TOGETHER WE CAN

Terrence Higgins Trust

Over-stretched and under strain:

A Mystery Shopper Approach to Access to Sexual Health Services in England, Scotland and Wales

Contents

Foreword from our Chief Executive, Richard Angell

It has become a cliché to state that sexual health services in England, Wales and Scotland are at crisis point. Recent data released by the UK Health Security Agency (UKHSA) in June 2023 show a marked increase in the transmission of infections such as syphilis and gonorrhoea, rising by almost a quarter (24%) compared with the previous 12 months. This has resulted in visits to sexual health services – whether online, via phone or in-person – increasing by 8% over the same period.

Despite this, funding has failed to match demand. In the most recent settlement the Public Health Grant has increased by just 3.3% in a 10% plus inflation environment. In the low inflation decade we have just experienced, the grant staying the same in real terms has been framed as a triumph as more often there has been real terms cuts. What are local commissioners to do with rising demand and a diminishing resource base?

The future of sexual health services lacks a clear, strategic vision with fragmented sexual health services increasingly seen as mere management of STIs, not speedy treatment and the halting of onward transmission. Prevention and health promotion work should be the focus. If more than 1,000 new STIs being diagnosed every day does not incentivise policy change and renewed investment, the future could look bleak.

That landscape is one that Terrence Higgins Trust – and our partners at British Association for Sexual Health & HIV (BASHH) – wanted to test. How accessible are sexual health services? Can appointments be easily booked and what monitoring by clinics takes place? If you can't get an in-person appointment, is a postal screen available?

Foreword from our Chief Executive, Richard Angell

Using a persona – 'Gabriela' – our research team contacted 57 sexual health services in England, Wales and Scotland to try to schedule an appointment. The ndings show in the starkest terms that continued resource constraints are driving down the option of face-to-face appointments. Waiting times grow. Drop-in services have barely resumed after the COVID-19 shutdown of sexual health services. Postal testing is all too rare, and where this exists so often do daily caps.

The fact Gabriela was not symptomatic will be used to dismiss this research and try to claim it is an overly pessimistic picture but consider this: 75% of women with chlamydia are asymptomatic, 50% of men. A postal test, while an access breakthrough for many, does not work for all. Gabriela might live in a multi-generational household and may not want her parents, let alone her grandparents, to intercept her package. Worse still, she might be in a monogamous relationship – what does having an STI test sent to the home say about their relationship? If she is at risk of – or experiencing – domestic violence, the arrival of mystery post might be a dangerous trigger point. Even if none of these barriers exist, Gabriela might just prefer to use the NHS face-to-face, and taking charge of her sexual health should be accommodated, not deterred. During the mpox outbreak, gay, bisexual and other men who have sex with men choose sexual health services as their preferred avenue for care. Gabriela has the same right and the NHS should meet her where she is.

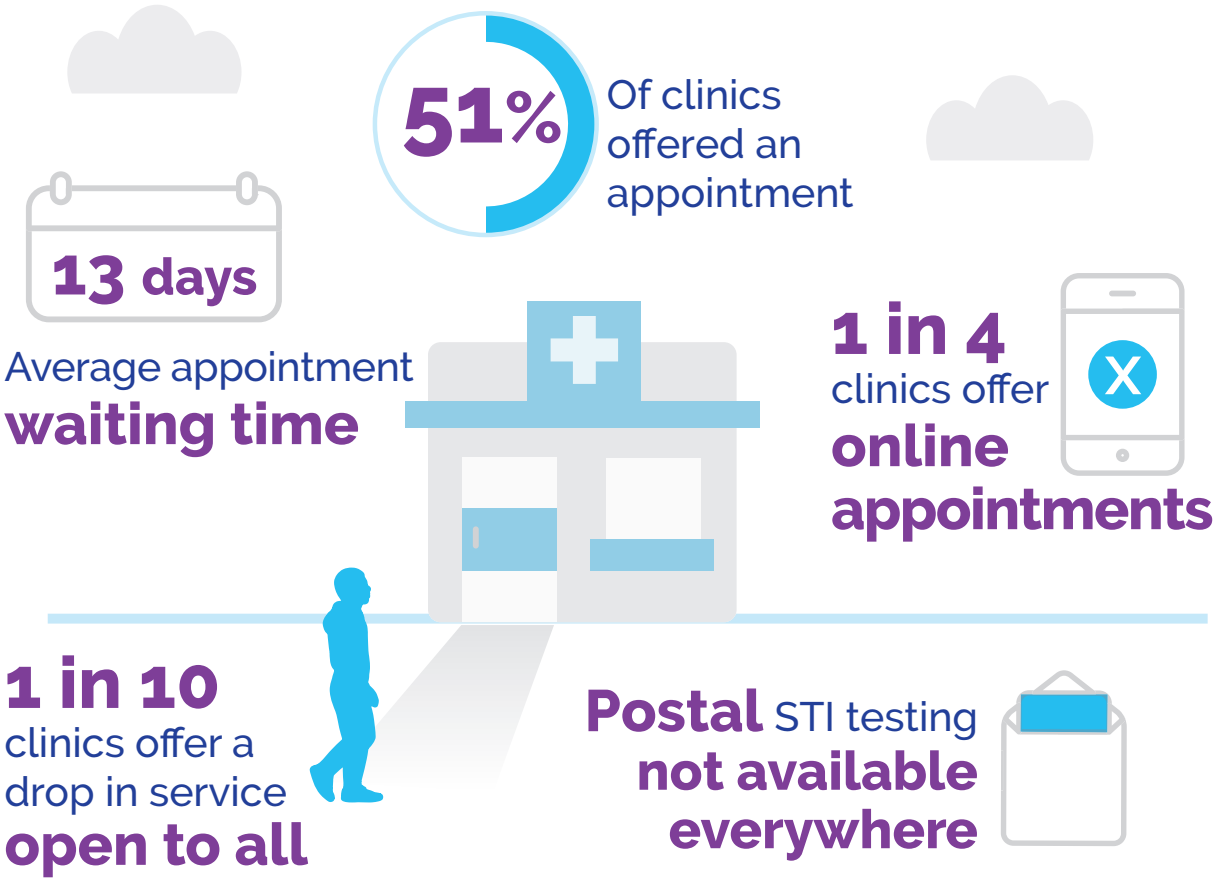
The picture our mystery shopper report paints is stark. One that policy-makers and providers must respond to. Our recommendations are clear: we must secure a free, all-nation, 365-day postal, STI and HIV testing service which is truly accessible; expanded use of tech innovations such as booking via NHS apps to enable flexibility and appointments at times that work for service users; and a clear recognition that the 48-hour waiting target should be more than an aspiration. Alongside our partners, we look forward to working to achieve each. Our thanks go to the research team, to our partners at BASHH and to those stakeholders who have helped shape the report.

Key findings and recommendations

After over a decade of austerity, and a recent infection crisis, the pressures sexual health services in England, Scotland, and Wales are under is threatening basic access and resulting in increased community transmission of otherwise treatable and preventable illness. Working with our partners, Terrence Higgins Trust wanted to assess the landscape for sexual health services in the three home nations.

Using a 'mystery shopper' methodology, we contacted 57 clinics to schedule a face-to-face appointment for our persona, a woman in her mid-twenties with no obvious STI symptoms.

We also surveyed the provision of postal STI services, drop-in services, and online booking systems. Our findings indicate that resource constraints for sexual health services across Great Britain are resulting in an emerging trend of 'gatekeeping' face-to-face appointments and too few alternatives provided.



Key findings and recommendations

The results of our survey show:

- Face-to-face appointments were offered **by only just over half of clinics** (51%) were contacted by telephone.
- **Waiting times for face-to-face appointments available to book via telephone averaged 13 days**, rising to 19 days in rural parts of England. People in Wales were least likely to be offered face-to-face appointments (38%), but when they were, the waits for an appointment averaged 9 days.
- **Booking an appointment online is difficult**, particularly outside of Scotland. Only 1 in 10 clinics in England had appointments available to book online, and no clinics in Wales were operating an online booking system. In contrast, in Scotland 44% of surveyed clinics were linked up to a central booking system.
- **Very few sexual health services (11%) offer drop-in services that are available to all**. A variety of tailored drop-in services were offered by 12 out of 40 clinics (30%) sampled in England. One drop-in service open to all was identified in Scotland, and one drop-in service tailored to under-18-year-olds was identified in Wales.
- **There are significant national and regional differences in access to postal STI testing**. While all clinics in Wales offered postal STI testing via a centralised service, only just over half (56%) of clinics sampled in Scotland did. In England, postal STI testing was offered by 91% of clinics in urban areas, as opposed to 70% and 71% of clinics in rural and semi-rural areas.
- Geography is sometimes used to exclude service users, particularly in the border areas.
- In Scotland, the right to anonymity may inadvertently be compromised in attempts to identify service users based on their address, name and date of birth.

Key findings and recommendations

We suggest addressing these issues in the following ways:

- Ensuring enough funding for sexual health
- Improving access to sexual health and minimising missed opportunities
- Strategic vision and accountability for sexual health
- Ensuring the universal access principle is upheld

Our report spells out how this can be achieved with 19 recommendations. Concrete steps that must be taken include:

- The Scottish and UK governments should replicate the Welsh system of a free, all-nation, all-year-round postal STI testing service.
- Sexual health appointments should be bookable via relevant NHS apps, in addition to the option of booking an appointment anonymously via the phone or online.
- A 48-hour waiting time target for access to sexual health appointments should be implemented and monitored as an indicator for the demand that central government, health boards and local authorities can use for planning purposes.

Recommendations for

URGENT action on sexual health

FREE country-wide **postal STI testing**

Appointments within **48 hours**

Easy booking via **NHS apps**

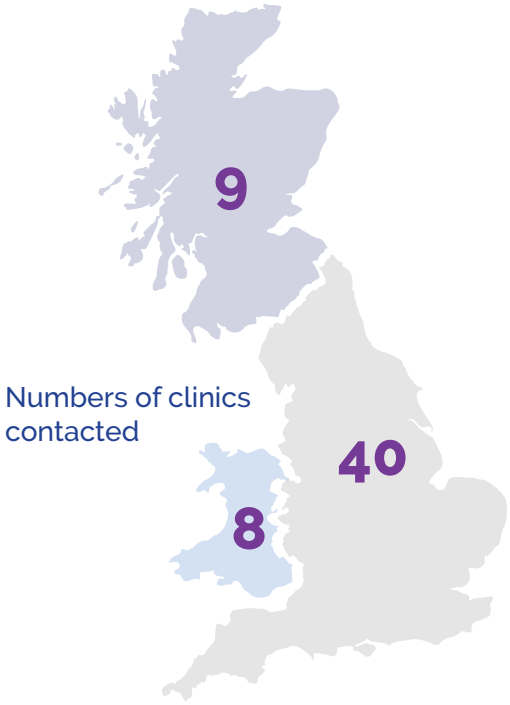
About this research

The 'mystery shopper' exercise was conducted by two researchers in November and December 2022. Approval was gained by BASHH to conduct the research. Clinics were contacted via telephone and online booking systems, where these were available.

We used the following scenario for a persona, who we nicknamed **'Gabriela'**:

- Cisgender woman aged over 25
- Had condomless sex a month ago with a new partner
- No symptoms
- Male and female sexual partners
- Had last test for a sexually transmitted infection (STI) a year ago
- Had a coil fitted a year ago

The persona of Gabriela was chosen because she would not be considered part of a group traditionally associated with HIV risk, would not have been eligible to access age-specific services for under 25-year-olds and to test whether the prioritisation of symptomatic patients amid resource constraints is undermining the universal access principle. Our research thus supplements similar research conducted by another research team in October and November 2021, whose mystery shopper reported symptoms of genital herpes.[1]



Numbers of clinics contacted

The researchers used the same appointment booking systems as service users. We attempted to contact 57 clinics in total: 40 in England, 9 in Scotland and 8 in Wales. Random postcodes were generated for England and Scotland, and the clinic nearest each postcode was contacted (excluding clinics only available to under 25-year-olds). For Wales, the decision was made to contact every sexual health service due to the small numbers.

1 McCarthy et al., "Mystery Shopping Service Evaluation of Access to Sexual Health Clinics in the UK, Presenting with Symptoms of Primary Genital Herpes". Sexually Transmitted Infections 98, A58. 2022.

About this research

We recorded which questions were asked on appointment booking. The researchers developed a framework for questions that may be asked on booking as part of a triage process. These were developed with reference to the BASHH clinical guidelines[2] and discussion with senior sexual health clinicians and service managers. Appendix 1 has the list of the questions included in the framework. We also gathered data regarding provision of drop-in services and postal STI testing by reviewing the sampled clinics' websites and capturing the information provided by call-handlers over the phone.

Rural-urban classifications were made based on the sampled postcode and census data. For England, a three-fold classification of rural, semi-rural and urban was made based on the local authority or council area that each postcode was located in. For Scotland, a two-fold classification of rural and urban was made in accordance with the postcode.

This research reflects a snapshot in time, and results need to be interpreted carefully. Services at the end of 2022 were still recovering from disruption caused by the COVID-19 pandemic and the Mpox outbreak and associated emergency vaccination programme. While it's not possible to correct for time-specific variations (for example, there may have been additional waits due to Christmas bank holiday closures), the fact remains people need to be able to access sexual health services at all times of year. Waiting times we found for appointments are far longer than guidelines recommend. Because the same exercise was repeated in different localities, we were able to discern differences in capacity between urban and rural parts of Britain, and to a lesser degree between the different nations.

2 British Association for Sexual Health and HIV, 2020. 2019 UK National Guideline for consultations requiring sexual history taking: Clinical Effectiveness Group British Association for Sexual Health and HIV. International Journal of STD and AIDS, 0(0), 1-19.

National context: Sexual Health Services in England, Wales and Scotland

National context: Sexual Health Services in England, Wales and Scotland

In Scotland and Wales, sexual health services (SHS) are commissioned by the NHS, with NHS Boards and Health Boards funding services in Scotland and Wales respectively. Since 2013, SHS in England have been commissioned by local authorities and funded via the Public Health Grant.

Funding in all three nations has been constrained over the last decade, but the issue of under-resourcing has been particularly acute in England. The Local Government Association (LGA) estimates SHS funding in England has reduced by 17% between 2015/16 and 2020/21, pushing services to "breaking point".[3] Equivalent funding figures are not available for Scotland and Wales, but in 2019 The Faculty of Sexual and Reproductive Health (FSRH) reported that insufficient funding for sexual and reproductive health in Wales has led to a number of issues, including staff shortages and long waiting times.[4] They observed that demand was regularly exceeding capacity in SRH services in Wales, with not all patients seen in a timely fashion.

Across the three nations, rates of many STIs are on the rise.[5,6,7] Publication of surveillance data varies widely between England, Wales and Scotland. The UK Health Security Agency (UKHSA) publishes annual data on STI testing and infections, which enables for year-on-year tracking of infections and SHS activity. Last year saw significant rises of gonorrhoea (50.3%) and syphilis (15.2%) diagnoses in England relative to 2021, despite only small increases since in testing rates. Data released by Public Health Wales shows that while the number of syphilis diagnoses is below the 2019 figure, diagnoses of chlamydia and gonorrhoea were at a 10-year high in 2022,

3 LGA, Breaking point: Securing the future of sexual health services. https://www.local.gov.uk/publications/breaking-point-securing-future-sexual-health-services, 2022

4 FSRH, Better care, a better future: Implementing our Vision for Sexual and Reproductive Healthcare in Wales April 2019, https://www.fsrh.org/documents/plan-implementation-fsrh-vision-wales, published 15 April 2019

5 UK Health Security Agency, Sexually transmitted infections and screening for chlamydia in England: 2021 report, https://www.gov.uk/government/statistics/sexually-transmitted-infections-stis-annual-data-tables/sexually-transmitted-infections-and-screening-for-chlamydia-in-england-2021-report#overall-trends-in-consultations-sti-testing-and-diagnoses-at-shss-among-england-residents, updated 4 October 2022

6 Public Health Scotland, STI diagnoses continue to rise in Scotland, https://www.hps.scot.nhs.uk/publications/hps-weekly-report/volume-54/issue-21/sti-diagnoses-continue-to-rise-in-scotland/, published 26 May 2020

7 Public Health Wales, HIV and STI trends in Wales: Surveillance Report, November 2019, https://phw.nhs.wales/topics/sexual-health/sexual-health-reports/hiv-and-sti-trends-in-wales-surveillance-report-november-2019/, November 2019

National context: Sexual Health Services in England, Wales and Scotland

with 22% and 127% increases respectively on the previous year.[8] The successful roll-out of nation-wide postal STI testing alone cannot account for these increases. In Scotland, the incidence of chlamydia has increased relative to the past two years but has not reach pre-pandemic levels.[9] Reported cases of gonorrhoea are, on the other hand, almost 50% higher than they were in 2019.[10]

There is no data currently being reported in any of the nations about waiting times for SHS, making it hard to gather accurate data on average waits for appointments. The Department of Health and Social Care briefly monitored time taken to be seen for the first time in genitourinary medicine clinics in England between 2009 and 2011. In November 2011, 89.1% of patients attending for the first time were seen within two days. Our findings indicate this is a very different picture from what is happening today. Likewise, the "Not PrEPared" report, published in autumn 2022, found that people are facing long waits to access PrEP[11].

Funding in all three nations has been constrained over the last decade

The Mpox outbreak in summer 2022 further exposed the fragility of SHS in the UK, with SHS in England reporting 30% of usual activity, such as STI testing, PrEP delivery, and contraception provision being displaced in order to manage mpox cases and run vaccination clinics[12]. Mpox has exacerbated problems caused by disruption during the COVID-19 pandemic and further demonstrated the lack of resilience in SHS and the need for capacity and emergency support to manage novel pathogens.

SHS also play a pivotal role in preventing transmission of HIV and identifying people living with undiagnosed HIV. The UK, Scottish and Welsh Governments have all

8 Public Health Wales, "Sexual Health in Wales: Sexually Transmitted Infections, Emergency and Long-acting Reversible Contraception provision and Termination of Pregnancy. Annual Report 2023 (Data to end of 2022)": https://phw.nhs.wales/publications/publications1/sexual-health-annual-report-2023/, July 2023

9 Public Health Scotland, "Chlamydia trachomatis infection in Scotland 2013-2022 report": https://www.publichealthscotland.scot/publications/chlamydia-trachomatis-infection-in-scotland/chlamydia-trachomatis-infection-in-scotland-2013-to-2022/, June 2023

10 Public Health Scotland, "Gonorrhoea infection in Scotland 2013-2022 report": https://www.publichealthscotland.scot/news/2023/march/gonorrhoea-infection-in-scotland-2013-2022-report/, March 2023

11 National AIDS Trust, Terrence Higgins Trust, PrEPster, Sophia Forum and One Voice Network, "Not PrEPared Barriers to accessing HIV prevention drugs in England": https://www.tht.org.uk/news/new-reportreveals-extent-barriers-prep-access-england, November 2022

12 As outlined in a joint letter from BASHH, BHIVA, ADPH, FSRH and English Commissioners' Group to DHSC and UKHSA on Monkeypox displacement, released October 2022. https://www.bashh.org/media/5553/jointletter-dhsc-and-ukhsa-monkeypox-displacement-noemail-addresses.pdf

National context: Sexual Health Services in England, Wales and Scotland

Last year saw significant rises of gonorrhoea (50.3%) and syphilis (15.2%) diagnoses in England relative to 2021

made commitments to ending new cases of HIV by 2030, in line with UNAIDS goals. Delivering against these targets for HIV testing and treatment requires SHS which can meet demands for PrEP and provide proactive HIV testing – including to groups other than gay and bisexual men and other men who have sex with men (GBMSM). Testing for HIV in SHS (including appointments relating to reproductive health and contraception) provides an opportunity for diagnosing HIV at an earlier stage, which significantly benefits both the individual diagnosed and public health by dramatically reducing the likelihood of morbidity and onward transmission. However, according to the latest data from UKHSA, HIV testing in SHS in England for women and heterosexual men still remains unacceptably lower than pre-pandemic rates – the 2021 figures showed testing rates were 20% lower for women and 41% lower for heterosexual men compared with 2019.[13]

There is stark variation in strategic oversight and leadership on sexual health across the three nations. In Wales, the most recent review of sexual health was in 2018. This included a recommendation for an all-Wales sexual health case management system[14], which the Welsh Government has recently committed to funding as part of its HIV Action Plan for Wales 2023 to 2026[15]. In Scotland, sexual health falls under the Sexual Health and Blood Borne Virus (SHBBV) Framework, which is currently awaiting publication. In England, there is currently no national strategic plan for sexual health. The UK Parliament's Health and Social Care Committee identified serious flaws in the structure and funding of SHS in England as part of their 2019 inquiry, calling cuts to funding for sexual health a "false economy"[16]. Terrence Higgins Trust and BASHH likewise identified serious need for a vision for sexual health in England as part of our 2020 State of the Nation report[17]. The UK Government committed to a Sexual and Reproductive Health Strategy (since renamed an Action Plan) for England. It looks unlikely, however, that the Action Plan will be published ahead of the next General Election.

13 UKHSA, HIV: annual data tables (HIV testing in England, Table 1), https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1107988/2022-HIV-testing-data-tables-England.ods, updated 1 December 2022

14 Public Health Wales, A Review of Sexual Health in Wales, https://phwwhocc.co.uk/wp-content/uploads/2020/07/A-Review-of-Sexual-Health-in-Wales-Final-Report.pdf, 2018

15 Welsh Government, HIV Action Plan for Wales 2023-2026, https://www.gov.wales/sites/default/files/publications/2023-03/hiv-action-plan-for-wales-2023-to-2026.pdf, 2023

16 Health and Social Care Committee, Sexual health, Fourteenth Report of Session 2017–19, https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/1419/1419.pdf, 2019

17 BASHH and Terrence Higgins Trust, The State of the Nation: Sexually Transmitted Infections in England, https://www.tht.org.uk/sites/default/files/2020-02/State%20of%20the%20nation%20report%20v2.pdf, published February 2020

Findings

For this exercise our researchers created a persona, 'Gabriela' – a woman in her late twenties who recently had condom-less sex with a man she met on a dating app. One month later she has no obvious symptoms of STIs, but would like to be seen at a sexual health clinic. This is a scenario that reflects contemporary trends in sexual behaviour, with the rise of digital applications for dating likely contributing to the increased demand in sexual health services.

'Gabriela' tried her luck with 57 clinics across England, Wales and Scotland, but struggled to get an appointment within the 48-hour window recommended by BASHH. She was only able to access an appointment at all in just half of cases. Demands on sexual health services means that a postal STI test is now the default gateway into many services.

Getting an appointment by phone

The current guidelines on management of STIs recommend rapid access to local services for STI testing and treatment within two working days for anyone with needs relating to STIs, and within four hours for those with clinically urgent needs.

We contacted 57 services across England, Scotland and Wales and were unable to get through to two services after several attempts and spending long periods on hold. One service was operating as a drop-in only and was not offering appointments. Urban sexual health services in England were particularly difficult to get through to on the telephone. One service took up to six attempts to get through on the telephone as the mystery shopper was not placed on hold. Another service required waiting for 25 minutes on hold before the call was answered.

On average across the 57 services contacted throughout England, Scotland and Wales, only 29 services (51% of the total) had face-to-face appointments available for booking via telephone.

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Findings

The average waiting time for a face-to-face appointment when booking via telephone was 13 days across Great Britain. In England, rural services had the longest waiting time of 19 days on average, with semi-rural and urban services having waiting times of 15 and 12 days respectively. Only a few clinics had the facility to offer appointments on weekday evenings or weekends outside of usual office hours.

Figure 1: Availability of face-to-face appointments when booking via telephone

Nation	Clinics with F2F appointments available to book via telephone	Mean waiting time in days
England	53% (21)	14 days
- Rural	50% (5)	19 days
- Semi-rural	43% (3)	15 days
- Urban	57% (13)	12 days
Scotland	56% (5)	13 days
Wales	38% (3)	9 days
Great Britain	**51% (29)**	**13 days**

Only 5 clinics proactively offered alternative appointment formats. These were all via telephone. No clinics offered virtual appointments, despite these being offered commonly during the COVID-19 pandemic[18] and the fact that virtual appointments have now become normalised in other parts of the UK healthcare sector.[19]

Where appointments were not available, the researchers were told to order an STI test kit online to be posted home, or in a handful of cases, to collect an STI test kit from the clinic.

18 Dema et al., 2022. Initial impacts of the COVID-19 pandemic on sexual and reproductive health service use and unmet need in Britain: findings from a quasi-representative survey (Natsal-COVID). The Lancet Public Health 7(1), e36–e47.

19 NHS, Video consultations, https://www.nhs.uk/nhs-services/gps/video-consultations/, Page last reviewed: 12 May 2023

No drop-in services open to all were available in Wales at the time of data collection.

Case Study 1 – Two geographically nearest sexual health services closed

A sexual health service in South Wales was contacted. The two nearest clinics that were listed on the service's website closed during the COVID-19 pandemic and had not re-opened. The third nearest clinic had an appointment available in 5 days' time but was located 16 miles away.

Online booking

In addition to phoning up the clinic, 'Gabriela' also attempted to book appointments online. The data on appointment availability comparing telephone and online booking methods (as shown in Figure 2) are unsurprisingly very similar, but the provision of an online appointment booking system for sexual health varied greatly.

Online appointment booking is important for several reasons, one of which includes accessibility for many different groups, for example for d/Deaf people, people who have speech and language difficulties, and people who require an interpreter. Having an online booking system also helps to protect people's confidentiality, if they are concerned about being overheard while speaking on the telephone, particularly for those who belong to a social group where their sexual behaviour is stigmatised.

In Scotland, there is a national appointment booking system provided by NHS Inform[20], but only 6 out of 9 clinics (67%) 'Gabriela' spoke with were fully signed up to this system. The others were partially signed up, with online booking available only for specific services such as coil fitting.

There was a particular lack of online booking provision in England and Wales. In England, only 9 out of 40 clinics (23%) had an online booking system, and only 4 (10%) clinics had appointments available to book via the online system. None of the clinics in Wales offered online appointment booking at the time of data collection.

Figure 2: Availability of face-to-face appointments when booking online

Nation	Clinics offering online booking for all F2F appointments	Clinics with F2F appointments available to book online	Mean F2F appt. waiting time in days
England	23% (9)	10% (4)	17 days
Scotland	67% (6)	44% (4)	12 days
Wales	0% (0)	-	-
Great Britain	**26% (15)**	**53% (8)**	**14 days**

20 NHS 24, Book a sexual health appointment online, https://www.nhsinform.scot/care-support-and-rights/nhs-services/sexual-health/book-a-sexual-health-appointment-online, last updated: 16 March 2023

Case Study 2 – Rigid appointment booking procedures

A semi-rural clinic in the East Midlands was contacted, and 'Gabriela' was told that appointments could not be booked over the telephone but only via the website. She proceeded to do this, but the next available appointment was in 40 days.

Drop-in services

The FSRH Service Standard for Sexual and Reproductive Healthcare guidelines recommend a mix of walk-in and booked appointments.[21] Although 'Gabriela' was referred to a drop-in service in the absence of available appointments on a few occasions, very few sexual health services offered drop-in services that were available to all. Only 6 services out of the 57 sampled (11%) offered this type of drop-in service. Of these, 5 were in England and 1 was in Scotland. No drop-in services open to all were available in Wales at the time of data collection.

There were a variety of tailored drop-in services offered by 12 out of 40 clinics (30%) sampled in England. For example, there were drop-in services offered to particular age groups such as under 25s, under 18s and under 16s. There were also drop-in services for cases deemed clinically urgent or for emergency contraception. Only 1 drop-in service was identified in Wales, which was aimed at under 18s.

Figure 3: Availability of drop-in services for a particular demographic or need and for everyone

Nation	Any type of drop-in service	Drop-in service available to all
England	30% (12)	13% (5)
Scotland	11% (1)	11% (1)
Wales	13% (1)	0% (0)
Great Britain	**25% (14)**	**11% (6)**

21 FSRH, FSRH Service Standards for Sexual and Reproductive Healthcare - September 2016, https://www.fsrh.org/standards-and-guidance/documents/fsrh-service-standards-for-sexual-and-reproductive-healthcare, published 30 September 2016

Findings

In England, 33 out of 40 clinics sampled (83%) offered postal STI testing, but there were rural-urban differences in this provision.

Postal STI testing

Postal STI testing can be a flexible and convenient way for people to access sexual health services. It also helps to make SHS accessible for people who have additional access needs or who live in locations where public transport may be limited and where sexual health clinics may be few and far between. Scotland and Wales are much more sparsely populated than England and this is reflected in the distances of the clinics from the sampled postcodes. On average, Scottish and Welsh clinics were located 13.2 and 13.0 miles away respectively from sampled postcodes. Clinics in England were located 4.8 miles away on average from sampled postcodes, with rural English clinics located on average 9.5 miles away.

Public Health Wales offers nationwide postal STI testing via Sexual Health Wales (previously called Frisky Wales). However, in England and Scotland, we found that the provision was much more varied. In England, 33 out of 40 clinics sampled (83%) offered postal STI testing, but there were rural-urban differences in this provision. 23 out of 40 urban clinics (91%) provided postal STI tests compared to only 12 out of 17 rural and semi-rural clinics (71%).

Two clinics (one in rural North West England, and one in rural South Scotland) that did not offer postal STI testing did however offer click-and-collect STI testing as an alternative where service users could collect test kits from the clinic to take samples independently. No clinic 'Gabriela' spoke with offered both options of postal STI testing and click-and-collect.

BASHH recommends that all asymptomatic sexual health service users are screened for chlamydia, gonorrhoea, HIV and syphilis as a minimum.[22] One of the Scottish services sampled only screened for chlamydia and gonorrhoea via postal STI testing. However, since this research was conducted the Scottish Government has awarded Terrence Higgins Trust Scotland the postal HIV self-test service.[23] This is free, available all year round and country-wide. The Scottish Government has also undertaken significant preparatory work to roll out a nation-wide postal STI service, to which it committed £370k in 2020.

22 BASHH Clinical Effectiveness Group, 2015 BASHH CEG guidance on tests for Sexually Transmitted Infections, https://www.bashhguidelines.org/media/1084/sti-testing-tables-2015-dec-update-4.pdf, April 2015 (amended December 2015)

23 Nandwani, R., Estcourt, C.S., Hutchinson, S.J., Steedman, N. on behalf of the Scottish HIV Transmission Elimination Oversight Group (HiTEOG), Ending HIV transmission in Scotland by 2030, https://www.gov.scot/publications/ending-hiv-transmission-scotland-2030/, November 2022.

Figure 4: Availability of postal STI testing

Nation	Percentage (number) of clinics
England	83% (33)
- Rural	70% (7)
- Semi-rural	71% (5)
- Urban	91% (21)
Scotland	56% (5)
Wales	100% (8)
Great Britain	**81% (46)**

Case Study 3 – Long waiting time for appointment with no facility for postal STI testing

A clinic in rural South West England offered 'Gabriela' an appointment in 21 days' time. This clinic neither offered postal STI testing nor a drop-in service, so this was the only means by which 'Gabriela' could access STI testing via the sexual health service.

Case Study 4 – Postal STI test kit supply issues and daily quota imposed

A call handler at a clinic in rural South East England advised 'Gabriela' to order an STI test, as she could not get an appointment without reporting symptoms. However, the clinic was experiencing supply issues of postal kits from the private company providing them. There was a daily quota of tests available, and 'Gabriela' was told that if she was unable to order the test, she should try again the next morning.

Asymptomatic presentation

The most common question asked by call handlers on appointment booking was the presence of any symptoms, which was asked by 78% of call handlers (42 out of 54). This question was usually asked in isolation, with no suggestions of which symptoms may indicate an STI or follow-up questions eliciting whether any specific symptoms such as genital discharge were present.

Apart from basic contact details, only a minority of call handlers asked any further questions. Only 26% of call handlers (15 out of 54) asked for 'Gabriela's' age or date of birth, but it may have been assumed that she was of adult age based on voice or communication style. Just 7% of call handlers (4 out of 54) asked about experience of sexual assault and only 1 call handler out of 54 enquired about impairment or disability for which there may be additional support or access needs.

Universal access principle

Due to the principle of universal access to sexual health care in the UK where anyone should be able to access sexual health care regardless of residence, questions about residency were not routinely monitored by the researchers. However, many call handlers asked for the mystery shopper's address, and some also requested information on residence status and GP registration. One call handler even asked the nationality of the mystery shopper without explaining the reason for the question. This is a sensitive question for a host of reasons (including that the mystery shopper in this case belonged to an ethnic minority group). Non-citizens are entitled to SHS if residing temporarily or permanently in the UK, and a question like this risks putting someone off from legitimately accessing care.

In Scotland, the National Sexual Health System (NaSH), which has been in place since 2008, enables sexual health clinics to share information between health boards for the purposes of public health monitoring. Many call handlers appeared to use the system to identify the mystery shopper, which caused issues when 'Gabriela' was using a false name and date of birth that did not match the address given. The mystery shopper was not denied an appointment on this basis, but the attempts at identification on appointment booking may create a barrier to those who wish to use sexual health services anonymously.

Case Study 5 – Appointment booking request turned down due to local authority area

When she contacted a clinic in the West Midlands, 'Gabriela' was asked several questions regarding residence, GP registration, and council tax to determine the local authority area. Despite contacting the nearest clinic to the generated postcode, she was told that they lived in the wrong area and would have to contact another clinic.

Case Study 6 – England-Wales national border issue with booking sexual health appointment

'Gabriela's' postcode was in Powys, but she was unable to locate any sexual health services offering appointments within the county. The nearest clinic was across the border, in England. The call handler at this clinic refused to book an appointment, instead signposting to Frisky Wales (since been renamed Sexual Health Wales), the national postal STI testing service run by Public Health Wales.

Conclusions

The sexual health system in Great Britain is under great strain

The findings from the mystery shopper exercise reflect a sexual health system that is under severe strain across Great Britain as a result of a decade of under-funding and rising demand. When the UK government last monitored appointment waiting times in England in November 2011, 89% of people attending a sexual health service for the first time were offered an appointment within 48 hours across Great Britain, increasing to a maximum of 40 days. Only half of clinics were able to offer an appointment to the mystery shopper at all and postal testing seems to have become the default entry points into many services.

Because demand exceeds service capacity, clinics naturally prioritise patients whose need is most urgent. Although this is common practice across the NHS and public health systems in general, our findings suggest that in the sexual health sector, patient prioritisation is done as an emergency response rather than as a planned and carefully calibrated form of triage. The criteria encountered by our researchers was inconsistent and incomplete. Almost half of clinics are using a pathway based purely on the presence or absence of symptoms indicative of an STI to prioritise appointments for those deemed most clinically urgent. Those who do not have symptoms, those who are less able to identify symptoms indicative of an STI, and those who are less able to effectively advocate for themselves are falling through the gaps of a system that increasingly provides only one route to access sexual health appointments. There is a substantial risk that this is exacerbating long-term inequalities in sexual health.

When the UK government last monitored appointment waiting times in England in November 2011, 89% of people attending a sexual health service for the first time were offered an appointment within 48 hours.

Conclusions

Postal STI testing is being used to plug the gaps in the system, and in many cases effectively acts as a triage for appointments, but access to this type of testing is also uneven. Wales is the only country offering nationwide postal STI testing. In rural and semi-rural England, this service was offered by only 71% (12 out of 17) of clinics. In Scotland, just 56% (5 out of 9) clinics offered postal STI testing. This is particularly problematic for service users who live in remote areas or who have impairments or conditions which may make visiting a clinic difficult. Addressing these discrepancies in the availability of postal STI testing is essential to ensuring equitable and universal access to sexual health services. At the same time, postal STI testing should supplement, not substitute, clinic-based sexual health services, and service users need to be offered the option of a timely appointment.

As well as difficulty booking an appointment in advance, many sexual health services were forced to close drop-in services over the COVID-19 pandemic, and our research indicates many have not had capacity to re-open them. Only 11% (6 out of 57) of clinics contacted offered a drop-in service open to all attendees, regardless of their age or other characteristics.

These trends are exacerbated by workforce issues. According to the FSRH, a lack of applications from candidates with relevant specialities meant over half of advertised community sexual and reproductive health consultant posts across England were left unfilled between 2018 and 2022.[24] The FSRH previously identified similar issues in Wales.[25] A survey conducted by the Royal College of Nursing in 2018 highlighted issues with access to training and supervision among nurses working in sexual and reproductive health as a result of under-funding.[26] Both service users and clinicians are struggling under the strain of an under-resourced and under-funded system.

> Commissioners are increasingly being placed in the impossible position of trying to stretch budgets to meet ever-increasing demands

24 FSRH, FSRH Response HEE Call for Evidence Strategic Framework, https://www.fsrh.org/documents/fsrh-response-hee-call-for-evidence-strategic-framework/, September 2021

25 FSRH, Better care, a better future: Implementing our Vision for Sexual and Reproductive Healthcare in Wales April 2019, https://www.fsrh.org/documents/plan-implementation-fsrh-vision-wales/, published 15 April 2019

26 Royal College of Nursing, Sexual and Reproductive Health. RCN report on the impact of funding and service changes in England, https://www.rcn.org.uk/professional-development/publications/pdf-006962, published 14 May 2018

Conclusions

In England, sexual health services have been funded via the Public Health Grant since 2013. Spending on sexual health by English local authorities has in real terms been cut by 29% per person since 2014/15.[27] For the current financial year, the Public Health Grant only increased by 3.2%[28], meaning there will be yet more real-terms cuts to funding available for services including SHS. Commissioners are increasingly being placed in the impossible position of trying to stretch budgets to meet ever-increasing demands.

As well as funding not keeping pace with rising costs, the Public Health Grant settlement is often not agreed until very close to the start of the new financial year. Most recently, the settlement was confirmed just a mere two weeks before the start of the next financial year – giving commissioners very little time to plan strategically for the longer-term.

A lack of national strategic leadership across all three nations is leading to a postcode lottery in sexual health provision

The situation is not unique to England, despite the different commissioning and funding structure in comparison to Wales and Scotland. In Scotland and Wales, sexual health services are still commissioned by NHS health boards, but there are no publicly available data regarding sexual health funding. The FRSH's 2018 review of sexual health services in Wales concluded that services were struggling to accommodate an increase in attendance at sexual health clinics.[29] Reflecting our mystery shopper's difficulty in accessing a nearby clinic in Wales, the review also found that there was a disparity in service provision across Wales.

A lack of national strategic leadership across all three nations is leading to a postcode lottery in sexual health provision and our findings suggest many people living on national, regional and local authority borders are losing out.

27 Health Foundation, Public health grant: "What it is and why greater investment is needed". https://www.health.org.uk/news-and-comment/charts-and-infographics/public-health-grant-what-it-is-and-why-greater-investment-is-needed, 2023

28 LGA, Public Health Grant allocations to local authorities 2023/24, https://www.local.gov.uk/parliament/briefings-and-responses/public-health-grant-allocations-local-authorities-202324, 27 March 2023

27 Health Foundation, Public health grant: "What it is and why greater investment is needed". https://www.health.org.uk/news-and-comment/charts-and-infographics/public-health-grant-what-it-is-and-why-greaterinvestment-is-needed, 2023

28 LGA, Public Health Grant allocations to local authorities 2023/24, https://www.local.gov.uk/parliament/briefings-and-responses/public-health-grant-allocations-local-authorities-202324, 27 March 2023

29 FSRH, Better care, a better future: Implementing our Vision for Sexual and Reproductive Healthcare in Wales April 2019, https://www.fsrh.org/documents/plan-implementation-fsrh-vision-wales/, published 15 April 2019

Conclusions

Erosion of fundamental rights to sexual health care

Resource constraints threaten to undermine two principles of sexual health care that have previously been considered fundamental to effective and equitable delivery of services: universal access and the right to anonymity. Despite the right to access sexual health care regardless of residence or immigration status, on several occasions 'Gabriela' was unable to access appointments at her nearest clinic or was unable to access an appointment at all due to her location.

In Scotland, call handlers sometimes used the National Sexual Health System to identify 'Gabriela' based on her address, name and date of birth. This risks compromising the right to anonymity and reflects a lack of recognition that some service users may choose to use a pseudonym to access the system. In addition, this might act as prohibitive barrier for those with no fixed address, prison leavers, those with no recourse to public funds and those in the immigration and asylum systems.

> Our study indicates that service pressures mean that triaging and gatekeeping is being designed around service needs, rather than the needs of service users.

We found that resource constraints for sexual health services across Great Britain have resulted in an emerging trend of services 'gatekeeping' and excluding out-of-area service users. One consequence of this may be a desire by services to identify service users where possible and – as a result - anonymity can no longer be guaranteed.

More fundamentally, our study indicates that service pressures mean that triaging and gatekeeping is being designed around service needs, rather than the needs of service users. This issue has already been recognised by the Scottish government in its 'Reset and Rebuild' recovery plan for Sexual Health and Blood Borne Virus (SHBBV) services following the COVID-19 pandemic.[30]

30 Scottish Government, Reset and Rebuild – sexual health and blood borne virus services: recovery plan, https://www.gov.scot/publications/reset-rebuild-recovery-plan-sexual-health-blood-borne-virus-services/pages/5/, published 4 August 2021.

Conclusions

Potential risk to HIV elimination targets

The under-resourcing of SHS also threatens to undermine progress towards ending new HIV transmissions by 2030 across Great Britain. While the proportion of people testing positive for HIV in England and Scotland continues to decrease among men who have sex with men, data from England has shown the test reactivity rate is rising for women and heterosexual men, despite only modest increases in the overall number of tests.

Worryingly, the mean CD4 count at time of diagnosis, a marker of immune system functioning, is lower than it was in 2019 for heterosexual men, people of Black African ethnicity and people aged 65 and over.[31] This is because the number of late HIV diagnoses are rising among these groups.

As stated, there is currently no contemporary data to show how HIV testing in Wales and Scotland was affected by the COVID-19 pandemic. However, in England, HIV testing rates in 2021 remain precipitously lower for groups other than GBMSM, compared with 2019.

This data represents huge numbers of missed opportunities to potentially identify people living with undiagnosed HIV – which is a vital part of the tools required if the Government is to hit the 2030 targets set by the UK, Welsh and Scottish governments. Sexual health appointments provide opportunities for HIV testing, particularly for people who may not proactively seek a test but who may be at higher risk of exposure, such as heterosexual women of Black African ethnicity.

Our research indicates that more work is needed to understand if service pressures may be behind the drop in testing rates for these groups and ensuring opportunities to engage people other than GBMSM in HIV testing do not get lost in the pressure of strained capacity.

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31 Lester J, Martin V, Shah A, Chau C, Mackay N, Newbigging-Lister A, Connor N, Brown A, Sullivan A and contributors. HIV testing, PrEP, new HIV diagnoses, and care outcomes for people accessing HIV services: 2022 report. The annual official statistics data release (data to end of December 2021). October 2022, UK Health Security Agency, London. https://www.gov.uk/government/statistics/hiv-annual-data-tables/hiv-testing-prep-new-hiv-diagnoses-and-care-outcomes-for-people-accessing-hiv-services-2022-report#:~:text=The%20definition%20of%20late%20HIV,with%20evidence%20of%20recent%20infection.

Conclusions

In addition to offering HIV testing, prevention of HIV transmission through PrEP is a cornerstone of HIV elimination strategies.[32]

However, the capacity of sexual health services to deliver PrEP is compromised. Our research in conjunction with National AIDS Trust, Sophia Forum, One Voice Network and The Love Tank in 2022, found that people attempting to access PrEP in England faced waiting times for appointments of up to 12 weeks and nearly half of clinicians thought workforce levels were inadequate to meet current demand for PrEP.[33]

A study from Wales also found PrEP utilisation among men who have sex with men reduced in Wales during the COVID-19 pandemic despite the continuing need for it, likely due to disruption of sexual health services.[34]

Sexual health appointments are also an important opportunity to increase PrEP awareness and acceptability among heterosexuals that may benefit from this form of prevention but who are less likely to be reached by PrEP outreach efforts. Unless services are adequately funded and resourced to perform these vital PrEP-related functions, the three nations may fail to reach the 2030 target of eliminating new HIV transmissions.

Widening sexual health inequalities

Our research has highlighted how difficult it is currently to access a sexual health appointment. This has particular implications for people who are disproportionately affected by poor sexual health outcomes. Government data demonstrate the real-life public health consequences of the reduced sexual health provision revealed by our research. In 2022, there was a 23.8% rise in new STI diagnoses in England compared to 2021, with particularly alarming rises in the rates of gonorrhoea (51%) and syphilis (15%) diagnoses.[35]

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32 Department of Health and Social Care, Towards Zero - An action plan towards ending HIV transmission, AIDS and HIV-related deaths in England - 2022 to 2025, https://www.gov.uk/government/publications/towards-zero-the-hiv-action-plan-for-england-2022-to-2025/towards-zero-an-action-plan-towards-ending-hiv-transmission-aids-and-hiv-related-deaths-in-england-2022-to-2025, Updated 21 December 2021

33 National AIDS Trust, Terrence Higgins Trust, PrEPster, Sophia Forum and One Voice Network, Not PrEPared Barriers to accessing HIV prevention drugs in England, https://www.tht.org.uk/news/new-report-reveals-extent-barriers-prep-access-england, November 2022

34 Gillespie, D., Couzens, Z., de Bruin, M. et al., 2022. PrEP Use, Sexual Behaviour and PrEP Adherence. Among Men who have Sex with Men Living in Wales prior to and during the Covid-19 Pandemic 2746–2757 (2022).

35 UKHSA, Sexually transmitted infections and screening for chlamydia in England: 2022 report, https://www.gov.uk/government/statistics/announcements/sexually-transmitted-infections-sti-and-national-chlamydia-screening-programme-ncsp-data-release-for-england-data-to-december-2022

Conclusions

Now more than ever, people should be able to get an appointment with a sexual health clinic if they have concerns about their sexual health.

Now more than ever, people should be able to get an appointment with a sexual health clinic if they have concerns about their sexual health. It is particularly concerning that in more than half of attempts to get an appointment, 'Gabriela' needed to be able to describe symptoms. Given that the majority of chlamydia cases are asymptomatic[36] and 'Gabriela' also meets key risk factors for chlamydia in that she has recently had condomless sex with a new partner.[37] This research indicates that many services may be relying heavily on age as a key criterion for assessing risk of infection.

There are many factors that interact in complex ways to mediate sexual health outcomes. These include social and demographic factors such as age, gender, ethnicity, sexual orientation and disability, as well as socioeconomic factors. Public health data in England and other research studies show that men who have sex with men, young people and people of Black Caribbean ethnicity experience poorer sexual health outcomes, with disproportionately high rates of certain STIs.[38]

For example, the number of gonorrhoea diagnoses nearly doubled among people aged 15 to 25 between 2020 and 2021 and people of Black Caribbean ethnicity had the highest diagnosis rates of all ethnic groups during this year.[39]

36 Geisler WM, Wang C, Morrison SG, et al., 2008. The natural history of untreated Chlamydia trachomatis infection in the interval between screening and returning for treatment. Sex Transm Dis; 35: 119–123.

37 Nneka C Nwokolo, Bojana Dragovic, Sheel Patel, CY William Tong, Gary Barker, Keith Radcliffe, 2015. 2015 UK national guideline for the management of infection with Chlamydia trachomatis. International Journal of STD & AIDS 2016, Vol. 27(4) 251–267.

38 Aicken et al., 2019. Pathways to, and use of, sexual healthcare among Black Caribbean sexual health clinic attendees in England: Evidence from cross-sectional bio-behavioural surveys. BMC Health Serv Res 19, 668 (2019).

39 UKHSA, Sexually transmitted infections and screening for chlamydia in England: 2022 report, https://www.gov.uk/government/statistics/announcements/sexually-transmitted-infections-sti-and-national-chlamydia-screening-programme-ncsp-data-release-for-england-data-to-december-2022

Conclusions

There are concerns that the current structure of sexual health services are not only failing to reduce sexual health inequalities, but may be widening them further.

These categories are not, of course, mutually exclusive. Evidence suggests that for people of Black Caribbean ethnicity, the higher rate is explained by socioeconomic factors rather than individual behaviours.[40] And, while rates of chlamydia detection increased across socio-economic groups between 2021 and 2022, they remain almost twice as high for young people living in areas with the highest levels of social deprivation.[41] This is despite utilisation of sexual and reproductive services in England being twice as high in women from the most deprived areas.[42]

More research is needed to explain the demographic discrepancies in sexual health outcomes. Sexual health services are subject to the Equality Act 2010: as public authorities, they must help to eliminate inequalities in outcomes due to socioeconomic disadvantage or having a protected characteristic under the public sector equality duty. However, there are concerns that the current structure of sexual health services are not only failing to reduce sexual health inequalities, but may be widening them further.

The triaging 'Gabriela' experienced meant she required a high baseline level of sexual health knowledge to effectively access services. She needed to be able to identify symptoms within herself and know that they may be caused by an STI to report them to the person at the end of the telephone. Few services supported her in symptom identification by suggesting what might be significant. Some symptoms suggestive of an STI are less specific to sexual health, such as unexplained abdominal pain. Additionally, some symptoms may be mistakenly attributed to other causes, such as vaginal discharge and thrush.

40 Bardsley, M., Wayal, S., Blomquist, P., et al., 2022. Improving our understanding of the disproportionate incidence of STIs in heterosexual-identifying people of black Caribbean heritage: findings from a longitudinal study of sexual health clinic attendees in England. Sexually Transmitted Infections 2022;98:23-31.
41 UKHSA, Sexually transmitted infections and screening for chlamydia in England: 2022 report, https://www.gov.uk/government/statistics/announcements/sexually-transmitted-infections-sti-and-national-chlamydia-screening-programme-ncsp-data-release-for-england-data-to-december-2022
42 Lifestyles Team, NHS Digital, Sexual and Reproductive Health Services, England (Contraception) 2021/22, 29 September 2022. https://digital.nhs.uk/data-and-information/publications/statistical/sexual-and-reproductive-health-services/2021-22

Conclusions

'Gatekeeping' policies also serve to exclude people from accessing the most convenient service for them. 'Gabriela' always contacted the clinic that was nearest geographically to where 'she' lived but was turned away in several cases where it was deemed that she lived in the 'wrong' area. There are a variety of practical reasons why someone may prefer to attend a clinic which is 'out of area': needing to minimise journey time, better public transport options to one clinic versus another, wanting to avoid being seen by people they know for fear of stigma, or preference based on previous experience of a service.

Almost half of the clinics 'Gabriela' contacted did not offer her an appointment and referred her to remote STI testing, which involves ordering a test kit online to be delivered to her address. 'Gabriela' had secure housing and an internet connection, but this one-size-fits-all approach could very easily exclude people from access to sexual health. For example, someone with an impairment or condition which would make self-sampling difficult should still be entitled to preserve their confidentiality and not rely on a friend or relative to assist them with sampling.

Additionally, 'Gabriela' may have shared accommodation with her family to whom she did not wish to disclose that she was sexually active or required an STI test, particularly if she belonged to a social group that stigmatised her sexual activities. Receiving an STI test kit in the post could have presented a risk to her wellbeing and safety.

Finally, consultations with clinicians offer an opportunity for opportunistic health promotion, which is a vital aspect of sexual health provision. Without this, people with sexual health needs would not get the opportunity to receive advice and education that could benefit them and the wider public. A key example of this is opportunistic offering of HIV tests. In 2022, the UK government recommended sexual health services to offer mpox vaccinations to gay/bisexual men (MSM) who attended sexual health clinics for other reasons, such as accessing STI testing or pre-exposure prophylaxis for HIV (PrEP).[43] People with complex needs, or whose sexual health is related in complex ways to their broader health and wellbeing also benefit from this more holistic support. People involved in chemsex or sexualised drug use, for instance, might need to access advice about substance dependency and require referral to specialised services or other agencies. Limiting access to sexual health means there may be missed opportunities for engaging with people on issues which go wider than immediate symptoms or concerns.

43 UKHSA, Investigation into Mpox outbreak in England: technical briefing 1. https://www.gov.uk/government/publications/monkeypox-outbreak-technical-briefings/investigation-into-monkeypox-outbreak-in-england-technical-briefing-1, Updated 23 September 2022

Recommendations

Ensuring enough funding for sexual health

- National governments in England, Wales and Scotland need to ensure there is increased funding specifically for sexual health services in order to meet the rising demand and deal with rising STI rates and unplanned pregnancy. Funding awards for sexual health services also need to increase each year by at least the rate of inflation plus 1%.
- There needs to be investment in the sexual and reproductive health workforce across sexual health services in Great Britain, with particular focus on increasing the number of training places available.
- UKHSA, Public Health Wales and Public Health Scotland should work with local government, Health Boards, NHS Boards (as appropriate) and BASHH to carry out return on investment modelling on the impact of investment in STI prevention and treatment interventions.
- The UK government should explore options for awarding multi-year Public Health Grant settlements in England specifically for sexual health, to enable commissioners to ensure longer-term strategic service delivery in their areas and reduce the administrative burden of regular retendering.

Improving access to sexual health and minimising missed opportunities

- The UK Government should look into replicating the Welsh system for nationally available postal STI testing services in England, using an uncomplicated and user-friendly online interface. The Scottish government should re-commit to launching nationwide the postal STI and BBV-self sampling service it announced in 2020, and provide clarity on plans for adequate centralised resourcing and governance.
- NHS services across Great Britain should work with SHS providers to make sexual health appointments bookable via the NHS app (or versions thereof).
- Sexual health commissioners in England, Wales and Scotland should ensure all new attendances at sexual health services are offered an HIV and syphilis test, as per BASHH guidelines.

Recommendations

Strategic vision and accountability for sexual health

- There is an urgent requirement for national strategies and leadership for sexual health across England, Wales and Scotland. Specifically:
  - The UK government needs to expedite publishing its Sexual and Reproductive Health Strategy/Action Plan, as promised in 2019.
  - The Scottish government's refreshed Sexual Health and Blood Borne Virus Strategy should include positive ambitions around surveillance data and service accountability, and it is vital that these measures are delivered in order to give sexual health the priority it needs in Scotland.
  - The Welsh government must develop a strategic vision for SHS, and follow through on parts of the HIV Action Plan for Wales that involve strengthening sexual health systems.
- Monitoring and evaluation frameworks should be developed by UKHSA, Public Health Scotland and Public Health Wales, in conjunction with their respective NHS bodies, to develop measures on reducing health inequalities in sexual health as part of sexual health strategies. These should include, but not be limited to: appointment unavailability, average waiting times for appointments, availability of postal STI services, and provision of drop-in services.
- The UK, Scottish and Welsh governments should implement and monitor 48-hour waiting time target for access to SHS in England, Scotland and Wales respectively. These should not be used as punitive measures for sexual health services, but an indicator for the demand that central government, health boards and local authorities can use for planning purposes.
- The Scottish and Welsh governments need to prioritise and invest in publishing regular and consistent surveillance data, to allow for up-to-date monitoring of trends in sexual health, as well as tracking of change year-on-year.
- As recommended by the Scottish government's recovery plan for sexual health and BBV services, clinical data and user trend statistics governing SHS delivery in Scotland, Wales and England should be supplemented with qualitative engagement with service users.

Recommendations

Ensuring the universal access principle is upheld

- Commissioners in England should ensure their SHS can provide services for people living in other English local authorities who want to access a service as an out-of-area patient.
- Funding mechanisms should be agreed between NHS Wales, NHS Scotland and NHS England to allow for out-of-area patients. These need to be developed to preserve the universality of sexual health provision in Britain.
- NHS England, NHS Scotland and NHS Wales should issue guidance for SHS clinics and booking services on how anonymity can be guaranteed. This is particularly important in the context of data sharing systems, namely NaSH in Scotland, and NHS Patient Record in England.
- Sexual health appointments should be bookable via an app for those who wish to do so, in addition to the option of booking an appointment anonymously via the telephone or online.
- A guarantee from the UK government that sexual health services will be de facto beneficiary of any additional funding to NHS Wales, as recommended by the Faculty for Sexual and Reproductive Health.

Below is a summary of recommendations, broken down by country:

Country Recommendations

Great Britain-wide

- National governments in England, Wales and Scotland need to ensure there is increased funding specifically for sexual health services in order to meet the rising demand and deal with rising STI rates and unplanned pregnancy.
- Investment in the sexual and reproductive health workforce across sexual health services in Great Britain, with particular focus on increasing the number of training places available.
- The UK, Scottish and Welsh governments should implement and monitor 48-hour waiting time target for access to SHS in England, Scotland and Wales respectively. These should not be used as punitive measures for sexual health services, but an indicator for the demand that central government, health boards and local authorities can use for planning purposes.

Recommendations

- As recommended by the Scottish government's recovery plan for sexual health and BBV services, clinical data and user trend statistics governing SHS delivery in Scotland, Wales and England should be supplemented with qualitative engagement with service users.
- Opt-out testing in sexual health services. Sexual health commissioners in England, Wales and Scotland should ensure all new attendances at sexual health services – GUM and contraception alike – are offered an HIV and syphilis test, as per BASHH guidelines.
- Monitoring and evaluation frameworks should be developed by UKHSA, Public Health Scotland and Public Health Wales, in conjunction with their respective NHS bodies, to develop impact measures on reducing health inequalities in sexual health. These should include, but not be limited to: appointment unavailability, average waiting times for appointments, availability of postal STI services, and provision of drop-in services.
- Funding mechanisms should be agreed between NHS Wales, NHS Scotland and NHS England to allow for out-of-area patients. These need to be developed to preserve the universality of sexual health provision in Britain.
- NHS England, NHS Scotland and NHS Wales should issue guidance for SHS clinics and booking services on how anonymity can be retained. This is particularly important in the context of data sharing systems, namely NaSH in Scotland, and NHS Patient Record in England. Sexual health appointments should be bookable via an app, in addition to the option of booking an appointment anonymously via the telephone or online.

England

- UKHSA should work with local government and BASHH to carry out return on investment modelling on the impact of investment in STI prevention and treatment interventions.
- The UK government should explore options for awarding multi-year Public Health Grant settlements in England specifically for sexual health, to enable commissioners to ensure longer-term strategic service delivery in their areas and reduce the administrative burden of regular retendering.

Recommendations

- The UK government should look into replicating the Welsh system for nationally available postal STI testing services in England, using an uncomplicated and user-friendly online interface. The Scottish government should re-commit to launching nationwide the postal STI and BBV-self sampling service it announced in 2020, and provide clarity on plans for adequate centralised resourcing and governance.
- NHS England should work with SHS providers to make sexual health appointments bookable via the NHS app.
- The UK government needs to expedite publishing its Sexual and Reproductive Health Strategy/Action Plan, as promised in 2019.

Scotland

- Public Health Scotland should work with NHS Boards and BASHH to carry out return on investment modelling on the impact of investment in STI prevention and treatment interventions.
- In addition to the free HIV postal testing offer available, The Scottish government should re-commit to launching nationwide the postal STI and BBV-self sampling service it announced in 2020, and provide clarity on plans for adequate centralised resourcing and governance.
- NHS Scotland should work with SHS providers to make sexual health appointments bookable via the NHS 24 app.
- The Scottish government needs to prioritise publishing regular and consistent surveillance data, to allow for up-to-date monitoring of trends in sexual health, as well as tracking of change year-on-year.

Wales

- Public Health Wales Health Boards and BASHH to carry out return on investment modelling on the impact of investment in STI prevention and treatment interventions.
- NHS Wales should work with SHS providers to make sexual health appointments bookable via the NHS Wales app.
- The Welsh government must develop a strategic vision for SHS and follow through on parts of the HIV Action Plan for Wales that involve strengthening sexual health systems.
- The Welsh government needs to prioritise publishing regular and consistent surveillance data, to allow for up-to-date monitoring of trends in sexual health, as well as tracking of change year-on-year.

About Terrence Higgins Trust

We're the UK's leading HIV and sexual health charity. We support people living with HIV and amplify their voices, and help the people using our services to achieve good sexual health.

Terry Higgins was one of the first people in the UK to die of an AIDS-related illness. He died aged 37, on 4 July 1982 at St Thomas' Hospital, London. By naming the trust after Terry, the founder members – his partner and friends – hoped to personalise and humanise AIDS in a very public way. From our small beginnings in a flat in central London, we have grown to become the UK's leading HIV and sexual health charity, and one of the largest in Europe. We have always been at the forefront of the fight against HIV and AIDS. Since we were formed, the needs of people living with and affected by HIV have been fundamental to our development.

Our vision

We strive for a future where there are no new cases of HIV, where people living with HIV get the support they need and there is good sexual health for all.

Our mission

- End new cases of HIV by 2030.
- Be here until the last person living with HIV needs us.
- Make sexual and reproductive health the priority it deserves to be.

We support people living with HIV and ensure their voices are heard, providing testing services for HIV and other sexually transmitted infections, and helping the people using our services to achieve good sexual health.

As well as provide services, we campaign on issues from relationships and sex education in schools to the proper funding of HIV services.

We also run community projects such as Positive Voices, which supports people living with HIV to tell their own stories, and work and skills programmes for people living with HIV. And on behalf of Public Health England, we lead It Starts With Me, the national HIV prevention programme.

Time is running out

Now is the time you can help end an epidemic that has killed 38 million people.

It's possible to be living with HIV and not know it. We **urgently** need your help to find and test everyone living with HIV in the UK. People with HIV who are on treatment can't pass it on.

Donate now and together we can end new cases of HIV in the UK by 2030.

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Appendices

Appendix 1 – Framework for recording questions asked on appointment booking

1. How old are you?
2. Can you talk privately?
3. When did you last have sex?
4. Was this with a new partner?
5. Has a partner recently informed you that they have been diagnosed with an STI?
6. Was protection / a barrier method of contraception used?
7. Are you on any other contraception / is there a chance you're pregnant?
8. Do you believe you might be at risk of HIV?
9. Are you using PrEP?
10. Do you have any symptoms of an STI?
11. When was your last menstrual period?
12. Have you been sexually assaulted?
13. Do you have any disabilities or impairments that we should be aware of?