of service delivery mechanisms, e.g. use of GUM clinics as a means of seeking the views of people waiting to see a doctor, or awaiting results. This might either be done 'face to face', by use of an 'in clinic' self completion questionnaire, or by use of 'in clinic' focus groups
- use of easy to understand language (including non English languages where appropriate) in all work obtaining patient views
- use of advocacy groups and VCOs as a means of supporting the articulation of service user views, either on an ongoing basis, or on a 'one off/project basis'

- development of PCT and Patient Forums to accommodate confidential discussion of stigmatising conditions, e.g. through use of a closed sexual health/HIV sub group
- development of patient forums in HIV services where patients have longer term service usage
- use of patient advocacy/voluntary organisations in a consultative and facilitative role
- requiring all providers to establish local mechanisms for soliciting the views of patients.

**Incorporating patient views within planning work** – there are a number of ways of achieving this which PCTs could consider, including:

- involvement of patient forum representatives within health improvement and modernisation planning groups and/or multi-agency planning teams.
- identification of officer responsibility for ensuring the views of patients are incorporated within planning discussions
- use of patient advocacy groups/voluntary providers to collate the views of patients
- involvement of patient advocacy groups/voluntary providers to articulate the views of patients within health improvement and modernisation and multi-agency planning teams (including teams developing care networks)
- use of patient advocacy groups/voluntary providers to support patients to contribute to local authority scrutiny work.

### **The Commission for Patient and Public Involvement in Health**

Following legislation in 2002 this new statutory body will set national standards for NHS patient and public involvement work. The commission will have local networks charged with developing the ability of communities to contribute to health decision making, supporting patients forums, commissioning independent complaints services and broadly enabling partnership approaches to public involvement.

*Adapted from NHS in 2002: preparing for change. HDA Briefing Paper for HIV Voluntary Organisations and people living with HIV. NHPIS 5.*

### **Increased use of Health Act and Section 31 Partnerships**

There is widespread support for government policy on partnership working, integrated services and quality user centred services. Local partners can create systems and structural arrangements that are flexible, locally appropriate and relevant to local needs.

The Health Act 1999 makes co-operation between NHS bodies and between the NHS and local authorities mandatory. The provisions allowing use of the flexibilities are enabling and allow NHS bodies or local authorities to delegate functions to a partner in the statutory or voluntary sector. They will retain liability for the discharge of their functions. Plans can then be described within the local health improvement and modernisation initiatives.

Users of services require responsive services co-ordinated to meet their needs. The partnership arrangements in the Health Act have been developed to give NHS bodies and local authorities the flexibility to be able to respond effectively, either by joining up existing services, or developing new co-ordinated services. These arrangements build on existing joint working but offer the opportunity for further innovative approaches to user focused services.

The partnership arrangements are provided for in sections 26 – 32 of the Health Act 1999.

In summary they cover:

- Section 26 – duty of co-operation between NHS bodies
- Section 27 – amending Section 22 of the NHS Act 1977, co-operation between NHS bodies and Local Authorities
- Section 28 – provides the legal framework for Health Improvement and Modernisation Plans
- Section 29 – amending Section 28A of the NHS Act 1977, which allows payments by Health Authorities to local authorities to NHS bodies for prescribed NHS functions
- Section 31 – introducing the operational partnership arrangements
- Section 32 – the removal of the statutory requirement for Joint Consultative Committees

The partnership arrangements are operational tools intended to be used in a wide number of situations where joining up services or resources will help to achieve better outcomes for users. They should enable the effective implementation of the sexual health and HIV strategy and facilitate links with other local and national agendas including social inclusion, neighbourhood renewal, teenage pregnancy action plans and health improvement and modernisation initiatives at local level.

Health services provided by the NHS can be joined more closely with functions of local authorities which are health related. It will be up to local commissioners and providers to determine why a local authority service has a health-related function and whether to make it part of the partnership arrangement.

*(see Appendix 3 South Downs Health NHS Trust example)*

**In summary, the flexibilities are:**

Pooled budgets (the pooling of budgets to meet specific aims and outcomes) which allow PCTs and local authorities to bring resources together into a single pot and be accessible to both partners to commission and provide services. The resources would lose their PCT or local authority identity and could be used on either PCT or local authority initiatives and activities at the discretion of agreed consortia or pooled budget managers.

**Lead commissioning** (transfer of the purchasing of services to one lead agency or organisation) where one authority would be able to delegate functions and transfer funding to the other to take responsibility and manage a single budget for commissioning integrated health and social care.

**Integrated provision arrangements** (transfer of the provision of services to one agency) will make it possible to provide some PCT and local authority services from within a single service provider.

The following principal benefits to service users from better integrated health and social care have been identified, including:

- improvement in access to care
- improvement in the quality of the patient experience
- improvement in levels of health care for people experiencing health inequalities
- increase in patient self management
- maximisation of public health benefits of treatment
- improved efficiency in the use of resources.

*(Policy Guidance on Integrating HIV Health and Social Care; Terence Higgins Trust Nov. 2002)*

## Aids Support Grant

The AIDS Support Grant (ASG) was introduced in 1989/90 to encourage the development of strategic plans within local authorities to respond to HIV infection and operational plans for the provision of services to meet the needs of people living with HIV and AIDS, and where appropriate, their partners, carers and families.

The purpose of the ASG is to encourage local authority social service departments to:

- develop strategic plans, based on local population needs assessments, for commissioning social care for people living with HIV/AIDS
- finance the provision of social care for people living with HIV/AIDS, and where appropriate, their partners, carers and families
- work in close co-operation with the NHS and the voluntary sector to develop models of innovative practice in the delivery of HIV-related care services
- support the cost of HIV/AIDS training relating to social care services.

The DH has begun a review of the ASG and the allocation formula. Social care and support remains an important component of packages of care for people living with HIV, and this care has largely been provided from the ASG.

However, needs have changed over the years since the ASG was first introduced, and the distribution of people requiring social support has also shifted. The success of combination therapies in delaying the progress of HIV, and the increasing numbers of women and children from black and minority ethnic groups requiring help and support have led to changes in the package of social care provided by social work departments and others. Dispersal of asylum seekers to areas outside London is beginning to have an impact on the planning and provision of care and support in areas where formerly few required care, and all these changes need to be considered within the discussions for the future of the ASG and any alternative arrangements to take its place.

Since 1994/95 funding has been allocated on the basis of live AIDS cases resident in each local authority area receiving HIV treatment in NHS facilities. Data is obtained through the Public Health Laboratory Service (PHLS). The scheme operates on a 70:30 basis, local authorities providing at least 30% of expenditure from their own resources.

The review will focus on the ASG's allocation formula, and the continuing relevance and effectiveness of the grant in the changing climate. Any decisions arising from the review will be disseminated to LAs, PCTs and StHAs when finalised in 2003.

## Funding Arrangements for HIV Treatment and Care 2002/03

### Financial allocations

Financial arrangements for HIV treatment and prevention have changed. From April 2002, the special allocations for HIV treatment, care and prevention became part of PCTs' main allocations, using target allocations issued to former health authorities in 2001/02 as the basis for this change. PCTs are now expected to offer patients access to comprehensive sexual health services funded entirely through their mainstream allocations.

From 2002/03 the weighted capitation formula used to inform allocations of former health authorities and PCT unified funding contains an element that adjusts populations for HIV prevalence. This adjustment is based on the numbers of HIV positive persons receiving NHS treatment in the previous calendar year in each former health authority and PCT. This is then further adjusted by a market forces factor to take account of unavoidable geographical variations in cost of providing HIV/AIDS services. The HIV/AIDS element of the formula is combined with the hospital and community health services (HCHS), GP prescribing and general medical services elements of the formula to set target shares of funding for StHAs and PCTs. These target shares are then used to inform the allocation of unified funding to StHAs and PCTs.

These are the resources available to PCTs for commissioning sexual health and HIV services within their unified budgets:

- PCT funding for primary care essential and additional clinical services – if a practice opts out of some additional clinical service provision this places an obligation for the PCT to look at alternative means of provision
- PCT unified budget with a protected floor for primary care services, for use in funding primary care enhanced services
- Previously HCHS, and previously used for funding GUM, contraception and abortion services, now part of PCT unified budget
- PCT unified budget, previously HCHS ringfenced, and previously used for funding HIV community, hospital and voluntary sector services
- PCT unified budget previously ringfenced, and previously used for funding HIV prevention services
- ASG for funding community and voluntary sector services (by agreement with local authority social services).

**This guidance recommends that:**

- **PCTs and StHAs agree an equitable method to meet the validated cost pressures for treatment of their residents living with HIV/AIDS, irrespective of where they attend for treatment, providing that treatment is in line with national British HIV Association Guidelines (BHIVA).**

NHS Trusts providing treatment and care for people with HIV should ensure that relevant data is collated on out of area service users. PCTs could collate data on a host PCT basis and provide details showing numbers, unit costs and responsible PCT to cross charge at end of financial year.

**This can be achieved by:**

- Ensuring cross-charges are based on up-to-date data on patient movement and that commissioning plans keep pace with changes in epidemiology
- A fixed cost per patient or at least a guidance cost range should be agreed between host consortia PCTs across boundaries. Costs are for HIV treatment and care including drugs as outlined in the *National Specialised Services Definitions Set – HIV/AIDS treatment & care services (definition no. 14). 3.3*
- HIV treatment and care remains an open access confidential service, allowing for flexibility and rapid changes in numbers

- Close liaison with local Drug Action Teams (DATS) who manage specific substance misuse allocations, to ensure that funding for needle exchange schemes and other services which link with HIV and hepatitis prevention are developed and maintained.

The action plan highlights that following the mainstreaming of the HIV allocations, levels of investment in HIV prevention, treatment and care will be monitored centrally, including any impact on the voluntary sector.

Data on levels of NHS investment on VCOs will be collected through the AIDS Control Act (ACA) returns, and any issues of serious concern will be addressed by the StHAs, or as a last resort, by the DH Directorates of Health and Social Care.

## Asylum Seekers and Overseas Visitors

The Home Office considers very carefully the conditions under which a person is permitted to enter the United Kingdom (UK). Each application is considered on its merits and the fact that a person is suffering from HIV/AIDS is not grounds for refusing entry if the person concerned otherwise qualifies under the Immigration Rules. There are no plans to introduce routine compulsory HIV testing for entrants to the UK who are subject to immigration control.

Eligibility for free NHS treatment is based on residence in the UK, not on British nationality or the past or present payment of National Insurance contributions or UK taxes.

### Asylum seekers

People who are seeking asylum in the UK are treated as ordinary UK residents for the purposes of NHS hospital treatment. As such, they will be treated on the same basis as anyone else eligible to receive NHS treatment, including antiretroviral drug treatment for HIV.

### Overseas Visitors

There is no provision whereby visitors to the UK can automatically access free NHS hospital treatment. Visitors are entitled to an HIV test, with pre test discussion and post test counselling free under the NHS, but any subsequent treatment is subject to the NHS charging regulations, introduced in 1982. These state that there is an obligation on NHS hospitals to identify and charge liable patients, that is those who are not judged to be ordinary residents or do not meet any of the specific categories of exemption. Where charges apply, they cannot be waived for any reason.

Further guidance reminding the NHS about the operation of these regulations will be issued in due course.

## Role of the Strategic Health Authority

StHAs will have a distinct performance management role in relation to the constituent NHS organisations within their boundaries, taking over many of the functions of the former NHS Regional Offices. They will be responsible for overseeing improvement of services in line with the national strategy and that implementation stays on track.

Responsibility will include ensuring the following key tasks:

- oversee commissioning arrangements for sexual health and HIV, including multi-agency commissioning implementation of three service levels as set out in the strategy

- oversee progress in meeting the standards and goals set out in the strategy implementation action plan and performance indicators (when published)
- monitor investment in HIV prevention, treatment and care and GU, contraception and abortion services
- support and oversee Section 31 partnerships
- ensure appropriate mechanisms are in place to ensure AIDS Control Act returns contain an accurate reflection of expenditure, investment and epidemiology.

Other areas that StHAs may consider are:

- to set the tone, and reinforce appropriate behaviours and expectations for PCT and PCT consortia working in relation to sexual health and HIV
- to facilitate relationship building between PCTs and PCT consortia
- to support PCTs to meet their capacity requirements (through StHA responsibilities for Workforce Development Confederations)
- to ensure sexual health and HIV are appropriately included within StHAs and PCT local plans (relative to need).

The strategy makes explicit that specific aims and standards on HIV testing, hepatitis B vaccine and the transmission of HIV should be included within the performance assessment framework (PAF). NHS performance indicators and reporting mechanisms will be agreed, in particular to monitor progress in reducing undiagnosed HIV, newly acquired HIV and gonorrhoea infections, and increasing the offer and uptake of hepatitis B vaccine. Progress towards the recommended national standard that women who meet the legal requirements should have access to abortion within three weeks of their first appointment with a GP or referring doctor may also be introduced. These indicators will be published and disseminated in 2003.

Each StHA will need a medical director or public health doctor with appropriate strategic management skills to ensure that PCTs are performance managed in implementation of the strategy. The Regional Public Health Groups and regional epidemiologists who will be employed by the Health Protection Agency from April 2003 may provide regional support. It is important that administrative changes do not destabilise the current national reporting systems. The reporting of new diagnoses of HIV by clinicians is vital to the understanding of the changing epidemiology of HIV in England, SOPHID is vital to understanding the workload distribution, and KC60 reporting (for which the DH is supporting migration to disaggregate reporting of new episodes) will provide comprehensive monitoring data.

## AIDS Control Act Returns

Section 1 of the ACA requires a number of listed bodies to make periodical reports to the Secretary of State relating to HIV/AIDS, including the number of people in the area with those conditions, particulars of the facilities and services provided and action taken on education and prevention. These reports have been made annually by former health authorities.

This responsibility will now fall to PCTs who will ensure that the information required is reported to StHAs who will report annually to DH. DH is currently reviewing the reporting mechanisms for the ACA to ensure alignment with the national strategy. Any further changes will be made explicit to PCTs and StHAs when agreed.

The DH will produce an annual report based on the returns from StHAs, which will be widely disseminated.

# Section Four

## Service Policy Issues for PCTs

### Introduction

The organisation of current NHS sexual health care provision is complex and fragmented. It is of uneven quality and often does not effectively meet needs for treatment or preventive care.

The main elements of a modern, comprehensive sexual health service are defined as providing:

- contraceptive care and abortion
- diagnosis and treatment of STIs and HIV
- prevention of STIs and HIV
- services that address psychological and sexual problems.

This section identifies a framework for developing sexual health services across a range of primary and specialist providers, concentrating on the main elements of service needed for comprehensive packages of care and treatment. The framework proposed in this section requires local stakeholders to gain an overview of what is available in each locality, and identify gaps and priorities for action. This should support work already undertaken as part of the baseline review exercise.

### A Framework for improving access to Sexual Health Services

This recommended framework is proposed to enable local health commissioners and providers to evaluate and improve the range of sexual health services available. It makes explicit the primacy of self-referral and open-access to specific elements of clinical care and the necessity of effective local referral networks and care pathways.

The framework also highlights the need for effective information for local people of all ages about how to find appropriate care.

The framework concentrates on the elements of sexual health care currently needed by people of all ages, genders and sexuality. Using this model, rather than that of the current configurations of provider organisations enables and frames the discussions necessary to migrate to a more flexible and developmental approach to improving care.

The elements of sexual health care defined in the framework were derived from extensive multi-disciplinary discussions. The skills and facilities (both premises and equipment) necessary for delivery of each care element were identified. Each element was then associated with one of three levels of complexity (specialisation), depending on the skills and service 'dedication' necessary to provide them.

## Considerations for the Three Service Level Elements

The service level components are essentially a commissioning tool to facilitate a more systematic approach to service provision. However, levels also represent, in general terms, the level of infrastructure, training and support required to deliver the components of that level. For instance, level one components will be available from generic practitioners with other clinical responsibilities. Training to support these components will be part of existing training structures such as undergraduate and basic professional training and will be expected to be present in the majority of services to which patients may self-refer, such as primary care services and self-referral sexual health services (contraception and GUM). Level two services require specific extra training, support and infrastructure. It is likely to be impractical and unnecessary for these components to be available in all sites and it will be essential to prioritise access to level two components. Level three components are those requiring specialist skills, facilities and more substantial infrastructure. This would include components, which can require immediate hospital backup such as inpatient HIV services and abortion services.

Providers in any setting may include elements from each level. Few, if any, will provide all. Explicit information about how, when and where to access 'missing' elements should be available from each provider.

Setting standards for these elements of health care and providing training to support clinical quality are important.

Essential skills for all those working in sexual health care provision include a well-informed and unembarrassed approach, which is non-discriminatory and careful of individual sensitivities. Local areas should consider the specific needs of vulnerable communities and ensure service delivery is relevant, appropriate and accessible to them.

Competence in taking an appropriate sexual history underpins this work. All those providing sexual health care should also be able to provide information on local access to other elements of care.

### Level 1 elements

Many of these basic elements can be undertaken in health care settings with facilities for interview and non-invasive examinations only (blood pressure measurement, urine testing). Others require facilities for genital examination and venesection (current cervical cytology screening, HIV testing).

The further development and practical implementation of non-invasive STI tests will extend the elements that can be grouped into Level 1.

The strategy will be implemented over the next ten years and primary care practices will need to negotiate a pace of change with PCTs to aim towards providing the full range of Level 1 elements, which will also be available on a self-referring basis from 'dedicated' sexual health providers.

### Level 2 elements

These elements require additional skills and/or facilities from providers. While many people will be referred by a GP, nurse or other health professional, access on a self-referring basis is also essential. Most of these elements of care will not be available from primary care teams and local sexual health commissioners will need to ensure access to adequate provision of these elements for their local populations.

### Level 3 elements

These elements are typically delivered in the context of specialist services configured to provide sexual health care as their main clinical activity. Level 3 elements should be offered in the context of a full range of clinical services at all levels to complement and support local primary care provision.

The framework enables local key stakeholders to review their current provision, and plan any necessary training or service developments to meet identified gaps. It will serve as a focus for local discussion and encourage a more client-centred view of access to necessary sexual health care.

*(see Appendix 4 for details of levels of service elements)*

**Local networks of sexual health services** can be developed to provide these three levels of services associated with increasing specialisation. Managed service networks for HIV treatment and care are encouraged, with links to non-specialist HIV services in primary care. VCOs and other stakeholders can be participants in their development.

Nationally agreed service standards are being developed by DH with key stakeholders. These will include (open) access, definition of care pathways, including links with mainstream services (such as mental health), availability of the full range of clinically effective services, staff training and development, service monitoring, audit and evaluation, information for patients, including support for drug adherence. Similar networks for children will be developed, linking to adult services to provide family clinics.

It is anticipated that service networks will take a number of years to establish fully.

Networks should:

- increase uptake and access (particularly for target groups) by providing a choice of easily available services, supported by better information and advertisement of local services, including open access contraception and GUM clinics
- identify the sexual health profile of local communities and baseline resourcing and activity, to develop services to address local needs and service gaps
- agree clear roles, responsibilities, and referral criteria within the network, supported by education and training of staff, as required
- develop care pathways
- set and monitor quality standards and targets
- monitor progress in meeting the aims, goals and standards in the strategy and implementation action plan.

### The New GMS Contract

The new General Medical Services contract is designed to allow GPs to do their job effectively, tackle the concerns they have about working conditions, deliver a positive future for primary care and, most importantly, result in a better deal for patients. At the time of producing this guidance, work is currently still proceeding on detailed negotiations and preparation of a priced contract. This will include looking at issues related to the sexual health and HIV strategy.

Although it will continue to be the case that GPs may opt out of providing contraception services, PCTs will be required to make suitable alternative provision for all women patients, either through another GP practice, a community-based service or an alternative provider.

The Royal College of General Practitioners (RCGP) will be producing guidelines for GPs and primary care provision of sexual health services in 2003.

## Dental Services

PCTs need to ensure that there are good dental health services available for people with HIV and AIDS. Dental services need to be accessible and well advertised in GUM and HIV clinics, through health promotion and VCOs and other key access to service points. PCT dental advisers and local dental committees can use the British Dental Association guidelines which provides regular advice on infection control and the provision of services to HIV positive people.

## Prisons

Health improvement and modernisation plans have been developed for prisons and need to be considered jointly with any other local initiatives when developing sexual health services. PCT commissioners will therefore need to work closely with prison staff to ensure that prison health improvement plans include targeted health promotion and prevention resources which include sexual health and drug action team plans for harm minimisation.

## Best Practice Guidelines for Contraception Services

The strategy consultation highlighted that accessibility to contraceptive services and the range of contraceptive methods available, including NHS funded sterilisation, vary widely. Contraceptive services can be provided in primary care, community family planning clinics and specialist young people's contraception services. The role of GP primary care teams in providing sexual health services including contraception services is described in detail in the previous section.

The Teenage Pregnancy Unit has issued best practice guidance on the provision of contraception and advice services for young people, and to be effective services should be commissioned and provided against the criteria in the guidance.

Principles developed by the **fpa** which should underpin all contraceptive services include:

**skilled and welcoming staff** – all clinical and non-clinical staff must be provided with appropriate accredited training in line with individual competencies, and clinical governance. This should include training and regular updates in contraception, STIs, sexuality, communication skills and inclusive practice to enable staff to provide accurate impartial and confidential advice and treatment to all patients.

**easily accessible, localised services** – providers must ensure that services are accessible by all members of the community, e.g. through appropriate opening times and location and provision of services for vulnerable and socially excluded groups. These might include interpreting/translation services, facilities for disabled people, the homeless, and those in remote or inaccessible areas e.g. through developing outreach programmes.

**confidential advice and treatment** – all services providing contraceptive care should have a clear confidentiality policy, which is well advertised and accessible to all.

**targeted detailed and relevant information** – services offering contraceptive care should be well publicised in local telephone directories (e.g. Thompsons and Yellow Pages), local GP practice leaflets

and notice boards, and other sexual health providers. The material should include up-to-date, relevant information in a variety of formats – i.e. large print, Braille, audio, video and in predominant community languages.

Integrated services – service providers offering continuing care should be able to offer patients clear, relevant information and guidance on referral pathways- i.e. access to Level 1 and 3 elements of care.

### Elements of a Best Practice Contraceptive Service include:

- arrangements for timely provision of all types of emergency contraception
- access to the full range of contraceptive methods including permanent methods
- provision of counselling and information for pregnancy planning and preconception care
- access to quick pregnancy testing and non-judgmental unplanned pregnancy counselling if required
- referral to abortion services without delay (should take account of the standards set out in the Royal College of Obstetricians and Gynaecologists' evidence based guideline 'The Care of Women Requesting Induced Abortion'). The recommended national standards that PCTs will work towards is that women who meet the legal requirements should have access to an abortion within 3 weeks of their first appointment with their GP or other referring doctor (other than in exceptional cases for example, where a longer wait is clinically appropriate)
- provision of outreach/domiciliary services for those unable to access mainstream services
- arrangements for clients with special needs to access all contraceptive services without undue delay e.g. appropriate young people's services, access to interpreters, outreach services for the homeless, sex workers, people with learning disability, clinic facilities for people with physical disability
- access to cytology screening without appointment
- access to psychosexual counselling
- advice on STIs and appropriate onward referral to GUM services
- testing for common STIs
- screening for chlamydial infection as per national guidelines.

### Best Practice Guidelines for Service Provision for Contraceptive Services include:

- clear display/advertisement of services provided, opening times and arrangements to provide information on how to access all types of emergency contraception out of hours
- open access service including daytime and evenings, enabling attendance on the same day during weekdays
- open access service for all types of emergency contraception maintained over weekends and public holidays by close collaboration between providers of contraception and other emergency services
- maximum waiting time of 2 hours for open access services

- adequate time for consultations ( between 15–30 minutes minimum) especially first pill counselling and prescription, counselling and provision of long acting methods of contraception, reproductive and sexual health problems, counselling and referral for permanent methods, abortion counselling and referral
- availability of written information to assist clients in making informed choices about methods of contraception, sexual and reproductive health
- all verbal counselling advice supported by appropriate written information for clients to take away and read
- use of evidence guided protocols based on Faculty for Family Planning and Reproductive Healthcare (FFRRHC) recommendations for clinical practice (where it exists) or World Health Organisation guidance
- due regard to the privacy and confidentiality of clients regardless of age and gender
- all clinicians providing general contraceptive services trained to the competencies expected for the Diploma in Family Planning of the FFPRHC or its equivalent prescribed by their educational body and show evidence of keeping up to date
- all clinicians offering specialist services e.g. IUD and implant trained to the competencies expected by the FFPRHC letters of competence or their equivalent laid down by their educational body and show evidence of keeping up to date
- training for all staff ( including clerical) relating to confidentiality, dealing with young clients and child protection issues
- promote effective links between key stakeholders (GUM, GPs, HIV, abortion services) to ensure cohesion and seamless approach for service users.

## Best Practice Guidelines for GUM and HIV Services

The aim of GUM is to provide a range of high quality accessible treatment care and prevention services for people attending with STIs, HIV and AIDS, and to meet the diverse service needs of those people in an open, non discriminatory and non judgmental way.

Elements of a comprehensive GUM service:

- a full sexual health screen offered to all clinic attendees
- treatment and health adviser support offered for the management of infection, the avoidance of re-infection and future safer sex strategy development for all attendees
- partner notification and contact tracing routinely conducted where a patient is diagnosed with a sexually transmitted infection (STI). Provider notification could also be available
- a recall system in place to ensure that anyone with an STI receives appropriate treatment and follow up
- home visits conducted in special circumstances where a patient fails to return to the clinic when diagnosed with an STI
- hepatitis B screening offered to all gay men, commercial sex workers, current or ex IVDU's and their partners, and people from areas where HIV is endemic
- a Hepatitis B vaccination recall programme in operation to ensure completion of the course

- safer sex information and risk reduction strategies offered to all those attending for Hepatitis B vaccination
- protocols in place within Trusts for liaison with other hospital departments for the diagnosis, treatment and follow up of patients diagnosed with possible sexual health related problems, i.e. gynaecology referrals for PID for follow up care and contact tracing/referrals from family planning where chlamydia is diagnosed for follow up care and contact tracing.

Best practice elements include:

## **GUM**

- open access service enabling attendance on the same day or next working day following suspicion of an STI
- booked appointment within 7 working days
- maximum waiting time for walk-ins of 2 hours
- management of STIs according to national/regional guidelines
- use of diagnostic techniques according to national/regional guidelines
- availability of hepatitis A vaccination
- access to female doctor where possible
- provision of data according to local/national requirements.

## **HIV Services**

- recommended appointment with HIV specialist (or a consultant) within two weeks of initial diagnosis.
- provision of antiretroviral therapy and monitoring according to national guidelines – regular viral load monitoring and information and support regarding the results of those tests will be supplied to all attendees where appropriate. This is especially pertinent since sexual health needs may change with changes in health status
- referral to specialist in-patient unit according to clinical need
- provision of emergency walk-in facilities
- encouragement of patient registration with general practitioners and good communication and involvement between GPs and specialist HIV services
- provision of support regarding compliance to antiretroviral therapy – involving both outpatient departments and community teams
- palliative/respite/terminal care as appropriate
- provision of information regarding uptake and adherence of therapies/outcome measures – e.g. in-patient rates, progression to AIDS rates, mortality rate
- provision of information regarding new HIV diagnoses, AIDS diagnoses and deaths according to national requirement
- co-ordinated access to social care and VCO services.

GUM and specialist HIV services provide a large proportion of HIV care in England. Quality care is also provided by other specialists who have relevant training and facilities including infectious diseases specialists some of whom provide HIV services almost exclusively in areas. HIV services may also be provided as part of a managed network of services for example, a walk in or 24 hour advice service may be available at a site different from the clinic where care takes place. Commissioners need to consider and account for these issues when allocating resources and undertaking service planning and developments in those areas.

Some key elements for health promotion and prevention service specifications for GUM and HIV services may include the following elements:

- HIV testing to be routinely offered during sexual health screening at clinics
- attendees without disclosed significant risk factors for HIV to have pre test discussion from the Health Advisors and/or Doctor/Nurse where appropriate.
- safer sex advice and information offered during consultation
- in the absence of infection, condoms and lubrication to be offered
- safer sex and risk reduction education and information to be offered to clinic attendees at all stages during their consultation with doctors, nurses and health advisers
- service users to have access to sexual health promotion and safer sex advice, including condom provision, hepatitis B vaccine, onward referral and relevant or appropriate information
- post exposure prophylaxis for occupational exposure and certain other exposures as recommended by the GUM consultant
- ethical HIV testing guidelines to be in place, with informed consent made explicit as good practice
- post exposure treatment advice, information and treatment should be offered following any needlestick injuries
- all HIV testing to be conducted in accordance with clinical guidelines produced by BHIVA to ensure ethical testing and appropriate treatment and care
- safer sex/risk reduction information and support following diagnosis of an STI and/or HIV to be offered to all attendees where and when appropriate
- partner notification of any potential risk of infection to be encouraged
- regular viral load monitoring and information and support regarding the results of those tests are supplied to all attendees where appropriate. This is especially pertinent since sexual health needs may alter with changes in health status
- support for partners and other family members including pre-test counselling, support and safer sex information and advice to be offered
- referral to other agencies in the voluntary and statutory sector to be available for ongoing support and/or counselling and/or other information
- referral to other NHS specialities such as drug services, psychology or health promotion are to be encouraged where relevant, particularly where there are concerns about drug injecting behaviour, or non condom use
- regular clinic information and updates on clinical matters of importance for gay men with HIV to be included in the local gay press, and in relevant local publications for African communities.

## Tackling inequalities in access to Abortion

Commissioners should work towards the recommended national standard that women who meet the legal requirements should have access to an abortion within 3 weeks of the first appointment with the GP or other referring doctor (other than in exceptional cases, for example where a longer wait is clinically appropriate).

At present, there are wide variations in access to abortion services, and in the choice of method of termination. Commissioners should be aware of the following recommended standards and good practice guidance set out in the strategy and implementation action plan:

- commissioners and service providers to ensure that information about local pregnancy counselling and termination services is readily available and widely publicised
- commissioners to ensure that services are available for all gestations within the legal framework. Efforts should be made to ensure that no group is marginalised and access to services is not dependent on an individual's postcode. That is, if grounds exist for a termination of pregnancy as defined in the 1967 Abortion Act, arrangements should be in place for the termination to be carried out locally, or at an alternative facility within the UK if the local unit is unable to provide this service in particular circumstances.

*(see Appendix 5 for further commissioning advice for abortion services)*

## Health Promotion and HIV/STI Prevention

The DH intends to publish a health promotion toolkit which aims to inform commissioners and providers of a wide selection of comprehensive evidenced based health promotion methods and good practice which can be commissioned and provided by a range of health promotion professionals in the statutory and voluntary sectors. It will also include a detailed report on the work undertaken by the Health Development Agency (HDA), which analyses in detail available evidence of effectiveness in health promotion.

The following section outlines some of the basic decision making processes that need consideration at local level to ensure that health promotion and prevention activity is included within plans for service delivery.

### What is Health Promotion and HIV and STI Prevention?

Health promotion and HIV and STI prevention can be defined as any activities which proactively and positively support the sexual and emotional health and well being of individuals, groups, communities and the wider public. Including emotional health in this acknowledges the strong link between people's emotional well being – as demonstrated by their levels of self-esteem for example – and their ability to take control over the decisions and choices which will affect their sexual health.

### What is the Health Promotion role for Sexual Health Services ?

In order to play their essential health promotion and HIV and STI prevention role, all sexual health services and support should:

- be offered in non-judgemental, respectful and sensitive ways
- provide clear, accurate, up-to-date information in attractive and accessible forms and language
- offer support and information in making healthy choices and fulfilling and healthy relationships.

### **What is the aim of Health Promotion and HIV and STI Prevention?**

The aims are to improve the positive sexual health of the general population and to reduce inequalities in sexual health, including reducing stigma and discrimination. Within this, more specific aims include facilitating more satisfying and fulfilling relationships, reducing rates of new HIV infections, reducing rates of STIs, reducing unintended pregnancies and reducing psychosexual problems.

### **What are the Objectives of Health Promotion and HIV and STI Prevention?**

Objectives include awareness raising, education and information giving, the development of services and service providers and developing skills and capacity building in individuals, groups and communities. Such capacity building enables particularly vulnerable individuals, group and communities to take greater control over their sexual health. It also offers them the opportunity to gain key skills such as negotiation, communication and assertiveness as well as enhancing their self-esteem, emotional well being and mental health. This is vital if we are to accomplish the daunting task of reducing inequalities in sexual health.

### **What is good practice in Health Promotion and HIV and STI Prevention?**

In order to be effective, sensitive and appropriate in meeting the multiplicity of sexual health needs within communities, health promotion and HIV and STI prevention work should:

- have a clear and explicit values base, which is grounded in a positive, holistic model of sexuality and sexual health
- work towards creating a culture, which is more tolerant, affirming and celebratory about sexual health and sexuality as vital aspects of human experience
- ensure the work is accessible to all and takes account of particular needs e.g. for people whose first language is not English or people with sensory impairment
- affirm diversity – for example in terms of sexuality, ethnicity, age, educational background or ability – and this should be reflected in all practice
- actively counter and challenge discrimination, prejudice and stigma
- acknowledge and support the rights and responsibilities of individuals, groups and communities in relation to their sexual health and well being
- enable people to develop practical skills (e.g. negotiation or assertiveness) as key elements of sexual health and related decision-making
- create opportunities for discussion, reflection and exploration of issues, values, feelings, attitudes and beliefs in relation to sexual health
- equip individuals and groups to be able to resist coercion, pressure, exploitation, abuse, discrimination, harassment and bullying
- contribute to the development of self-esteem
- promote collaborative and multi-agency work including partnerships with the voluntary and community sector
- be informed by a research and evidence base, which ensures maximum effectiveness and the best use of finite resources.

### **What methods are used for Health Promotion and HIV and STI Prevention?**

Some methodologies used in health promotion and HIV and STI prevention are directly delivered with individuals, groups and communities – these would include community development, sex and relationships education, group work – particularly with vulnerable and marginalised groups, one-to-one work, condom distribution, publicising sexual health services, detached, outreach and street work, peer education and peer involvement programmes, the production and dissemination of materials and promoting opportunities for screening and testing.

More indirect methodologies tend to focus on professionals, agencies and service-providers. These would include staff training, information dissemination and updates, the development of policies and strategies which support sexual health, research and community needs assessments, media work and the promotion of strong inter-agency working. Work with the voluntary and community sector is vital and should encompass both organisations working directly on sexual health issues and those with a broader, less focused but related remit – such as Relate, Samaritans and Victim Support.

For this work to be effective, different methodologies will need to be used with individuals, groups or communities in order to respond sensitively and appropriately to their particular needs. The methodology will need to be carefully chosen to ‘match’ the needs of the individual, group or community, which is the audience or target group for the work. Furthermore, throughout all of these endeavours, it will be vital to draw on the existing literature and evidence about what makes for effective interventions.

### **What are the usual settings for Health Promotion and HIV and STI Prevention?**

Sometimes the term “health promotion” is used solely to describe work done in clinical or surgery settings by service-providers to improve the sexual health of service-users. The reality is that it is a much more widespread activity than this. It is delivered by staff from a range of disciplines in many settings within the community for example clinics, surgeries or sexual health services. Community-based settings can include youth and community centres, churches and social clubs, residential care settings, prisons, bail hostels and young offenders’ institutions and formal education settings such as schools, further education colleges, tertiary colleges, training colleges and universities. Health promotion and HIV and STI prevention initiatives are often delivered via detached and outreach work which is always done on the territory of the group or individuals being worked with – for example on the streets and in parks, pubs and clubs, saunas and public sex environments.

Training and support will be vital for staff, teams and services to increase their understanding, skills and confidence in delivering sexual health services and programmes which can play a positive role in promoting health and preventing HIV.

The health promotion toolkit will be disseminated and should be used as intended, that is as a “SILVER STANDARD” approach to which services can realistically aspire and should be commissioned at local level to meet the needs of local populations.

### **Evidence Based Planning and Practice**

Decisions about policy and practice in the public sector are increasingly driven by consideration of the best available evidence. Examination of the literature on ‘what works’ in a particular area can result in greater cost effectiveness (selecting the best value intervention) and overall impact (selecting the most appropriate intervention for a population’s needs). In addition, where local interventions are subsequently assessed and evaluated, the findings from this work can be ‘fed’ back into the evidence base, improving understanding of what works and ultimately improving the delivery and effectiveness of services.

## **The Evidence base**

DH commissioned the HDA to draw together the available evidence, assess what works and make clear recommendations on future approaches. This report is unpublished at the time of writing, but will be available early in 2003.

A brief summary is outlined below of some key findings to inform practice and commissioning.

### **HIV Prevention Evidence Base**

This focuses on the priority populations for the sexual transmission of HIV. The evidence from reviews suggests that interventions with men who have sex with men are more likely to be effective if they are:

- placed within the broader context of men's lives, addressing the range of factors which influence risk at both the personal level (e.g. knowledge, skills) and the structural level (e.g. discrimination towards gay men, gay community norms towards condoms)
- tailored and targeted to specific sub-populations of men who have sex with men, for instance black gay men and working class gay men
- multi-component (using small group work), focusing on risk reduction, sexual negotiation and communication skills training and rehearsal (e.g. through role-play or identifying 'triggers').

There is some evidence from reviews that interventions delivered at the community level (particularly peer-led) can be effective in influencing the sexual risk behaviours for commercial sex workers.

So far, the HDA has been unable to identify any evidence from reviews to inform HIV prevention with African communities and with people with HIV.

### **STI Prevention Evidence Base**

The evidence from reviews suggests that the main features of effective health promotion/education interventions are:

- incorporation of theoretical models of behaviour change, or components of these models, as a basis for intervention, development and implementation
- provision of basic, accurate information about the risks of unprotected intercourse and methods of avoiding unprotected intercourse
- multi-component – including activities such as skills development, motivation building and attitude change in addition to factual information. Information provision alone is insufficient to influence behaviour change; personal and structural factors such as attitudes towards safer sex and condoms, motivation, the influence of significant others, wider social influences, as well as practical skills all play an important part in the ability to change behaviour
- incorporation of specific behavioural skills training, for example how to use condoms
- based on a detailed understanding of background behaviours, beliefs and risk perceptions of the target population. Formative research can be useful in developing programmes which are appropriate to the target population in terms of age, gender, sexual experience and culture
- use of peer educators, particularly with adolescent audiences. Some adolescents may be more comfortable receiving sexuality-related information from peers rather than adults, and peers may also have added credibility because of their perceived recent experience of the issues under discussion

- emphasis on promoting condom use, rather than abstinence. Telling people not to have sex is unlikely to be an effective intervention
- of appropriate duration, it requires considerable time and multiple activities to change the various antecedents of sexual risk-taking behaviour.

Local commissioners and practitioners can contribute to the development of a more wide-ranging evidence base by monitoring and evaluating local interventions.

## Role of Nurses

Nurses are pivotal to the successful delivery of the strategy for sexual health and HIV in primary and specialist care. They have a key role in educating, managing and supporting service users and patients across a range of settings in both clinical and non clinical settings, and are able to play a broader role in detached and outreach settings for those users who are excluded from main stream service provision.

The nurse role in sexual health and HIV has extended considerably in the past decade with more supplying emergency and ongoing hormonal contraception to patients and the use of Patient Group Directions (PGDs). The use of PGDs has gone a long way in utilising the skills of nurses more effectively and efficiently, particularly in providing a more flexible service to patients. Good examples of this are evident in accident and emergency departments, schools, youth services and walk-in centres where specially trained nurses are able to provide sexual health screening, testing and advice and for example, supply emergency hormonal contraception. Expansion of sexual health consultant roles is a new initiative which places expert sexual health nurses at the forefront of national implementation. Support from PCTs and clinical colleagues is imperative for the ongoing success of these posts and may be considered a priority in areas of high prevalence of HIV, high unintended pregnancy rates and high numbers of STIs.

Nurses are increasingly undertaking the Independent Nurse Prescribing course and can prescribe medicines in their own right. Many are trained to fit intrauterine contraception (IUDs) and Implanon implants (long acting reversible methods), and provide advice and information to women seeking further information and advice about contraception.

School nurses are ideally placed to deliver on the sex and relationships education curriculum in schools and are the key health care professionals to ensure standardised programmes delivered to young people in partnership with the teachers. They can also provide a key role in signposting people to other specialist or voluntary services in local areas, and providing links with those services.

Nurses also have a key role in managing and supporting patients and service users with HIV and AIDS. They are instrumental in developing care packages to meet complex needs of many patients with HIV and AIDS.

It has long been recognised that nurses are key providers of care and support, particularly in relation to sexual health issues, and many are expected to take on additional roles without necessarily being offered the opportunity to undertake further training to equip them to do this. Career pathways need development to ensure that nurses are equipped for roles in advanced nursing practice, research, education and other specialisms for sexual health. Nurses working in specialist fields can also facilitate training for generic nurse practitioners and develop training packages to support further skills and competencies.

The Royal College of Nursing (RCN) are currently developing a distance learning package for nurses in order to promote the delivery of Level 1 services, and to improve the knowledge base of nurses. This will

cover a range of sexual health and HIV information and education, including contraception, sexually transmitted infections, informed consent, confidentiality, pelvic inflammatory disease, infertility and HIV, and the development of communication skills to relate appropriately with patients.

The RCN are developing further packages of information, advice and education for nurses to help develop skills and competencies across sexual health and HIV, and to encourage the extension of the nurses role in providing care and support across the whole range of service provision. This will include further examples of good practice in developing PGDs for other procedures. Further training implications will be considered as part of the training strategy (see next section).

Further information on the role of the nurse in providing sexual health services can be obtained from the RCN Sexual Health Adviser and Sexual Health Forum.

## Role of Health Advisers

A Health Advisers Working Party was convened in April 2001 to respond to the National Strategy for Sexual Health and HIV consultation document, and the recommendations to increase the role of health advisers. Consequently the DH commissioned work on a Manual for Health Advising Practice currently being compiled by the Society for Health Advisers in Sexually Transmitted Disease (SHASTD). This publication will be available early in 2003.

Health advisers work within multidisciplinary teams where they share sexual health work with a number of different professional groups. The core roles of health advising are:

- partner notification, and improving partner notification within clinics and in the community
- counselling
- sexual health promotion
- health promotion work/link work between sexual health services and sexual health promotion in community settings
- key roles in supporting clinical outreach services based in non-clinic settings.

There was commitment in the strategy to increase the role of health advisers, and the action plan suggests a development of the roles and responsibilities of health advisers within GUM, particularly in relation to partner notification.

The recommendations below outline an approach that PCTs may consider which will help to develop the health advisers role in the short term. However this should be considered a minimum increase as there may be a need to substantially increase the number of health advisers particularly as they take on more partner notification (in response to wider STI screening) and a greater role in community based sexual health promotion.

### Recommendations from working group

- Every GUM department should have health advisers
- There should be no single-handed health adviser posts
- There should be at least one whole time equivalent health adviser for every consultant led site in GUM

- Evidence based standards detailing best practice and partner notification should be developed
- Health adviser qualifications should be established by 2004 (and will be established by 2005 at the latest).
- Protected training budgets for continuing health-advising education should be established
- Minimum expectations for continuing health adviser education should be defined.

## Implications for Training and Workforce Issues

One key element of the strategy's implementation action plan is a robust training plan which is currently being developed. This will be a vital step in equipping all the relevant professionals with the skills and confidence to deliver high-quality sexual health services and health promotion, HIV and STI prevention.

During the consultation period following the draft strategy's publication, certain themes kept recurring in relation to training. These included:

- the importance of training for health professionals in non-clinical skills such as communication and confidentiality
- the importance of retention and recruitment of staff across clinical and care and support organisations, including VCOs
- the important place of training in the development of positive awareness and attitudes and in tackling issues of stigma and prejudice
- The need to influence the training programmes of all professionals with a role in supporting or promoting sexual health within the NHS and more broadly. These professionals would range from commissioners of services, GPs, nurses, pharmacists, health promotion specialists and receptionists to teachers, youth workers, social workers and drugs workers
- Workforce considerations need to be planned locally in partnership with the Workforce Confederations, particularly in relation to training developments for the provision of more integrated sexual health service developments.

The training mapping and strategy report and recommendations will be disseminated and available from the DH in 2003.

## Confidentiality

The NHS Trusts and Primary Care Trusts (Sexually Transmitted Diseases) Directions 2000 set out the following information on confidentiality:

- Every NHS Trust and PCT shall take all necessary steps to secure that any information capable of identifying an individual obtained by any of their members or employees with respect to persons examined or treated for any sexually transmitted disease shall not be disclosed except -
  - for the purpose of communicating that information to a medical practitioner, or to a person employed under the direction of a medical practitioner in connection with the treatment of persons suffering from such a disease or the prevention of the spread thereof, and
  - for the purpose of such treatment or prevention.

In December 2002, the British Medical Association (BMA) and the Association of British Insurers (ABI) issued joint guidelines '**Medical information and insurance**' which sets out information that should be released to companies that are processing health information.

The guidelines state:

- in order to prevent people from being deterred from seeking advice and getting tested for HIV and other sexually transmitted infections (STIs), that doctors do not have to reveal all aspects of their patients' sexual health history.
- that there is no reason to disclose single incidents of STIs, or even multiple episodes, provided there are no long-term health implications.
- in addition, and in line with existing ABI guidance, insurance companies should not ask whether an applicant for insurance has taken an HIV or Hepatitis B or C test, had counselling in connection with such a test, or received a negative test result. Doctors should not reveal this information when writing reports and insurance companies will not expect this information to be provided. Insurers may ask only whether someone has had a positive test result, is awaiting a test result, or is receiving treatment for HIV/AIDS or Hepatitis B or C.

Further guidance in the form of a Confidentiality Toolkit is available free from the RCGP, and there are a range of publications available from professional bodies concerned with patient confidentiality, e.g. Brook, THT, BMA, RCN, **fpa** and RCGP. A Confidentiality Toolkit is available from the DH as part of the implementation plan for the Teenage Pregnancy Strategy.

## What are the Key Challenges?

### **Key challenges for PCTs and StHAs include:**

- increasing demand and pressure on all sexual health services (contraceptive, abortion, HIV/GUM and GPs) and variations on provision of these services across the country
- capacity building in:
  - staffing
  - premises
  - information technology
- access to these services and waiting times
- stakeholder involvement and buy in
- the development of managed clinical and other service networks, and the consequent loss of autonomy for some clinicians
- chlamydia screening – costs and availability
- wide provision of affordable/free condoms
- laboratory costs and improvements to diagnostic testing and equipment
- changes in HIV funding formula and allocation process
- equitable provision of effective long acting methods of contraception
- developing consortia arrangements
- ensuring the care needs of people with HIV are met
- acknowledging the diversity of communities and ensuring that services are accessible to locally diverse communities.

## Conclusion

There is considerable enthusiasm and support nationally for successful implementation of the first ever national strategy for Sexual Health and HIV. This success will be dependent on a number of variables and factors, which will enable us to tackle the challenges identified and to begin the programme of change and modernisation in line with the Planning and Priorities Framework. Preventing poor sexual health has significant potential not just for better sexual health, but for the better use of finite resources. Prevention of unplanned pregnancies, HIV and infertility will have major benefits for overall health and wellbeing, and for NHS resources.

These guidelines are a means of support to PCTs to facilitate local action plans and to enable them to identify priorities which will inform their future investment planning in sexual health services. It is an evolving process and this document reflects current thinking which will be updated as we move towards our goals. Consultation on the implementation of the strategy will continue with key stakeholders and will inform our progress towards successful implementation of the sexual health and HIV strategy.

It is now for key stakeholders to take the implementation forward and to plan according to these guidelines taking into account all the considerable pressures priorities and constraints across all sexual health services.

The DH would like to thank those who have assisted with these guidelines and welcome feedback and involvement from those championing the agenda for sexual health at local level.

# Appendix 1

## Overview of key points in the National Strategy for Sexual Health and HIV

The aims of the national strategy are outlined in the introduction.

The strategy and subsequent action plan proposes to achieve these aims by:

- providing clear information so that people can take informed decisions about preventing STIs, including HIV
- developing a new information campaign for the general population
- producing a sound evidence base for effective local HIV/STI prevention
- developing managed networks for HIV and sexual health services, with a broader role for those working in primary care settings and with providers
- collaborating to plan services jointly so that they deliver a more comprehensive service to patients
- evaluating the benefits of more integrated sexual health services, including pilots of one-stop clinics, primary care youth services and primary care teams with a special interest in sexual health;
- beginning a programme of screening for chlamydia for targeted groups in 2002
- stressing the importance of open access to GUM services and, over time, improving access for urgent appointments
- ensuring access to a full range of contraceptive services are provided for those that need them
- addressing the disparities that exist in abortion services across the country
- increasing the offer of testing for HIV to ensure earlier access to treatment for those infected and limiting further transmissions of the virus
- increasing the offer of hepatitis B vaccine
- setting standards for the treatment of STIs and for the treatment, support and social care of people living with HIV
- setting priorities for future research to improve the evidence base of good practice in sexual health addressing the training and development needs of the workforce across the whole range of sexual health and HIV services.

### **Immediate priorities identified in the implementation action plan are:**

- publication of commissioning guidelines and a health promotion toolkit
- publication of a training mapping and strategy report and recommendations
- disseminate evidence of effectiveness for HIV and STI prevention

- improve the quality of national helplines
- publication of African HIV frameworks for prevention and care services and new model of delivery for national African HIV health promotion led by the voluntary sector
- roll out of the chlamydia screening programme to 10 areas
- appoint to an Independent Advisory Group to facilitate national implementation
- publish HIV service standards
- commission further standards for broader sexual health
- launch new sexual health information and awareness campaign
- roll out the HIV prejudice and discrimination campaigns
- improve information and advice available to the public on sexual health
- monitor investment and progress on the strategic implementation national.

# Appendix 2

## SW London Consortium

### Case Study – The South West London HIV & GUM Commissioning Consortium

The South West London HIV & GUM Commissioning Consortium was established in May 1999 as a joint initiative between Kingston & Richmond Health Authority (K&RHA), Merton, Sutton & Wandsworth Health Authority (MSWHA) and Croydon Health Authority (CHA), and is responsible for assessing need, developing strategy and commissioning GUM and HIV services for South West London. This built on previous joint working by the three HAs in conjunction with five of the corresponding Local Authorities, namely: Kingston, Richmond, Merton, Sutton and Croydon in the commissioning of HIV voluntary sector services since this responsibility had been devolved by the former South Thames (West) Regional Health Authority in 1994.

Following the changes in the NHS in April 2002, the Consortium was retained by the successor bodies to the three HAs and now works on behalf of the five Primary Care Trusts (PCTs) within the boundaries of the South West London Strategic Health Authority (namely: Croydon PCT, Sutton & Merton PCT, Wandsworth PCT, Kingston PCT and Richmond & Twickenham PCT).

The Consortium, based in Croydon, is managed by a steering group of commissioning, finance and public health personnel from the participating PCTs and is staffed by 0.6wte Consortium Manager, 1.0wte Commissioning Manager and 1.0wte Contracts & Information Officer.

A Prevention Advisory Group (PAG), made up of health promotion specialists from across SWL, facilitate a co-ordinated approach to HIV Prevention and advise the Consortium on HIV prevention needs and services.

During 1999/2000, two additional groups were established, an HIV/GUM Consultant and Service Managers' Forum and a Specialist HIV Pharmacists Group. These fora helped to facilitate a sector wide approach to the delivery of services by benchmarking services, developing standards and looking at service developments in line with a sector model. These groups were key to the establishment of the South West London HIV & GUM Clinical Services Network, which covers all of the HIV and GUM Services in South West London (Mayday, St. Georges, St. Helier, Queen Marys and Kingston)

The consortium arrangement is coterminous with the local StHA and with the local HIV and GUM clinical network and this is beneficial in that it covers a defined health economy area. The consortium also represents the interests of South West London in London-wide commissioning arrangements through the London HIV Consortium.

## **How services work in South West London**

Commissioning of hospital based services:

- contracts are negotiated by the Consortium based at Croydon PCT
- contracts are hosted by lead PCTs
- finance is mapped between PCTs to resource hosted contracts
- services are performance managed and co-ordinated by the Consortium.

Commissioning of community services:

- responsibility of individual PCTs
- consortium influences strategy relating to community services.

Commissioning of voluntary sector services:

- consortium meets with local authority commissioners to develop and agree joint commissioning principles and intentions
- contracts are negotiated and hosted by the Consortium based at Croydon
- finances are held by the Consortium.

Strategy

- Consortium acts as the strategic lead on HIV and GUM service issues
- Consortium develops HIMP and SAFF sections on HIV for each local Health Economy.

Information

- Consortium acts as a point of reference/contact for information on HIV and GUM issues
- Consortium developing a framework for HIV service user involvement across the sector covering statutory health and local authority and voluntary sector services.

# Appendix 3

## Integration of the HIV/AIDS Service

Brighton & Hove Social Care & Health  
South Downs Health Trust

### Introduction

Using 1999 Health Act flexibilities and section 31 partnership working, the following teams were integrated from April 2002

- Social Care & Health Specialist Community HIV Team
- South Downs Health Trust – HIV/AIDS Team (Mental Health)
- South Downs Health Trust – HIV/AIDS (Community Nursing).

This document outlines the following

- reasons for the proposal (the context),
- the scope of the integration (the dimensions of the proposed integrated team)
- what we hoped to achieve from the integration (the why)
- the process and timescale for the work including steering group membership and action plans (the process).

### The Context

In December 2000, a review group was established to address the two key challenges currently facing the HIV/AIDS and GU services in Brighton & Hove, namely the need to deliver quality services for the future whilst addressing the immediate and longer term capacity problems.

A demand modelling exercise was completed involving assessing service trends over the past three to five years with the second stage being to project the actual number of patients treated forward to 2005 in order to estimate the future demand on services.

As such, the epidemiological model suggested that there will be a need to ensure that

- services have enough capacity to meet increasing demand
- are flexible enough to meet the changing needs of the client group – due to changes in treatment regimes, which have resulted in increased activity in the primary care and voluntary sector
- service providers are appropriately qualified and updated (clinical governance).

## The Dimensions

The community teams involved in the proposed integration were:

- Social Care & Health -Specialist Community HIV – Team
  - 1 part time Service Manager
  - 1 part time Resource Manager
  - 15 hours of OT time commissioned from the OT dept
  - 1 full time Care Manager Resource Officer Grade 6
  - 1 full time Community Care Support Worker Grade scale 5
  - 1 full time Team Administrator Grade Scale 3
  - 1 part time Team Administrator Grade Scale 3
  - 1 part time Development worker
  - 1 part time Housing Officer (part of the Housing Department Team)
- South Downs Health Trust – HIV/AIDS Team (Community Nursing)
  - 2 full time G grade Community Nurses
  - 1 full time H grade Community Nurse
  - 1 full time Clinical Medical Officer (vacant post)
  - 1 full time A/C 3 Clerical Support
- South Downs Health Trust -HIV/AIDS Team (Mental Health)
  - 1 part time Consultant (3 sessions)
  - 1 full time H grade RMN Nurse
  - 1 part time A/C 3 Clerical Support

There were other equally important partners in the HIV/AIDS service such as Brighton Health Care and we worked in parallel with them in order to continue exploring wider sexual health partnerships. In order to meet the April 2002 target it was felt necessary to concentrate on the above teams who actually worked in the community.

## Why should we integrate the Services?

Although each team is doing important work, there were felt to be areas of duplication between Social Care & Health and South Downs Health Trust.

Because of this there was sometimes confusion on the part of clients and colleague agencies regarding roles. Comments from clients have included “Why can’t I just have the one visit that covers both areas of work?”.

Staff within teams were working very well together and this was an opportunity to further develop the existing good work.

## What we achieved with an integrated scheme

- One point of contact for the client. A client can ring a contact number and speak to a professional who can help with both health & social care issues
- For new patients a single assessment process that encompasses all aspects from health & social care

- A care pathway designed for and agreed with the client, that includes all appropriate services
- Devising training and development programmes for staff that provide common outcomes for care
- By pooling budgets and resources to gain maximum benefit for the client.

## The Process

- Steering Group Membership
- Timescales
- Action Plans.

# Appendix 4

## Elements of Service for Levels One Two and Three

### Level 1 elements

Sexual history taking (All practitioners)

Generic information for STI prevention/safer sex advice

Information re local GU provision

Information about the full range of contraceptive methods and where these are available

First prescription and continuing supply of oral contraception (combined + progestogen-only)

First prescription and continuing supply of injectable contraception

Emergency oral contraception

IUD/IUS routine follow-up

Referral for female sterilisation

Referral for vasectomy

Assessment and referral for psychosexual problem

Pre-conceptual advice/provision of folic acid

Counselling/screening for genetic disorders (sickle, thalassaemia, CF etc)

Primary investigation of menstrual disorders

Free NHS pregnancy testing and appropriate referral

Estimation of gestation (VE or U/S)

Referral for antenatal care

Testicular examination

Referral for TOP assessment

Cx cytology for screening programme

Referral for colposcopy for abnormalities from routine screening

Hepatitis B screening and immunisation

Chlamydia screening(urine) – men and women

HIV testing and counselling (with referral pathways)

Testing symptomatic women for STIs (GC, chlamydia, TV)

Sexual Abuse – assessment and referral

First episode herpes – assessment and referral

On-going supply of condoms for safer sex/contraception

Genital Warts – assessment and referral  
Substance misuse history (inc. IDU)  
Hepatitis C testing and counselling (with referral pathways)  
Appropriate management of vaginal discharge  
Men with symptomatic STIs – assessment and referral  
Awareness of local voluntary sector sexual health providers, referrals  
Recognition, assessment and onward referral re:FGM  
Diagnoses and treatment of UTIs in men (with referral)

## Level 2 elements

Problems with choice of contraceptive methods  
Investigation and treatment of problems with oral contraceptives  
Cu and medicated IUD insertion  
Emergency IUD insertion  
Diaphragm fitting and follow-up  
Contraceptive implant insertion and removal  
Screening asymptomatic women for STIs  
Screening asymptomatic men for STIs  
Testing symptomatic men for STIs  
Treating STIs  
Treatment of first episode herpes  
Treatment of genital warts (+ ref for all modalities)  
Tests of cure STIs  
Contact tracing/partner notification  
Management of recurrent herpes (including suppressive Rx) and initiation of suppressive treatment  
Management psychosexual problems  
Management organic sexual dysfunction  
Vasectomy surgery  
Assessment for TOP (self referral)  
School sexual health provision

## Level 3 elements

Outreach services for STI prevention/contraception

Colposcopy and out-patient treatment

Specialised HIV services

IUD/IUS problem clinics

Local co-ordination and specialist back-up for sexual assault including forensic sciences

Termination of pregnancy service

Vulval diseases (specialist dermatologist services)

Penile dermatoses (specialist dermatological services)

Specialist STI services (e.g.: Syphilis, recalcitrant TV, problem warts/HSV/recurrent NSU)

STI services for groups with special needs (e.g.: gay men, young people, some black and ethnic minority populations, sex workers)

Specialist contraception services (e.g.: new modalities, services for groups with special needs (young people, some black and ethnic minority populations, those with complex problems)

# Appendix 5

## Points that need to be addressed when Commissioning Abortion Services from the NHS or Independent Sector

### General

- All abortion provision must meet the requirements of the Abortion Act 1967, as amended.
- Account should be taken of doctors with a conscientious objection to abortion. GPs and other practitioners with a conscientious objection to abortion should make their views known to women and refer them to another doctor without delay.
- There are wide variations between PCTs (formerly health authority areas) in funding abortion services. The RCOG *recommends* that at least the NHS should fund 75% of induced abortions.
- The requirements of women with special needs should be addressed. Arrangements should be made for non-English speaking women and a woman doctor available as required.

Commissioners need to ensure that the abortion service they commission meets the needs of their local population. Services can be commissioned from NHS and independent sector providers, provision should be comprehensive and include [all or most of] the following elements:

### Access to services

- Printed information and a telephone help-line should be available to inform women on where to go for pregnancy testing (including free pregnancy testing), counselling and how to access abortion services in order that they can access these services quickly.
- A telephone referral system should be available or, failing that, referrals should be sent by fax, e-mail or 1st class post. Referrals should also be accepted from sources other than general practitioners i.e. family planning clinics, GUM clinics and the women themselves, in order to minimise delay.

### Information for women

- Accurate, impartial printed information, should be available to support verbal advice, which women considering abortion can understand and may take away and read before the procedure
- Information should also be available about possible complications and sequelae of abortion. The RCOG produce a patient leaflet which is available for use by the NHS and independent sector.

## Pre abortion management

- Facilities for additional support, including access to social services, should be available for those women who need more support in decision making than can be provided in routine clinic setting.
- Providers should have access to ultrasound scanning equipment for the cases where it is needed, for example where a gestation is in doubt.
- Chlamydia screening should be offered to women seeking a termination. Screening rather than prophylactic treatment offers women the option to notify their partners to protect themselves from re-infection.

## Service Provision

- Services should be available for all gestation bands. It is not acceptable to restrict services by the woman's age, gestation, income, parity or marital status.
- A choice of methods should be available for each gestation band.
- Waiting times should meet the standard set by the action plan and be no longer than a maximum of three weeks.
- An adequate number of staffed inpatient beds must be available for those women who are unsuitable for day-case care.
- As far as possible, women admitted for termination should be cared for separately from other gynaecological patients.

## Aftercare

- Anti-D IgG should be offered to all non-sensitised RhD negative women following abortion.
- Women should be given written information about the symptoms they may experience and state those that would make an urgent medical consultation necessary. A 24-hour help-line telephone number should be given for women worried about pain etc. Urgent clinical assessment, and emergency gynaecological admission must be available when necessary.
- Women should be offered a follow-up appointment within 2 weeks of the abortion.
- Referral for further counselling should be available for those women that require it.
- Before discharge, future contraception should have been discussed with each patient and supplies offered.

# Appendix 6

## Sources of help and further information for Professionals working in Sexual Health and HIV

### National (UK)

The following list represents a mix of UK professional bodies, voluntary and statutory agencies with a sexual health, family planning or HIV remit. As such, they are a potential source of information, advice and resources for professionals. Agency descriptions draw on a variety of sources, including the agencies' websites and the NAM UK AIDS Directory published by NAM Publications (see below).

These organisations and more can be found in the Gateway and Links sections of the NHPIS website at <http://www.hda-online.org.uk/html/nhpis>. The Links section also includes useful web-based sources of information and research, including journals, online databases and agencies overseas.

- **AGUM (Association of GUM)** – specialist medical society that provides advice and support for doctors practising genitourinary medicine (GUM) in the UK. Principally concerned with service issues. Maintains directory of GUM clinics for the UK & Republic of Ireland. Contact: Dr Immy Ahmed-Jushuf, Hon Secretary, Dept of Genito-Urinary Medicine, Nottingham City Hospital NHS Trust, Hucknall Road, Nottingham NG5 1PD. Tel: 01244 363 097; fax: 01294 363 095; Website: <http://www.agum.org.uk/>
- **AHPN (African HIV Policy Network)** – umbrella organisation for agencies working around HIV prevention and support with African communities in the UK. Co-ordinates development of national strategies with these communities and receives funding from the Department of Health to co-ordinate national HIV health promotion. Contact: Max Sesay, c/o NAT, New City Cloisters, 196 Old Street, London EC1V 9FR. Tel: 020 7814 6722; fax: 020 7216 0111; email: [max.sesay@nat.org.uk](mailto:max.sesay@nat.org.uk)
- **AIDSMap** – extensive HIV/AIDS gateway website, produced by NAM in collaboration with the British HIV Association and the International HIV/AIDS Alliance. Includes news, the latest treatment information, symptoms and illnesses, a personal pill planner and directories of organisations. Website: <http://www.aidsmap.com>
- **AVERT** – leading UK based AIDS education and medical research charity. The website consists of over 150 pages of information, and is accessed by more than 30,000 people a week. The free HIV/AIDS information service answers queries from students, health professionals, academics, as well as people living with HIV and AIDS and their friends and families. AVERT also operate the “AVERTING AIDS and HIV” international grant scheme. Contact: 4 Brighton Road, Horsham, RH13 5BA. Tel. 01403 210202; fax: 01403 211001; email: [avert@dial.pipex.com](mailto:avert@dial.pipex.com) or [info@avert.org](mailto:info@avert.org) website: <http://www.avert.org>
- **BHIVA (British HIV Association)** – A UK wide forum consisting mainly of medical practitioners who work primarily in the HIV field. Meets regularly with a view to developing practical therapy guidelines. Contact: Organising Secretariat, 1 Mountview Court, 310 Friern Barnet Lane, London, N20 0LD. Tel: 020 8446 8898; fax: 020 8446 9194; email: [bhiva@bhiva.org](mailto:bhiva@bhiva.org); website: <http://www.aidsmap.com/bhiva/index.htm>

- **Black Health Agency** – sexual health prevention services to black communities through the peer education project, the provision of a national African AIDS helpline and running training and awareness sessions. Support services to people infected and affected by HIV. Lead agency for the Northern Forum, which works on HIV prevention services for African communities across northern region of England. Contact: Zion Community Resource Centre, 339 Stretford Road, Manchester, M15 4ZY. Tel: 0161 226 9145; fax: 0161 227 9380; email: [info@blackhealthagency.org.uk](mailto:info@blackhealthagency.org.uk); website: <http://www.blackhealthagency.org.uk>
- **BPAS (British Pregnancy Advisory Service)** – charity established in 1968 to provide a safe, legal abortion service. Now Britain's largest private abortion provider, supports reproductive choice by advocating and providing services for those who wish to prevent or end an unplanned pregnancy. Provide fee-paying abortion services, and act as an agency for NHS funded abortions. Information for practitioners and public. Contact: Austey Manor, Wootton Wawen, Solihull, W Midlands B95 6BX. Tel: 01564 793 225; email: [info@bpas.org](mailto:info@bpas.org); <http://www.bpas.org.uk>
- **Brook** – information service first to young people on sexual health and educational issues, and then to provide information to professionals and adults. Target users are teachers, health promotion officers, youth and community workers, and health professionals (incl. doctors and nurses). Prevention-oriented: concerned primarily with sex education and research on prevention issue. Contact 421 Highgate Studios, 53–79 Highgate Road, London, NW5 1TL. Tel: 020 7284 6040; fax: 020 7284 6050; email: [admin@brookcentres.org.uk](mailto:admin@brookcentres.org.uk); website: <http://www.brook.org.uk>
- **CHAPS (Community HIV/AIDS Prevention Strategy) Partnership** – collaboration of agencies conducting prevention work with gay men in the UK. Funded by the Department of Health and co-ordinated by THT (see below). Produced *'Making It Count: A collaborative planning framework to reduce the incidence of HIV infection during sex between men'* in September 2000. Contact THT, 52–54 Grays Inn Road, London WC1X 8JU. Tel: 020 7831 0330; fax: 020 7242 0121; email: [info@tht.org.uk](mailto:info@tht.org.uk); website: <http://www.tht.org.uk>
- **CHILD – The National Infertility Support Network** – Founded in 1979 in the 'International Year of the Child', a registered charity which aims to provide high quality information and support to those suffering from infertility. Contact: Charter House, St Leonards Road, Bexhill-on-Sea, East Sussex, TN40 1JA. Tel: 01424 732 361; fax: 01424 731 858; email: [office@child.org.uk](mailto:office@child.org.uk); website: [www.child.org.uk](http://www.child.org.uk)
- **Centre for HIV & Sexual Health** – established in 1987. Works collaboratively in alliances with statutory and voluntary agencies and community groups in Sheffield, as well as forging links with organisations regionally, nationally and internationally. Training programme delivered throughout the UK on a broad variety of topics related to sexual health. Wide range of publications and resources including manuals, leaflets, games, posters, videos and tool-kits. Local work includes community development, support for teachers, schools and youth workers in Sex and Relationships Education, support for primary care staff, campaigns and capacity-building. Contact: 22 Collegiate Crescent, Sheffield, S10 2BA. Tel: 0114 226 1900; fax: 0114 226 1901; email: [chiv.admin@chs.nhs.uk](mailto:chiv.admin@chs.nhs.uk); website: <http://www.sexualhealthsheffield.co.uk>
- **Department of Health, Sexual Health and Substance Misuse team** – provides national leadership for implementation of the national sexual health and HIV strategy. Contact: Skipton House, 80 London Road, London SE1 6LH. Tel: 0207 972 2000; email: [Sexual-Health-&-HIV@doh.gsi.gov.uk](mailto:Sexual-Health-&-HIV@doh.gsi.gov.uk)
- **Department of Health, Teenage Pregnancy Unit** – provides leadership for national implementation for the teenage pregnancy strategy. Contact: Address and phone number as above; email: [MB-Teenage-Pregnancy-Unit@doh.gsi.gov.uk](mailto:MB-Teenage-Pregnancy-Unit@doh.gsi.gov.uk); website: [www.teenagepregnancyunit.gov.uk](http://www.teenagepregnancyunit.gov.uk)

- **Drugscope** – created through merger of the Institute for the Study of Drug Dependence (ISDD) and the Standing Conference on Drug Abuse (SCODA). Drugscope is a charity whose objective is to inform policy development and reduce drug-related risk. Library and resource centre includes ‘grey’ literature. Enquiry service provides information at various levels of complexity. Produces comprehensive range of publications. Contact: 32–46 Loman Street, London, SE1 0EE. Tel: 020 7928 1211; fax: 020 7928 1771; email: [services@drugscope.org.uk](mailto:services@drugscope.org.uk); website: <http://www.drugscope.org.uk>
- **HIV Commissioners Liaison Group (England)**. Contact: Rod Thomson (Chair) at email: [rod.thomson@southsefton-pct.nhs.uk](mailto:rod.thomson@southsefton-pct.nhs.uk)
- **Europap UK** – network of HIV/STI prevention in prostitution projects in UK and Europe. Contact: Imperial College School of Medicine, Norfolk Place, London, W2 1PG. Tel: 020 7594 3315; fax: 010 7402 2150; email: [europap@ic.ac.uk](mailto:europap@ic.ac.uk); website: <http://www.europap.net>
- **Faculty of Family Planning and Reproductive Health Care** – established in 1993, The Faculty grants diplomas, certificates and equivalent recognition of specialist knowledge and skills in family planning and reproductive health care. As a body, it promotes conferences and lectures, provides members with an advisory service and publishes *The Journal of Family Planning and Reproductive Health Care*. Contact: 19 Cornwall Terrace, London, NW1 4QP. email: [mail@ffprhc.org.uk](mailto:mail@ffprhc.org.uk); website: [www.ffprhc.org.uk](http://www.ffprhc.org.uk)
- **fpa** – registered charity working to improve the sexual and reproductive rights of all people throughout the UK. Provides publications and training for professionals, consumer leaflets on contraception, abortion and STIs, helpline for the public and professionals, reference library and information service, community projects, policy consultancy service. Contact: 2–12 Pentonville Road, London, N1 9FP Tel: 020 7837 5432; fax: 020 7837 3042; email: [susanm@fpa.org.uk](mailto:susanm@fpa.org.uk); website: <http://www.fpa.org.uk>. Also offices in Wales (Tel: 029 20 644 034), Scotland (Tel: 0141 576 5088), and Northern Ireland (Tel: 028 90 222 603). For publications and orders contact **fpa Direct**, PO Box 1078, East Oxford DO, Oxon OX4 6JE. Tel: 01865 719 418.
- **Fertility UK** – provides information to the general public and health professionals on all aspects of fertility awareness. Services include: evidence-based natural family planning (NFP) information and teaching services; fertility awareness education for sub-fertile couples; a range of educational resources; a referral service to local accredited NFP teachers; email helpline service for UK residents; university accredited training for health professionals. Contact: Bury Knowle Health Centre, 207 London Road, Headington, Oxford, OX3 9JA. email: [admin@fertilityuk.org](mailto:admin@fertilityuk.org); website: [www.fertilityuk.org](http://www.fertilityuk.org)
- **Gay Men Fighting AIDS** – founded in 1992 and in 2001 merged with Big Up, an organisation for Black gay men. Volunteers are supported and trained to develop health interventions for gay men, including workshops, press adverts, a newsletter and website. Interventions to improve the health of HIV positive gay men include press work and workshops. General health work includes smoking cessation workshops. Contact Unit 42 Eurolink Centre; 49 Effra Road, London, SW2 1BZ. Tel: 020 7738 6872; fax: 020 7738 7140; email: [gmfa@gmfa.demon.co.uk](mailto:gmfa@gmfa.demon.co.uk); website: <http://www.metromate.org.uk/>
- **Genito-Urinary Nurses Association** – a national association working to ensure the voice of genito-urinary nurses is heard. GUNA promotes GU nurses skills and development by improving education and training and encouraging networking with colleagues in the GU field of medicine. Contact: <http://www.guna.org.uk>
- **HealthPromis** – the national bibliographic database of the Health Development Agency (see below). It contains references to journal articles, books and reports on health promotion, evidence based health and health policy issues. The database covers a wide range of public

health topics and focuses on issues surrounding interventions, their evaluation and prevention in general. Its intended audience includes health professionals, policy makers and researchers. Website: <http://healthpromis.hda-online.org.uk>

- **Health Education Board for Scotland** – Scotland’s national agency for health education, health promotion, health advice and health information. Contact: Woodburn House, Canaan Lane, Edinburgh, EH10 4SG. Tel: 0131 536 5500; fax: 0131 536 5502; email: [infoservices@hebs.scot.nhs.uk](mailto:infoservices@hebs.scot.nhs.uk); website: [www.hebs.com](http://www.hebs.com)
- **Health Development Agency** – a special health authority, working to improve the health of people and communities in England, in particular, to reduce health inequalities. In partnership with others, it gathers evidence of what works, advises on standards and develops the skills of all those working to improve people’s health. Develops the evidence base for interventions to prevent HIV, STIs and teenage pregnancy. Provides the National HIV Prevention Information Service (see below). Hosts the National Healthy School Standard (NHSS) – a joint Department for Education and Skills (DFES) and Department of Health (DH) initiative to support the development of healthy schools in England through local education and Health Partnerships. Contact: Holborn Gate, 330 High Holborn, London, WC1V 7BA. Tel: 020 7430 0850; website: <http://www.hda-online.org.uk>
- **Health Promotion Agency for Northern Ireland** – set up in 1990 as a special agency of the Department of Health, Social Services and Public Safety (DHSSPS). Aims to provide leadership and strategic direction to all those involved in promoting health in Northern Ireland. Contact: 18 Ormeau Road, Belfast BT2 8HS. Tel: 028 9031 1611; fax: 028 9031 1711; email: [info@hpani.org.uk](mailto:info@hpani.org.uk); website: [www.healthpromotionagency.org.uk](http://www.healthpromotionagency.org.uk)
- **Health Protection Agency** – new agency from April 2003 to provide a dedicated field service and an integrated approach to protecting the public against infectious diseases and chemical and radiological hazards. Combines the existing functions of the Public Health Laboratory Service (see below), the National Radiological Protection Board, the Centre for Applied Microbiology & Research and the National Focus for Chemical Incidents; and brings together into one agency key professions working in health protection. This includes Consultants in Communicable Disease Control, Health Emergency Planning Advisors and Infection Control Nurses. <http://www.doh.gov.uk/cmo/hpa/index.htm>
- **Herpes Viruses Association** – started in 1981, now a registered charity. Aims to improve understanding of herpes viruses and help people with herpes viruses by: a helpline (020 7609 9061); a quarterly journal, *SPHERE*; leaflets on every aspect of herpes simplex; seminars, events, workshops, etc. Contact: 41 North Road, London, N7 9DP. Tel: 020 7607 9661; Website: <http://www.herpes.org.uk>
- **HIV Forum for Children and Young People** – brings together a wide range of organisations concerned with children, young people and HIV/AIDS. Aims to provide an effective voice for children and young people who are living with HIV and to build child-centred policy and practice recommendations. Undertakes national and local policy and practice development, the development and dissemination of good practice, lobbying, advocacy and media work. Contact: 8 Wakely Street, London EC1V 7QE. Tel: 020 7843 1911; fax: 020 7843 6053; website: <http://www.ncb.org.uk/hivforum/index.htm>
- **Human Fertilisation and Embryology Authority (HFEA)** – set up in the UK in 1991, ensures that all UK treatment clinics offering in vitro fertilisation (IVF) or donor insemination (DI), or storing eggs, sperm or embryos, conform to high medical and professional standards and are inspected regularly. Collects comprehensive data about such treatments, and provide detailed advice and information to the public. The HFEA also licenses and monitors all human embryo research, supervising controlled research for the benefit of humankind. Contact: Paxton House, 30 Artillery Lane, London, E1 7LS. Tel: 020 7377 5077; fax: 020 7377 1871; email: [admin@hfea.gov.uk](mailto:admin@hfea.gov.uk); website: [www.hfea.gov.uk](http://www.hfea.gov.uk)

- **Impotence Association** – a charitable organisation which was set up to help sufferers of impotence (erectile dysfunction) and their partners and to raise awareness of the condition amongst both the public and the medical profession. Contact PO Box 10296, London, SW17 9WH. Tel: 020 767 7791; email: [admin@impotence.org.uk](mailto:admin@impotence.org.uk); website: [www.impotence.org.uk](http://www.impotence.org.uk)
- **Institute of Psychosexual Medicine** – seeks to promote the study and practice of psychosexual medicine through seminar training and research. Contact: 12 Chandos Street, Cavendish Square, London, W1G 9DR. Tel: 020 7580 0631; website: [www.ipm.org.uk](http://www.ipm.org.uk)
- **ISSUE** – offers a confidential and comprehensive service, which includes factsheets, information, support, counselling and literature on infertility and reproductive health. Contact: The National Fertility Association, 114 Lichfield Street, Walshall, West Midlands, WS1 1SZ. Tel: 01922 722888; fax: 01922 640070; email: [glenis@issue.co.uk](mailto:glenis@issue.co.uk); website: [www.issue.co.uk](http://www.issue.co.uk)
- **Mainliners** – works with ex- and current injecting drug users and commercial sex workers affected and infected by HIV and hepatitis. Services include helpline, drop-in (including needle exchange), monthly magazine, training courses and seminars, and outreach work. Contact: 38–49 Kennington Park Road, London, SE11 4RS. Tel: 020 7582 5226; fax: 020 7582 6999; email: [linersmain@aol.com](mailto:linersmain@aol.com); website: <http://www.mliners.org>
- **Marie Stopes International** – a registered charity established in 1976 to provide sexual and reproductive health services. A major provider of abortion, vasectomy and female sterilisation services to both fee paying clients and under NHS agency agreements. Providers of general family planning and well woman/well man screening. Contact: 153–157 Cleveland Street, London, W1T 6QW. Tel: 020 7574 7400; fax: 020 7574 7417; email: [info@stopes.org.uk](mailto:info@stopes.org.uk); website: [www.mariestopes.org.uk/abortion-help.co.uk](http://www.mariestopes.org.uk/abortion-help.co.uk)
- **Medical Foundation for AIDS and Sexual Health** (formerly known as the BMA Foundation for AIDS) – charity which works with policy-makers and health professionals, to promote excellence in the prevention and management of HIV and other sexually transmitted infections. Supported by the British Medical Association. On behalf of the Department of Health, co-ordinated a project to produce updated national standards for NHS HIV services. Also, involved in a project to disseminate learning about managed networks and how obstacles to their development might be overcome. Contact: BMA House, Tavistock Square, London, WC1H 9JP. Tel: 020 7383 6345; fax: 020 7388 2544; email: [enquiries.medfash@medfash.bma.org.uk](mailto:enquiries.medfash@medfash.bma.org.uk); website: <http://www.medfash.org.uk>
- **MSSVD (Medical Society for the Study of Venereal Diseases)** – Independent medical foundation and educational body established in 1922 and based at the Royal Society of Medicine. Provides up to date information to consultants registrars, nurses clinical assistants, anyone involved in GU medicine. Promotes clinical research through special interest groups. Contact: Royal Society of Medicine, 1 Wimpole Street, London, W1M 8AE. Tel: 020 7290 2968; fax: 020 7290 2989; email: [mssvd@rsm.ac.uk](mailto:mssvd@rsm.ac.uk); website: [www.mssvd.org.uk](http://www.mssvd.org.uk)
- **MIDIRS (Midwives Information Resource Services)** – an educational charity set up in 1985. Aims to be the central source of information relating to childbirth and to disseminate this information to midwives and others, both nationally and internationally. Provides range of publications and services, including an enquiry service. Contact: 9 Elmsdale Road, Clifton, Bristol, BS8 1SL. Tel: 0800 581 009; fax: 0117 925 1792; website: <http://www.midirs.org/>
- **NAM Publications** – produces a range of resources, including AIDS Reference Manual, UK AIDS Directory of agencies, European AIDS Directory, HIV & AIDS Treatments Directory, AIDS Organisations Worldwide and AIDS Treatment Update newsletter. NAM's resources are also available online, including a treatments database, directory of service organisations, hundreds of links and free downloadable resources. Contact NAM Publications, 16a Clapham Common, London SW4 7AB. Tel: 020 7627 3200; fax: 020 7627 3101; email: [info@nam.org.uk](mailto:info@nam.org.uk); <http://www.aidsmap.com>

- **NANCSH (National Association of Nurses for Contraception and Sexual Health)** – the only national professional organisation for nurses working within contraception and sexual health. Contact: 9 Church Close, Drayton Bassett, Staffordshire, B78 3UJ. Tel: 01827 260117; fax: 01827 260154; email: [nancsh@dial.pipex.com](mailto:nancsh@dial.pipex.com); website: <http://www.nancsh.org.uk>
- **National AIDS Trust (NAT)** – policy and advocacy charity working to maximise prevention efforts and fight discrimination affecting people with HIV/AIDS. Sponsor of the UK HIV Policy Forum – a forum that brings together key voluntary sector agencies, researchers, user groups and commissioners to work collaboratively in HIV policy developments. Also sponsor of the English HIV policy Forum, a similar cross-sector forum, but with English remit. Involved in London, English and African HIV strategy developments. Produces *Impact*, a national HIV policy bulletin. Co-ordinates World AIDS Day activities. Contact: New City Cloisters, 196 Old Street, London, EC1V 9FR. Tel: 020 7814 6767; fax: 020 7216 0111; email: [info@nat.org.uk](mailto:info@nat.org.uk); website: <http://www.nat.org.uk>
- **Health Promotion Wales (National Assembly for Wales)** – promoting health and wellbeing in Wales. Contact: Cathays Park, Cardiff, CF10 3NQ. Tel: 029 2068 1245; email: [hpwebmaster@wales.gsi.gov.uk](mailto:hpwebmaster@wales.gsi.gov.uk); website: [www.hpw.wales.gov.uk](http://www.hpw.wales.gov.uk)
- **National HIV Prevention Information Service (NHPIS)** – a free specialist information service for people with a professional interest in HIV prevention, based at the Health Development Agency. NHPIS produces briefing papers, current awareness publications (Current HIV Education Research), an online catalogue to local reports, a Research and Practice/Interests Database (RAPID) and an extensive website with useful links and online publications. Tel: 020 7061 3192; fax: 020 7061 3393; email: [nhpis@hda-online.org.uk](mailto:nhpis@hda-online.org.uk); <http://www.hda-online.org.uk/nhpis>
- **National Youth Agency** – covers sexual health as relates to youth, youth workers in local authorities and others dealing specifically with youth issues. Publications include *Youth Policy Updates*, reading lists and briefing papers on government policy, sexual health and education. Published an education policy toolkit as part of a 2-year, government-funded project called *Sex and Relationships*. Contact: 17–23 Albion Street, Leicester, LE1 6GD. Tel: 0116 285 3700; fax: 0116 285 3777; email: [nya@nya.org.uk](mailto:nya@nya.org.uk); website: <http://www.nya.org.uk>
- **Naz Project London** – provides sexual health and HIV prevention and support services to the South Asian, Middle Eastern, North African, Horn of African and Latin American communities in London. Contact: Palingswick House (Annexe), 241 King Street, London, W6 9LP. Tel: 020 8741 1879; fax: 020 8741 9609; email: [naz@naz.org.uk](mailto:naz@naz.org.uk); website: <http://www.naz.org.uk/>
- **Network of Self-Help HIV/AIDS Groups** – independent voluntary organisation which was established in 1989 to promote good networking between new and existing HIV self-help and support groups throughout the UK. There are over 50 groups in The Network sharing skills, knowledge & expertise. Aim to ensure that the voice of people living with HIV is heard as a key contribution to the sector's response to the HIV pandemic. Contact: Eurolink Business Centre, Unit 14, 49 Effra Road, London, SW2 1BZ. Tel: 020 7738 7178; fax: 020 7274 0193; email: [admin@selfhelp.org.uk](mailto:admin@selfhelp.org.uk); website: <http://www.hivselfhelp.org.uk/>
- **Pan London HIV/AIDS Providers Consortium** – a consortium of over 50 voluntary and community organisations providing HIV services in the Greater London area. Works collaboratively with members to speak with a collective voice, understand and influence the policy agenda of local and national government, argue for improved strategic planning, develop joint working, develop standards for best practice and work with commissioners. Contact: New City Cloisters, 196 Old Street, London, EC1V 9FR. Tel: 020 7251 6188; fax: 020 7251 6599; email: [consort@consort.demon.co.uk](mailto:consort@consort.demon.co.uk)

- **Positively Women** – provides support and services to women living with HIV, including treatment advice, bi-monthly newsletter, support groups, outreach, advocacy and children's services. Contact: 347–349 City Road, London, EC1V 1LR. Tel: 020 7713 0444; fax: 020 7713 1020; email: [info@positivelywomen.org.uk](mailto:info@positivelywomen.org.uk); website: <http://www.positivelywomen.org.uk>
- **Public Health electronic Library (PHeL)** – 'virtual' branch library of the National electronic Library for Health. Co-ordinated by the HDA, PHeL is designed to help improve the dissemination and communication of information within the NHS and public health professionals. It contains information on policies, initiatives, organisations, networks, data, evidence, in-practice case studies, guidelines, websites and events. Website: <http://www.phel.gov.uk>; email: [phel@hda-online.org.uk](mailto:phel@hda-online.org.uk)
- **Public Health Laboratory Service (PHLS) Communicable Disease Surveillance Centre (CDSC)** – collates and analyses HIV/AIDS and STI surveillance data for England and the UK (in collaboration with Scottish Centre for Infection and Environmental Health). The website includes 'pdf' versions of the *Communicable Disease Report (CDR) Weekly*, *Communicable Disease and Public Health* (formerly CDR Review) and other reports. Also available are slides and factsheets. See under 'Facts & Figures', then choose 'AIDS' or 'HIV' or a specific STI. Contact: 61 Colindale Avenue, London, NW9 5DF. Tel: 020 8200 1295; fax: 020 8358 3130; email: [webadmin@phls.org.uk](mailto:webadmin@phls.org.uk); website: <http://www.phls.co.uk>
- **Royal College of General Practitioners (RCGP)** – provides information and advice on all aspects of primary care for GPs and other college members. Guidance to GPs on issues like confidentiality with people under 16 years of age. Has an HIV Working Group. Contact: 14 Princes Gate, Hyde Park, London, SW7 1PU. Tel: 020 7581 3232; fax: 020 7225 3047; email: [info@rcgp.org.uk](mailto:info@rcgp.org.uk) website: <http://www.rcgp.org.uk>
- **Royal College of Nursing (RCN)** – maintains a Sexual Health Forum and produces a Sexual Health bulletin for all nurses whose work involves a sexual health role. Has developed its own Sexual Health Strategy (November 2001). Contact: Royal College of Nursing, 20 Cavendish Square, London W1G 0RN. Tel: RCN Direct 0845 772 6100; Website: [www.rcn.org.uk](http://www.rcn.org.uk)
- **Sex Education Forum** – umbrella body founded in 1987 and based with the National Children's Bureau. Works within a broad sexual health framework, views sexual health and sex education as entitlements. Supports professionals working with children in all settings, not just schools. Produces free termly newsletter *Sex Education Matters*, each issue of which includes Forum Factsheets on issues like *Sex and relationships education for disabled children*. Other publications include *Framework for Sex and Relationships Education* and resource lists for working with different audiences. Contact: National Children's Bureau, 8 Wakely Street, London, EC1V 7QE. Email: [sexedforum@ncb.org.uk](mailto:sexedforum@ncb.org.uk); website: <http://www.ncb.org.uk/sef/>
- **Sigma Research** – social research group specialising in the behavioural and policy aspects of HIV, AIDS and sexual health; part of the University of Portsmouth. Work includes needs assessments, evaluations and service and policy reviews funded from a range of public sources. Sigma Research is the main research partner in the England-wide 'CHAPS' initiative, a collaborative HIV prevention strategy for gay men which is funded by the Department of Health. Contact: Unit 64 Eurolink Centre, 49 Effra Road, London, SW2 1BZ. Tel: 020 7737 6223; fax: 020 7737 7898; email: [admin@sigmaresearch.org.uk](mailto:admin@sigmaresearch.org.uk); website: <http://www.sigmaresearch.org.uk>
- **Society of Consultants in Reproductive Health** – national organisation for consultants in reproductive health and community gynaecology, concentrating on political issues and standards. Contact details: Alison Bigrigg (Director), The Sandyford Initiative, 2/6 Sandyford Place, Glasgow, G3 7NB Tel 0141 211 8157

- **Society of Health Advisers in Sexually Transmitted Diseases (SHASTD)** – national organisation with approximately 300 members out of an estimated 350 health advisers in the country. Provides opportunity for members to meet and work towards further professional development. Local groups meet regularly and an annual conference is held each Spring. The Society's Newsletter is produced 3 times per year. A Council of elected officers and regional representatives meets 6 times a year to set standards, produce statements and address specific issues by setting up working groups. Contact: MSF Centre, 33–37 Moreland Street, London, EC1V 8BB. Email: [shasts@talk21.com](mailto:shasts@talk21.com); website: <http://www.shasts.org.uk>
- **SPOD (Association to Aid the Sexual and Personal Relationships of the Disabled)** – aims to ensure disabled people's sexual identity and needs are recognised. Contact: 286 Camden Road, London N7 0BJ. Tel: 020 7607 8851; fax: 020 7700 0236; email: [info@spod-uk.org](mailto:info@spod-uk.org); website: <http://www.spod-uk.org>
- **Terrence Higgins Trust (THT) and Lighthouse** – established in 1982, THT is the leading HIV & AIDS charity in the UK and the largest in Europe. Produces health promotion campaigns and a wide range of resources for working with communities affected by HIV, including UK Africans and gay men. Also co-ordinates the CHAPS Partnership (see above) which delivers integrated HIV prevention interventions to gay men in cities where HIV is a particular problem. Produces research briefings and policy papers for professionals. Provides support and services for people living with HIV. Operates THT Direct Helpline (see Helplines below). Contact: 52–54 Grays Inn Road, London WC1X 8JU. Tel: 020 7831 0330; fax: 020 7242 0121; email: [info@tht.org.uk](mailto:info@tht.org.uk); website: <http://www.tht.org.uk>
- **UNAIDS** – as the main advocate for global action on HIV/AIDS, UNAIDS leads, strengthens and supports an expanded response aimed at preventing the transmission of HIV, providing care and support, reducing the vulnerability of individuals and communities to HIV/AIDS, and alleviating the impact of the epidemic. Contact: 20 Avenue Appia, CH-1211, Geneva 27, Switzerland. Tel: +4122 791 3666; fax: +4122 791 4187; email: [unaids@unaids.org](mailto:unaids@unaids.org); website: <http://www.unaids.org>
- **World AIDS Day** – commemorated around the globe on 1st December with news and events to highlight progress made in the battle against the epidemic. The National AIDS Trust co-ordinates UK activities and produces awareness and educational materials. <http://www.worldaidsday.org/>

## Helplines

- **BPAS (British Pregnancy Advisory Service)**. Tel: 08457 30 40 30.
- **Brook** – provides free confidential sex advice for young people. Tel: 0800 0185 023. Email enquiries to Brook at [information@brookcentres.org.uk](mailto:information@brookcentres.org.uk) or visit their website: [www.brook.org.uk](http://www.brook.org.uk)
- **London Lesbian and Gay Switchboard**. Tel: 020 7837 7324; website: [www.llgs.org.uk](http://www.llgs.org.uk)
- **Marie Stopes International**. Tel: 0845 300 8090; website: [www.mariestopes.org.uk/abortion-help.co.uk](http://www.mariestopes.org.uk/abortion-help.co.uk)
- **National AIDS Helpline** – free & confidential, 24 hours, 7 days/week. Tel: 0800 567 123
- **National Drugs Helpline** – free & confidential, 24 hours, 7 days/week. Tel: 0800 77 66 00
- **RESPOND** – sexual abuse issues regarding people with a learning disability. Tel: 0800 808 0700; website: [www.respond.org.uk](http://www.respond.org.uk)

- **Sexual Health Direct** (formerly the Contraceptive Education Service) – run by **fpa** – confidential information and advice on contraception and sexual health, for consumers and professionals, Mon-Fri 9am-7pm. Tel: 0845 310 1334.
- **Sexwise** – sexual health information for 12–18 year olds, 7am-midnight, 7 days/week. Tel: 0800 28 29 30
- **THT Direct Helpline** – gateway to HIV services, support and information. Operates Monday to Friday 10am to 10pm; 12pm to 6pm Saturday and Sunday. Tel: 0845 1221 200

## Local Agencies

A number of national agencies have local affiliations, including:

- Brook (see above)
- THT Lighthouse (see above)
- Network of Self Help HIV/AIDS Groups (see above)

Contact the national agencies above for details.

In developing local links, the following may be helpful starting points:

- Council for Voluntary Service (CVS) – a source of information on local voluntary and statutory agencies. Find them in the phone book.
- National Council for Voluntary Organisations (NCVO) – umbrella organisation for the voluntary sector in England. Produces a directory of organisations. Tel: 0800 2798 798; website: <http://www.ncvo-vol.org.uk>
- UK AIDS Directory – directory of over 2000 national and local HIV-related agencies (see NAM Publications above)
- Local Authority – education departments, social services, youth services, etc
- Schools (and school nurses)
- Teenage Pregnancy Co-ordinators – one for each local authority, plus there are regional co-ordinators at the Government Offices for the Regions (contact DH Teenage Pregnancy Unit above)
- Regional Public Health Observatories – see Association of Public Health Observatories at <http://www.pho.org.uk>
- Strategic Health Authority public health department/director
- Library or information department of local (ex) health authority
- PCT 'lead' for sexual health (contact DH policy team – see above)
- Family planning clinics (see phone book and fpa's website and helpline)

# Appendix 7

## Service Planning Monitoring and Evaluation Checklists for Improving Services at a Local Level

Checklists are intended as a tool for commissioners to assess relevance for their own areas, and to monitor service planning and developments according to local need. As stated earlier, it is important that commissioners and providers use the DH HIV standards document, the health promotion toolkit and training strategy in conjunction with this checklist. Professional bodies (e.g. FFPRHC, RCGP, RCOG, MSSVD, AGUM, BHIVA,) have assisted in this guidance by providing information on minimum elements for service delivery (*see section 4*), and have detailed guidance available on clinical practice and standards for service delivery. Combined they will offer detailed guidance on best practice and models of delivery.

Detailed teenage pregnancy action plans are in place across England to implement the teenage pregnancy strategy, and many areas have seen increased levels of funding in order to improve access to services for young people and increase partnership work across health, social care and health and voluntary sector organisations. A range of initiatives are therefore already underway which will add value to the aims of the broader national sexual health and HIV strategy. Partnerships with those currently involved, and lessons learnt from those experienced in providing sexual health services will increase the impact for local implementation.

Prior to beginning this process some commissioners will need to consider any potential gaps in their knowledge about their local area and national organisations, and may use Appendix 6 as an aide memoir to existing information and national sources of help available.

### Good Practice on Developing Service Level Agreements and Monitoring Arrangements

Contracts with NHS Trusts and other statutory services are agreed in formal arrangements between the PCTs and providers, and are mainly related to acute clinical commissioning. However, the agreements to deliver health promotion and prevention activities need formal processes which can enable both the commissioners and providers to develop agreements on activity levels. These should meet the needs of populations and facilitate implementation and therefore the aims of the strategy. Commissioners may also consider three year contracts in line with NHS planning guidance.

Commissioners and providers may find the ASTOR useful as a means of agreeing what proposed activities should aim to achieve.

### What is an Astor?

The **ASTOR** is a standardised planning tool that can be used to describe each planned sexual health promotion/HIV prevention intervention in terms of its **Aims, Setting, Targets, Objectives, Rationale/resources**; i.e. what and how much will be done, for whom in order to achieve specified

outcomes. The information contained within the ASTORs can be summarised to compile a series of **Activity Grids** that specify the contracted levels of activity within the **Service Level Agreement (SLA)** or contract between the commissioning body (PCT or consortium) and the service provider. Service providers can then monitor and report levels of activity against these pre-specified objectives. This standardised format also allows the commissioning body to maintain a database of all HIV prevention/sexual health promotion work being delivered in their area, thereby providing a detailed and searchable (e.g. by method, setting and target group) HIV prevention/sexual health promotion 'activity map'. Evaluation strategies can then be developed in line with the anticipated outcomes described in the ASTOR which will inform both the 'needs map' and the 'activity map' which will in turn inform the review of the local action plan of the HIV & Sexual Health Strategy

## Service Planning, Monitoring & Evaluation Process

The use of **ASTORS** for service level planning, monitoring and evaluation of activities can be achieved using the following process:

- agencies describe each activity/intervention they plan to deliver using standardised ASTOR format and submit to PCT
- completed ASTORs are assessed (type and level of activity, quality, scope, value for money, duplication etc.) against Sexual Health & HIV Strategy local action plan and agreed
- ASTORS are summarised into activity grids which describe the level of service delivery within the service level agreement
- the service level agreement (SLA) is 'signed off' by the agency and the commissioner
- the actions, measures and targets described in the activity grids of the SLA provide the criteria against which actual service delivery can be monitored and reported
- ASTORS also describe the project outcomes (i.e. what will be different for the target group after the project) which provide the criteria for evaluating the effectiveness of the project.

ACTIVITY GRID – example

Project Title & Summary	Target Population	Setting	Method	Activity	Targets	Intended Outcomes
<p><i>Scene Based Condom and Lube Distribution</i></p> <p>To provide scene using gay men with easy access to appropriate condoms and lube via gay scene based distribution</p>	<p>Scene using gay men</p>	<p>Gay businesses &amp; venues</p> <p>Gay beaches</p> <p>Gay community orgs</p>	<p>Direct contact</p>	<p>Maintain agreement from gay venues to act as distribution points</p>	<p>Agreement from 95% of gay venues</p>	<p>All men are equipped and competent to negotiate sex</p> <p>Men have easy access to strong condoms and water-based lube</p> <p>Men have the skills to correctly use condoms and lube</p>
				<p>Recruit sessional workers</p>	<p>3</p>	
				<p>Run training events for sessional workers</p>	<p>3 sessions per year</p>	
				<p>Hold regular packing sessions</p>	<p>Minimum 4 sessions per month</p>	
				<p>Distribute condoms and lube to venues</p>	<p>12000 per month</p>	
				<p>Inform men of new developments with condoms and lube</p>	<p>As required</p>	

## ASTOR – example

<b>Project Title:</b> Scene based condom distribution	<b>Name of Project Lead:</b> Charlie Smith – Open Body Services-South	
<b>Project Aim:</b> (short summary of objectives and outcomes) To distribute free condoms and lube to gay men on the gay scene.		
<b>Target Population:</b> (who is the project targeted at?) Scene using gay men	<b>Setting:</b> (where will the project take place?) Gay businesses & venues	
<b>Method:</b> (list the health promotion method/s utilised by the project) Direct Contact Health Promotion		
Project Objectives: (what will you do to make the project happen?) Gain agreement from gay venues for condom bowl placement. Hold regular packing sessions Recruit sessional workers. Run training events for sessional workers per year. Distribute condoms & lube to venues each week.	<b>Measures: (what will you monitor?)</b> number of venues number of sessions number of sessional workers employed number of training sessions number of condoms distributed	<b>Targets:</b> 95% of gay venues min 4 per month 3 3 per year 15 000/month
<b>Project Outcomes:</b> (what will be different for the target group after the project?) [These should relate directly or indirectly to the MIC health promotion aims] <b>All men are equipped and competent to negotiate sex. (Aim 2)</b>		
<ul style="list-style-type: none"> <li>Men have easy access to strong condoms and water-based lubricants (2.3)</li> <li>Men have the skills to correctly use condoms and lubricant (2.4)</li> </ul>		
<b>Rationale:</b> (what evidence has informed the project?)		
<ul style="list-style-type: none"> <li>Gay Men's HIV Prevention Strategy</li> <li>Rubberstuffers evaluation</li> <li>Gay Men's Sex Survey</li> <li>Zorro</li> </ul>		
<b>Evaluation:</b> (how will you find out if the project has done what it set out to do?)		
<ul style="list-style-type: none"> <li>Feedback from venues owners/managers/staff re: uptake of condoms.</li> <li>Monitoring of number of condoms provided to venues.</li> <li>Question re: access to condoms in population study (e.g. NGMSS, Lesbian &amp; Gay Community Needs Assessment).</li> </ul>		
<b>Partners:</b> (who else will be involved in the project?) Gay venues		
<b>Budget:</b> £54 000 – resources		

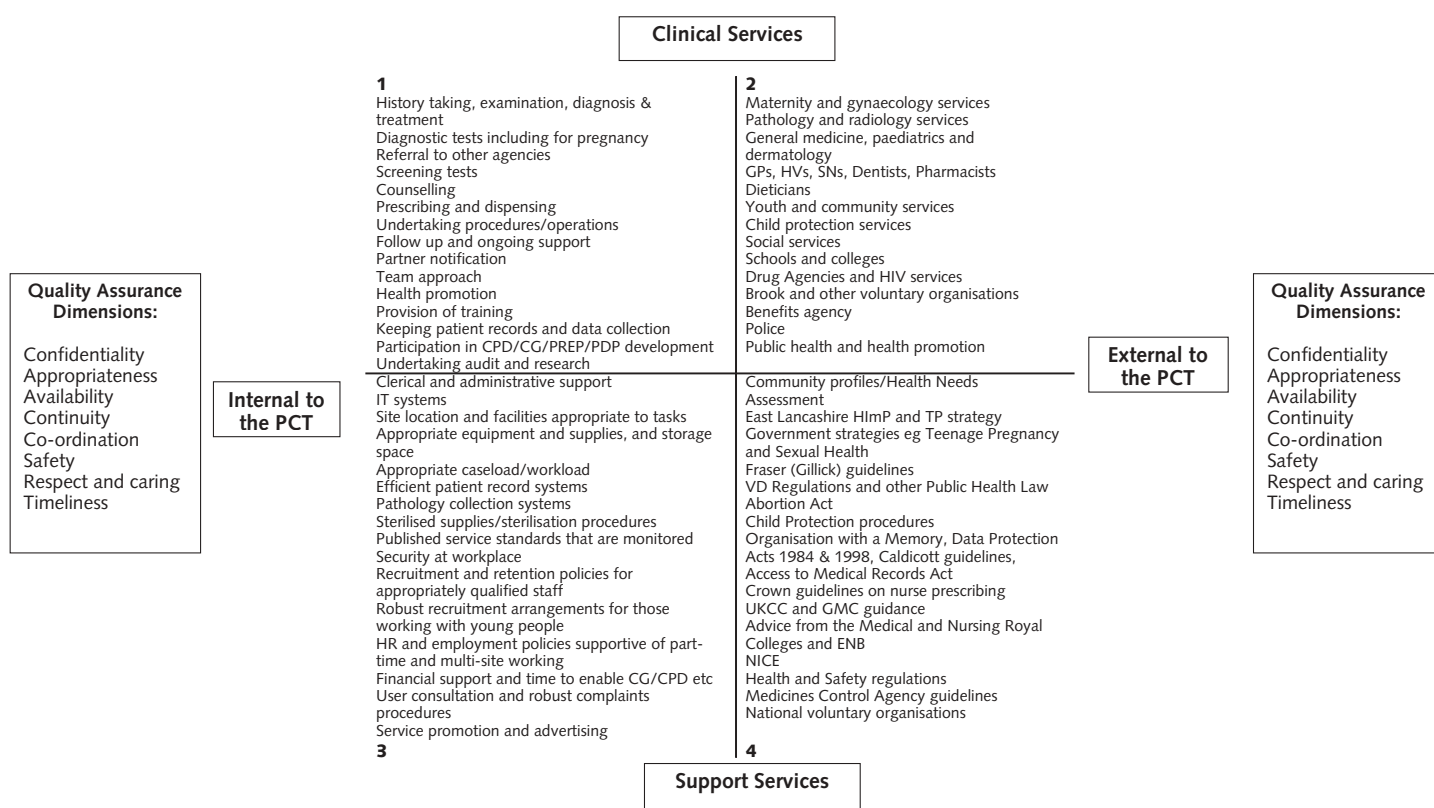
# Appendix 8

## Example Clinical Governance Framework

A clinical governance framework for professionals providing sexual health services:

The figure illustrates a possible clinical governance model for sexual services. It is based on a primary care clinical governance model developed by Professor Ellie Scrivens.

### A Clinical Governance Framework For Sexual Health Services



**Quadrant 1:** The rationale of the framework is that health professionals and their employers will need to ensure that they are able to provide a range of services/tasks outlined in this quadrant. The tasks described are for a “generic” professional providing a sexual health service, the balance of which will depend on the nature of the service and the health needs of the clients seen. The framework can be redrawn to consider individual aspects of professional activity in more detail. Clearly, appropriate training and qualifications are mandatory. Trusts and their employees have a dual responsibility to ensure that they are appropriately qualified to undertake the tasks expected of them and to remain up-to-date. Quality assurance in professional activity should develop a needs led, evidence based and consistent approaches. This is largely the responsibility of individual health professionals and teams. If shortfalls are identified these should be made known to Trust managers. The quality assurance boxes in the figure suggests a range of dimensions that need to be considered to ensure high quality services are (and are seen to be) provided.

**Quadrant 2:** This identifies in broad terms the important linkages that health professionals need in order to undertake their clinical work, such linkages need to be recognised, promoted, developed and fostered by Trusts.

**Quadrant 3:** lists the organisational support that health professionals require when undertaking their clinical work. Responsibility to ensure adequate provision of this essential non-clinical support lies with the Trust.

**Quadrant 4:** lists some of the national and local policy context in which sexual health services are operating. It also recognises community and district health needs as a backdrop for the service. Awareness of this milieu should be a professional and Trust responsibility.

## Conclusions:

Effective contributions and support from health professionals will help deliver high quality sexual health services. The clinical governance framework outlined here indicates that in order for health professionals to undertake clinical tasks safely and effectively, they are dependent on the active support of other professionals and agencies. Efficiency in sexual health services will require staff to have appropriate caseloads/workloads, the use of evidence based protocols, regular intra and inter professional links and meetings, sufficient opportunities for CPD and audit, and having adequate administrative infrastructure. Trusts providing these services should be able to demonstrate how such features will be recognised, safeguarded, developed and managed. The best available advice is that when Trusts develop their sexual health strategies they seek appropriate professional advice and support.

# References

The National Strategy for sexual health and HIV

**Published: London, Department of Health, 2001. Available from Department of Health, PO Box 777, London SE1 6XH**

The National Strategy for sexual health and HIV Implementation Action Plan

**Published: London, Department of Health, 2002. Available from Department of Health, PO Box 777, London SE1 6XH**

Shifting the Balance of Power within the NHS:

Securing Delivery/Department of Health

**Publisher: London, Department of Health. Available from Department of Health, PO Box 777, London SE1 6XH, 2001**

The **fpa's** Guide to Commissioning Sexual Health Services

**Publisher: London (2–12 Pentonville Road, London N1 9FP): Family Planning Association, 1998**

The New NHS Modern Dependable

**UK Gov corp auth: Department of Health**

**Publisher: London: The Stationery Office, 1997**

**Monograph series: (Cm; 3807)**

# Glossary

<b>ACA</b>	AIDS CONTROL ACT
<b>ASG</b>	AIDS SUPPORT GRANT
<b>ASTORS</b>	AIMS, SETTINGS,TARGETS,OBJECTIVES,RESULTS
<b>AGUM</b>	ASSOCIATION OF GENITO URINARY MEDICINE
<b>BHIVA</b>	BRITISH HIV ASSOCIATION
<b>DH</b>	DEPARTMENT OF HEALTH
<b>FFPRHC</b>	FACULTY OF FAMILY PLANNING AND REPRODUCTIVE HEALTH CARE
<b>fpa</b>	(formerly) FAMILY PLANNING ASSOCIATION
<b>GMS</b>	GENERAL MEDICAL SERVICES
<b>GPs</b>	GENERAL PRACTITIONERS
<b>GUM</b>	GENITO URINARY MEDICINE
<b>HAART</b>	HIGHLY ACTIVE ANTIRETROVIRAL THERAPY
<b>HCHS</b>	HOSPITAL AND COMMUNITY SERVICES
<b>HIV</b>	HUMAN IMMUNODEFICIENCY VIRUS
<b>LMC</b>	LOCAL MEDICAL COMMITTEE
<b>MEDFASH</b>	MEDICAL FOUNDATION FOR AIDS AND SEXUAL HEALTH
<b>MSSVD</b>	MEDICAL SOCIETY FOR VENEREAL DISEASE
<b>PCTs</b>	PRIMARY CARE TRUSTS
<b>PGDs</b>	PATIENT GROUP DIRECTIONS
<b>PHLS</b>	PUBLIC HEALTH LABORATORY SERVICE
<b>PMS</b>	PERSONAL MEDICAL SERVICES
<b>RCGP</b>	ROYAL COLLEGE OF GENERAL PRACTITIONERS
<b>RCN</b>	ROYAL COLLEGE OF NURSING
<b>RCOG</b>	ROYAL COLLEGE OF OBSTETRICS AND GYNAECOLOGISTS
<b>StHAs</b>	STRATEGIC HEALTH AUTHORITIES
<b>SLA</b>	SERVICE LEVEL AGREEMENTS
<b>STIs</b>	SEXUALLY TRANSMITTED INFECTIONS
<b>THT</b>	TERENCE HIGGINS TRUST







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*30404/Effective Commissioning of Sexual Health and HIV Services* can also be made available on request in braille, on audio cassette tape, on disk, in large print, and in other languages on request.

*30404/Effective Commissioning of Sexual Health and HIV Services* is available on the department's website at: [www.doh.gov.uk/sexualhealthandhiv](http://www.doh.gov.uk/sexualhealthandhiv)