


Moving forward: Progress and priorities – working together for high-quality sexual health

Government response to the Independent Advisory Group's review of the National Strategy for Sexual Health and HIV



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Ministerial Foreword



Good sexual health is an important aspect of health and wellbeing and it is vital that people have the information, confidence and the means to make choices that are right for them. It helps people to develop positive relationships and enables them to protect themselves and their partners from infections and unintended pregnancy.

The Government published the first ever national strategy for Sexual Health and HIV in 2001, *Better prevention, Better services, Better sexual health: The national strategy for sexual health and HIV*, in recognition of the need to ensure services are available that meet people's needs and to address rising levels of sexually transmitted infections (STIs) and unintended pregnancies. This groundbreaking approach set out to transform and modernise sexual health services in England, reduce STIs, HIV and unintended pregnancies.

Over the last eight years, a huge amount of work has gone into implementing this ambitious programme of work within Government and across all levels of the NHS. We are highlighting some of the key achievements in the following pages. The Government's continuing commitment to improving sexual health was underlined in *High Quality Care for All*, which was published in 2008. It identified sexual health as being one of the six priority areas for Primary Care Trusts (PCTs) to commission comprehensive wellbeing and prevention services to meet the needs of their local population.

The work that has been undertaken to date to implement the Sexual Health and HIV Strategy has had a real impact on the lives of many people. They are now able to access clinics more quickly and the range of services they receive has greatly improved. We need to make sure these improvements are sustained and embedded to ensure swifter progress is made and rates of STIs and unintended pregnancies are reduced.

It is important to review progress and examine what more needs to be done, so we commissioned the Independent Advisory Group (IAG) for Sexual Health and HIV to review the implementation of the strategy. The IAG are to be congratulated on the high quality and comprehensive report they produced in July 2008. The Government's response highlights how the Government will implement the national level recommendations over the next two years.

The current ten-year sexual health strategy ends in 2011. It is vital that we start shaping what we can do to improve sexual health. At the beginning of 2010, I look forward to bringing together all the main players who can help us to make even more of a positive difference to people's lives.

A handwritten signature in black ink that reads "Gillian Merron". The signature is written in a cursive, flowing style with a small horizontal line underneath the name.

Gillian Merron MP
Minister of State for Public Health

1. Introduction

1.1 The sexual health strategy

1. The first ever holistic strategy for sexual health, *Better prevention, better services, better sexual health – The national strategy for sexual health and HIV*, was published in July 2001. Following consultation, a detailed implementation action plan was published in the following year. A huge amount of work has been undertaken to take forward these actions as highlighted in Appendix 2 of *Progress and priorities – working together for high quality sexual health*.

1.2 Priority and targets for sexual health

2. Since the strategy was published, sexual health has been identified as a priority area for action in the NHS. Targets and indicators include the following:
 - A 50% reduction in the under-18 conception rate (births and abortions) by 2010 (from the 1998 baseline rate). This is one of five lead indicators used to measure progress on the Public Service Agreement increase the number of children and young people on the path to success (PSA14).
 - The NHS Operating Frameworks for 2008/09 and 2009/10 include a tier two Vital Signs indicator for reducing the prevalence of chlamydia. The target includes screening the following proportions of 15–24-year-olds for chlamydia: 17% in 2008/09, 25% in 2009/10 and 35% in 2010/11.
 - The 48-hour genito-urinary medicine (GUM) access target is included in the Operating Framework for 2009/10 as a standard to be maintained.
3. National Support Teams (NSTs) for sexual health, teenage pregnancy and response to sexual violence are continuing to support the most challenged primary care trusts (PCTs), especially on the chlamydia screening target, teenage pregnancy and contraception.

1.3 The strategy review and recommendations

4. In 2007, the Government commissioned the Independent Advisory Group (IAG) to undertake a review of progress in implementing the 2001 sexual health and HIV strategy.
5. The aim of the strategy review was to review the impact of the sexual health and HIV strategy, highlighting developments since publication and making recommendations for the future. In particular, the strategy review was commissioned to consider the following areas of change:
 - policy changes (for example, strengthened commissioning, health reform, shifting the balance of power)
 - structural changes (for example, devolution of decision making, NHS configuration)
 - service delivery changes (for example, plurality of service delivery, integration of services)
 - clinical changes (for example, development of the role of nurses and pharmacists, treatment practices).
6. The IAG subsequently commissioned the Medical Foundation for AIDS and Sexual Health (MedFASH) to work with them in developing the strategy review. Their comprehensive report entitled *Progress and priorities – working together for high quality sexual health* was published in July 2008. The report was welcomed by the Government which noted that it provided a detailed and wide-ranging analysis of what has been achieved to date and what still needs to be done to make sure that people have the information and services that meet current and future needs.
7. The report highlights priority action in five key stage areas:
 - prioritising sexual health as a key public health issue and sustaining high-level leadership at local, regional and national level
 - building strategic partnerships
 - commissioning for improved sexual health
 - investing more in prevention
 - delivering modern sexual health services.
8. The report contains 70 cross-cutting recommendations for national (26 recommendations), regional (12 recommendations) and local

(32 recommendations) level action. The report recognises the progress that has been made in implementing the strategy to date but also highlights many of the challenges that have been faced in both changing sexual behaviour and improving service provision across all areas of sexual health. This response focuses on the recommendations made at national level. It is for strategic health authorities (SHAs) and PCTs to consider the implementation of the regional and local level recommendations, on a voluntary basis.

9. However, to support implementation at a regional level, the Department of Health (DH) worked with Keith Wilson at the Government Office for Yorkshire and The Humber to undertake a review of co-ordination of the various roles managing sexual health and teenage pregnancy at regional level. This review came up with a number of useful findings and we are working with regional colleagues to take forward implementation. In particular, we are working with South West SHA to pilot bringing together all staff working in different organisations (the SHA, Government Offices and Health Protection Agency (HPA)) into one team and under one manager to strengthen regional co-ordination and delivery. This work and emerging outcomes will be shared with other regional colleagues.
10. It should be highlighted that sexual health is a very broad area, which affects and impacts upon most of the population. While the original strategy was ambitious and set out a challenging programme of work to improve the sexual health of the population, those at highest risk of poor sexual health are often from specific population groups with varying needs. These groups include: young people; men who have sex with men (MSM); people from African communities; people living with HIV; sex workers; victims of trafficking; victims of sexual and domestic violence and abuse; and other marginalised or vulnerable groups. As recognised in *Progress and priorities*, it has been necessary to prioritise some of these groups in order to make progress and achieve results.

1.4 The future of sexual health

11. The current strategy ends in 2011 and consideration is already being given to what further action will be needed to continue to make improvements to sexual health. The outputs from the sexual health conference to be held early next year will form the basis for the Government's consideration as to the next steps.

2. Achievements since 2001

2.1 Sexually transmitted infections and HIV

12. We recognise that, overall, the number of sexually transmitted infections (STIs) has continued to increase since the strategy was published. However, the reasons for this are complex. We have seen major improvements in access to GUM services, alongside significant increases in capacity (there was a 28% increase in attendances in 2007/08 and a 14% increase in 2008/09). We are also seeing more people coming forward for screening than ever before; in England there was a 16% increase in the number of people screened for STIs in 2007. In 2006, 38% of those screened tested positive for an STI; in 2007, this reduced to 35%.
13. This means that more people are being tested and therefore having infections detected. It also means that more people than ever before are getting the information, tests and advice they need. Rapid treatment and detection cuts the risk of transmitting STIs. If this increased access is maintained, we believe it could have a significant impact on the control of STIs in the coming years. However, there is no room for complacency and the overall increase in infections again highlights the need, identified in the strategy, to continue to take urgent action to tackle STIs.
14. Since publication of the 2001 strategy, life expectancy and HIV treatment regimens continue to improve, and for many HIV is increasingly seen as a manageable long-term condition. We have also seen an increase in community-based HIV testing services, and increased uptake of voluntary HIV testing in both MSM and heterosexuals. However, although more HIV testing is taking place, around a quarter of people with HIV are unaware they have HIV. Increasing the offer and uptake of HIV testing and improving its detection in non-HIV specialist settings remains a priority.
15. Following publication of *Health Inequalities: Progress and Next Steps* in 2008, we are funding eight new projects, both within and outside London, aimed at piloting new approaches to HIV testing in a range of health and community-based settings. DH has committed to reducing the level of undiagnosed HIV by offering HIV testing outside traditional GUM settings, including community and primary care settings. DH has allocated £750,000

for this work in 2008/09, and the projects will be evaluated to see whether further work is needed.

16. We have sustained and increased our investment to £2.9m a year in our targeted HIV health promotion programmes for MSM and African communities, managed by the Terrence Higgins Trust and the African HIV Policy Network respectively. The Terrence Higgins Trust, through the CHAPS partnership, designs and delivers information, campaign and other materials specifically targeting MSM. The African HIV Policy Network, through the National African HIV Prevention Programme, develops and disseminates information and materials on HIV prevention, targeting people from African communities living in England.
17. To help those who are living with HIV, the AIDS Support Grant, provided to local authorities to support their HIV social care packages, has increased following the 2007 Comprehensive Spending Review (CSR) from £16.5m in 2001/02 to £21.8m in 2009/10 and £25.5m in 2010/11.
18. We recognise that actual or perceived stigma and discrimination can have a detrimental effect on uptake of testing and other services. In May 2007, DH published *Tackling HIV stigma and discrimination*, setting out the action DH and other government departments are taking to reduce HIV-related stigma. This included funding for the National AIDS Trust, NAM Publications and MedFASH to deliver on priorities for action identified by the DH consultation. All of these projects have now been completed.
19. We have also funded work through the African HIV Policy Network, to produce two linked toolkits to help Christian and Muslim faith leaders to address issues of stigma around HIV within their communities. Research has shown that the majority of Africans living in the UK are adherents of either the Christian or Muslim faiths and that support from their faith, leaders and communities is an important factor in combating the stigma they still suffer around HIV. These toolkits were launched in June 2009.
20. Since 1997 broader government action, including the legislative and policy developments on equalities, will have helped to address HIV-related stigma and create a social environment that is supportive of HIV health promotion. Examples include the repeal of Section 28, the equalisation of the age of consent, the introduction of civil partnerships and the amendments to the Disability Discrimination Act 2005, which now covers HIV from the point of diagnosis (rather than from the onset of AIDS).

2.2 Access to genito-urinary medicine

21. There has been considerable investment in and focus on supporting improvements to GUM clinics since the strategy was published. This includes investment to improve the quality of the buildings in which services are provided. *Progress and priorities* acknowledges that there have been vastly improved waiting times for GUM, and that DH should continue to build on this success and move forward with offering local services that meet the needs of the community. We are keen to improve access to sexual healthcare services by offering people more convenient options for getting screening and testing, including in non-healthcare community settings to relieve the burden on traditional more specialist services.
22. Between 2005/06 and 2007/08 there was a national Local Delivery Plan target that, by March 2008, all first attendees at GUM clinics should be offered an appointment to be seen within 48 hours of contacting the service. In March 2008 this target was delivered, with:
 - 99% of patients offered an appointment to be seen within 48 hours; and
 - 86% of patients seen within 48 hours.
23. The latest data shows that the target, on the whole, is being sustained (99.8% offered appointments and 87.8% seen within 48 hours in March 2009). As an existing standard, GUM access was, and continues to be, a Care Quality Commission indicator for both PCTs and acute trusts. Now that the target has been delivered, an 'operational standard' has been agreed of 98% of patients to be offered an appointment within 48 hours. This tolerance of 98% allows services a small amount of legitimate flexibility, while maintaining a challenging target. The sexual health NST continues to support areas in maintaining and improving access, while the DH Performance Delivery Team is continuing to performance manage organisations against these operating standards.
24. In addition, since April 2007 we have been using a new monitoring system to assess progress towards the target, with data collected directly from clinics on a monthly basis. This dataset, called the genito-urinary medicine access monthly monitoring (GUMAMM), can be used to monitor and assure equality of access on the basis of ethnicity, gender and age, patient choice and the patient's perspective on waiting times.

2.3 National Chlamydia Screening Programme

25. Genital chlamydia infection is the most commonly diagnosed STI among young people attending GUM clinics in England, accounting for 65% of all cases. Young people (aged between 16 and 24) represent only 12% of the population but account for nearly half of all people with STIs.
26. In 2003, the Government introduced the National Chlamydia Screening Programme (NCSP), and every PCT in England is now offering screening as part of the programme. Opportunistic screening is offered to all sexually active women and men, aged under 25 years, in a variety of health and non-healthcare settings such as youth services, prisons and military bases. This opportunistic approach has been found to be effective in reaching those at highest risk.
27. The data for 2008/09 shows that PCTs have made significant progress since last year, with 15.9% of the target population tested. Since the programme was launched in 2003, we have seen the following:
 - Nearly 1.5 million (1,462,637) tests have been performed by the NCSP between 2003 and the end of March 2009, increasing from just over 17,000 in 2003/04 to nearly 760,000 (759,027) in 2008/09.
 - We have seen a positivity rate of 8.8% among screened women and 7.4% in screened men since the programme began. The highest positivity levels were found in women aged 16–19, men aged 20–24, those reporting behavioural risk factors and certain ethnic groups.
 - Those screened were mostly of white ethnicity (67%) and female (71%). The proportion of screens in men has increased year on year (year 1: 7%; year 6: 33%).
 - Screening is occurring in an increasingly diverse range of settings, with the majority in community contraceptive and sexual health services (33%), general practice (15%) and educational settings (11%).
28. The NCSP gives immediate benefit to everyone who takes part and means that we are able to stop chlamydia in its tracks. Chlamydia can lead to problems that include infertility in women and can be carried unknowingly by men as well as women. By detecting it earlier we are making a real and measurable difference to the lives of young people. The rate of screening of young people is a major achievement and it is essential to continue to make progress and increase screening volumes so that we can consider moving to a more outcome-focused indicator on reducing chlamydia prevalence.

29. A review of the delivery of the programme has recently been completed by Dr Ruth Hussey, Regional Director of Public Health for NHS North West. We are now implementing the findings from the review.
30. With the programme now established and showing the ability to screen at increased levels, during 2009/10 DH will be introducing a public campaign encouraging young people to accept chlamydia screening when offered.

2.4 Public sexual health campaign

31. In November 2006 we launched the Condom Essential Wear campaign, which aims to normalise condom use among 18–24 year olds in order to protect against STIs. The campaign tracking has indicated very high levels of campaign awareness and message clarity. It has also indicated increased awareness of the need for condom usage during casual sex, and for protection against STIs. The tracking has also noted indications of increased condom usage, particularly among those aged 25 to 34 years, with a significant proportion attributing this directly to media influence. This dovetails with the public campaign work (*RUThinking?* and *Want respect? Use a condom*) undertaken by the Department for Children, Schools and Families (DCSF) and provides a continuous messaging programme for all age groups – from under 16 to adulthood.
32. Following the announcement of new money for contraception services, the campaign strategy has been reconsidered to incorporate not only condom normalisation and contraception but also support to the NCSP, now that screening levels have increased significantly. This review is looking at how messages that the target audience see as contradictory can be successfully combined. The new communication strategy will come into effect in late 2009. We anticipate that this will continue the progress made thus far by the previous sexual health and teenage pregnancy campaigns in reshaping the presentation of sex and relationships across society.
33. In addition, following demand identified by the NSTs, regional social marketing posts have been funded in each SHA area. Their role has been to support areas in developing social marketing strategies that effectively target those most at risk.

2.5 Contraception

34. As the IAG's report highlights, improving contraceptive services is key to delivering the strategy's aim of reducing unintended pregnancies. We are now implementing a comprehensive programme of work to support accelerated delivery in this area.
35. In February 2008 we announced an extra £26.8m investment for 2008/09 to improve women's access to contraception and help to reduce the number of teenage pregnancies.
36. Of this, £12.8m was allocated to PCTs in their main allocations. DH wrote to PCTs in June 2008, via the NHS publication *The week* to note that the allocations included £12.8m to improve contraceptive services. PCT general allocations were further uplifted by 5.5% in 2009/10.
37. In 2008/09 £10m of this funding was allocated to SHAs, with a further £10m in 2009/10, to be used innovatively in those areas with high levels of teenage pregnancy and repeat abortion rates. Both the teenage pregnancy and sexual health NSTs have been assisting commissioners in how best to target these additional resources. We are aware that a number of excellent projects have already been funded using these additional funds, and we fully expect that these projects will help to build improved and sustainable contraceptive services in the future. It is particularly encouraging to see that many projects focus on the provision of long-acting reversible contraceptives (LARC), which have a higher rate of efficacy than other contraceptives such as the pill.
38. £2m was also allocated to develop contraceptive services in further education (FE) colleges. In 2009/10, the money is being used as follows:
 - £1.6m has been allocated to SHAs for them to support improvements in local sexual health services for young people in FE.
 - £0.4m will be used for initiatives that directly support the FE sector, including a focus on staff training, sexual health services for those with learning difficulties and improvements in STI screening.
39. A programme to support consistent implementation of You're Welcome has been put into place across the nine regions working through the Government Offices. At the end of March 2009, 68% of PCT areas had signed up to implement You're Welcome and work to its national priorities for 2009/10. These include general practice, health services in education settings, contraception and sexual health services and abortion service providers.

40. Ensuring that people receive accurate information about contraception is a key priority. Section 3.4 gives details of the contraception element of DH's forthcoming sexual health campaign. In addition, from 1 April 2009 GPs were incentivised through the Quality and Outcomes Framework (QOF) to give their patients improved advice on contraception, particularly on long-acting reversible methods of contraception.

2.6 Teenage pregnancy

41. Despite a small (2.6%) increase in the under-18 conception rate between 2006 and 2007, the 2007 rate is still 10.7% lower than it was in 1998 – the baseline year for the teenage pregnancy strategy. Within the overall reduction in under-18 conceptions, teenage births have fallen by almost a quarter, whereas teenage abortions have increased by 6.5%.
42. Progress across the country is mixed. While a fifth of local areas have achieved under-18 conception rate reductions of over 20% (twice the national average), a similar proportion of local areas have rates that are static or increasing. Additional support has been provided to areas with high and increasing rates, through Government Offices and the NST for teenage pregnancy.
43. The additional funding to improve access to contraception referred to in Section 3.5 is, in part, being used to develop contraceptive and sexual health services in places that young people can access easily, such as schools and FE colleges. A mapping survey conducted in 2007 by the Sex Education Forum shows that around three-quarters of colleges and 30% of secondary schools now provide some level of contraceptive and sexual health (CASH) provision – in some cases offering a broad CASH service providing advice, condoms, emergency contraception, pregnancy testing, STI screening and a range of contraception options, including LARC.
44. The Government's decision to make personal, social and health education (PSHE) statutory in all key stages, including sex and relationships education (SRE), will ensure that young people receive a more comprehensive SRE programme and a more consistent offer across all schools.

2.7 Abortion

45. The latest data for 2008 shows that we have made excellent progress in improving access to abortion services, with more abortions being performed at earlier stages in pregnancy than ever before: 90% of all abortions in 2008

were carried out at under 13 weeks and 73% at under ten weeks. What is more, an ever-increasing number were funded by the NHS: 91% in 2008 compared with 78% in 2002.

46. Many areas have made changes to their services to help reduce barriers to access, and this is reflected in the number of women able to have their abortions earlier. This shift has also allowed women more choice of the method of abortion: 38% of all abortions in 2008 were early-medical abortions, and this number continues to rise. That is why we are progressing our work to develop a protocol to allow the provision of early medical abortion in a community medical setting.
47. The need to link contraceptive and abortion services with a clear and short patient pathway is regarded as good clinical practice, and will be stressed in the good practice guidance for the commissioning and provision of contraceptive and abortion services that will be published later this year.
48. We have also taken steps to tackle repeat abortions by ensuring that, from 1 April 2009, the national contract for the provisions on NHS abortions includes a requirement for providers to supply women with post-abortion contraception and advice. DH is working with stakeholders to develop a standard service specification that will improve the delivery of abortion services (including contraception) and will reduce unacceptable local variations in the standard of service provided. This framework will be ready for use from April 2010.

2.8 Conclusion

49. These are just some of the actions that we have taken since the first sexual health strategy was published in 2001. The recommendations that the IAG has produced will further help and support progress towards achieving the strategy's aims.
50. In the following section we provide a more detailed response to the review's national recommendations and how we are taking forward implementation.

3. Response to national-level recommendations

Note: page numbers following the recommendations relate to the IAG's report, *Progress and priorities – working together for high quality sexual health*.

3.1 Priority for action 1: Prioritise sexual health as a public health issue and sustain high-level leadership at local, regional and national level

Provide strong and effective leadership for sexual health and maintain it as a priority public health issue across government. (p50)

Adopt a more integrated, cross-governmental approach that recognises the importance of good sexual health in achieving general well-being and keeping people healthy as well as the relationship between sexual ill-health, poverty and social exclusion. Explicitly, it should link sexual health policy to all other related policy areas at national, regional and local levels. Draw up a map of these links and the opportunities they provide to further sexual health, in order to direct national and regional effort, and support those working at a local level in making the connections across various policy areas. (p52 – under priority for action 2 – Build strategic partnerships).

51. As already highlighted, the Government remains committed to improving sexual health and providing strong and effective leadership in this area. As well as setting national targets and indicators this commitment is demonstrated by inclusion of sexual health in *High Quality Care for All*. Sexual health and teenage pregnancy indicators feature in the National Indicator set. Teenage pregnancy is the second most popular indicator (chosen by 106 local areas) in the National Indicator set and is the fifth most popular indicator chosen by PCTs in terms of their commissioning priorities. This highlights the level of commitment at local level to making progress.
52. DH is currently taking forward a piece of work, as part of the delivery of *High Quality Care for All* to strengthen and link all aspects of the prevention agenda, including sexual health. While this work is at an early stage at present, we expect that the agenda it sets will allow strong links between practitioners at local level to be forged or re-forged, and that local people will benefit from this new approach.

53. To ensure that all the work we are undertaking to implement the strategy supports the DH's duties towards equality, we are currently producing an equality impact assessment for sexual health work at the national level.
54. Governance for monitoring progress on sexual health and teenage pregnancy is through senior level boards within DH (Performance Committee) and DCSF (Youth Board). The Youth Board is responsible for ensuring delivery of the Government's youth PSA, 'to increase the number of children and young people on the path to success'. In doing so the Board:
- prioritises the strands and projects
 - ensures that delivery plans for the strands and projects within the programme are developed, owned and implemented
 - provides direction regarding issues/risks that are escalated and in turn escalate any issues to the Permanent Secretary's Group
 - ensures that any strands and projects are appropriately resourced
 - ensures that the appropriate links are made within the programme, with other PSAs and other government departments so that the programme continues to work effectively across government.
55. Departments with representation on the Youth Board include DCSF, DH, Cabinet Office, HM Treasury, including the Prime Minister's Delivery Unit, Ministry of Justice, Home Office, Department for Work and Pensions, Communities and Local Government, Department for Culture, Media and Sport and Department for Business, Innovation and Skills.
56. Other initiatives from within DH and other government departments that impact positively on sexual health, include the following.

You're Welcome

57. A programme to support the consistent implementation of You're Welcome has been put into place across the nine regions working through the Government Offices. The funding has contributed to the delivery of:
- the first wave of services to be awarded the You're Welcome quality mark. Over half were contraceptive service providers plus one GP and an abortion service provider
 - regional events showcasing You're Welcome application in all nine Government Office areas

- You're Welcome within GUM services, in consultation with the British Association for Sexual Health and HIV (BASHH).
58. At the end of March 2009, 68% of PCT areas had signed up to implement You're Welcome and work to the national priorities for You're Welcome 2009/10. These include general practice, health services in education settings, contraception and sexual health services and abortion service providers.
 59. The inclusion of sexual health in Lord Darzi's *High Quality Care for All* was a clear call to action for senior leaders in the NHS, who have now produced plans to ensure that sexual health remains a top local priority.
 60. On teenage pregnancy in particular, Ministers and other senior leaders work closely with areas facing the greatest challenges to help them to improve their performance, and DH plans to undertake further management support for NHS organisations.

Cross-departmental work on HIV

61. DH works with other government departments and agencies to ensure issues relating to HIV are addressed. Examples include working with the Crown Prosecution Service, the Ministry of Justice and voluntary sector partners on the Crown Prosecution Service's policy statement and guidance to prosecutors on the intentional or reckless sexual transmission of infection, and working with the UK Border Agency on migrants with HIV.
62. DH also works with the Department for International Development, supporting them in implementing *Achieving Universal Access – the UK's Strategy for halting and reversing the spread of HIV in the developing world*. DH also participates in the European Commission's AIDS think tank, which that has provided opportunities to share with others our good practice on national HIV health promotion programmes for MSM and African communities.

e-Learning for Healthcare

63. The DH e-Learning for Healthcare programme develops and delivers nationally quality assured e-learning material to support the professional and generic workforce's learning and development, and to improve multi-disciplinary team working.

64. e-Learning for Healthcare is currently working with the Faculty of Sexual and Reproductive Healthcare (FSRH) to develop materials which will allow the FSRH to offer some elements of its Diploma and Letters of Competence in Subdermal Implants and Intrauterine Contraceptives online. The comprehensive curriculum currently under development includes:
- contraception
 - sexually transmitted infections
 - planning a family
 - early pregnancy assessment including referral for abortion
 - recognising psychosexual problems
 - providing care for young people
 - the law relating to confidentiality, to sexual activity and to young people.
65. It is hoped that all of the modules will be available from January 2010.
66. e-Learning for Healthcare, BASHH and the Royal Colleges of Physicians are working together on a project for specialist training in sexual health and HIV. This project will deliver a comprehensive e-learning programme comprising all the knowledge components of the UK sexual health and HIV specialist medical training curriculum. The programme will be delivered in three levels (introductory, advanced and specialist), and will consist of approximately 200 e-learning sessions, each around 20 minutes in length. The training package is designed to provide the knowledge framework, which can then be supplemented by training in clinical settings. It is anticipated that doctors will be able to register for e-learning in sexual health and HIV during the academic year 2009/10.

Cross-departmental work on sexual violence

67. DH is working closely with the Home Office to ensure delivery of a high quality and holistic service for victims of sexual violence, whatever their age, gender or social circumstance, including sex workers and those who are victims of trafficking. Victims should receive the help and support they need quickly in order to overcome the physical, sexual and mental health impacts. They should be safe and be able to access high-quality care and support – no matter where they live.
68. The Department has recently established a NST on Response to Sexual Violence with funding of £1.4million. Working with the Home Office, its role

is to deliver on the Home Secretary's commitment that each Police Force area should have a Sexual Assault Referral Centre (SARC) by 2011. The team works locally to bring together experts from the health service (including sexual health, children and young people, mental health, primary care and emergency medicine), SARCs, forensic services, the Crown Prosecution Service, the third sector and the police to advise on developing local service provision for victims of sexual violence.

69. As part of the current cross-government violence against women and girls strategy consultation, a Health Task Force has been established to identify the role and the response of health services in preventing, identifying and supporting women and girls who are victims of violence and abuse, and to make recommendations on what more could be done to meet their physical, sexual and mental health needs.

Links between alcohol and sexual health

70. Work has started to look at how the Government can better support research, interventions and prevention for sexual health and alcohol misuse in young people to reduce risk-taking behaviour. It will also consider the role of alcohol in sexual violence and abuse and the resulting impact on the victim's sexual health. A consultation meeting with researchers, academics and public health professionals took place on 5 May 2009. Work to implement the findings from the workshop will take place over the next year.
71. All of this activity demonstrates that cross-government working on sexual health is in place. Work has already started to map sexual health to other government priorities and this will be published by the end of the year.

Case Study: The Bridge Sexual Assault Referral Centre

The Bridge Sexual Assault Referral Centre (SARC) is located on the second floor of Bristol's Sexual Health Service. This location allows users of the SARC direct access to specialist sexual health services. Facilities available in the building include a contraceptive advice service, a pregnancy advice service, a sexual health screening service and HIV Post Exposure Prophylaxis after Sexual Exposure provision. Sexual health advisors, psychosexual counsellors and specialised GUM doctors are also available on site. The sexual health facility also offers a drop-in facility that generates referrals to The Bridge where victims are able to be seen immediately and can discuss the options that are available to them.

The pathways between all of the services allows for direct access to any of them and an information sharing policy ensures that all the victim's needs are met quickly and sensitively. Sexual Health services are an intrinsic part of the victim's care plans and contribute to the high standards of care that all of them receive.

There is also the capacity to hold case conferences and become part of shared learning. Regular teaching sessions and group meetings are also available to The Bridge staff, contributing to their learning and development, which is of clear benefit to victims.

Develop a single local inter-agency sexual health performance scorecard to support active management, and assist with local prioritisation and the monitoring of improvement and progress by PCTs and SHAs/Government Offices, as appropriate. (p50)

72. DH supports this recommendation and implementation has already commenced. In July 2008, the South West Public Health Observatory was commissioned to develop a balanced scorecard for sexual health.
73. This scorecard will be a voluntary aid that could be used to support the development and performance management of sexual health. It will be a source of information for public health, sexual health commissioning and performance management. It will act as a tool to enable service providers and commissioners to run reports, view and compare the latest data in a variety of formats, including PCT-level maps, tables and graphs. Some of these reports will be open access while others will have access restricted to service providers and commissioners. Composite sexual health indices that will enable rapid local assessments of sexual health are also in development.

74. The first phase of the scorecard will be available from the end of August 2009. It will focus on young people and the indicators recommended by the IAG in their review and will allow for the monitoring of the following:
- proxy indicators of the joint DH/DCSF PSA target on teenage conceptions
 - outcomes of the deployment of contraception monies to SHAs.

Strengthen national support to local services by extending the role of the NST to other areas of sexual health service provision (e.g. contraceptive and abortion services). (p50)

75. The DH NST for sexual health has proven to be very beneficial in securing partnerships with PCTs and sustaining access to GUM services. However, the sexual health NST's visits in the past three years have also addressed broader issues and routinely include strategic planning and commissioning of a broad range of sexual health services, which includes chlamydia, contraception and abortion services. The intention has been to ensure that local sexual health epidemiological evidence is used by public health workers to inform commissioning intentions in line with the sexual health strategy.
76. In addition, the teenage pregnancy NST advises on contraception and sexual health services and abortion, both in terms of commissioning and service provision. Although the focus of their work is on young people, the whole range of sexual health services is considered.
77. Feedback from PCTs and sexual health services demonstrates that NST input is valued. Over the past 12 months the NSTs have taken on a remit to assist PCTs to deliver on chlamydia screening. In addition, they are supporting SHAs and PCTs to improve access to LARC. However, there remains scope for developing and refining this remit further and the sexual health NST will continue to use this approach to support delivery of the strategy over the next few years. In future, this will take into account progress against the balanced scorecard, as described above.
78. DH is determined to deliver a high quality and holistic service for all victims of sexual assault, which is why it has recently established a response to sexual violence NST. Working with the Home Office, its role is to deliver on the Home Secretary's commitment that each police force area should have a SARC by 2011 (see paragraph 68).

Use the NST to share learning and disseminate good practice (e.g. develop the *High Impact Changes* publication approach taken for GUM 48-hour access, extending to chlamydia screening and contraceptive services). (p51)

79. We agree that the NSTs for sexual health, teenage pregnancy and the response to sexual violence have a key role to play in sharing and disseminating good practice. Over the past three years, NSTs have developed and commissioned guides such as the *10 High Impact Changes: For Genitourinary Medicine 48-hour access* (2006); *Sexual Health Needs Assessment – a how to Guide* (2007); *Genitourinary Medicine 48-hour Access: Getting to target and staying there* (2008); Commissioning chlamydia screening *Quick wins and sustainable services: Hitting the target without missing the point*. (HPA 2008) and work is underway on further guidance.
80. In their work with individual PCTs, the NSTs undertake initial diagnostic assessments that help to identify both strengths and challenges. The NST then makes specific recommendations for improving commissioning and delivery systems. Follow-up support provides customised interventions to improve and sustain performance, such as a stakeholder workshop to develop and expand local chlamydia screening activity.
81. In addition, the NSTs regularly share good practice at local, regional, and national conferences. This work will continue and the NSTs will work to develop a database of good practice to be shared with the local areas.
82. The NST works closely with the NCSP team at the HPA who have an important role to play in disseminating good and emerging practice in delivering chlamydia screening. The NCSP encourages PCTs to evaluate new initiatives and to share learning. The NCSP is also commissioned to continue to develop relevant practice guidance, which is informed by evidence and local experience.
83. In addition to the NSTs, the DH sexual health policy team now includes a dedicated post working with SHAs to provide support, advice and guidance on effective use of the funding that has been allocated to them to work with PCTs in improving access to contraception. This intensive, 'hands-on' support has been welcomed by SHAs and should help to ensure that the projects initiated with these time-limited funds are sustained into the future.

Ensure there is an overarching body or mechanism for strategic overview and planning in sexual health research, involving the DH, the HPA and the research community, and with input from policy-makers, commissioners and practitioners. (p51)

Review the research funded by the DH/Medical Research Council Sexual Health and HIV Research Strategy Committee and through other funding streams (e.g. National Prevention Research Initiative), to identify continuing evidence gaps and establish effective mechanisms to foster evidence building and knowledge transfer. (p51)

Establish a central register of research and good practice not published elsewhere, with inclusion subject to selection criteria and peer review. (p51)

Build infrastructure and training to support independent clinical research in sexual health, particularly in areas where it is currently weak, notably contraception. (p51)

84. We are pleased that the report recognises there is now a much improved evidence base in the UK for sexual health, but we recognise that more can be done.
85. We will give consideration to how we can work with others to enable strategic overview and planning of sexual health research – taking into account existing structures, partnerships and joint planning mechanisms.
86. DH will always consider funding good-quality research that supports our sexual health and HIV priorities. DH funds research and development through two main routes:
 - The National Institute for Health Research (NIHR) is a virtual institute specifically designed to deliver the Government's research strategy *Best Research for Best Health* – a new national health research strategy. It has a key role in supporting clinical and applied research and translating health research findings into health and economic benefits for the UK.
 - The DH Policy Research Programme (PRP) commissions research to provide the evidence base for policy development and evaluation of policy implementation in health and adult social care.
87. We recognise the importance of knowledge transfer, and we will explore how policy-makers can make best use of existing research evidence and

data, including how to disseminate research findings to commissioners and front-line providers. In so doing we will look at ways of engaging with and building on existing initiatives, such as the synthesis and spread of knowledge through NHS evidence.

88. We accept, as a general point, the importance of promoting the recruitment, retention and development of research staff across all health professions. The NIHR and its partners are funding programmes to build research capacity and facilitate research career pathways across a range of professions, including doctors, GPs, nurses, midwives and allied health professionals.

3.2 Priority for action 2: Build strategic partnerships

Review how elements of the sexual health and HIV strategy focusing on young people can be better integrated at national, regional and local level with the teenage pregnancy strategy to meet the holistic sexual health needs of all young people in terms of both education and service provision. (p52)

89. We have already taken action to strengthen joint working with DCSF and the Teenage Pregnancy Unit to better integrate the sexual health and teenage pregnancy strategies. We have done this in a number of ways. The additional funding for contraception that has been allocated to SHAs and PCTs is being used to help to reduce teenage conceptions, but should also result in improved contraception services for women of all ages. As already highlighted, the sexual health policy team is working closely with SHAs to ensure that this funding is used as effectively as possible, especially in teenage pregnancy hotspots.
90. *Healthy lives, brighter futures*, the cross-government strategy for children and young people's health, has highlighted the inseparable nature of health, learning and achievement. We are using the interlinked frameworks of You're Welcome, the Healthy Further Education Programme and the National Healthy Schools Programme to encourage the development of high-quality services that are more responsive to young people's needs. The partnerships that are being built to develop locally appropriate services are involving young people in design, review and evaluation. This approach is helping to improve accessibility and acceptability of health information, advice, treatment and care for teenagers, including those in vulnerable groups.
91. We are also highlighting the need to ensure that organisations locally are working together to ensure that sexual health policy, in particular the

chlamydia screening programme, works in conjunction with the teenage pregnancy strategy to ensure young people receive high-quality sexual health interventions, including contraceptive and relationship advice, however they access services or sexual health professionals. The work currently being undertaken on improving access to sexual health services in FE colleges, and in encouraging local organisations to meet the You're Welcome service standards, will be of particular relevance.

92. The work to integrate roles on sexual health, teenage pregnancy and chlamydia in the South West SHA (see section 1.3) will also support the integration of service delivery.
93. The work of the response to sexual violence NST includes building partnerships across all sectors working with young people to ensure they are able to identify and address the needs of young people who have been victims of sexual violence. It includes improving pathways and provision of services for young people who have been victims of sexual violence or coercive sex.

Case study: Using theatre to educate teenagers in the East of England

The East of England SHA's teenage pregnancy lead has helped fund a theatre production company to run workshops in schools in certain parts of the region. All of the workshops were well-evaluated by both staff and students, and additional funding has been provided to cover some of the post-production cost of turning the theatre play into a feature length film. The SHA has commissioned the workshop using this film to be held in every college in the region.

Case Study: Integrating media work within East Sussex PCT supported improvements in chlamydia screening rates

East Sussex PCT has integrated its sexual health, teenage pregnancy and chlamydia media work and created a media steering group which delivers three sexual health campaigns a year. Working in this way, the budgets have been pooled and a marketing coordinator has been appointed to support the chlamydia work.

The campaigns run through schools, community settings and youth work and deliver three key messages about unwanted pregnancies, condom use and chlamydia screening. This approach has been multi-agency and has made use of youth workers, clinicians and support teams to deliver the key messages. The branding that has been developed is evidence-based and tested using the social marketing model.

The results have been very impressive and chlamydia screening performance went from 2% to 13% in the three-month period following the launch of the initial campaign in December 2008.

Give due recognition to the unique role the national third sector has in driving forward and shaping developments in sexual health and HIV. In line with the strategy set out in government's review of the third sector, ensure it is a valued and core part of the continuing national dialogue, and that it is appropriately funded to sustain and support this role. (p52)

94. Following the Third Sector Funding and Investment Review, completed earlier last year, new third-sector funding arrangements aimed at increasing transparency and effectiveness have been introduced. The Section 64 General Scheme of Grants has been replaced by the Third Sector Investment Programme which, for 2009, has two new funding programmes.
95. The Innovation, Excellence and Service Development Fund seeks to support third-sector organisations to test and develop new, innovative approaches to improving health and well-being; promote and disseminate practice that is proven to achieve excellent outcomes; build the capacity and capability of third-sector organisations to develop sustainable and stable business models, including connecting with the health and social care commissioning and system management environment.

96. The fund also supports projects with the potential for national impact in line with DH objectives of better health and well-being and better care for all. Organisations can apply individually, or in partnership with others. The fund will support capacity building of third-sector organisations, enabling previous Section 64 core grant holders to develop their organisation through a more sustainable business model. We have planned for a budget of up to £6.4 million in 2009/10 to support this fund.
97. The Third Sector Strategic Partner Programme represents a shift from historical relationships where the department has 'core' funded organisations to more strategically relevant investment in developing the capability of the third sector and supporting clear, coordinated communication from the sector to the department and vice versa.
98. The programme is a cross-cutting approach that will work across DH policy areas, through the partners, to build wider third-sector capability and understanding of the health and social care environment to enable the sector to engage in a more informed way to utilise their full potential.
99. We have planned for a budget of up to £2 million in 2009/10 to support this programme. We are considering how the programme will develop in 2010 and are in the process of identifying the specific gaps in terms of reach across and into the third sector through the existing cohort of strategic partners.
100. Since the launch of the sexual health strategy in 2001, DH has invested £11 million in core and project support grants to 40 third-sector organisations in the sexual health and HIV field. As well as supporting the development of innovative approaches in encouraging increases in testing and better access to services (especially among black and minority ethnic groups), the funding has provided stability to a number of organisations which has enabled them to play a leading role in the delivery of the national strategy. In particular, DH has increased the funding provided to the Terrence Higgins Trust, fpa and the African HIV Policy Network to support the expansion of their national programmes of work in HIV prevention and sexual health.

Engage and fully involve the professional bodies representing sexual health providers, such as doctors, nurses and health advisers, to offer leadership within their professions in support of innovation and service evolution. (p52)

101. We agree that it is essential that we continue to work with relevant professional bodies to ensure strong leadership and achieve common aims

