

**A NEW
SEXUAL HEALTH
STRATEGY FOR
WALSALL (2009):**

**towards high quality
prevention and
accessible integrated
services**

Executive Summary



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Executive summary

Sexual health is a leading priority for the NHS, following a sustained rising incidence of human immunodeficiency virus (HIV) and sexually transmitted infections (STIs), while there are continuing concerns regarding teenage pregnancy and access to termination of pregnancy (ToP). Genitourinary medicine (GUM) clinics and family planning (FP) services struggle to address need and meet demand. This is certainly the case in Walsall. Sexual health is a significant health inequality; another NHS priority, requiring responsive and user friendly services to address equity and specific needs. Accordingly, there is a national focus on changing delivery of sexual health services, particularly in making them more integrated and accessible. These are all issues that challenge those who plan and deliver sexual health services in Walsall. They provide the background to this document, which updates the previous 2003-2006 strategy and its elaboration within the Director of Public Health's Annual Report: *Sexual health in Walsall* (Walsall PCT 2003). That strategy in 2003 responded to the National Strategy in 2001 and the action plan that followed in 2002 (Department of Health 2001, 2002).

Poor sexual health can have serious long term consequences. HIV infections are fatal if they remain undetected and untreated; some STIs may lead to malignancy. STIs can remain silent and all can be transmitted to unsuspecting contacts. Unwanted pregnancies and sexual dysfunction can have a devastating and life long impact on people's lives. Many affected people experience shame and face major obstacles, or have concerns about confidentiality, in freely discussing their problems. This often results in too late a presentation for effective advice, help or treatment. It is clear that while sexual health services must be accessible, they must always convey a strong sense of human understanding, trust, and confidentiality.

This report presents a renewed strategic approach to sexual health, reflecting the vision of NHS Walsall. It is informed by a recent comprehensive needs assessment of sexual health across the borough of Walsall, and by recent commissioning work that has demanded the collaboration of providers from the acute trust, community health, primary care, specialist groups, health promotion, and the local authority, to establish a model of sexual health service provision that is accessible, integrated, efficient, and effective. This strategic approach has two overall aims:

- Improve the sexual health of the Walsall population.
- Reduce sexual health inequalities.

In order to meet these aims, a number of objectives have been identified:

- Reduce the transmission of STIs and HIV by targeted prevention and health promotion, together with effective screening and timely interventions that focus on treatment and contact tracing.
- Provide accessible, high quality, integrated sexual health services that are sensitive to a person's needs around issues of confidentiality, stigma, and sexual wellbeing.
- Pay particular attention to the clear sign-posting of services that target the young people of Walsall to ensure:
 - 1 full compliance with the teenage pregnancy strategy
 - 2 timely and equitable access to termination of pregnancy.
- Enhance the effectiveness of existing services that target gay and bisexual men, sub-Saharan African people, and commercial sex workers.
- Establish the targeting of socially excluded and *hard to reach* groups of Walsall people, especially regarding undetected STIs and HIV, and uptake of appropriate contraception.
- Improve the detection of hidden, unmet sexual health need in the general Walsall population, particularly with regard to sexual dysfunction.

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Walsall has a high incidence of STIs although, in line with data nationwide, rates have started to plateau or decline. The borough had the highest rates of syphilis in the West Midlands (2005), as outbreaks swept through the country. Rates exceeded those for TB, with more than 100 cases annually (previously, Walsall recorded one or two cases per year). This led to the combined deployment of GUM and specialist outreach services to target, screen and treat one high risk group, gay and bisexual men. Again, rates for this STI have since declined. Another STI, *Chlamydia trachomatis*, has been the subject of the recently introduced national screening programme that targets young people. Around 10% have been screened positive, conforming to the national average, but screening in a socially excluded area of Walsall detected 20%. This reinforces our second principal aim of needing to address sexual health inequalities, by targeting *hard to reach* groups.

HIV presents a particular challenge, since affected people live longer and so the resource required to treat them increases. Gay and bisexual men (otherwise referred to as MSM: men who have sex with men) are still the leading risk group for acquiring the infection within the UK, but numbers of new HIV infections are now highest among immigrant groups (generally acquired heterosexually in their countries of origin). People arriving from sub-Saharan Africa are those with the highest rates of HIV. Both high risk groups in Walsall continue to be the focus of specialist outreach teams, but there needs to be an improved coordination with other local services.

Recent commissioning of sexual health services across the UK has been influenced by the national policy of provision through an integrated *hub and spoke* model, the aim being to maximise the potential of available resources, providing the right treatment to the right people at the right time and place. This is being adopted in Walsall, along with the recognition that young people will need to be provided with services through an entire range of networks, extending to modern information technology. Convenience combined with high discretion will be to the fore, along with prevention and community based strategies, and pro-active screening.

Over the past 10 years, Walsall had among the highest rates for teenage pregnancy in the West Midlands. Rates have since reduced significantly through implementation of a successful strategy. Progress towards teenage pregnancy targets is now steady. As a reward for this effort, a recent official audit suggested that Walsall should approach the Department of Health (DH) for a revised and realistic target to ensure continued high morale. Rates for access to ToP were among the worst in the country, especially for early medical abortion. Again, steady progress has since been made, but it will be important to maintain this improvement. Plans have already been made to step up progress in 2009/10, through developing sexual health and contraceptive services, and increasing access to abortion. The following provides examples of key activity areas:

- Sexual health centres in primary care
- *One stop* integrated GUM/FP service
- Early medical ToP in the community
- Extension of Young People's outreach clinics
- Mainstream chlamydia screening
- Walsall sexual health website
- Sexual health staff training
- Medivend machines!

The 2001 National Strategy has recently been reviewed, with a move towards developing high quality sexual health (Independent Advisory Group 2008). This report and updated strategy draws on guidance from that review. This report is divided into a number of chapters to provide a structure for producing the strategy. The *principal conclusions* and *headline recommendations* from the chapters are presented below; they will provide a basis for a sexual health action plan for Walsall. This will inform a change process and prioritisation of required future funding that will give the borough its very first approach to a holistic and integrated sexual health.

Three levels of service provision in the National Strategy for Sexual Health and HIV

Level 1

To be provided by all primary care teams and specialist services

- Sexual history and risk assessment
- STI testing for women
- Chlamydia screening in women ages < 25 years
- Assessment and referral of men with symptoms of STI
- Contraceptive information and services
- Pregnancy testing and referral
- Cervical cytology screening and referral
- Hepatitis B immunisation
- HIV testing and counselling

Level 2

To be provided by primary care teams with a special interest, or commissioned from specialist providers

- Testing and treatment of STIs
- Chlamydia screening women ages < 25 years
- Partner notification
- IUD and contraceptive implant insertion
- Vasectomy

Level 3

To be provided by specialist services

- Specialised STI management and partner notification
- Specialised HIV treatment and care
- Specialised and highly specialised contraception
- Outreach for STI prevention
- Outreach contraception services

Levels or tiers of sexual health services provision

CONCLUSIONS AND RECOMMENDATIONS

Walsall's first sexual health strategy set out key tasks (2003). Achievement/progress since then can be summarised:

GREEN	<ul style="list-style-type: none"> • Excellent overall trends on early access to terminations and on teenage conceptions • Improved access to GUM and targets achieved on HIV testing and hepatitis B vaccine uptake in <i>at risk</i> GUM attendees • Significant decline in gonorrhoea infection
AMBER	<ul style="list-style-type: none"> • Ongoing progress with targeted local prevention will need more focused effort following the recent issue of Walsall strategies on sexual health promotion and information • Continued progress on the one stop shop approach (especially in Level 1 services, including youth clinics) and recent progress on the development of integrated services is good, but there are barriers to GP engagement
RED	<ul style="list-style-type: none"> • The widened role of primary care has been poor and is being addressed by a local enhanced (Level 1) and pilot (Level 2) services approach to support integration (see Figure for the three levels of service) • Slow rising incidence in HIV is relentless: there is urgent need to increase testing among high risk groups outside GUM and improve care for those living with the infection • Chlamydia screening has only recently been introduced through the national programme, but is seriously behind schedule in Walsall on meeting targets and is receiving urgent attention

Further necessary progress on delivering quality sexual health to the people of Walsall can be summarised through a list of **main recommendations** that:

A address issues raised above in the RED areas of activity; and

B also address other shortcomings identified in this document.

A. ADDRESSING RED AREAS OF ACTIVITY

1. Widening the role of primary care will be necessary to support the **integration of sexual health services** (Levels 1, 2 and 3).

- **Widening the role of primary care** Most GPs provide only a contraceptive service, and many provide condoms, pregnancy testing, and emergency hormonal contraception (EHC), but it is intended that a Locally Enhanced Service (LES) will extend Level 1 services. More GPs are needed to provide Level 2 services (only six undertake vasectomies and two contraceptive implants). It is planned that a dedicated sexual health centre will eventually be established in each of the four primary care clusters of Walsall, to increase the availability of Level 2 services.

- **Integration, beginning at Level 3** GUM and Hatherton Centre FP Level 3 services have already started to integrate, so that each becomes a contraception and sexual health (CASH) service. The services are conveniently town centre located, but for integration to work effectively, both should occupy the same site. There is an opportunity based on the uncertainty around both premises locations in 2010. Either FP should join the *state of the art* new GUM premises at the Manor Hospital, or a new combined site is identified in the town centre. If the latter, that portion of GUM devoted to HIV management should remain at the hospital. The new integrated centre would represent the Level 3 *hub* of all sexual health services across Walsall; providing training and support for all GP practices, to ensure they have the competencies to provide a full range of Level 1 services, and also to oversee the establishment of the four Level 2 primary care enhanced service centres (*spokes*).

This integrated model will bring all providers of sexual health into a single sexual health service. Commissioning intentions to promote this model are already in force through the LDP 2008-2011. The programme includes:

Four primary centre *spokes*: a pilot will be pursued in one of the four areas to begin with.

Integration of FP and GUM: underway through the two GUM consultants providing sessions at the Hatherton Centre; delivering a CASH service at both premises, dual training of staff, and promoting integration among outreach staff.

College outreach clinics: established at the two Walsall college locations with support from a Hatherton centre nurse specialist working in partnership with a Teenage Pregnancy Team health adviser.

Workforce training and audit of services: led by the GUM consultants and supported by a training and assessment committee.

Sexual health information and social marketing strategy: Health Promotion has been commissioned to undertake a major programme of communication to launch awareness of sexual health services.

- **Resources required for integration/outreach** This will primarily involve an already overstretched GUM, whose consultants are driving the integration and increased outreach agenda; also needed to address mounting concerns about HIV (refer below). Staff required:
 - 1 **GUM Associate Specialist**
 - 2 **Outreach Health Adviser** (outreach to Level 1 and specialist HIV services)
 - 3 **Health Care Assistant** (consultant support for integration)
 - 4 **Outreach Manager/coordinator** (of all outreach activity)
 - 5 **Dual trained GUM/FP nurse**
 - 6 **FP Associate Specialist.**

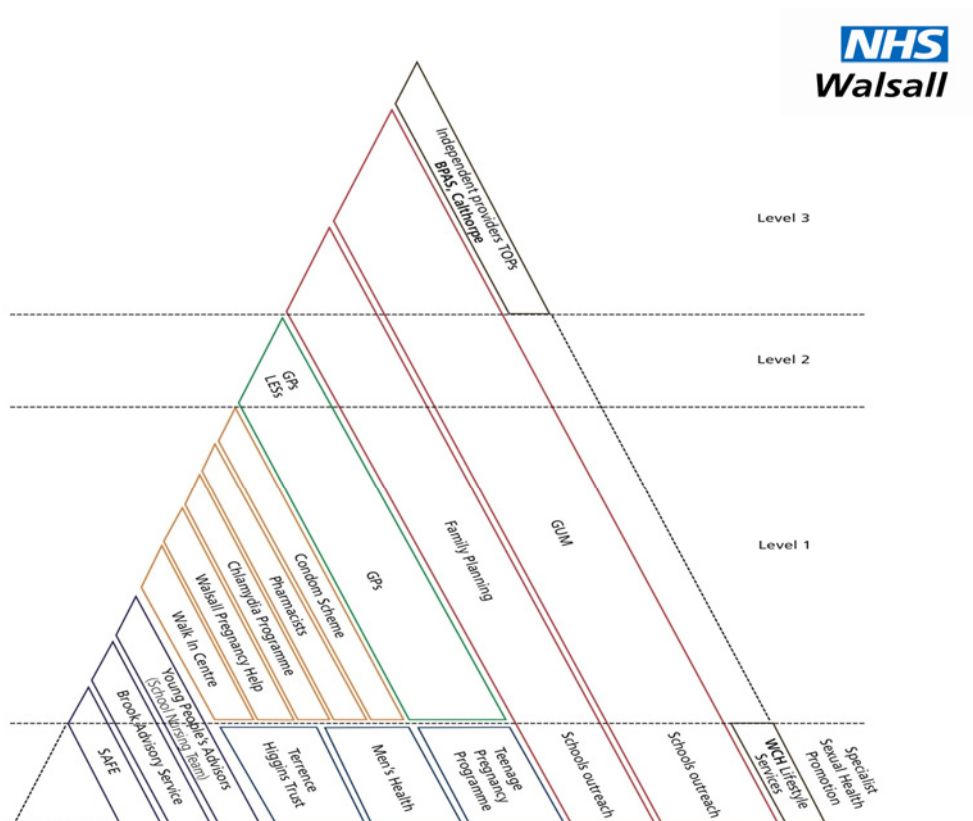
2. Increase HIV testing among high risk groups and improve care for HIV positive people.

- The Men's Health Project is over stretched; the project requiring GUM consultant direction and health adviser leadership. The project assists GUM outreach staff at the gay sauna venue on a monthly basis to screen for a number of infections, in particular HIV and syphilis. Over a two year period, in just over 20 sessions, 35 cases of syphilis and 9 cases of HIV were detected; an opportunity indicating need for an increase in frequency to at least twice monthly.
- Health and social care services for people living with HIV are ill developed in Walsall. Very few people are involved, mainly through the Men's Health Project, GUM services, the Terence Higgins Trust (THT) African Project, and a Supporting People housing officer. This urgently needs attention, given the rising HIV incidence and longevity of people with the infection. A business case is being made for an HIV nurse to attend to the specific health needs of HIV patients both in hospital and in the community, but an entire package is required.

- The THT African Project to detect HIV infection has introduced a new testing pilot. As with the Men's Health Project, it requires consultant direction and supervision, and the direct support of the GUM health adviser. Outcomes data are required, based on the estimated 500 African population living in Walsall.

3. Improve on chlamydia screening

- *Walsall is not on track to meet the 2008/09 17% chlamydia screening target.* There is good engagement of contraceptive services in providing screening, but a much fuller engagement of primary care and pharmacies will require a local enhanced services approach. While schools are prepared to accept screening only on site, they are hesitant about the treatment component.
- *Chlamydia screening needs to be embedded into mainstream clinical service delivery.* At present in Walsall there are 24 screening and treatment sites, and 32 screening only sites. These sites encompass GP practices, pharmacies, and youth centres. It is clear that much more innovation is required to maximise screening opportunities to increase coverage, usually through outreach, eg pubs and clubs, college campus sites, hostels, and through agencies such as the Youth Offending Service.



B. ADDRESSING OTHER SHORTCOMINGS

Selected important ones, along with principal conclusions, are listed as follows:

- Sexual health strategies must be linked to other relevant health and social care strategies, *eg* while there are strong links with the Walsall teenage pregnancy strategy, this needs to be replicated with others such as alcohol, children and adolescents, *etc.* Another important link is with mental health services; relating to lack of expert support for psychosexual disorders. This linkage must be reflected in the 2009 sexual health action plan, deriving from this new strategy.
- The Independent Advisory Group on Sexual Health and HIV in its Annual Report, *Why sexual health is a cross governmental issue* (2007), recommends that there are benefits in merging budgets centrally for all sexual health and contraceptive services (including Health Promotion). Also recommended by the Independent Advisory Group's MedFASH review of the national strategy (2008). There is no centralised local sexual health budget for Walsall. There are separate budgets for GUM, Family Planning, teenage pregnancy, local enhanced services, chlamydia, HIV and AIDS, and sexual health development.
- Walsall's Local Area Agreement focuses on teenage pregnancy but does not include and extend to the wider sexual health. Sexual health needs are identified in the Joint Strategic Needs Assessment (JSNA) but are currently confined to teenage pregnancy. However, the next phase of the planned sexual health needs assessment is to decide on a minimum core data set, and then to include it on the JSNA. A recommended data set has already been suggested (end of Chapter 1 and Conclusions sections) as additions to teenage pregnancy and comprise indicators relating to: termination of pregnancy; chlamydia screening; contraception; genitourinary medicine (access to GUM and early diagnosis of HIV); and sexual assault referral centres.
- Although essential Level 1 services are widely available across the borough – through sexual health advice and services that include pregnancy testing, emergency hormonal contraception (EHC), and condom distribution, at a wide variety of locations, *eg* 63 GP practices, 63 pharmacies, youth clubs, children centres – they need to be more comprehensive and better sign-posted.
- As already stated, Walsall is making good progress on three of the four principal health targets (teenage conceptions, ToP, 48 hour GUM access) but not on the one relating to chlamydia screening. In the meantime, it would be prudent and as well for Walsall to prepare for the following new expected targets:
 1. Percentage of all contraceptives dispensed that are long acting reversible contraceptives (LARCs).
 2. Rate of prescribing of each LARC method in primary care.
 3. Proportion of HIV diagnoses where the CD4 cell count is less than 200 at time of diagnosis (the lower the count, the later the diagnosis).
 4. Proportion of those reporting sexual assault who are seen within sexual assault referral centres (SARCs). **Note:** Walsall has a SARC.
- Drivers to improve the access to and uptake of LARCs have been teenage conceptions and issues around terminations. Additional contraceptive funding has been allocated to build on this drive. Improved effort is required in Walsall to increase the proportion of contraceptives dispensed taken up by LARCs. This is currently at 17%; below the 19% regional and the 23% national averages. The current under development of Level 2 sexual services in primary care across Walsall is one area that requires attention in order to improve performance.

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- Services are deficient or lacking in Walsall in the following two areas:
 1. **Erectile and sexual dysfunction:** very limited services are available through GUM, the Hatherton Centre, and a few GPs, but there clearly needs to be a major health promotion drive and services enhancement to address this issue.
 2. **People with learning disabilities:** this is a neglected area at national level and sexual health services for this group are not optimal for a variety of reasons.
- There are persisting concerns that need addressing around the following issues:

Confidentiality – especially in reception and waiting room areas of services.

User friendliness – more effort required in training reception and health care staff.

User involvement – needs special attention to ensure much fuller engagement in the development of services.

Data – lack coordination and timeliness, although will improve as integration of services continues to develop.

Referral pathways – lack commonality; will improve with the integration agenda.
- The Independent Advisory Group on Sexual Health and HIV's Medical Foundation for AIDS and Sexual Health (MedFASH) review of the national strategy (2008):
 1. recommends that sexual difficulties in the population, especially among older people, should receive greater attention and more resources.
 2. indicates that dual training (GUM and FP) should be a norm in any workforce sexual health development.
 3. suggests that primary care involvement in sexual health is hampered by its insignificant place in the Quality and Outcomes Framework (QOF).
 4. states that sexual assault (especially in young women and in disabled women), as managed through SARCs, should receive the closer engagement of specialised sexual health services.