



SSHA SOCIETY OF
SEXUAL HEALTH ADVISERS

Sexual Health Advising

Developing the Workforce

Guidance document for sexual health advisers, Higher Education Institutions, strategic and public health leads and commissioners on the implications of new arrangements for educational and practice preparation of sexual health advisers

Working in partnership with the Department of Health



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June 2008

Foreword

The Department of Health is delighted to welcome the publication *Sexual Health Advising – Developing the Workforce, a guidance document for sexual health advisers, higher education institutions, strategic and public health leads and commissioners on the implications of new arrangements for educational and practice preparation for sexual health advisers*.

This document is the culmination of extensive collaborative work led by the Department of Health with the Society of Sexual Health Advisers (SSHA), the union UNITE and the Nursing & Midwifery Council (NMC).

Sexual health advisers are a key part of the sexual health workforce and should be recognised as extremely valuable for the role they play in dealing with complex issues around sexually transmitted infections, HIV infection, sexual assault, partner management and psychosexual counselling. They are also integral to the successful implementation of the *National Institute of Clinical Excellence (NICE 2007) guidance on one to one interventions to reduce the transmission of sexually transmitted infections including HIV, and to reduce the rate of under 18 conceptions especially among vulnerable and at risk groups*.

As sexual health services are delivered in more varied settings to ensure patient choice, the future role of the sexual health adviser must expand into the community.

The opportunity now offered by the NMC for sexual health advisers who are nurses to register as Specialist Community Public Health Nurses (SCPHN) on part 3 of the register, either by completing a programme of study or by migration via portfolio, is both a welcome and timely development. Alternative options are outlined in this document for sexual health advisers who are not registered nurses.

This work fulfils a government commitment in the National Sexual Health and HIV Strategy (DH 2001) to develop the role of the sexual health adviser and I am confident that with the commitment and support of key stakeholders, this can and will happen.

I would like to acknowledge the contribution, commitment and sheer hard work of the National Professional Committee of the Society of Sexual Health Advisers, Carol English of UNITE, Liz Plastow and Julie Matthews from the NMC and Anne McNall who is the author of this document.

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Contents

Purpose of this paper

Section 1

| | |
|--|---|
| The current situation | 1 |
| The national context | 1 |
| Strategic direction and working upstream | 2 |
| Meeting service user needs | 2 |
| The reality of involvement in sexual health services | 3 |
| Other relevant drivers in sexual health context | 4 |
| A public health approach | 5 |
| The way forward | 5 |

Section 2

| | |
|--|----|
| A Guidance for those currently practising as a sexual health adviser | 6 |
| Migration to Nursing & Midwifery Council (NMC) Register via portfolio | 6 |
| Sexual health advisers not eligible to register with the NMC | 6 |
| B Guidance for Higher Education Institutions (HEIs) | 8 |
| Programme Validation/modifications | 8 |
| Inclusion of practising sexual health advisers in the teaching and assessment team | 9 |
| Identification and development of practice learning environments | 9 |
| Developing practice teacher capacity | 10 |
| C Guidance for strategic and public health leads, sexual health, education and workforce development commissioners | 10 |
| Mapping exercise of sexual health advisers in post | 12 |
| Cost/benefit analysis of supporting existing sexual health advisers to register with the NMC and achieve practice teacher status | 12 |
| Estimated number of sexual health adviser posts required | 13 |
| Projected number of new sexual health advisers to be recruited and trained in each area via the SCPHN programme | 13 |
| Commissioning of a sexual health adviser pathway of SCPHN programme in each SHA area | 13 |
| Conclusion | 14 |
| References | 15 |
| Appendix 1 – sexual health adviser competencies | 18 |

The purpose of this paper is

Section 1

- To outline the background to recent developments with regard to the education and registration of sexual health advisers in the future.

Section 2

- To outline the actions and developments required:
 - by sexual health advisers currently in post
 - by universities who wish to provide sexual health adviser education
 - by strategic leads, commissioners and managers to enable and support this development.

Section 1

The current situation

There are approximately 500 sexual health advisers employed in Britain at present (SSHA 2007). They are employed within genitourinary medicine services (GUM), in community sexual health advising roles and within the national chlamydia screening programme.

Of the 421 sexual health advisers who responded to a recent survey, 336 were nurses by background, 13 social workers, and 67 from counselling backgrounds. The remaining 46 were from areas such as psychology, psychotherapy, education and sexual health training (SSHA 2007).

Their role traditionally has been focused on the public health aspects of sexually transmitted infections (STIs), with prime responsibility for partner notification and management; that is, the spectrum of public health activities in which sexual partners of individuals with STI or HIV infections are notified, counselled on their exposure and offered services. Partner notification aims to break the chain of transmission of sexual infections, through identifying, counselling and screening sexual partners/contacts of index patients, treating if appropriate and offering education and health promotion on an individual basis (SSHA 2004). This has been demonstrated to be an effective aspect of managing sexually transmitted infection (Payne & O'Brien 2005; NICE 2007).

Although recognised as a professional group under *Agenda for Change* (DH 2004a) there has been no nationally recognised programme of preparation for the sexual health adviser role (a target of the National Strategy for Sexual Health & HIV, DH 2001a), nor registration with one professional body. The advent of reports highlighting the need for registration of practitioners to protect the public (DH 2006c), as well as the need to prepare practitioners thoroughly to develop and deliver competency based contemporary sexual health services, have contributed to the recent debate and agreement (McNall 2005) to offer education leading to registration to future sexual health advisers via the Specialist Community Public Health Nursing (SCPHN) Programme (NMC 2007).

The roles of education commissioners, strategic leads and universities in facilitating and developing such programmes are outlined. Arrangements for eligible existing sexual health advisers to register with the NMC via portfolio have been agreed (NMC 2007) and are outlined in more detail in this paper. The arrangements for existing sexual health advisers who are not eligible for registration with the NMC are also outlined and current developments explained.

The national context

In recent years there has been a growing interest in sexual health and an emerging focus on sexual health and sexual health services in health care policy (DH 2001; DH 2004b). The increasing levels of STIs, poor access to sexual health services and the failure to

reduce unintended pregnancy rates in line with national targets have led to sexual health becoming a priority area (DH 2004b), with national targets reflected in local delivery plans (LDPs) where trusts are monitored on their ability to increase access to services and respond to other sexual health priorities (DH 2004f, 2005b).

Strategic direction and working upstream

It has become clear that the factors that contribute to good sexual health and cause sexual ill health, are multi faceted (DH 2001; 2004b). In considering how best to promote sexual health and manage sexual ill health effectively it has become increasingly necessary to develop greater understanding of individuals and communities in order to target need more effectively. It is not enough to continue doing what we have done before; we need to constantly review practice both with individuals and at a population level to ensure that energy and resources are targeted most effectively to gain the greatest possible health improvement as reiterated in *Our Health, Our Care, Our Say: A New Direction for Community Services* (DH, 2006a).

The National Strategy for Sexual Health & HIV (DH 2001) suggests that nurses and sexual health advisers have key roles in achieving the strategic aims, envisaging services which offer a more holistic approach to sexual health and service delivery that not only offer effective interventions to manage sexual ill health but also develop understanding of how sexual ill health can be prevented and sexual health promoted locally.

Meeting service user need

The Recommended Standards for Sexual Health Services (MedFASH/DH 2005) broaden the requirements of service delivery to include the service user perspective. The concept of service user participation in the development, delivery and evaluation of care is a major component of contemporary health and social care policy (DH 1990; 1999; 2000). Section 11 of the Health and Social Care Act, and more recently Section 242 of the National Health Service Act (2006d) places a duty on NHS trusts, Primary Care Trusts (PCTs) and Strategic Health Authorities (SHAs) to make arrangements to involve and consult patients and the public in the planning and organization of services. There has been an obligation since 2003 for services to demonstrate how they are engaging with service users to provide appropriate services (DH 2003b). This reflects the current political agenda to provide a “patient led NHS” (DH 2005a).

The Recommended Standards for Sexual Health Services (MedFASH/DH 2005) also highlight this as a key aspect, and suggest

“Commissioners and Services should:

- Promote active user participation and involvement in the planning and organization of services
- Develop their understanding of the various communities they serve

- Recognise and respond to social exclusion, discrimination and power imbalances (such as those between genders or individuals) in a way that enhances access, and promotes effective use of services.
- Ensure all staff involved in sexual health services are committed to non-discriminatory working practices and delivery of care” (MedFASH/DH 2005, p33)

They also propose **audit indicators**, which include:

- Evidence of services working with user groups
- Service specifications include user involvement
- Involvement of all communities and population groups served, including high need communities, in planning and evaluating services
- Services able to demonstrate action they have taken in response to feedback. (MedFASH/DH 2005, p38)

The Independent Advisory Group for Sexual Health & HIV (IAG 2004) also recommend that “local and national mechanisms to obtain feedback from patients attending GUM clinics” are developed, and recognise an absence of mechanisms in place to “register patient voice about contraceptive services” (IAG 2004, p16). They also acknowledge the nature of abortion means there are no vocal user groups, and suggest service providers use surveys or other means to gather women’s views.

The reality of involvement in sexual health services

However, there has been little development on realising these goals, as a literature review (McNall 2003, updated 2006) identified that comparatively little is known about sexual health service user views, and much of the evidence available can be criticised for its failure to explore perceived need, relying instead on positivist approaches to demonstrate satisfaction with what is offered. It also found evidence of the limited ability of sexual health services to meet service user need with expressed sexual morbidity, perceived stigma, unmet needs and dissatisfaction with the diagnosing health care providers counselling on emotional and sexual issues in some contexts.

Sexual health services are provided for the whole community, who theoretically may all have sexual health needs, yet access to, and uptake of services is affected by the negative perception of such services (Scouler et al 2001). Serrant-Green (2005) demonstrates that despite the burden of sexual ill health being unequally distributed across populations including young people and members of minority ethnic communities, there is little research or evidence to give practitioners direction on how best to address their specific issues. She reiterates that the social and political aspects of sexual health such as the experiences and views of diverse groups needs to be introduced (Serrant-Green 2004).

Despite the highly visible concept of patient and public involvement in contemporary health and social care policy, there has been little evidence of this happening in general areas of practice let alone in sensitive or stigmatized areas of care, nor of findings impacting positively on patient care (DH 2004d). As the Terence Higgins Trust/BHIVA/PACTI (2004; 2005) highlighted, a third of PCTs have not undertaken any sexual health

needs assessment and many fail to involve the views of service users and local people relying on local epidemiology and demographic trends.

Furthermore, Evans & Farquhar (1996), Holgate & Longman (1998), Duncan et al (2001), Scouler et al (2001), Nack (2001), and Dixon-Woods et al (2001) have demonstrated that sexual health patients felt responsible that their problem(s) result from their own behaviours or inadequacies, felt stigmatized, were reluctant to give negative feedback, and therefore could reasonably be defined as disempowered. Although the development of Local Involvement Networks (LINKS) are proposed to improve the current level of involvement (DH 2006b) traditional approaches to patient and public involvement may be less appropriate in the context of sexual health because of the sensitive nature and stigma service users perceive, and new ways of working are necessary to realise patient led sexual health services (DH 2005a) which are locally relevant.

Mezzone (DH, 2003b) suggests that user involvement, to be effective, should be a thread running through the sexual health commissioning process, and should be an ongoing activity to reflect changing need and priorities. In order to move policy into practice, practitioners not only need skills and appropriate approaches to elicit views from those often excluded from involvement, but the skills to influence the commissioning process, negotiate, effect and lead change and new developments in practice.

Other relevant drivers in the sexual health context

Whilst there is no doubt that insight into the users' experiences of sexual ill health is essential to sexual health service provision, their view alone may be inadequate for two reasons.

Firstly, services need to respond not only to the needs of the individual, but also to the public health. For example, the rising trends in prevalence of STIs have caused great concern, not least because of their potential impact on the fertility of those they affect, and other health, social and economic consequences (HPA 2007). This results in evidence based interventions, such as partner notification being employed to break the transmission of STIs, particularly when asymptomatic presentation means the person potentially infected is unlikely to attend otherwise. It is unlikely that service users would prioritise such activity in a service, yet there is clear evidence of: its success in preventing the spread of STIs (Ellis & Grey 2004); it being cost effective (Payne & O'Brien 2005), and active co-operation of individuals once its aims are explained despite it being a difficult thing to do (Catchpole 2001, Faldon 2000).

Secondly, since current health care is target driven, there are a range of sexual health targets (such as 48 hour access to GUM, DH 2005b; MedFASH/DH 2005) which are used as measurable performance indicators for practice and must inform local delivery plans.

To further develop sexual health practice an approach is needed that is able to address the apparent paradox of community and user need with strategic direction and local priorities in an area of practice where stigma and power imbalances militate against this.

A public health approach

Public health has been defined as:

“The science and art of preventing disease, prolonging life and promoting health through the organised efforts and informed choices of society, organisations, public and private, communities and individuals” (Wanless, 2004).

The following principles, outlined by the DH (2003c) and the RCN (2007) underpin public health work:

- Knowing the health needs of the population – not just those who use services
- Making sure services are accessible to those whose needs are greatest – engaging and targeting effectively
- Getting local people involved in identifying needs and developing healthy lifestyles through better understanding of the factors that affect sexual health and wellbeing
- Working collaboratively with others in a range of services to tackle the wider determinants of health – leading partnership working
- Being aware of and ready to respond to infectious disease outbreaks, and other threats to health
- Being catalysts and advocates for health gain, influencing policy and resource allocation
- Using evidence to guide practice interventions.

The RCN (2007) in a paper developed by an alliance of organisations, highlighted the potential contribution of nurses with public health knowledge and skills to improving the health of the public.

The way forward

Agreement has been reached that the future preparation of sexual health advisers in theory and in practice will be via the Specialist Community Public Health Nursing Programme (NMC, 2007). This programme is based on the 10 key principles of public health (see Appendix 1).

From 2008, universities may offer a pathway in sexual health advising alongside those for preparing health visitors, school nurses and occupational health nurses.

It is important that all stakeholders work collaboratively to move this forward to ensure there is geographical equity in the future provision of education and practice preparation to further develop the public health workforce in sexual health.

Section 2

A

Guidance for those currently practising as a sexual health adviser

1 Migration to Nursing & Midwifery Council (NMC) Register via portfolio

The option to migrate to the Specialist Community Public Health Nursing (SCPHN) part of the NMC Register is open from **October 2007 until December 2009** to those who meet the following criteria:

- Currently in employment as a sexual health adviser
- Already registered on the nursing or midwifery parts of the NMC Register
- Working at individual and population level to impact on sexual health.

The application pack and proforma (application pack 4 for sexual health advisers) should be downloaded from the NMC website www.nmc-uk.org

A number of Higher Education Institutions (HEIs) have agreed to verify the portfolios. Their details can also be found on the NMC website at Annexe 8 of the SCPHN section. This will be subject to a charge (which may vary between institutions), unless this is supported locally via workforce development funding (see Section C). Registration with the NMC is also subject to a charge, and re-registration is required to ensure fitness to practice and for the protection of the public.

Registration by portfolio entitles the applicant to call themselves a SCPHN but does not give an academic award.

If the sexual health adviser wishes to receive an academic award as well as registration as a SCPHN (which is a minimum of a Bachelors Degree with Honours at level 6 of the National Qualification Framework for England, Wales and Northern Ireland. Comparable levels of award across the UK can be viewed via the link, http://www.scqf.org.uk/downloads/QualsCrossBoundaries_Sco.pdf)

they should apply to undertake the SCPHN programme (sexual health adviser pathway) which will be provided by some HEIs from September 2008. Some accreditation of prior (experiential) learning may be offered.

2 Sexual health advisers not eligible to register with the NMC

Some practising sexual health advisers will not be eligible to register with the NMC because they:

- Are not registered as a nurse or midwife on the NMC Register
- Have been registered on the NMC register but have let their registration lapse

- Are registered with another statutory regulator such as the General Social Care Council.

The options open to such practitioners are:

2.1 Do nothing

If the sexual health adviser is in employment they could choose to stay with their current statutory regulator, and re-register as required. If they are not registered or regulated currently they need to consider the implications of the DH White Paper (2006c) on the regulation of health professionals.

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_065946

2.2 Access a return to practice course

in order to re-register as a nurse or midwife if their registration has lapsed. This would allow the potential for future registration as a SCPHN via access to a SCPHN programme, or migration via portfolio (until December 2009). Further information on how to do so is available on the NMC website www.nmc-uk.org and via local health care or PCTs.

2.3 Register with the UK Voluntary Public Health Register (UKVPHR)

At present accreditation plus regulation applies only to the structured training programmes leading to specialist registration such as non medical directors of public health (level 8). However the UKVPHR is currently conducting a feasibility study on practitioner regulation as part of the Public Health Skills and Career Development Framework (PHSCDF) implementation aiming for a common regulatory framework (CRF) for public health practitioners. The latest information and final version of the framework is available at: http://www.phru.nhs.uk/Doc_Links/PHSCF_comm_fina1291007.pdf

http://www.phru.nhs.uk/Doc_Links/PHCFPostCons_v131107.pdf

There have been some exploratory meetings where agreement in principle has been achieved that sexual health advisers working at a population level could potentially demonstrate the core and defined public health competencies in health improvement and health protection within the framework, at level 6 (senior/specialist practitioners) with those leading teams or specialising in particular areas capable of reaching level 7 (advanced practitioner). It is recognised that a practitioner's levels of competence may not be at an equal level across core and defined areas of competence.

Work is continuing to agree a mechanism for registration on the UK Voluntary Register for Public Health Specialists (UKVRPH) for sexual health advisers with regulation if registration and regulation for public health practitioners is agreed nationally. Further developments will be made available via the Society of Sexual Health Advisers (SSHA).

B

Guidance for those HEIs wishing to provide sexual health adviser education as a pathway of the SCPHN Programme

1 Programme Validation/modifications

Although some HEIs offer aspects of sexual health adviser education, such as specific modules on partner notification and management, future educational provision should be situated within the framework of the standards for education for specialist community public health nursing, which are outlined within the standards of proficiency for specialist community public health nurses (NMC 2004)

<http://www.nmc-uk.org/aFrameDisplay.aspx?DocumentID=324>

This offers general guidance on curricular content and design, academic standard, length of programme, student support and assessment and practice learning and assessment. The NMC has now agreed that in the future HEIs may offer a pathway of this programme for sexual health advisers.

<http://www.nmc-uk.org/aFrameDisplay.aspx?DocumentID=3427>

As well as meeting the standards of proficiency for SCPHN this pathway should facilitate the development of the knowledge, skills and attitudes to apply the 10 principles of public health to the context of sexual health advising practice, and achieve the competencies identified in Appendix 1. Please note that the NMC detail these competencies against learning outcomes in Annexe 1 on their website, but more detail of the competencies to be demonstrated in practice are included in Appendix 1 in this document.

HEIs wishing to offer such a pathway will be required to have a conjoint validation with the NMC quality assurance agency to ensure all relevant standards in academic and practice terms will be met.

For those HEIs already providing SCPHN programmes, the implications of offering an additional pathway in sexual health advising practice are:

- **Potential increase in programme numbers**

Many areas have experienced a reduction in supported places for SCPHN programmes, in line with reduced spending on workforce development. Although numbers of sexual health advising pathway students may be small in relative terms, the SCPHN cohort size can be increased and viability of programmes strengthened.

- **Opportunities for shared learning/exchange of skills and knowledge**

It is recognized that the sexual health knowledge and skills of much of the existing workforce is limited (DH 2001). There is much to be gained from developing the capacity of a range of practitioners working in public health roles to recognise and respond to sexual health need (Williams, 2007).

2 The need to include practising sexual health advisers in the teaching and assessment team

The standards of proficiency for SCPHN (NMC 2004) indicate that students should be supported in academic learning by appropriately qualified teachers, who hold qualifications and experience relevant to the area of practice. The programme leader of existing SCPHN courses will be on part 3 of the NMC register, but specific knowledge and skills of the application of public health principles to sexual health is essential, and may necessitate partnership arrangements with sexual health advisers in practice to provide pathway support if this is not available within the SCPHN academic teaching team.

3 Need for identification and development of practice learning environments to support practice based learning around sexual health

SCPHN students are required to spend 50% of the 52 week programme in practice learning settings (NMC 2004). This will include placements working alongside sexual health advisers, such as in chlamydia screening programmes community sexual health advising and within sexual health departments. Alternative placement areas could include:

- school health nurses delivering PSHCE/SRE and school based sexual health services, with prison health staff,
- sexual health promotion teams
- health visitors working with specific communities
- sexual health outreach workers
- patient and public involvement staff
- community pharmacists providing sexual health services.

A consolidating period of practice of at least 10 weeks at the end of the programme must be spent in an area of practice specific to the pathway where the student will manage and lead developments.

All practice placement areas used are subject to auditing of the practice placement environment for its suitability in supporting the learning and assessment of students (DH/ENB 2001) and this will be a requirement of validation of a sexual health adviser pathway of the SCPHN programme.

Further guidance on the quality of practice placements is available in the document *Placements in Focus: Guidance for Education in Practice for Health Care Professions* (DH/ENB 2001).

http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4009511

4 The need to develop practice teacher capacity to support learning, teaching and assessment in the sexual health context

The NMC (2006) standards to support learning and assessment in practice indicate that students on SCPHN programmes must be supported and assessed by practice teachers. The practice teacher must make the final assessment of practice and confirm to the NMC that the required proficiencies for entry to the register have been achieved. The criteria for achieving practice teacher status and the competencies and outcomes they must demonstrate (NMC 2006) can be found on pages 20–22 of the document <http://www.nmc-uk.org/aFrameDisplay.aspx?DocumentID=1914>

This indicates that the practice teacher

“Who makes a judgement about whether the student has achieved the required standards of proficiency for safe and effective practice must be on the same part of the register as that which the student is intending to enter.” Furthermore, “they should have clinical currency and capability in the field of practice in which the student is being assessed.” (NMC 2006, p20).

Whilst existing practice teachers on the SCPHN part of the NMC register (such as health visitors and school nurses) could fulfil the role they could not offer the level of applied knowledge and skills, so there is a requirement to identify sexual health advisers in each placement provider area who are either already registered on the SCPHN part of the NMC register by nature of a previous qualification, or who have the capacity to migrate via the means described in section A of this paper.

They should also be supported to achieve practice teacher status. This will require the support and commitment of their line managers not only to achieve practice teacher status, but also to fulfil the role effectively to support the practice learning and development of the future workforce capacity.

Higher education institutions providing SCPHN programmes will have mechanisms in place to allow SCPHNs to meet the standards, competencies and outcomes for practice teachers (NMC 2006) through taught modules or supported work based learning.

C

Guidance for strategic and public health leads, sexual health, education and workforce development commissioners

A public health approach to sexual health aims to reduce health inequalities and help close the health gap but can only occur if the right people with the right skills are in place to deliver this agenda. The SCPHN programme offers such knowledge and skills to sexual health advisers; develops and assesses competence, and allows for regulation of practitioners to protect the public.

As suggested in the Public Health Workforce Development Resource Pack (NHS 2007) a more innovative approach to commissioning training, based on planned future need, can support new ways of working and significantly increase workforce capacity.

http://www.healthcareworkforce.nhs.uk/resources/public_health/public_health_workforce_development_resource_pack.html

The numbers of sexual health advisers nationally are relatively low, yet the workload attached to partner management continues to grow as more STIs are diagnosed through increased throughput in GUM departments, and the chlamydia screening programme as well as community based level 1 and 2 sexual health services (DH 2001). This workload is unlikely to reduce as uptake targets for STI testing continue to increase.

There remains an urgent need to work effectively with individuals not only to manage their current infection, but to prevent onward transmission and future sexual ill health through tackling the factors leading to poor sexual health not only at individual level but at population level too. This requires practitioners with ability to work in a public health role and with flexibility of approach to identify and respond to localised need.

The commissioning toolkit to support the National Strategy for Sexual Health & HIV (DH 2003) highlights the need for increasing numbers of sexual health advisers and the importance of a minimum standard of education and the need for protected training budgets. Supporting the development of sexual health practitioners who can work in this way with relevant partners can lead to innovative services which impact on local need.

Exploration of local need for HIV fastest service for men who have sex with men, led to partnership working with Terence Higgins Trust, MESMAC (Men who have sex with men action in the community) and the local PCT to deliver a community based service for rapid HIV testing, developed and supported by sexual health advisers.

- Takes service to a population in need in a venue they are comfortable with
- Helps HIV testing uptake target
- Reduces number of people with undiagnosed HIV
- Increases likelihood of early diagnosis which improves outcome
- Offers auditable evidence of responding to user need with flexible service provision
- Demonstrates partnership working with future plans to support MESMAC workers to offer test with care pathways in place for sexual health advisers to manage people who test positive.

Contact Kathryn Kain, senior sexual health adviser, Newcastle PCT
Kathryn.kain@newcastle-pct.nhs.uk

Sexual health advisers working within the CSP have identified a need for wider STI testing and sexual health care with young people at the community venues they are happy to attend. They have bid for financial support for a level 2 service, developed pathways and protocols to support this model and worked in partnership with existing services to aid referral when required.

- Takes service to population in need
- Helps meet 48 hour access target by reducing burden on GUM
- Sexual health adviser led service in community is more cost effective than GUM provision in terms of payment by results (PbR)
- Provision of emergency contraception helps meet the teenage pregnancy targets
- Use of PGDs allows complete episode of care and holistic approach.

Contact Debra Chalmers, CSP manager, hosted by Durham PCT
Debra.chalmers@cdpct.nhs.uk

Sexual health advisers are working with lay people, voluntary agency workers, school health nurses, community development workers and local government staff, using participatory appraisal as a means of identifying sexual health need with those who don't access services as well as those who do and identifying public perception of how services need to develop and other changes that would better meet local need and current targets.

- This will contribute to the local delivery plan and commissioning process
- Demonstrate auditable indicators of patient and public participation
- Allow a systems approach to developing practice across the strategic partnership
- Allow public to offer their suggestions to improve access to services and meet needs of specific groups.

Contact Helen McIlveen, clinical lead sexual health services, North Tyneside PCT

helen.mcilveen@northtyneside-pct.nhs.uk

Recommendations

Workforce development to meet future need is not an exact science, however in order to develop future capacity and practice, it is suggested that relevant stakeholders in each SHA area are involved to give consideration to:

1 A mapping exercise of the numbers of sexual health advisers in post per PCT area and their current characteristics (see Section 2 A & B of this paper for further details)

- Whether already registered on the SCPHN part of the NMC register by nature of a previous qualification
- Whether working at a population level and eligible and able to migrate via portfolio by December 2009
- Whether they require the SCPHN programme in order to register as a sexual health adviser and be regulated by the NMC on part 3 of the register
- Whether already meeting the Practice Teacher Standards (NMC 2006)
- Whether in need of development to meet the Practice Teacher Standards (NMC 2006)
- Whether not eligible to register on SCPHN part of the register and reasons for this.

2 A cost/benefit analysis of supporting existing sexual health advisers to register with the NMC and achieve practice teacher status

- To develop knowledge, skills and capacity to allow sexual health advisers to work in new ways in a public health approach
- To offer protection of the public through registration and regulation
- To enable sexual health advisers to support practice teaching and assessment of the future workforce

- If strategic and financial support is not forthcoming, sexual health advisers may consider financing their own migration, but are less likely to consider practice teacher status as a requisite, which will not allow for the teaching and assessment of future workforce via the required SCPHN programme.

3 The estimated number of sexual health adviser posts required to reflect LDP priorities, and respond to:

- The prevalence of STI locally and subsequent partner management requirements
- The identification of sexual health need within local communities and resource required to respond to this through service development, partnership working and the development of care pathways and policies
- The requirement for user led services and evidence of service development based on identified need as well as strategic drivers and access targets (MedFASH/DH 2005).

4 The projected number of new sexual health advisers to be recruited and trained in each area via the SCPHN programme from September 2008

- This must reflect the capacity of existing sexual health advisers who are SCPHN registered and have practice teacher status to provide practice teaching and assessment. The practice teacher to SCPHN student ratio is usually 1:1
- This should take on board the duration of SCPHN programmes which are one year full time or two years part time.

5 Commissioning of a sexual health adviser pathway of SCPHN programme in each SHA area

- There is a need to develop the public health workforce by commissioning relevant education which develops knowledge and skills (DH 2003b; NHS 2007)
- There should be equality of access geographically to relevant education and training of staff
- There is likely to be one or more HEI provider of the SCPHN programme in each SHA area
- The HEI provider must be able to provide appropriate theoretical and practice learning to adapt their existing SCPHN programme to the specific practice competencies required by sexual health advisers (see Appendix 1) in a cost effective manner
- Many areas already have existing recruitment sponsorship and secondment arrangements in place for SCPHN programmes for health visitors, school nurses and occupational health nurses which could be developed to incorporate sexual health advisers based upon projected workforce development need for sexual health adviser posts
- Students of the SCPHN programme must have supernumerary status, and if attending a part time programme be placed in an alternative practice placement other than that in which they are usually employed. It would be beneficial to consider this development strategically to offer support for all trusts to develop the sexual health adviser workforce regardless of where existing staff able to offer practice teaching and assessment are employed.

Conclusion

This paper outlines the need for strategic planning and support for sexual health advising as part of the multidisciplinary partnership work ongoing to impact on the sexual health and wellbeing of our nation.

It summarises the potential contribution of sexual health advisers to:

- The 10 key principles of public health and their application to sexual health work, particularly partner management and prevention of STIs
- Patient and public involvement in the challenging context of sexual health
- Informing the commissioning process
- Identifying, developing, leading and managing change in practice to meet public health targets.
- Using and developing the evidence base on effective sexual health interventions
- Demonstrating auditable outcomes of practice development in response to service user need as well as other key drivers.

It is acknowledged that many changes have occurred within sexual health services in recent years in order to respond to strategic direction and public health priorities, (DH 2006e) some of which have threatened the traditional role of sexual health advisers working only at an individual level within GUM departments.

Whilst there is a clear evidence base for the importance of partner management activity and individual sexual health promotion focusing on behaviour change and risk reduction (NICE 2007), it is also imperative to work at a population level with communities to tackle the determinants of sexual health and ill health. This may ultimately lead to changes in current working patterns and models of service delivery, as practitioners work in new ways to best meet need.

A public health workforce supported by skilled sexual health advisers working at individual and population level offers a way forward.

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Appendix 1

Sexual Health Advising Competencies mapped against standards of proficiency for entry to Part 3 of the NMC Register (Specialist Community Public Health Nursing) (NMC, SSHA, 2007)

| Principle | Domain Search for health needs | Sexual health adviser practice competencies |
|---|--|---|
| Surveillance and assessment of the population's health and wellbeing | <ul style="list-style-type: none"> • Collect and structure data and information on the health and wellbeing and related needs of a defined population • Analyse interpret and communicate data and information on the health and wellbeing and related needs of a defined population • Develop and sustain relationships with groups and individuals with the aim of improving health and social wellbeing • Identify individuals, families and groups who are at risk and in need of further support • Undertake screening of individuals and populations and respond appropriately to findings. | <p>Demonstrate ability to contribute to health and social sexual health needs assessment of a defined population, using both epidemiological and user led data.</p> <p>Appraise and apply various approaches to working with diverse, vulnerable and stigmatised individuals and groups to identify need in the context of sexual health.</p> <p>Demonstrate effective assessment of holistic sexual health needs to include:</p> <p>Competence/ability to consent</p> <p>Risk assessment for STIs including HIV and other blood borne infections</p> <p>Need for appointment via triage</p> <p>Need for partner notification/management</p> <p>Contraception and conception</p> <p>Sexual difficulty/assault/abuse</p> <p>Other factors impacting on sexual health eg. mental health, substance use, psycho-social issues.</p> <p>Perform venepuncture to obtain blood samples for</p> <p>testing for STIs, to monitor disease progression, to clarify immune status & contribute to non invasive screening for STIs.</p> <p>Negotiate and implement an appropriate plan of care for individuals with differing sexual health needs.</p> |

| Principle | Domain Stimulation of awareness of health needs | Sexual health adviser practice competencies |
|--|--|---|
| Collaborative working for health and wellbeing | <ul style="list-style-type: none"> • Raise awareness about health and social wellbeing and related factors, services and resources • Develop, sustain and evaluate collaborative work. | <p>Demonstrate ability to make appropriate referrals to a range of agencies, such as Relate, sexual assault services, social services, child protection team, health psychology.</p> <p>Demonstrate effective partnership working in planning, participating in and evaluating collaborative projects or programmes to protect, promote and improve sexual health and wellbeing.</p> |
| Working with, and for communities to improve health and wellbeing | <ul style="list-style-type: none"> • Communicate with individuals, groups and communities about promoting their health and wellbeing • Raise awareness about the actions that groups and individuals can take to improve their health and social wellbeing • Develop capacity and confidence of individuals and groups, including families and communities, to influence and use available services, information and skills, acting as advocate where appropriate • Work with others to protect the public's health and wellbeing from specific risks. | <p>Demonstrate effective interpersonal skills in a range of situations common to sexual health advising practice:</p> <p>Telephone triage</p> <p>Providing advice on sexual health issues</p> <p>Pre/post test discussion for HIV/hepatitis</p> <p>Risk reduction approaches</p> <p>Results giving/giving difficult news</p> <p>Contact data interviews</p> <p>Partner management</p> <p>Working with interpreters</p> <p>Facilitating behaviour change and self efficacy, motivational interviewing, solution focused brief therapeutic interventions</p> <p>Teaching skills to promote sexual health, assertiveness, condom use</p> <p>Outreach, group and community development work</p> <p>PSHCE/SRE work.</p> <p>Demonstrate self awareness and sensitivity when working with those with sexual health problems or concerns.</p> |

| Principle | Domain Influence on policies affecting health | Sexual health adviser practice competencies |
|--|--|--|
| <p>Developing health programmes and services and reducing inequalities</p> | <ul style="list-style-type: none"> • Work with others to plan, implement and evaluate programmes and projects to improve health and wellbeing • Identify and evaluate service provision and support networks for individuals, families and groups in the local area or setting. | <p>Contribute to the planning, implementation and evaluation of collaborative programmes and projects to protect, promote and improve sexual health and wellbeing.</p> <p>Use research, evidence and records to audit and evaluate current local practice.</p> <p>Address actual or potential inequalities and discrimination in practice.</p> |
| <p>Policy and strategy development and implementation to improve health and wellbeing</p> | <ul style="list-style-type: none"> • Appraise policies and recommend changes to improve health and wellbeing • Interpret and apply health and safety legislation and approved codes of practice with regard for the environment, wellbeing and protection of those who work with the wider community • Contribute to policy development • Influence policies affecting health. | <p>Review current sexual health policy and practice in light of national drivers and local needs assessment.</p> <p>Contribute to policy and pathway development related to sexual health and wellbeing.</p> |
| <p>Research and development to improve health and wellbeing</p> | <ul style="list-style-type: none"> • Develop, implement, evaluate and improve practice on the basis of research, evidence and evaluation. | <p>Demonstrate ability to learn from practice supervision and develop own practice.</p> <p>Demonstrate practice developments based upon a range of evidence.</p> |

| Principle | Domain Facilitation of health-enhancing activities | Sexual health adviser practice competencies |
|--|--|--|
| <p>Promoting and protecting the population's health and wellbeing</p> | <ul style="list-style-type: none"> • Work in partnership with others to prevent the occurrence of needs and risks related to health and wellbeing • Work in partnership with others to protect the public's health and wellbeing from specific risks | <p>Demonstrate effective partnership working in managing people with, or at risk from STI's or other sexual health problems</p> <p>Demonstrate ability to work in partnership with patients/clients to negotiate shared goals and facilitate adherence to treatment/management plan</p> <p>Safely supply and administer common treatments, vaccinations and medications for sexually transmitted infection and other sexual health issues in accordance with professional and organisational standards and current evidence base.</p> <p>Apply knowledge of epidemiology, diagnosis and management of STI's to partner notification/management</p> <p>Appraise the methods and approaches used to facilitate partner notification/management and select appropriate approaches with clients.</p> <p>Use a range of methods to locate and inform sexual contacts.</p> <p>Demonstrate skill in the implementation of partner notification and management</p> <p>Demonstrate skill in the follow up completion and documentation of partner notification.</p> <p>Identify and utilise opportunities for practice development.</p> |

| Principle | Domain Facilitation of health-enhancing activities | Sexual health adviser practice competencies |
|--|--|--|
| Developing quality and risk management within an evaluative culture | <ul style="list-style-type: none"> Prevent, identify and minimize risk of interpersonal abuse or violence, safeguarding children and other vulnerable people, initiating the management of cases involving actual or potential abuse or violence where needed | <p>Recognise and respond appropriately when neglect, abuse or violence is suspected.</p> <p>Demonstrate ability to work in partnership with those with sexual health problems or concerns within an ethical framework and professional guidelines.</p> <p>Demonstrate defensible decision making to support your practice in complex sexual health advising situations</p> |
| Strategic leadership for health and wellbeing | <ul style="list-style-type: none"> Apply leadership skills and manage projects to improve health and wellbeing. Plan deliver and evaluate programmes to improve the health and wellbeing of individuals and groups | <p>Develop and present a public health project proposal to impact on sexual health and wellbeing and evaluate outcome</p> <p>Demonstrate ability to influence the commissioning process</p> <p>Demonstrate project management skills</p> |
| Ethically managing self, people and resources to improve health and wellbeing | <ul style="list-style-type: none"> Manage teams, individuals and resources ethically and effectively | <p>Demonstrate ability to learn from practice supervision</p> |



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