Terrence Higgins Trust

Disturbing Symptoms 5

How Primary Care Trusts managed sexual health and HIV in 2006 and how specialist clinicians viewed their progress.

A Research Report

February 2007

The HIV and sexual health charity for life

Website: www.tht.org.uk **THT Direct:** 0845 12 21 200
Registered office: 314-320 Gray's Inn Road, London WC1X 8DP
Tel: 020 7812 1600 **Email:** info@tht.org.uk

© Terrence Higgins Trust, January 2007. Code 1006
Terrence Higgins Trust is a registered charity no. 288527. Company reg. no.1778149.
Registered in England. A company limited by guarantee.
Design **Felton Communication** 020 7405 0900 Ref: 10223

Disturbing Symptoms 5

How Primary Care Trusts managed sexual health and HIV in 2006 and how specialist clinicians viewed their progress

February 2007

Contents

1. Introduction ... 3

2. Executive Summary of Key Findings ... 4

3. The Surveys ... 5

4. PCT Findings ... 6

5. Clinician Findings ... 17

Appendix One: The Surveys ... 30

Appendix Two: Recommended Reading List ... 32

1. Introduction

Since 2002, the organisations representing the main providers of sexual health and HIV services in England (the British HIV Association, Providers of AIDS Care and Treatment, Terrence Higgins Trust and from 2005, the British Association of Sexual Health and HIV) have annually reviewed the planning, commissioning and delivery of sexual health and HIV services at local level.

Recently sexual health has been creeping up the English political agenda. In 2004, the public health White Paper, *Choosing Health* was published. The paper came with a promise of £300 million of extra funding for sexual health, to be allocated to local services largely through Primary Care Trusts (PCTs). *Choosing Health* also introduced national targets on access to GUM clinics, the reduction of teenage pregnancy and tackling gonorrhoea and chlamydia. In 2005, the Government announced that sexual health would be an NHS priority area for the coming year. The scene was set for a real improvement in the UK's sexual health.

The 2004 and 2005 surveys showed that, finally, some services were beginning turn things round, but despite national targets and funding commitments, and an increasing focus on the health improvement role of the NHS, the local picture has remained mixed. Services and staff have struggled with rising patient numbers, staff shortages, ongoing under-investment and dilapidated buildings. According to UNAIDS the UK has the fastest growing HIV epidemic in Western Europe and Health Protection Agency (HPA) figures show rising levels of poor sexual health. Where are we going wrong?

The answer lies in transforming national commitment into local action. With increased pressure on PCTs to achieve financial balance and deal with an ongoing programme of change within the NHS, there is a real danger that sexual health will be left behind. Investment in sexual health now will undoubtedly pay dividends in the future, and more PCTs need to plan for the long-term. The money is available. The dedication of staff has never been in doubt. All that is needed now is for PCTs to act appropriately.

2. Executive Summary of Key Findings

- The responses in 2006 show a continuing disconnect between national strategy and local action on sexual health.
- There has been a loss of expertise in local sexual health planning. Increasingly, the responsibility for commissioning sexual health services is shifting to non-specialist staff who have a lower profile within the PCT and are less likely to have specific experience in sexual health services. (see 4.2)
- More clinicians than ever before gave us their views in 2006's survey, and although they reported an improved situation in some areas, there is clearly uncertainty and frustration about some aspects of sexual health and HIV services. (see 5.1)
- Although sexual health was a national NHS priority in 2006, two thirds of clinicians still reported that sexual health and HIV were not sufficiently prioritised at local level. (see 5.9)
- Local funding for sexual health continues to be a problem. Just under two thirds of responding PCTs indicated that all or part of their *Choosing Health* money had been diverted away from sexual health services. Both PCTs and clinicians expressed frustration about the loss of this money, and a number of respondents asked for future funding to be ringfenced. (see 4.7)
- The introduction of Payment by Results is causing concern for both PCTs and clinicians, who are worried that money generated by GUM services will not be reinvested in sexual health. (see 4.9 and 5.10)
- Despite the increasing importance of well-informed commissioning, more than two in five responding PCTs could not say that a local sexual health needs assessment had taken place in the last three years. (see 4.5)
- Difficulties in accurately predicting patient numbers and needs may be affecting local drugs budgets. Over half of clinicians reported that they would be overspent by the end of the year and a quarter of respondents were unable predict their spending on drugs. (see 5.4)
- Restrictions on prescribing certain drugs are becoming more common. Over a third of clinicians reported that prescribing restrictions for HIV drugs were either already in place or had been discussed. Two in five of those clinicians were in London. (see 5.8)
- The profile of key sexual health areas in local health plans has fallen once again. The areas that were least often mentioned in Local Delivery Plans were contraception, HIV, and abortion. These are also the areas that are not linked to any national targets. (see 4.3)
- 2005's survey showed that some clinics were reaching their 48 hour GUM appointment target by changing their booking systems. 2006's responses confirmed this, with half of clinicians who reported a change in their appointment system directly attributing it to the introduction of the target. (see 5.5)
- Progress in establishing planning bodies for sexual health in PCTs has stagnated. In comparison to 2005, the same proportion of PCTs had a Managed Service Network and exactly the same proportion had a planning body in place. (see 4.4 and 4.6)
- Where Managed Service Networks are in place, they are engaging an increasing number of stakeholders. The growing role of the third sector in sexual health services is reflected in the greater proportion of MSNs which involved the voluntary sector. (see 4.6)

3. The Surveys

3.1 This is the fifth report in the *Disturbing Symptoms* series, which has been running since 2002. The original aim was to present the findings of annual surveys of the state of local HIV and GUM services. In 2005, BASHH joined the original collaborating partners, THT, BHIVA and PACT and the survey questions were widened to cover more areas of sexual health.

3.2 Each year, short surveys are sent to Primary Care Trusts (PCTs) and sexual health and HIV clinicians. The survey questions are tailored to PCTs and sexual health clinicians, and are adapted yearly to reflect any significant developments or changes in the previous year. The core questions are closed, but both questionnaires give respondents the opportunity to make further comments at the end on key issues that have affected them.

3.3 The surveys capture the views of key staff and give a snapshot of how wider changes in the NHS are impacting on sexual health and HIV services. Feedback from previous years shows that respondents value the opportunity to express their views, and results are used to present evidence to parliamentarians, the Department of Health and other key stakeholders.

3.4 The geographical coverage of the survey is necessarily restricted to England, to reflect the scope of the National Strategy for Sexual Health and HIV and the authority of the Department of Health.

3.5 In 2006, the PCT questionnaire was again sent to PCT Chief Executives, who were asked to pass it on to the most appropriate person within their sexual health team for completion.

3.6 The specialist clinician survey was distributed through the professional membership of both BHIVA and BASHH.

3.7 Both surveys were designed to allow anonymous responses, although respondents were asked to indicate which English NHS region they were based in. Individual anonymity was guaranteed, but some respondents chose to disclose their identities.

3.8 Although there may be some self-selection bias in the responses, there was a good geographical spread of responses from most regions. Traditionally, there are always more clinician responses from the London region, as HIV services are more concentrated there.

3.9 A small number of responses from non-specialist clinicians and those from Scotland, Wales and Northern Ireland were excluded from final analysis.

3.10 The survey responses were collated and analysed by the THT Policy and Public Affairs team.

3.11 The report was commented on by officers from the other collaborating organisations before final publication.

4. PCT Findings

4.1 Sample breakdown

The 2006 survey was again sent directly to PCT Chief Executives, and returned by 65 separate PCTs. The number of responses remained steady in comparison to the 66 received in 2005. Given that PCT reconfiguration was taking place shortly after the surveys were sent out, it is notable that so many PCTs still took the time to express their views.

Table 1: Regional origin of PCT responses

South West	18%
South East	17%
East Midlands	14%
Yorkshire and Humberside	14%
London	12%
North West	11%
East of England	8%
North East	5%
West Midlands	2%

Regional categories changed slightly from 2005 in order to reflect the new NHS regions. Responses from the South East remained high, and response rates from London, the South West, North West and the East of England all went up. The biggest improvement in response rate was in the South West.

Response rates from the West Midlands have traditionally been low, but dropped from 9% in 2005 to 2% in 2006. This meant that only one PCT out of the 30 in the West Midlands at the time responded to the survey.

4.2 Key PCT sexual health contacts

Table 2: What is your post?

Director /Asst. Dir of Public Health or PH Specialist	35%
Health Promotion/ Health Improvement Specialist	17%
Sexual Health Lead	14%
Service Development/Modernisation	8%
Other	8%
Commissioner (SH/HIV)	6%
Commissioner (general)	6%
No response	6%

PCT Chief Executives were, as before, asked to pass the questionnaire on to their member of staff most knowledgeable about sexual health planning and services. In 2005, just over half of the respondents to the survey were the designated PCT lead for sexual health within their PCT.

In 2006, only one in five of those answering the survey were either the designated sexual health lead or sexual health commissioner. The biggest group of respondents were senior Public Health staff, whose main role is far wider than sexual health. Others who responded to the survey on behalf of the PCT included two clinicians and a community nurse manager.

We are concerned that this indicates a loss of expertise in sexual health planning. Public Health specialists, managers and general commissioners have a range of demanding responsibilities, and are less likely to have specific recent experience in sexual health issues.

Table 3: If you are not the lead commissioner for sexual health and HIV, which post is?

No response	32%
Joint Commissioning or done by another PCT	25%
Commissioning Manager/Director (General)	18%
Other	9%
Commissioning Manager/Director (SH/HIV)	7%
Don't know	5%
Director of Public Health	4%

Nine people did not answer this question because they had indicated that they themselves were the SH lead or SH commissioner. However, of the remaining 56 respondents, 21 could not say who their lead commissioner for sexual health and HIV was. One PCT responded that there was "no such post", despite the fact that having a named sexual health lead is a requirement of the National Strategy for Sexual Health and HIV, which has been in place since 2001.

Of those who could answer, fewer than one in ten said that sexual health services were commissioned by a sexual health commissioner.

It was notable that five people who had previously said that they were the sexual health lead or manager then went on to indicate that other posts were responsible for commissioning sexual health services.

Overall, the picture is that sexual health commissioning is being done by non-specialists, and indications are that the management profile of sexual health within PCTs is relatively low.

4.3 Local Delivery Plan priorities

Table 4: Which of the following are explicitly mentioned in your PCT's Local Delivery Plan?

STIs	75%
General Sexual Health	66%
Contraception	37%
HIV	35%
Abortion	32%
No response/ Don't know	7%
None are mentioned	3%

Local Delivery Plans (LDPs) set out the PCT's intentions for the next three years, and should show how the PCT plans to reflect national targets at a local level. A four-part national PSA target for sexual health has existed since 2004. This means that all LDPs should at least mention one or more sexual health service areas.

The proportion of respondents who said that STIs were mentioned had increased from 67% in 2005 to 75% in 2006, and those mentioning general sexual health remained steady at 66% compared to 65% last year. This is encouraging, and reflects the positive impact of national targets at a local level.

However, coverage of all other areas of sexual health in the LDP had decreased, with the biggest decrease being in contraception. This was mentioned in 50% of LDPs in 2005, but in only 37% in 2006. It is notable that those areas where a decrease has occurred are also those not linked to specific national targets.

7% of respondents could not tell us which sexual health areas, if any, were mentioned in their LDP. One respondent told us that there was "No LDP this year due to financial recovery plan". Although financial stability is important, in the long-term resources can be saved through good planning and the targeted investment of funding. It is essential that short-term financial balance is not achieved to the detriment of strategic long-term planning and investment in health improvement, which in the end, will result in a healthier and more stable financial situation.

4.4 Local sexual health planning

Table 5a: Does your PCT have a planning body for sexual health services?

Yes	94%
No	6%

This was the second time that this question had been asked, and the response in 2006 was identical to 2005's. Although the overwhelming majority of PCTs do have a planning body for sexual health, it is disappointing that further progress has not been made in ensuring that all PCTs have such planning mechanisms in place.

Table 5b: If yes, who sits on the planning body?

GUM/HIV staff	97%
Family planning staff	89%
Sexual health commissioner	85%
Public Health lead or specialist	87%
Voluntary Sector	69%
Local Authority	56%
Other	20%
Patients and the Public	15%

We then went on to ask about the participation of key stakeholders in the planning body, where it existed. Only the 61 respondents who had said their PCT had a planning body went on to answer this question.

Two PCTs indicated that GUM/HIV staff were not involved in their planning body, and 15% of planning bodies did not include a sexual health commissioner. Collaboration between key stakeholders from community and hospital-based care improves the effectiveness of sexual health planning. A failure to include key sexual health and HIV staff in planning processes will affect coordination between health promotion, diagnostics and treatment services.

The only group whose involvement in planning had increased was public health specialists, which was 74% in 2005 and was 87% in 2006. However, in 2005 Public Health involvement was mainly through the Director of Public Health, whereas in 2006 an increased number of less senior public health specialists were mentioned.

Of the 12 respondents who gave an answer of "other", seven specified what post the "other" held. Two mentioned Health Protection Agency staff, who would be able to give vital input on local HIV and STI epidemiology. One respondent said the acute Trust's Business Manager was on their planning body and one PCT planning body included a representative of local prison staff.

Whilst this does indicate some innovation in the involvement of stakeholders, the overall picture again suggests a loss of expertise in sexual health planning.

4.5 Needs assessment

Table 6: When did your PCT last undertake a specific needs assessment for sexual health and HIV?

0-1 years ago	29%
1-3 years ago	26%
3+ years ago	23%
Don't know/ no response	22%

This question was asked slightly differently in 2006, to encourage respondents to be more accurate about when their PCT's last sexual health needs assessment had taken place.

In 2004's survey 51% of respondents said that a sexual health needs assessment had taken place within the previous year. Two years later in 2006, this number had fallen dramatically, with less than a third of responding PCTs undertaking a sexual health needs assessment during the previous year.

In fact, 45% of PCTs could not say that a needs assessment had taken place in the last three years. Nearly a quarter of respondents reported that the last needs assessment had been more than three years ago and more than one in five could not say whether such an assessment had taken place at all. Although this is better than the one in four who could not say in 2005's survey, there is still a significant proportion who do not know. As we said in 2005, *"Given that this survey is likely to be filled in by one of the PCT staff with the greatest knowledge of local sexual health planning, this is problematic"*.

Needs assessment is a vital tool in planning appropriate services and given the newly strengthened role of commissioning, it will be more crucial than ever for PCTs to understand their local populations. It is therefore extremely concerning that so little up-to-date needs assessment exists, and that this situation has consistently worsened over the last four years of this survey.

We strongly recommend that regular needs assessment be made a requirement of PCTs' planning process for sexual health.

4.6 Managed Service Networks

Table 7a: Does your PCT have a managed service network for sexual health and HIV?

No	34%
Yes	26%
In development	25%
Don't know/ no response	16%

The percentage of PCTs with a Managed Service Network (MSN) has stayed the same but the percentage with networks in development dropped from 33% in 2005 to 25% in 2006.

While it is encouraging that over half of PCTs either already have or are planning an MSN, it is disappointing that the number of PCTs with established MSNs has not increased, and of some concern that their development is decreasing rather than continuing. This may be a reflection of increasing financial pressures on PCTs.

There was a large increase in the number of respondents who were unable to tell us whether their PCT had a Managed Service Network. Only 3% of respondents could not answer this question in 2005, compared with 16% in 2006, indicating a worrying lack of awareness about the role and purpose of Managed Service Networks, which is linked to the diluted role of sexual health experts in service planning.

Table 7b: If yes, is it (or will it be) supported by:

51% of respondents (33) told us in part 'a' that they either already had an MSN or that one was in development. Of those 97% (32) went on to tell us about how the MSN was supported.

Organisational support (non-financial)	44%
Don't know	34%
Recurrent funding	25%
Non-recurrent funding	9%

Although increased funding was available for sexual health during 2006, there was a striking reduction in the proportion of respondents who told us that their network was supported by recurrent funding, from 41% in 2005 down to 25% in 2006. The amount of non-financial support increased slightly, but over a third of responding PCTs could not say how their network was supported. This is almost certainly a reflection of the greater number of non-specialists who have responded to 2006's survey and the loss of expertise that this represents.

Table 7c: Which providers are/will be involved in your managed service network?

94% of those with a Managed Service Network (31 respondents) went on to tell us which providers were involved in their network.

GUM	90%
Primary Care	84%
Voluntary sector	84%
Local Authority	48%
Other acute services	42%
Other services	29%
Don't know	10%

Despite confusion about the role of MSNs and the comparatively low level of support they enjoy, where networks are in place they seem to be engaging more stakeholders. The amount of involvement from all the providers listed has increased, with the biggest rise being in the involvement of the voluntary sector: 63% in 2005 and up to 84% in 2006. This is probably a reflection of the increasing variety of providers involved in delivering sexual health services.

Of the nine respondents who told us that other services were involved in their MSN, most did not specify which these services were, one mentioned family planning services and one mentioned the Health Protection Agency.

Table 7d: What is the position of the lead officer in the managed service network?
97% of respondents (32) went on to answer a question about their MSN's lead officer.

Don't know	31%
Other	25%
Director of Public Health	19%
Commissioner	19%
Consultant/GP	6%
Sexual health services manager	3%
Clinical Director	3%

The most common single response to this question was that people did not know who the lead officer was, with almost one in three unable to say. However, this was an improvement on 2005's survey, when 40% of respondents could not name the network's lead officer.

Of those who did not know who their MSN's lead officer was, one had already told us that they were the commissioning manager for sexual health, one was the Assistant Director of Public Health and sexual health lead and one was the teenage pregnancy and sexual health coordinator. It is concerning that these key sexual health staff could not name the network's lead officer, and demonstrates a further lack of knowledge of their own PCT's sexual health structures.

Of the eight respondents who categorised their lead MSN officer as "other", three indicated that the lead officer had not yet been appointed. Three respondents also indicated that there was a specific post of "Network Director". The involvement of Directors of Public Health as lead officers has fallen from 24% in 2005 to 19% in 2006, and the number of clinical directors and sexual health managers leading MSNs remains very low.

4.7 PCT spending on HIV and sexual health

Table 8: Compared with last year, has your PCT's spending on HIV and STIs:

Increased	55%
Stayed the same (+cost of living uplift)	26%
Stayed the same (no uplift)	5%
Decreased	6%
Don't know	8%

Questions about finance remain sensitive and similarly to 2005, almost one in ten respondents were unwilling or unable to answer this question about funding. The proportion of PCTs who had increased their spending on HIV and STIs went up slightly, although given that the first part of the £300m for sexual health promised in the 2004 *Choosing* Health White Paper was allocated to PCTs in April 2006, it is disappointing that spending had not increased more comprehensively.

Table 9: Has the local *Choosing Health* money for sexual health been spent on sexual health services in your area?

Yes	37%
No	37%
Some of it	22%
Don't know	5%

This was a new question this year, and the responses explain why spending on HIV and STIs had not increased in all PCTs, despite the notional allocation of additional funding from Government (see above).

David Nicholson, Chief Executive of the NHS announced in December 2006 that not only was the NHS expected to rebalance its books in the next year, but that he expected there to be financial surplus in the Health Service by 2008. Given this continued emphasis on financial recovery, it is not surprising that overall, 59% of respondents indicated that either all or part of their *Choosing Health* money had been diverted away from sexual health services. In a later question, a number of respondents told us that the money had been used instead to offset budget deficits.

The diversion of this money will affect delivery of services in key areas of sexual health. Responses to the open question at the end of the survey indicated that some PCTs will be unlikely to meet targets around chlamydia screening and 48 hour GUM access without the investment of this funding (see 4.9).

We ask the Government to take urgent action to ringfence future sexual health funding and enable PCTs to spend allocated money on the services for which it was intended.

4.8 Community-based services

Table 10: Has there been an increase in non-acute (primary or community based) sexual health services in your area in the last year?

Yes	66%
No	29%
Don't know	5%

This was a new question for 2006 for both PCTs and clinicians. It is encouraging to see that two thirds of respondents reported that community-based sexual health services have increased in the last year.

The importance of community-based services for preventing as well as treating STIs and HIV is now well-established. Modernising sexual health services and moving them out of traditional GUM settings is absolutely vital to ensure that people who need services can access them easily and conveniently. Given that community-based services also provide value for money, it is important that more PCTs struggling with deficits consider redesigning sexual health services as a way to maximise effectiveness and efficiency.

4.9 Help to improve sexual health

Table 11: What would enhance your ability to make greater progress locally in reducing the incidence of HIV/STIs?

This question was repeated from last year, and 43 out of the 65 respondents made comments in this open section. Of those comments made by multiple respondents:

More financial resources (of which, ringfenced including *Choosing Health* money to be ringfenced)	44% (26%)
Greater capacity (of which, more staff)	19% (12%)
Cross sector collaboration	12%
Service modernisation	12%
More training for staff	12%
More meaningful national targets	9%
More health promotion	7%
Stability in the NHS	7%
Community-based services	7%
National sexual health campaign	7%
Better local data	5%
Prioritisation by the PCT	5%

Although a slightly lower proportion of respondents said that they wanted more funding (50% in 2005 down to 44% this year), more respondents explicitly said that they wanted funding to be ring-fenced (17% in 2005 up to 26% in 2006).

A number of respondents specifically commented on the diversion of the *Choosing Health* money, and told us that greater improvements in their service provision could have been made if this money had been available. Comments on funding also included some concerns about the implementation of Payment by Results (PbR), and how this would impact on sexual health investment.

12% of respondents told us that more staff would be helpful in reducing HIV and STI incidence, which was up from 9% in 2005. This may also be a reflection of the current financial climate, particularly in Trusts where redundancies have occurred, or where posts have been frozen.

For the first time 7% of respondents also said that more public education on sexual health was a priority, with a significant number specifically mentioning the need for a national sexual health promotion campaign. In 2004, the Government pledged £50m through the *Choosing Health* White Paper for a national health promotion campaign. By the end of 2006 just over £3m of this money had been spent on media encouraging young people to use condoms. While this is a welcome start, we urge the Government to invest the remaining £46m in a sustained sexual health promotion campaign as soon as possible.

Some comments from responding PCTs

"*Choosing Health* money was not ring-fenced and was part of the "growth" element of the annual allocation for PCT. The "growth" was topsliced by the Strategic Health Authority as the PCT has one of the largest deficits in the country. In addition as part of the PCT's recovery plan, public health budget for health promotion services were cut back in 2006/07. We are not able to meet the targets set out in sexual health operation framework and in particular the GUM 48 hours access and opportunistic chlamydia screening in the primary settings."

"Adequate resources - ringfenced. *Choosing Health* allocation."

"Ringfence for HIV money."

"Ringfenced funding -allowing a longer term approach as opposed to "knee jerk "pump prime funding. Teenage pregnancy is only one part of the story."

"Money for staff. Commitment for sexual health as an important public health issue and concern. Stopping block contracts and establishing SLA with providers. Understanding where all the money is for sexual health. Although I am starting to find out where some of the money is, I still have no idea where money for treatment of HIV is and who is the named commissioner. I think people believe it is me, but it definitely isn't, although with permission I would gladly do it! "

"More investment, government policy on improving GUM services is disaffecting (sic) HIV patient care. This requires additional investment. Commitment from GUM colleagues to support the development of community based sexual health services."

"Integration of GUM/family planning services, especially for under 25s. PCT pay lip service to change but do not commit. I am supposed to be lead clinician and strategic planner and lead nurse (as PCT refuse to employ/replace lead nurse) and everything else to do with sexual health on 11 hours a week including clinics!!"

"Circulation of guidance on managing workload. Many staff responsible for GUM/HIV are from public health (in PCTs) and don't have the experience of managing this."

"Better integration of services and development of nursing skills."

"National Public Health campaigns working across organisations and risk behaviours (e.g. binge drinking)"

5. Clinician Findings

5.1 Clinician sample

Table12: Regional origin of clinician responses

London	32%
South East	17%
Yorkshire and Humberside	12%
North West	10%
West Midlands	8%
East Midlands	6%
East of England	6%
South West	5%
North East	4%

There was a massive increase in the number of clinician responses, from 88 in 2005, up to 231 in 2006. It is notable that so many more clinicians wished to give us their views, and suggests that there is real strength of feeling about recent developments in sexual health and HIV services.

The regional categories for clinicians were also adjusted in 2006 to reflect NHS regions. As always, London and the South East produced the most responses; this is largely due to the greater prevalence of HIV, which means there are more HIV clinicians based in these regions.

Response levels in most other regions remained quite steady in comparison to 2005's results, with the notable exception being a welcome increase in response levels in the West Midlands, which went up from 3% in 2005 to 8% in 2006. Response rates in the South West also dropped from 9% in 2005 to 5% in 2006, which was in contrast to the PCT survey, where the South West was the highest responding region.

Table 13: Type of clinicians responding

GUM clinician (mainly GUM)	54%
GUM clinician (mainly HIV)	25%
Other (mainly Paediatric HIV Specialists)	7%
Infectious diseases clinician (mainly ID)	6%
Nurse (mainly HIV specialist nurses)	5%
Infectious diseases clinician (mainly HIV)	4%

For the first time a small number of nurses (12) answered the questionnaire and this is perhaps a reflection of the expanding role of nurses in HIV and sexual health service

provision. Responses from other groups of clinicians all remained at proportionally about the same levels, with GUM clinicians being the largest single group of respondents.

5.2 Changes in access to services

Table 14: How have your open access (self-referral) GUM or HIV services changed over the last 12 months?

Got better	32%
Stayed the same	43%
Got worse	23%
Don't know	2%

The responses to this question illustrate a markedly improved situation. In 2005, only 17% of clinicians reported a positive change in access to their services, whereas in 2006, nearly double that proportion were able to say things had got better. Correspondingly fewer clinicians said things had got worse: a third reported negative changes in 2005 and this is down to around a quarter in 2006.

One respondent who reported that things had got worse went on to qualify this by saying that "Although patient activity (is) the same, now more GP referrals so less availability for self-referral".

Increasing use of referrals was a notable theme in 2005's results, and it may be that this trend has continued. This might explain why, although things seem to be much better, one in four clinicians still thought access had worsened. It is also possible that the continued implementation of the 48 hour access target for GUM is affecting the way in which people can access services. This is further addressed at paragraph 5.5.

5.3 Turning people away

Table 15: Do you often have to turn people seeking an initial diagnosis away without providing a service?

Yes, often	18%
Yes, occasionally	36%
No	42%
Don't know	3%
No response	1%

Responses to this question also painted a somewhat improved picture. In 2005, around one in four clinicians reported having to often turn patients away, and in 2006 that figure had gone down to fewer than one in five. However, the number of clinicians who said they had to occasionally turn patients away has remained fairly steady and too high.

Overall, more than half of respondents have either often or sometimes had to turn away patients seeking an initial diagnosis. HPA figures still estimate that a third of people with HIV remain undiagnosed, and recent US research indicates that up to 70% of onward transmission of HIV is from those still undiagnosed. Given that research also shows that up to 30% of people exhibiting STI symptoms continue to have sex, it is clear that improving access to testing, diagnosis and then treatment is absolutely crucial. Without service modernisation and an increase in capacity, the UK will not be able to turn its HIV and STI epidemics around.

5.4 Drugs budgets

Table 16: Will your clinic drugs budget be overspent by the end of the year?

Yes	56%
No	18%
Don't know/no response	26%

While over half of the clinicians indicated that their drugs budgets would be overspent, this was an improvement on 2005, when two thirds of clinicians had indicated they would have exceeded their budget. Historically, clinic budgets were set based on the previous year's spending, so any funding not used would be lost from the coming year's budget. It is likely that as the NHS becomes more cash conscious and Payment by Results is implemented there will be less of a perverse incentive to overspend.

However, the uncertainty about drugs budgets that has been a trend in the last three years has continued. In 2006, more than one in four clinicians could not predict whether they would be overspent. This unpredictability and the continuing level of overspend on drugs raises questions about the quality of local planning and the accuracy with which budgets correspond to levels of need.

Given that more than two in five responding PCTs indicated that they had not undertaken a local sexual health needs assessment in the previous three years (see 4.5), this mismatch between drugs budgets and the needs of local populations is not surprising.

5.5 Appointment systems

Table 17a: Has your clinic's appointment system changed since the introduction of the 48 hour GUM access target?

Yes	44%
No	48%
Don't know	5%
No response	3%

Achieving the 48 hour access target was an NHS priority in 2006, and so this is the sexual health objective likely to be highest in a PCT's priorities. Although the 2005 survey did not include a specific question on the target, it became clear from extra commentary in response to our question on waiting times that changes to appointment systems had taken place at some clinics.

This was confirmed by the responses 2006's specific question, with more than two in five clinicians saying their appointment system had changed since the introduction of the target.

Table 17b: If yes, how? Do you believe this is related to the introduction of the target?

102 respondents indicated in the above question that their appointment system had changed since the introduction of the target. 90% (92) of those respondents went on to answer a question about how their appointment system had changed.

Of these respondents, 50% (46 respondents) believed that changes *were* related to the introduction of the 48 hour access target.

59% (54 respondents) of those who told us their appointment system had changed went on to describe that change. Respondents indicated that their clinic had taken one or more of the measures below:

Increased walk-in	35%
Restricted booking	22%
More appointments	19%
More nurse-led clinics	13%
Now walk-in only	9%
More triage	6%
Less follow-up	4%
Less triage	4%
No walk-in	2%

In general, it seems that clinics are increasing the openness of their appointment systems, with the most common measure being to increase walk-in access. This is in line with the Department of Health and MedFASH recommendations in the 2006 guidance, *10 High Impact Changes for Genitourinary Medicine 48 hour access*. Of some concern are the clinics who have restricted booking (mostly so that patients can only book for a short period in advance), and the clinics who are now walk-in only, as neither of these measures is likely to make it any easier for patients to make convenient appointments.

It is clear that there is real confusion about how best to improve access, with clinics opting for a wide range of measures, some in direct contradiction of each other. The small number of clinics doing less triage are of real concern, as urgent cases are more likely to be missed.

5.6 Activity versus capacity

Table 18a: In the last year, patient activity has:

Increased	81%
Decreased	3%
Stayed the same	14%
Don't know/ no response	2%

89% of respondents in 2005 reported that patient activity had increased, compared to 81% in 2006, and the proportion of respondents who said that activity had stayed the same almost doubled, from 6% in 2005 up to 14% in 2006. Some respondents who reported decreased patient activity then went on to later comment on their need for more staff or the refurbishment of premises.

Table 18b: If patient activity has increased, has clinic staffing also increased in line with it?

Of the 188 respondents who indicated that patient activity had increased in the above question, 99% (186) went on to answer this question about staffing.

Yes	18%
No	78%
Decreased	2%
Don't know	2%

In 2005 only 3% of respondents whose patient numbers had increased were also able to say that staffing had increased. In 2006 this figure had increased sixfold to 18%, but this still left four out of five clinicians coping with increased patient activity and static or reduced staffing levels.

Once again, extra comments in this section revealed that financial uncertainty and lack of extra resources have taken their toll on staff numbers and morale:

"Less staff, more work, more pressures, morale decreased."

"We have gone 'at risk' based on PBR tariffs."

"None since 1992."

The first recommendation of *10 High Impact Changes for Genitourinary Medicine 48 hour access* is that services should assess potential gaps between demand and capacity. Providers need to determine whether extra capacity is needed, or if service modernisation may offer a more effective solution to growing patient numbers. Failure to address this issue will continue to take a toll on staff morale.

5.7 Impact of changes on clinical service provision

Table 19a: In the last year, has your ability to provide GUM (other than HIV) services:

Got better	22%
Stayed the same	33%
Got worse	30%
Don't know/ no response	15%

Table 19b: In the last year, has your ability to provide HIV services:

Got better	17%
Stayed the same	55%
Got worse	24%
Don't know/ no response	4%

For both GUM and HIV services, more respondents than in the previous year reported that their ability to provide services had improved. The proportion of those able to report an improvement for GUM services had doubled from 11% in 2005 to 22% in 2006, and for HIV services the figure rose from 10% to 17%. Correspondingly fewer respondents said their ability to provide services had worsened, down to 30% from 39% for GUM services and from 28% to 24% for HIV.

However, considering the amount of extra funding that was made available in 2006 and the higher priority afforded nationally to sexual health, it is disappointing that the majority of respondents in both services still felt that things had either stayed the same or got worse.

This response pattern bears out comments elsewhere, which indicated that *Choosing Health* money had not reached sexual health services and that HIV and sexual health were not a high enough priority for their PCT or local NHS Trust. Overall, the picture is one of dislocation between national priorities and local action on funding and service improvement.

5.8 Treatment restrictions

Table 20: Has your PCT/Trust restricted prescribing of any specific HIV medications or tests due to costs?

Yes	13%
No	55%
Not yet, but discussions have taken place	22%
Don't know	10%

This question was asked in a slightly different way this year, to establish which PCTs had actually implemented restrictions, and which were considering doing so. In 2005, 24% of respondents reported that their PCT or Trust had *discussed* restricted prescribing with some degree of pressure.

This year, 35% of respondents reported that restrictions were either already in place (13%), or that discussions about restrictions had taken place (22%). This represents a significant move towards drug rationing within HIV services, and is of serious concern.

Further analysis revealed that 41% of respondents who reported either existing prescribing restrictions or discussions about restrictions were based in London. According to the HPA's 2006 annual report 56% of people accessing HIV care in England in 2005 did so in London. The introduction of prescribing restrictions has the potential to affect over 24,000 people living with HIV.

Not all combinations of anti-retroviral medication are suitable for all people with HIV. New drugs tend to be more expensive, but may be essential for people who have developed resistance to previous combinations, and severe side effects can rule out the use of certain treatments for some people. It is vital, therefore, that treatment decisions be made primarily according to clinical need. We accept that where two drugs have the same clinical effect, cost will be a factor in prescribing decisions, but no-one should be denied access to a particular test or treatment for financial reasons alone.

Our results show us that drug rationing is an increasing feature of HIV treatment, and urgently needs further scrutiny.

5.9 Relative priority afforded to sexual health

Table 21: Are HIV and sexual health sufficiently prioritised within your local health services?

Yes	22%
No	66%
Don't know	12%

In 2005, only 19% of clinicians believed that HIV and sexual health were sufficiently prioritised at a local level. While this figure had gone up slightly to 22% in 2006's survey, two thirds of clinicians still believed that HIV and sexual health were not given a high enough local priority.

A number of respondents took levels of local spending on sexual health as the measure for how high a priority this area was given in local health services. The diversion of the *Choosing Health* money was of serious concern to clinicians, some of whom provided extra comment on this question:

"The trust has to balance the books so our GUM budget has been cut compared with previous years. The *Choosing Health* money has disappeared!"

"*Choosing Health* money has been taken to cover PCT deficit therefore unable to provide STI service as planned/promised."

"We received NO *Choosing Health* money from any of the three PCTs we deal with."

This is further evidence of the disconnect between national priorities and funding commitment, and local action and spending on HIV and sexual health.

5.10 Payment by Results

Table 11: How do you believe Payment by Results will impact on your ability to provide GUM/HIV services?

Don't know	29%
Negatively	24%
Positively	22%
No response	17%
No impact	8%

This and the following three questions were printed on the reverse side of the questionnaire, which may have resulted in a slightly lower response rate.

The introduction of the Payment by Results (PbR) system means that providers of NHS services will be paid a set price from the NHS tariff for each intervention or episode of care, regardless of how much it costs them to offer that service. In effect, if a service can be provided more cheaply than the NHS tariff price, this allows providers to generate extra income for re-investment in services.

A question on PbR was introduced in 2006 to capture clinicians' general mood around the new system. The most popular response was that clinicians did not know what impact PbR would have and the overall picture was extremely confused, with no real consensus on how PbR might affect sexual health and HIV services.

Several respondents commented that PbR might be beneficial if income generated by GUM services was re-invested in sexual health, but there was concern that this would not happen:

"Depends how much is top sliced by the Trust."

"If we can keep the money we might be able to return to the previous staffing levels."

"If they pay us correctly without top slicing."

"If the money actually comes to us. Our Trust has taken all the increased funding for this year by PbR so we have not benefited at all."

Following the diversion of such a large proportion of the *Choosing Health* money, it is not surprising that staff continue to be concerned about the investment of money in sexual health services.

5.11 Community based services

Table 12: Has there been an increase in non-acute (primary or community based) sexual health services in your area in the last year?

No	41%
Yes	28%
No response	16%
Don't know	15%

This question had also been asked of responding PCTs for the first time in 2006, and the difference between the two sets of results is notable.

While 66% of responding PCTs reported that community based sexual health services had increased in their area, less than half that proportion of responding clinicians reported the same thing. Similarly, 29% of PCTs had said there had not been an increase in these services, whereas 41% of clinicians said such services had not increased.

The proportion of clinicians who did not know whether there were more community based services in their area was three times higher than the 5% of PCT respondents who were unable to say.

These results show a lack of consensus between PCTs and clinicians about what is happening at a local level and it may well be that where service redesign is taking place, this needs to be communicated more effectively to everyone involved.

5.12 Help to improve sexual health

Table 13: What would enhance your ability to make greater progress locally in reducing the incidence of HIV/STIs?

59% of respondents (136) made extra comments in this open-ended question. Of those comments made by multiple respondents:

More/better administered funding (of which, *Choosing Health* money/ringfenced funding)	44% (24%)
More staffing (all clinical posts)	34%
Better support/management from Trust or PCT	19%
Better/larger accommodation	18%
More public education/awareness	12%
Community-based services	11%
Better diagnostics	10%
Modernised/reorganised services (esp. more use of nurses)	8%
Better/more admin staff	4%
Better service targeting towards at risk groups	4%
Better/more targets	4%
Wider opening hours	3%
Better/more PHSE	2%

The views expressed by clinicians mirrored some of the commentary from responding PCTs to this same question. Both sets of respondents commented on the need for protected funding, need for more staff, and both mentioned how a national public awareness campaign would be helpful in improving sexual health.

In 2005, 25% of responding clinicians said that more or better administered funding would be helpful; in 2006 that figure went up to 44%. Significantly, a quarter of respondents specifically commented on the allocation of the *Choosing Health* money, mainly asking for this and similar funding to be ringfenced.

Comments on funding also included concerns about the administration of PbR and the potential for money accrued within sexual health to be diverted elsewhere and not re-invested.

Compared to 2005, a substantially smaller proportion of clinicians thought that extra clinical staffing would be helpful (2005: 54%, 2006: 34%). However, more clinicians recommended that community based services should be increased (2005: 7%, 2006: 11%).

Some comments from responding clinicians

"Being allocated *Choosing Health* money. Being allocated PbR funding to invest in service rather than the Acute Trust using any extra income to cross subsidise other specialities."

"Ringfencing of HIV/GUM money. Money has been diverted to fund Trust's deficits to great detriment of HIV/GUM (staffing positions lost, freezing of posts-leading to a reduction in capacity)."

"Ringfence money for STI/SH. Evidence shows that more progress was achieved for sexual health during period of ring fencing than otherwise."

"To get ANY of the *Choosing Health* allocation. We received none despite having a costed plan within the allocation that would have increased capacity by 30%."

"It's scandalous. How can Department of Health sit there and say they are making it a priority and then "look the other way" when the PCT keep the money to bail out the mismanagement that allowed them to accumulate a debt of millions? It's a farce."

"Cynically, it might be said that Department of Health investment in sexual health via *Choosing Health* monies was a gesture. If they had actually intended this investment to go into sexual health it would have been ringfenced."

"All of the *Choosing Health* monies allocated to the local PCT have been used to meet the PCT deficit. The PCT has also opted out of the chlamydia screening programme. Family planning services are being cut back. The PCT does not see HIV/sexual health as a priority."

"An assurance by PCT that they will use PbR for all our extra attendances. Increase in workload averages 10% per year (last two years). PCT asked us to restrict to 3% this year. In fact has increased by 16%. Not sure how PCT will deal with this. We can't restrict growth in activity while simultaneously meeting 48 hour target."

"Receive the money to which we will be entitled by PbR-I cannot believe the money will ever reach us, instead it will be used to settle the Trust's debts I think."

"We need investment-we have vision and enthusiasm but unsupported by our execs (until they started to panic about 2008 but still no money) and have received not a penny of C*hoosing Health.* We are very concerned about PbR (we have very low reference costs and high activity)."

"Extending the hours of our clinic, evenings and Saturdays-but no staff availability and nurses not interested."

"More community based services and simpler testing/management protocols for primary care."

"More staff for clinics, possibly providing sexual health advice in alternative settings - voluntary agencies, young parent projects etc."

"Restructuring of the service i.e.; acute/community based-allowing an integrated GU/reproductive health service."

"Working with community services, not in opposition. PCTs have stopped GPs using our GUM services to facilitate national led directives i.e. screening etc."

"Giving GPs access to NAATs* for gonorrhoea and chlamydia. A period of stability - no more NHS re-organisation."

"Provision of targeted education/prevention programmes, including working with voluntary sector closely. Dedicated MSM services in GUM clinics. Much wider availability of (rapid) HIV testing (GP surgeries, prisons, voluntary and community groups, mobile services, etc.)"

"Good preventative work by the GU service which is lacking."

"Public Health orientation, rather than mainly primary care view of managing services."

"Political will at the top of PCTs or Acute Trusts. Clearer direction from Department of Health -ambiguous at the moment."

"Better engagement by PCT - sexual health isn't a priority. They are rigid in their attitudes to sexual health in secondary care which would be great if they were providing sexual health services elsewhere but they are not."

"There has been no commissioning of HIV services since 2001 - lead commissioner for HIV service and my local commissioning PCT each said the other was responsible."

"Having reasonable, informed and accessible commissioners to work with. I've spent a year talking to people who seem unable/unwilling/too ill informed to engage in any action."

"We have had no specialist commissioner for sexual health since the last one resigned in July 2004. It is consequently very hard to find anyone at the PCT to talk to. At regional commissioning meetings all too frequently nobody from our PCT turns up, even though we have by far the highest HIV prevalence/incidence and the highest rates of chlamydia/gonorrhoea/syphilis/LGV/acute hepatitis C in the region."

"Recruiting staff. All vacant posts currently frozen."

"Increase the nurse skill mix and grade to improve the level of nurse led care."

"Higher grades for GU nurses so that these can see patients more independently."

“Most of our HIV activities are judged on the basis of SOPHID* database. The database however depends on regular administrative input that we have been devoid of. As a result SOPHID reflects an 'underestimate' of our activities.”

“Funding for local and national HIV awareness campaigns similar to the recent chlamydia ones.”

“We can't expand our services without more space, but the PCTs various arms (commissioning vs. service provision) aren't speaking to each other so we are deadlocked. The clinic’s health and safety report expressed extreme concerns in 2003 re; safety for staff and patients. Because of the pressure of the 48 hour target we've had to ignore the safety concerns and increase patient throughput, but now can't physically fit more patients in the clinic!!”

“A greater awareness of the impact of rapid demographic changes.”

“Development of GUM service in neighbouring PCT - huge population uses our service.”

“Having a clinic in a neighbouring town so people especially young/disadvantaged people would have easier access - so far clinic facilities not adequate in neighbouring town. Also clinics at weekends/evenings would increase access.”

“Repatriate non entitled nationals as HIV medication (ART*) is becoming available in many countries. Stop wasting money on programmes like chlamydia screening in the community - divert that money to NHS GUM service, centralise.”

“Amnesty for asylum seekers, allowing effective targeting of populations from countries of high HIV prevalence. Effective PSHE in schools, without the spectre of religious constraint.”

“Companies sending personnel to high risk areas should be made somewhat responsible for staff health.”

Glossary

** NAATs – Nucleic Acid Amplification Technology, a method of testing for chlamydia and gonorrhoea that uses either a urine sample or cervical swab.*

** SOPHID - Health Protection Agency’s database of the number of people accessing NHS HIV services.*

** RSH – Reproductive and Sexual Health*

Appendix One: The Surveys

PCT Questionnaire

1 **My PCT is based in:**

2a **What is your post?**

2b **If you are not the lead commissioner for sexual health/HIV, which post is?**
- Don't know ☐

3 **Which of the following are explicitly mentioned in your PCT's LDP? Please tick all that apply.**
- Sexually Transmitted Infections (STIs) ☐
- General Sexual Health ☐
- Abortion ☐
- HIV ☐
- Contraception ☐
- Don't know ☐

4a **Does your PCT have a planning body for sexual health services? If no, go to Q5.**
- Yes ☐
- No ☐
- Don't know ☐

4b **If yes, who sits on the planning body?**
- GUM/HIV staff ☐
- Family planning staff ☐
- Sexual health commissioner ☐
- Director of Public Health ☐
- Voluntary sector ☐
- Local authority ☐
- Patients/ public ☐
- Don't know ☐
- Other ☐

If other, please specify:

5 **When did your PCT last undertake a specific needs assessment for sexual health and HIV?**
- 0-1 year ago ☐
- 1-3 years ago ☐
- 3+ years ago ☐
- Don't know ☐

6a **Does your PCT have/ will it have a Managed Service Network for sexual health/ HIV? If no go to Q7.**
- Yes ☐
- No ☐
- In development ☐
- Don't know ☐

6b **If so, is it (or will it be) supported by:**
- Recurrent funding ☐
- Non-recurrent funding ☐
- Organisational support (non-financial) ☐
- Don't know ☐

6c **Which providers are/ will be involved in your Managed Service Network? Please tick all that apply.**
- GUM ☐
- Primary care ☐
- Voluntary sector ☐
- Local authority ☐
- Other acute services ☐
- Don't know ☐
- Other services ☐

If other, please specify:

6d **What is the position of the lead officer in the Managed Service Network?**
- Director of Public Health ☐
- Sexual health services manager ☐
- Commissioner ☐
- Consultant/GP ☐
- Clinical Director ☐
- Don't know ☐
- Other ☐

If other, please specify:

7 **Compared with last year, has your PCT's spending on HIV and STIs:**
- Increased ☐
- Stayed same (+cost of living uplift) ☐
- Stayed same (no uplift) ☐
- Decreased ☐
- Don't know ☐

8 **Has the local Choosing Health money for sexual health been spent on sexual health services in your area?**
- Yes ☐
- No ☐
- Don't know ☐

9 **Has there been an increase in non-acute (primary or community-based) sexual health services in your area in the last year?**
- Yes ☐
- No ☐
- Don't know ☐

10 **What would enhance your ability to make greater progress locally in reducing the incidence of HIV/STIs? Continue overleaf if necessary.**

Specialist clinician questionnaire

1 I am based in:

London ☐ East of England ☐ West Midlands ☐ North West ☐ South West ☐
South East ☐ East Midlands ☐ North East ☐ Yorks. & Humberside ☐

2 I am a:

GUM Clinician (mainly GUM) ☐ GUM Clinician (mainly HIV) ☐ Infectious Diseases clinician (mainly ID) ☐
Infectious diseases clinician (mainly HIV) ☐ Other ☐ If other, please specify:

2b How has your open access (self-referral) GUM or HIV services changed over the last 12 months?

Got better ☐ Stayed the same ☐ Got worse ☐ Don't know ☐

3 Do you often have to turn people seeking initial diagnosis away without providing a service?

Yes, often ☐ Yes, occasionally ☐ No ☐ Don't know ☐

4 Will your clinic drugs budget be overspent by the end of the year?

Yes ☐ No ☐ Don't know ☐

5a Has your clinic's appointment system changed since the introduction of the 48 hour GUM access target?

Yes ☐ No ☐ Don't know ☐

5b If yes, how? Do you believe this is related to the introduction of the target?

6a In the last year, patient activity has:

Increased ☐ Decreased ☐ Stayed the same ☐ Don't know ☐

6b If patient activity has increased, has clinic staffing also increased in line with this?

Yes ☐ No ☐ Don't know ☐

7a In the last year, has your ability to provide GUM (other than HIV) services:

Got better ☐ Stayed the same ☐ Got worse ☐ Don't know ☐

7b In the last year, has your ability to provide HIV services:

Got better ☐ Stayed the same ☐ Got worse ☐ Don't know ☐

8 Has your PCT/Trust restricted prescribing of any specific HIV medications or tests due to cost?

Yes ☐ No ☐ Not yet, but discussion has taken place ☐
Don't know ☐

9 Are HIV and sexual health sufficiently prioritised within your local health services?

Yes ☐ No ☐ Don't know ☐

10 How do you believe Payment by Results will impact on your ability to provide GUM/HIV services?

Positively ☐ Negatively ☐ No impact ☐ Don't know ☐

11 Has there been an increase in non-acute (primary or community based) sexual health services in your area in the last year?

Yes ☐ No ☐ Don't know ☐

12 What would enhance your ability to make greater progress locally in reducing the incidence of HIV/STIs? Continue overleaf if necessary.

Appendix Two: Recommended Reading List

Disturbing Symptoms series (1, 2, 3 & 4) (Terrence Higgins Trust/BASHH/BHIVA/PACT from 2002) available at www.tht.org.uk

Review of Primary Care Trust Local Delivery Plans 2005-2008 (Brook, fpa, Medical Foundation for AIDS & Sexual Health, National AIDS Trust, Terrence Higgins Trust, 2006) available at www.tht.org.uk

Creating a patient-led sexual health service (Terrence Higgins Trust, 2005) available at www.tht.org.uk

Sexual Health and HIV: an urgent economic and public health challenge (Brook, fpa, Medical Foundation for AIDS & Sexual Health, National AIDS Trust, Terrence Higgins Trust, 2004) available at www.tht.org.uk

10 High Impact Changes for Genitourinary Medicine 48-hour Access (Department of Health with MedFASH 2006) available at www.medfash.org.uk

Choosing Health: making healthy choices easier (Department of Health, 2004) available at www.dh.gov.uk

The National Strategy for Sexual Health and HIV (Department of Health, 2001) available at www.dh.gov.uk

British HIV Association website (includes clinical guidelines)
www.bhiva.org

British Association of Sexual Health and HIV website (includes clinical directory and primary care testing guidelines)
www.bashh.org

Terrence Higgins Trust website (includes many policy and practice publications including those above)
www.tht.org.uk

This report was produced by
Terrence Higgins Trust, PACT,
BHIVA and BASHH

PACT
c/o St. Stephens Centre
Chelsea & Westminister Hospital
369 Fulham Road
London SW10 9TH

Tel: 020 8846 6184
Fax: 020 8746 5611

BHIVA
1 Mountview Court
310 Friern Barnet Lane
London N20 0LD

Tel: 020 8446 8898
Fax: 020 8446 9194
Email: bhiva@bhiva.org
Website: www.bhiva.org

BASHH
Royal Society of Medicine
1 Wimpole Street
London W1G 0AE

Tel: 020 7290 2968
Fax: 0207290 2989
Email: bashh@rsm.ac.uk
Website: www.bashh.org

This report was edited by Victoria Field and Lisa Power of Terrence Higgins Trust. Data analysis was by Chris Quince and Victoria Field of THT, with support and comments from officers and members of BHIVA, BASHH and PACT. Many thanks to all who contributed and who returned the forms.

For further copies of this publication, or to make inquiries about its content, please contact:
Policy and Public Affairs Division, Terrence Higgins Trust, 314-320 Gray's Inn Road, London WC1X 8DP.
Tel: 020 7812 1632 **Email:** policy@tht.org.uk