Independent Advisory Group
on Sexual Health and HIV

Independent Advisory Group on Sexual Health and HIV

Response to New Developments in Sexual Health and HIV/AIDS Policy

Commentary on the Government's Response to the Health Select Committee's 3rd Report of Session 2004-5

February 2006

FUNDING

The allocation of funding at a local level to sexual health services is a key challenge facing the NHS at the moment and the IAG believes that government may need to intervene with PCTs to ensure funding reaches its target.

Failures in funding by PCTs – in terms of both allocation and distribution – is jeopardising the 48 hour access target, hindering improvements in sexual health services and allowing STIs to continue to increase.

Those working in GUM were encouraged by the commitment to extra sexual health spending, including £130 million for GUM services alongside the Choosing Health consultation and £15 million to be spent on GUM infrastructure. However, at the moment poor access times persist and the 48 hour target looks challenging.

The IAG is particularly concerned that funds intended for GUM and contraceptive services do not always reach their target. Evidence from several different PCTs suggests that investment intended to improve sexual health service provision is being sidelined by PCTs to cover budget deficits and for other purposes. We believe that the government must take steps to ensure that funding reaches its allocated service. PCTs that fail to fund and improve services should face repercussions. There are no sanctions against PCTs and SHAs that don't meet targets. If PCTs and SHAs fail to meet targets in 2008, there is currently no comeback.

It is the view of the IAG that the Healthcare Commission should consider what tangible, outcome-based monitoring can be put in place at a local level to demonstrate the impact of extra monies. We would also urge that the appointments for clinical networks are strengthened with a view to eventually devolving responsibility for local commissioning to these networks. It is the belief of the IAG that a comprehensive clinical network is best placed to determine allocation of funds for sexual health services in their locality. These networks will also be accountable for improvements in the services, and it is important that public health leadership within the networks is included, as a needs assessment over a geographical area is necessary in order to commission services to meet that need. Clinical networks alone will not necessarily focus on the issue of controlling and preventing STIs.

The disparate timing in the reporting of the various audits of services is a cause for concern. For example, the contraceptive audit should report soon but the first round of funding is due to be delivered to PCTs on 1st April 2006. This, at most, allows just two months for the results of the audit and its implications for the distribution of funding to be considered.

CHLAMYDIA

The IAG welcomes the National Chlamydia Screening Programme (NCSP) for 16-24 year olds. While younger people are most at risk of contracting chlamydia, the needs of older women should not be ignored. The inclusion of young men in the screening programme is a positive step, but it should be recognised that there are differences in the behaviour of men which require more innovative programmes to reach them.

There are limits to opportunistic Screening Programmes: the reliance of the NCSP on young people accessing healthcare services for another reason may hamper its effectiveness. By the government's own admission this will exclude 31% of young men and 10% of young women. The IAG believes innovative solutions, such as the free over the counter chlamydia screening at Boots the Chemist, should continue and be fully evaluated. Mechanisms should be put in place to ensure that cases identified through these sectors are appropriately managed, including partner notification and prevention advice, and that they link into surveillance systems to capture these cases.

The IAG urges the government, despite the limits of the new GMS contract, to incentivise General Practitioners to undertake more screening. General Practitioners have unmatched accessibility and geographical coverage[1]. Also, evidence shows that not only do young people prefer to go to their General Practice, rather than a specialist clinic, for advice about STIs and contraception[2], but that 40.5% of all patients attending a GU clinic and 39.9% of those with an STI had already seen their GP in the first instance. This means that primary care could be an important setting for STI control[3].

However, there is also a need to allow other services to evolve to meet the needs of users. The development of alternative ways of reaching people, such as the Boots scheme, can only have a positive effect on sexual health.

While the focusing of resources on young people who are most at risk of contracting chlamydia is understandable, it is essential that the needs of older people should not be ignored. Traditionally, older people tend not to be considered, or consider themselves, 'at risk' of contracting STIs. However, a change in circumstances that results in a sexual partner change, such as divorce or widowhood, can leave older people vulnerable to contracting STIs. Providing screening for older people has been identified as an 'averagely cost effective' intervention in *Health Economics of Sexual Health*[4], a recent Department of Health report, and should be considered.

1 Audit Commission 2002, A Focus on General Practice in England
2 BMJ 2005, 330:590-3, Tripp and Viner
3 Sexually Transmitted Infections 2003. 79:134-6 Treating Sexually Transmitted Infections in Primary Care; a missed opportunity? Cassell, Brook & Mercer.
4 Payne, N and O'Brien, R Health Economics of Sexual Health; a guide to commissioning and planning, September 2005

The IAG are pleased to see that NAA testing is now used in most laboratories testing for chlamydia, but it is a cause of great concern that a test which misses 30% of infections is still to be used in some places until March 2007. Government has put money into NAATs and there is now no excuse for the continued use of the less effective EIA (enzyme immuno-assay) testing. PCTs should be aware of the possible legal consequences of providing a false negative result using this test. The IAG believes that those PCTs that are tardy in adopting the new test should consider the implications should a person whose chlamydia has been missed due to the use of sub standard testing decide to embark on legal action.

GUM

The IAG joins the Select Committee in welcoming the 48 hour access target for GUM services. However, we believe that the gold standard should be open access for all, where an individual can visit a clinic without an appointment and be seen the same day, or, if they prefer, book an appointment at a convenient time for them. Those working in GUM were encouraged by the additional spending on sexual health and a recent review of literature in the *Health Economics of Sexual Health*[5] indicates that good access to STI services with very short or no waiting times is 'outstandingly cost effective'.

Meeting the 48 hour target may be difficult and strategic planning of investment is needed to ensure that the government achieves its aim. There is currently a geographical variability in access times, with people in the North and outside of London generally having to wait longer. A national GUM service review is currently underway to undertake a multidisciplinary assessment of each GUM service in England, highlighting factors both facilitating and obstructing their ability to offer a prompt and high quality service. The review will offer recommendations for service improvements arising from the assessment of GUM clinics, PCTs and SHAs. The findings from this survey and its recommendations will be given to the Department of Health and will be very important in the strategic planning of expenditure in order to meet the 48 hour access target. While we are still so far from meeting the universal 48 hour target in most areas, it may be prudent to look at prioritising people who are most likely to have a sexually transmitted infection in order to try and maximise the impact on transmission. Providing same/next day services for people with symptoms suggesting an STI or who have been exposed to an STI would be an important step towards universal 48 hour access.

5 Ibid

REPRODUCTIVE HEALTH

The IAG believes that it will be difficult to measure how effective deployment of the £40 million allocated to contraception services has been because of changes in the commissioning structure outlined in Commissioning a Patient-Led NHS, the lack of a Local Delivery Plan monitoring line on contraception and delay on the publication of the contraceptive audit results.

We are concerned that there has so far been little focused work on access to contraception, which, in light of the proposed change in commissioning, is very worrying. There is a clear need to bridge the gap between the target to reduce unwanted teenage pregnancies and the daily experience of so many women of all ages, especially the most vulnerable, whose access to friendly, supportive and clinically adequate contraception is so limited.

The Department of Health maintains that the very act of undertaking the audit will provide each SHA and PCT with the information to review and improve its services locally. However, the introduction of practice based commissioning and the timetable for PCTs to divest themselves of provider functions means that there is an added upheaval about who will be commissioning the services and from where. This is particularly salient when commissioning community based contraceptive services.

The IAG believes that contraceptive services should meet certain minimum standards:

- All professionals providing contraceptive advice including General Practitioners and Practice Nurses should be adequately trained to do so. The MedFASH standards should be used as a benchmark for best practice
- A full range of contraceptive methods for women and men should be easily accessible in each PCT area
- Services should be available in a variety of settings at times that are convenient to users as dictated by the users

The economic arguments supporting the government's investment in contraceptive services are overwhelming. Research by **fpa** shows that for every £1 spent on providing wide availability to good contraception there is a corresponding saving of over £10[6]. By changing the supply of contraception to better reflect women's preferences and increasing the availability of different long acting methods of contraception, the number of unwanted pregnancies would fall and abortion and maternity services would be relieved of £500 million of unnecessary spending over 15 years. This represents an annual saving of £33 million[7].

The increased accessibility provided by community contraceptive services is especially important for women who are at high risk of unintended pregnancy. Ensuring access for the most vulnerable and marginalised groups has been made possible by these services. The IAG is concerned about evidence which indicates that disinvestment by some PCTs in community contraceptive services is occurring.

There is clear evidence of disinvestment in community contraceptive services over the past 12 months as PCTs try to balance their final position. It is difficult to predict the impact of practice based commissioning on sexual and reproductive health care provision in future. Community contraceptive services are particularly vulnerable given the lack of emphasis on contraception in the National Strategy for Sexual Health and HIV.

The loss of these services will have a negative effect on the 1.2 million women who relied on community contraceptive clinics in 2003/4, when 2.6 million visits were made to these services. Some strategic thinking is needed to consider alternative ways forward.

The IAG agrees with the Select Committee that abortion services are an important aspect of sexual health services. However, we feel that the target to ensure that all women have access to abortions within three weeks of the first appointment with the GP or other referring doctor could be more ambitious.

Abortion at an early stage of pregnancy contains less risk for women and allows them increased choice in abortion method. Delaying by just one week could remove these options. As well as being best practise in terms of quality of care, an average reduction in delay of 10 days from referral to abortion would increase the proportion of all abortions carried out under 10 weeks to 71% which would, in economic terms, represent a saving of up to £30 million per year (depending on the profile of abortion methods chosen)[8]. The IAG would therefore like to see this target reduced and PCTs striving for an average reduction in waiting time from three weeks to two weeks from first appointment to termination.

6 McGuire A and Hughes D (1995) *The Economics of Family Planning Services*, **fpa**

7 Armstrong, N and Donaldson C, *The Economics of Sexual Health*, London, **fpa** 2005

8 Ibid

SEXUAL HEALTH MEDIA CAMPAIGN

The IAG joins the Select Committee in welcoming the government's decision to launch a health education campaign aimed at improving sexual health. It is important that good quality targeted, accurate, information is available to all and, if managed well, this campaign could go some way to improving basic awareness of the issues around good sexual health. The IAG is, however, concerned that the media and health education campaign is supported by appropriate distribution of condoms. The campaign will promote the carrying and using of condoms, but many parts of the NHS are unable to provide free or cheap supplies to people requesting them.

We welcome the Department of Health's offer to include stakeholders in the development of the campaign, in order for it to be as effective as possible. However, the IAG strongly believes that while a nationwide media campaign is a positive step, the more targeted and personal the information provided at an early age is, the more effective it will be. High quality, mandatory Sex and Relationships Education at school is therefore vital.

PSHE

Personal, Social and Health Education equips young people with knowledge, skills and values for life. It can help raise their self-esteem, enable them to make safe and informed choices and develop strong and positive relationships throughout their lives. It is critical that we improve this area of education as a priority. The IAG shares the concerns of the Select Committee and the government on the teaching of PSHE by non-specialist teachers, such as form tutors. Assessment and inspection highlights that PSHE programmes delivered by these teachers are of a significantly poorer quality than that delivered by trained, specialist staff.

In order to improve the quality of PSHE across schools, it is vital that professionals are trained and equipped to deliver high quality education. Moreover there must be support for teachers so that they feel confident and able to teach this subject. Although there is a PSHE certification/ Continuing Professional Development (CPD) scheme in place for teachers and school nurses, anecdotal evidence suggests that this does not, in all instances, improve practice sufficiently. Staff are not signing up to it in the numbers hoped for. Some of those who have joined report that there is too great a focus on preparing a written portfolio and not enough time spent learning skills needed in the classroom.

The IAG recommend that the government undertake a thorough review of PSHE teaching in schools. Priority should be given to:

- Working with the Teacher Development Agency to include PSHE in core Initial Teacher Training programmes
- Engaging the DfES and DoH in discussions to improve the quality and effectiveness of specialist PSHE training and CPD for teachers and school nurses, in particular focusing on improving the content of CPD programmes
- Increasing the number of teachers and school nurses who receive specialist training
- Involving external specialist professionals in the delivery of PSHE programmes
- Establishing training standards to ensure that all those who deliver PSHE are fully competent to do so

The IAG supports the Select Committee's position that the government's failure to make PSHE and SRE a statutory requirement is lamentable. Whilst we admire the government's desire to support teachers currently providing PSHE, we believe that the government should further commit to ensuring that PSHE and SRE is available to all. The IAG think that it is important to make PSHE and SRE a statutory foundation subject at all key stages of the curriculum. This would raise the status of the subject, ensure that it is afforded sufficient time and resources within the curriculum as a whole and guarantee minimum standards for the content of PSHE delivered by every school. The IAG remains convinced that PSHE will continue to be inequitable unless it is made a statutory foundation subject at all key stages of the national curriculum.

WORKFORCE AND TRAINING

For staff to provide good sexual health services requires intrinsic ability and sensitivity, coupled with excellent training. The government's strategy to improve sexual health puts nurses at the front line of service provision and means nurses must be properly trained to deal with sexual health issues. The IAG believes that all pre and post registration nurses should have access to sexual health modules during their programme of training together with the opportunity of clinical placements in sexual health.

We share the concern of the Select Committee about the shortage of consultants specialising in sexual health and believe that the government should address the Royal College of Obstetrics and Gynaecology's current training requirements for consultants in sexual and reproductive health. At the moment there is a structured modular package for staff grades and associate specialists run by the Faculty of Family Planning, but this is not funded by the Deaneries.

We are encouraged that the government recognises training to be the bedrock for delivering high quality sexual health services and as such hope that the government will consider the following recommendations:

- PCTs should ensure that the Sexually Transmitted Infections Foundation (STIF) and other courses continue to expand throughout the UK to introduce an equitable supply of training opportunities in basic knowledge, skills and attitudes for medical and nursing practitioners in primary care
- PCTs should have a training budget so that training requirements do not reduce patient throughput
- PCTs should ensure that training, support and audit is undertaken for all new non-GUM settings where diagnosis and treatment of STIs is undertaken
- The number of centrally funded training posts for subspecialty training in Sexual and Reproductive Health should be increased in order to provide services of quality and safety. There is a need for Consultants to work as a team to plan strategic direction and organise and deliver training programmes for all three levels of the Strategy

The IAG welcomes the £200,000 allocated by the Department of Health for the Distance Learning Skills Course for Nurses. To date over 1,000 students have accessed this programme and its popularity emphasises the need that exists for such training.

No mention is made by the Select Committee or the government of nurse consultants. The IAG believe that a course on contraception, with a format similar to the STIF course, should be available to both nurses and doctors. Discussion is taking place with the Faculty of Family Planning and the Department of Health should review the outcome.

CHARGES FOR OVERSEAS VISITORS FOR HIV/AIDS TREATMENT

The debate on charging overseas visitors for HIV treatment needs to be completely separate from debates surrounding immigration and asylum. This is a public health problem and should be addressed as such. The issue of overriding importance is the need to curb the spread of HIV in the UK, an issue that charging fails to address thus threatening to drive the disease further underground.

The IAG believes that the decision not to exempt HIV from NHS charges is likely to increase transmission of HIV and, with the cost of just one onward transmission to the NHS in mind, we believe the government should reconsider this ruling.

Research suggests that charging for treatment prevents some people, particularly within immigrant communities, from coming forward for testing and treatment regardless of whether or not they are eligible for free treatment. If at risk groups are dissuaded from getting tested by the possibility of charges they will remain unaware of their HIV status. If HIV positive, they may be more infectious, as they will be less likely to access advice on avoiding onward transmission. They are also going to be more susceptible to other infections.

Evidence collected by the Terrence Higgins Trust (THT) and the George House Trust (GHT) looked at 60 recent migrants to the UK who approached their service and found that 75% of people who had recently migrated were not diagnosed until they had been in the UK for at least 9 months. They found that there was no single, identifiable way in which people subsequently diagnosed with HIV entered the UK. Crucially, they also found that the reasons people were tested varied from army medical to sexual assault, with the most common reason being the onset of severe illness. Many people were also tested during pregnancy.

THT describes a case of a long-stay visitor who was rushed to a North London hospital. The woman's illness was diagnosed as HIV related and she was charged £2,000 for her treatment. Intimidated by the bill, she discharged herself, self medicated, and had to be readmitted to intensive care, where costs for her treatment came to £23,000 for that one episode alone. Treatment for HIV in the UK for one year is only £10,000, from which we can see that it is far cheaper to treat someone for HIV than it is to continually pay for intensive care treatment. Further, recent figures from St George's, a leading London HIV clinic, show that the cost of a bed in intensive care for just one week is the direct financial equivalent of a whole year of anti-retroviral therapy. The case for the cost-effectiveness of anti-retrovirals is proven by the fact that anyone who is not treated with anti-retrovirals can look forward to an increasing spiral of stays in ICU.

The exemption from charges of STIs and tuberculosis is part of the excellent public health responses over the past century to the challenge of infectious disease. From the Royal Commission report in 1916 onwards, the UK has adopted a pragmatic and effective approach in which the public health benefits of free treatment to control infectious disease outweighs the 'moral' or 'financial' benefits of withholding free treatment. We strongly believe that the government should consider including HIV in this list of exemptions on the same grounds. To single out HIV for charges can be seen to penalise people with HIV over other STIs unfairly and contributes to HIV discrimination.