Government Response to the Health Select Committee's Third Report of Session 2002-03 on Sexual Health

Presented to Parliament by
the Secretary of State for Health
by Command of Her Majesty
September 2003

Government Response to the Health Select Committee's Third Report of Session 2002-03 on Sexual Health

Presented to Parliament by
the Secretary of State for Health
by Command of Her Majesty
September 2003

Government Response to the Health Select Committee's Third Report of Session 2002-03 on Sexual Health

INTRODUCTION

This Command Paper sets out the Government's response to the Health Select Committee's Third Report of the Session 2002/03 on Sexual Health.

Sexual Health in England

The Government recognises and shares the Committee's deep concerns about the poor state of sexual health. However, England is not alone in facing increasing rates of sexually transmitted infections (STIs). France, the Netherlands, Sweden and Switzerland all reported increases in gonorrhoea and outbreaks of syphilis are occurring in a number of European countries. New diagnoses of HIV are also continuing to increase in Western Europe. At the end of 2001, the UK had an HIV rate of 0.1% compared to rates of 0.5% in Portugal, 0.5% in Spain and 0.4% in Italy[1]. This reflects prompt action on a number of fronts, including health promotion, needle exchange schemes, screening of blood, the availability of open-access Genito-Urinary Medicine (GUM) clinics and careful surveillance and analysis of trends.

Poor sexual health continues to disproportionately affect those who are often already vulnerable or socially excluded including gay men, young people, women and black and ethnic minorities. The latest data on STIs published by the Health Protection Agency (HPA) on 5th July 2003 show that levels are continuing to rise. Chlamydia remains the most commonly diagnosed STI, having increased by 14% between 2001 and 2002. The total number of diagnoses in 2002 was 81,680. Cases of syphilis also continued to increase, although it is important to keep in mind that the actual numbers remain relatively small (1163 new diagnoses of primary and secondary infectious syphilis in 2002). Viral infections also continued to increase, but the rise was smaller. However, there has been a reduction in the year-on-year increases for all reports of syphilis, genital warts and genital herpes infections. Also in 2002, gonorrhoea diagnoses in gay men fell by 5% nationally and by 11% in London, where over half of all cases in gay men are diagnosed. Rates of gonorrhoea infection are often an indicator of sexual risk taking behaviour so these latter data are encouraging.

However, sexual health is not just about disease. Planning parenthood, understanding contraception and the age of first sex can all have an important impact on individuals and communities. Tackling Britain's unacceptably high rates of teenage pregnancy remains a key priority. There are very encouraging signs that the Teenage Pregnancy

1 Data from the UNAIDS Report on the Global HIV/AIDS epidemic (July 2002)

Strategy is working, good progress is being made towards our goal of halving the under 18 conception rate by 2010. In 2001, conception rates in under 18s were 3% lower than in 2000. The total reduction since 1998 is 10% which means that around 8000 pregnancies in girls under 18 have been prevented.

Government Action

To improve sexual health in England, the Government created the first ever National Strategy for Sexual Health and HIV ('The Strategy'). Published in 2001, the Strategy is rightly a long-term commitment to improve sexual health. The Government strongly believes that the aims, principles and interventions detailed in the Strategy provide the best means of achieving better sexual health and is, therefore, firmly committed to effective implementation. The Strategy proposes a wide-ranging and holistic model for modernising sexual health services. In line with the principles of the NHS Plan, the Strategy aims to provide a comprehensive range of services which are designed around the needs of the patient; respond to the needs of different populations; and, continually improve the quality of services.

Publication of the Strategy was followed in June 2002 by the publication of an Implementation Action Plan, which set out 27 clear action points which would be undertaken to deliver the Strategy's objectives. Rapid progress has already been made in many of the key areas which will drive implementation. In particular:

- Rollout of a national chlamydia screening programme is underway – one of the first in Europe;
- A Commissioning Toolkit and Health Promotion Toolkit have been published to aid Primary Care Trusts (PCTs), both have been very well received;
- For the first time we have an Independent Advisory Group (IAG) for sexual health and HIV to advise Government on implementation and any further action necessary to achieve the Strategy's aims;
- We have developed a bold and innovative national adult sexual health ('Sex Lottery') campaign. Early feedback has been very positive;
- HIV treatment standards will be published shortly (October 2003);
- An additional £14 million has been invested in GU and abortion services in 2003/04 and over £6 million was invested in 2002/03;
- The evidence base for HIV prevention has been reviewed and the findings published by the Health Development Agency (HDA).

Investment and resources

The Committee raised concerns about the resources available for sexual health across the board, and for GUM in particular. The Government agrees that additional investment is needed to reduce waiting times and improve capacity in sexual health services. In particular, we have prioritised funding for GUM and termination of pregnancy services from the sexual health and HIV budget. However, this only represents a relatively small proportion of the resources available for local service development. Shifting the Balance of Power has allowed PCTs to take control of the

main revenue allocation, giving them the necessary flexibility to provide services to best meet local needs. The Government has provided considerable new resources to PCTs through the Spending Review Settlement to enable resources to be much more closely matched to the needs of local people. The 2002 Budget provided a significant increase in resources over the next five years – an annual average increase of 7.4% in real terms raising the expected level of health spending to 9.4% of Gross Domestic Product (GDP).

The Strategy sets out a long-term programme working towards safer sexual behaviour, modernised services and better sexual health for the whole population. We recognise that sustained sexual behavioural changes in the population and dramatic improvements in services won't happen overnight. It is not simply a matter of spending money, but of developing a targeted approach; strengthening public health interventions; identifying vulnerable groups; joining up with a wide range of other initiatives and stakeholders to work towards long-term behavioural change; and, services which provide for a wide range of sexual health needs. We will continue to ensure close links with the Government's Teenage Pregnancy Strategy and the Infectious Diseases Strategy *Getting Ahead of the Curve*. Development of the Strategy has already demonstrated the Government's commitment to raising the profile of sexual health as a priority issue. We will continue to work with Strategic Health Authorities (SHAs) and PCTs to ensure that local people have ready access to services through a range of appropriate settings.

However, the Government does recognise the need for additional targeted investment in areas where there are the most pressing sexual health problems. To this end, £47.5 million has already been invested to implement the Strategy with a commitment to provide a further £20 million in each of the next two years. Of this, we have invested £15 million in GUM services, £9.5 million in chlamydia screening and £5 million in termination of pregnancy services. In response to the strong concerns being expressed by the Committee and others about poor access to sexual health services, an additional £11 million will be allocated to sexual health this year: £5 million will be allocated to GUM services, £5 million to facilitate the introduction of a more reliable, non-invasive chlamydia test and a small boost (£1 million) to contraception services. All funding will be carefully targeted for maximum pay-off to ensure it is distributed where it is most needed. There will also be an additional £400,000 for targeted HIV health promotion.

We share the Committee's concerns that sub-optimal tests for chlamydia, with less dependable accuracy rates, are still being used in many areas and will address this as a matter of priority. We will invest £8 million (which includes the additional £5 million highlighted above) this year to help enable laboratories to switch to the preferred molecular amplification test. The Chief Medical Officer (CMO) has now written to PCT Chief Executives highlighting the concerns about the use of the sub-optimal test for chlamydia and seeking bids for funding to ensure that all major laboratories in each region of England use Nucleic Acid Amplification Tests (NAATs).

Implementing the Strategy

Local Implementation

The Committee welcomed the Government's National Strategy for Sexual Health and HIV. To ensure really effective Strategy implementation, we have already funded every local area to carry out a baseline service mapping exercise to identify existing gaps and weaknesses. We are analysing the results and will publish a summary report very shortly. We have also conducted a mapping exercise of the training currently undertaken by, and available to, staff working in all areas of sexual health. We can only deliver high-quality sexual health services if staff are appropriately trained so that they are well placed to respond to all patient needs. This work will be used to help develop a sexual health training strategy to improve skills and development within the sector and improve the quality of the service to the patient.

Over 99% of PCTs have now identified a named sexual health and HIV lead to drive forward the implementation of the Strategy at local level. To aid them in this role, we have published a toolkit for the effective commissioning of sexual health and HIV services. This aims to help and support PCTs in exploring options for improving local services and improving the sexual health of the population by providing strategic direction, frameworks and models for service delivery. A companion toolkit on Effective Sexual Health Promotion was published in June 2003. This provides practical guidance and best practice for all those working in the field of sexual health promotion and HIV prevention. Both documents have been disseminated through a series of conferences for key stakeholders and through direct communication with sexual health leads. We believe that spreading best practice is fundamental in improving the sexual health of the nation.

One-Stop Shops

As part of the commitment in the Strategy to develop and evaluate more effective models of services, three models of sexual health one-stop shops are being evaluated. One-stop shops are services which provide contraceptive and GU services on a single site. An experienced team from University College London and Bristol University will lead on this evaluation which will assess the benefits and cost effectiveness of three one-stop services in comparison with six traditional services. A broad range of stakeholders, including service users, will be involved in the evaluation.

Chlamydia Screening Programme

The Government will continue to support the national implementation of the screening programme for chlamydia – the most common STI. We have sought expressions of interest for another 10 screening areas which will produce approximately 400 additional testing sites in those areas where infection rates are highest.

Review of Evidence

In line with the Strategy, the HDA was commissioned by the Department of Health to review the evidence base for effective HIV and STI prevention and to make recommendations. It has now undertaken an extensive review of published research evidence (from the UK and internationally) to highlight "what works" to prevent or

reduce the sexual risk of HIV transmission for target groups. The results of this review in respect of HIV were published in March 2003.

Health Promotion

The Committee supported the Government's aim of reducing the prevalence of undiagnosed HIV infection. The Government continues to support targeted sexual health promotion and HIV prevention work in partnership with leading organisations in the voluntary sector. This includes specialised HIV prevention work for gay men and African communities – the two sectors of society hit hardest by the epidemic. As mentioned earlier, for 2003/04 the Department of Health will invest an additional £400,000 to promote the benefits of HIV testing and to evaluate models of testing services in community settings.

Contraception Services

Women are at risk of unintended pregnancy as well as STIs and HIV. In 2001, 23.2% of conceptions in England and Wales ended in a termination of pregnancy. We are therefore taking a number of steps through both the Sexual Health and Teenage Pregnancy Strategies to improve access to contraceptive services and the range of methods of contraception that are available. We will work with key experts to implement a work-plan to support the improvement of contraception services and gather evidence on any disinvestment in services at PCT level.

The sexual health and HIV strategy links closely to the Teenage Pregnancy Strategy in its aims of reducing unintended pregnancies. For example, the Teenage Pregnancy Unit has published guidance on improving young people's access to sexual health services in a range of settings including schools and in the wider community. At local level, clinics and GP practices have been audited against this guidance to identify gaps in service provision.

Abortion Services

The Strategy highlighted inequalities in access to abortion services and the long waiting times experienced by many women. The Strategy and Commissioning Toolkit stress that services should be developed to provide NHS-funded abortions in line with the Royal College of Obstetricians and Gynaecologists (RCOG) clinical guideline *The Care of Women Seeking Induced Abortion*, ensuring that women who meet the legal requirements for an abortion are referred without delay. In 2002/03 we provided £1 million to PCTs and a further £4 million this year to help them work towards meeting the national standard of a three week maximum waiting time from the date of referral.

Sex and Relationships Education

The Committee raised concerns about effective Sex and Relationships Education (SRE) and called for Personal, Social and Health Education (PSHE) to be made statutory. The Government recognises the need for effective SRE, and how this can lead to improved sexual health. This must be undertaken within a broader social and emotional framework, which is why we recommend that SRE form part of PSHE. We are rolling out an innovative professional development programme for teachers of PSHE which includes a specialist module for SRE. The Government's Teenage

Pregnancy Unit (TPU) has commissioned a toolkit of best practice in PSHE for Initial Teacher Training (ITT) providers, and the Teacher Training Agency's (TTA) own guidance highlights the importance of SRE. The quality of SRE will be monitored, and OfSTED will be inspecting PSHE (including SRE) in secondary schools later in the year.

Independent Advisory Group

To help ensure effective implementation of the Strategy, the Government has drawn together an Independent Advisory Group (IAG) on Sexual Health and HIV. The membership of this group includes a wide range of experts in the sexual health and HIV field, from both the statutory and voluntary sector. The group will monitor progress, including any further action necessary to achieve the Strategy's aims, and will advise the Government on implementation. The Sexual Health IAG contains a rich blend of experience and is well placed to ensure that the Government has the best possible advice and information.

Raising the Profile and Priority of Sexual Health

The Strategy is gradually raising the profile of sexual health. Although there are no specific targets, access to sexual health services, particularly for disadvantaged groups and areas, are referred to in the "Reducing Inequalities" section of the Priorities and Planning Framework [PPF] for 2003-2006. The clear message is that we expect PCTs to be addressing issues around waiting times and investing appropriately in these services. We would expect to see this appropriately reflected in SHAs' Local Delivery Plans (LDPs), in turn feeding through to PCTs.

The CMO and Chief Nursing Officer are keen to develop good practice ways of raising the profile of sexual health within the existing PPF and LDPs in liaison with all the SHAs. Work on this will be taken forward as soon as possible in Autumn/Winter 2003/04.

Ministers also wish to see a new indicator in the PCT star rating for sexual health, and we shall be developing our ideas for a GUM service waiting time indicator and other sexual health indicators.

Furthermore, Ministers will be taking every opportunity to underline the importance of sexual health to help ensure that, as far as possible, sexual health needs are taken into account at every level of planning.

The Green Paper *Every Child Matters* recognises that along with teenage pregnancy, sexual health more generally is a very important issue. It needs to be kept firmly in mind when Government is addressing the challenge to allow children and young people realise their full potential, by keeping them safe and improving their health.

Response to the Health Select Committee – Summary of key points

- The Government shares many of the Committee's concerns, and believes these will be addressed through the continued implementation of our long-term sexual health strategy (recommendation 51, page 12).

- The Government will be working in a variety of ways to help increase the priority of sexual health within the existing PPF and LDPs (recommendation 50, pages 11 and 12).
- To address the concerns about capacity problems in GUM, we are investing a further £5 million this year, in addition to the £10 million already committed, to help address backlogs and long waiting times in the areas where it is most needed (recommendation 9, page 15).
- £5 million of new money will be used to facilitate the shift from the sub-optimal test for chlamydia, to the more reliable NAATs. The CMO has made PCTs aware of the concerns regarding the chlamydia test and has asked them to prioritise the introduction of the NAATs wherever possible (recommendation 17, pages 22 and 23).
- £1 million new investment in improving contraception services, targeting those areas where this investment will be most effective (recommendation 29, pages 30 and 31).
- The national screening programme for chlamydia is being rolled-out to a further 10 areas this year, which will create approximately 400 new chlamydia testing sites within the structure of the programme, in addition to the 400 already in the programme (recommendation 15, page 20).
- We agree with the Committee's recommendation for the introduction of a performance indicator for GUM of a 48-hour waiting time, similar to that for GPs. The Department of Health is actively exploring how systems of data collection can be put in place to facilitate this (recommendation 13, pages 9 and 10).
- The Department of Health will publish recommended standards for the treatment of HIV, based on the model used by the National Service Frameworks (NSFs). Similar standards for other areas of sexual health, including STIs, reproductive health and psychosexual problems are also in production (recommendation 50, pages 11 and 12).
- The Department of Health will invest an additional £400,000 in 2003/04 for targetted HIV health promotion (recommendation 24, pages 26 and 27).

A comprehensive response to all 51 of the Health Select Committee's conclusions and recommendations follows. We have grouped these under headings to provide the most helpful response. The recommendations are not, therefore, taken in order.

Detailed Response to the Committee's Recommendations

The Priority for Sexual Health

1. While we have some reservations about some of the detail in the Strategy (and indeed about areas where there is scant detail) we regard as entirely commendable the decision of the Government to produce the Strategy. We would like to see measures going well beyond what it proposes, but would want to acknowledge that the Strategy represents an excellent starting point and a foundation which can be developed. (Paragraph 5)

The Government welcomes the Committee's recognition of the National Strategy for Sexual Health and HIV as the right starting point from which to improve sexual health in England. The Strategy is a challenging one. It is important to recognise that successful implementation will take time, but that a good deal has already been done. In some areas, such as chlamydia screening, we are already leading the way in Europe, however, there is still a lot more to do. The Committee has highlighted many of the avenues where more needs to be done in its 51 recommendations, all of which are addressed below.

6. Although we support the Government's drive to improve sexual health services via the Strategy, without wholesale advances in sexual health provision these targets will be tokenistic. (Paragraph 82)

The Strategy's goals help to focus efforts to implement the Strategy. They also allow us to monitor progress and to highlight problem areas. We will, therefore, for the first time, be producing data to measure progress against these goals and this will be published by the HPA later this year. We will also supplement these national level goals with local indicators and we are working to improve data collection to enable these to be measured. As better local data become available over the next two years, we propose to include one or more of these indicators within the NHS performance assessment process. In particular, we are working to develop a measure of waiting times for GUM services (see Recommendation 13). This, or an alternative, better indicator identified by CHAI, should form part of the star ratings of local NHS organisations and therefore provide a real incentive for the improvement of services. This is in addition to the indicator already in place for sexual health for 2002/03.

13. We welcome the fact that the Department is developing a waiting times indicator as a means of monitoring the effect of its recent investment on access to clinics. However, this will merely duplicate existing activity since the Public Health Laboratory Service and the Speciality Societies for Genito-urinary Medicine already monitor waiting times, and evidence of the extent of the problem is not wanting. So we are unconvinced that this measure

alone will do much to address what amounts to a public health crisis. We recommend that there should be a presumption that anyone wishing to access genito-urinary medicine should be able to do so on the day of, or day after, presentation to a clinic. If a target of 48 hours to see a GP is appropriate then a target of 48 hours for the treatment of what is potentially a communicable disease is essential. Without such standards of access the very delays in accessing treatment will inevitably cause further disease and that in turn will contribute to the pressures on services. It is also essential that if clinics do not allow patients to book an appointment more than 48 hours in advance, this does not conceal the problem of patients who are not able to make an appointment. (Paragraph 110)

We agree that, given the need to prevent the onward transmission of potentially communicable disease, access to GUM services within 48 hours is an appropriate aim. Treatment should then be provided according to clinical need.

Responsibility for commissioning and, increasingly, providing GUM services rests with PCTs. Ministers wish to see an additional indicator for sexual health in the star rating system for PCTs, by 2005/06 or earlier if possible, given the priority which they attach to sexual health. They have therefore asked officials to work with CHAI to determine the most effective indicator. One of the options to be considered particularly carefully is that of a GUM service waiting time indicator.

The information collected by the Speciality Societies, referred to by the Committee, is derived from ad-hoc surveys of GUM clinics and, while this provides a valuable overall picture, it cannot provide detailed systematic information on waiting times at PCT level for performance management purposes. We are therefore working with the HPA to develop the means by which such information can be obtained.

We believe that the necessary ground work will be completed in time for a waiting times indicator to be put in place for the year 2005/06 at the latest. If in discussions with CHAI we find either a more effective indicator for sexual health or a means to introduce the waiting time indicator earlier, assuming this remains the best option, we shall do so.

47. The crisis in sexual health services seems to us a consequence of several factors:

- **A failure of local NHS organisations to recognise and deal with this major public health problem**
- **A lack of political pressure and leadership over many years**
- **The absence of a patient voice**
- **A lack of resources**
- **A lack of central direction to suggest that this is a key priority**
- **An absence of performance management. (Paragraph 319)**

[See recommendation 48, overleaf]

48. We therefore recommend that the Government takes urgent steps to ensure that access to high-quality sexual health services is prioritised and resourced. (Paragraph 323)

The Government accepts that sexual health services have suffered under-investment and a lack of priority over many decades. However, this Government was the first to address sexual health in a holistic way and the Strategy is the first dedicated to sexual health and HIV. Access to sexual health services, particularly for disadvantaged groups and areas, are referred to in the "Reducing Inequalities" section of *"Improvement, Expansion and Reform: The Priorities and Planning Framework [PPF] for 2003-2006"*. We therefore expect PCTs to be addressing issues around waiting times and investing appropriately in these services. PCTs are now responsible for securing the provision of the full range of services for their local population, including sexual health services. Ensuring an appropriate level of funding for sexual health services is also a matter for PCTs (in addition see recommendation 2, page 17).

49. The best way of achieving this would be the launch of a dedicated National Service Framework for sexual health and we recommend that this be done. We understand, however, that the development of an NSF can take a number of years. Therefore, as an interim step we recommend that the Department should insist that sexual health is tackled, as a public health priority, at a strategic health authority level by adding it to the Planning and Priorities Framework 2003-06. The Department should set in place a rapid and urgent review of sexual health need, services, sexual health promotion, and treatment. This will need to be done jointly with SHAs and PCTs. To ensure that SHAs fully embrace this new responsibility, SHA Directors of Public Health should be responsible for the delivery of a 48-hour access target within their patch within two years, which should be supported by specific targets relating to reductions in the numbers of cases of the major sexually transmitted diseases. (Paragraph 324)

[See recommendation 50, below]

50. We are well aware of the danger of prescribing an NSF as the necessary panacea for any particular problem in the health service. There are numerous competing demands for priority and resources within the health service. However, the dramatic and spiralling decline in the nation's sexual health, the fact that this decline impacts most seriously on the most disadvantaged in society, and the danger that if nothing is done there will be a further deterioration with profound consequences convinces us that this is an area desperately in need of prioritisation. Further, we believe that the process of drawing up an NSF in this area could be expedited. The Strategy and its supporting documents already provide a very substantial basis, meaning that the development timescale could be condensed considerably. The Medical Foundation for AIDS and Sexual Health work on standards and networks could be woven into an NSF. If this option were pursued, in our view, the NSF should contain a maximum access target of 48 hours for access to a GUM or specialist family planning clinic, and be supported by specific targets relating to an eventual reduction in the number of cases of the major sexually transmitted diseases. As with other NSF targets, these should form part of PCT local delivery plans. (Paragraph 325)

The Government has no plans to develop a NSF for sexual health as the Strategy is already in place. Under Shifting the Balance of Power, the emphasis is to move away from centralised control and target setting and towards the dissemination of good practice to improve the quality of services. The Strategy already aims to drive up standards and reduce unacceptable variations in sexual health services. It also recognises the value of developing specific standards for sexual health and HIV to improve services and address inequalities. The standards for HIV treatment will be published shortly (October 2003) and are based on the NSF model with clear, evidenced-based recommended standards and interventions. Sexual health standards covering STIs, reproductive health and sign-posting to psychosexual services are now under development. We expect PCTs to use these recommended standards to inform service provision.

The Government does not support an urgent national review of sexual health in conjunction with PCTs and SHAs. The need to improve and modernise services, health promotion and treatment has already been established. The Government's priority is to move forward with implementation of the national Strategy which sets clear goals and standards for improvement. However, we shall also be working with SHAs to explore over the coming months what flexibilities there may be in local planning arrangements to help raise the priority of sexual health. We have already funded local areas to carry out baseline reviews.

The Government supports a second indicator for sexual health in the star rating system for PCTs, by 2005/06 or earlier if possible, including the option of a GUM service waiting time indicator. (See recommendation 13).

We will also consider developing a performance indicator for contraception services. However we will need to carefully consider whether a waiting time indicator is the most appropriate option here. Another possible option for an indicator is access to the full range of methods of contraception.

51. We have been appalled by the crisis in sexual health we have heard about and witnessed during our inquiry. We do not use the word 'crisis' lightly but in this case it is appropriate. This is a major public health issue and the problems identified in this Report must be addressed immediately. (Paragraph 326)

The Government recognises and shares the Committee's deep concerns about the poor state of sexual health. As set out in the Introduction to this response, England is not alone in facing increasing rates of STIs.

A comprehensive programme of work to implement the Strategy is already underway, however, and the Government is making good progress. In particular:

- Over 99% PCT leads have now been identified;
- The Commissioning Toolkit has now been published to aid PCTs in commissioning sexual health services;
- The Sexual Health IAG has been established;
- The national adult sexual health ('Sex lottery') campaign has been launched and early feedback has been positive;

- HIV treatment standards will be published shortly (October 2003);
- Over £14 million has been invested in GU and abortion services this year and £6 million last year;
- The chlamydia screening programme is now underway and will be expanded soon;
- Bids for one-stop shop sexual health services have been assessed and the three successful services have been announced;
- The sexual health promotion toolkit has been published;
- DH funded sexual health helplines have been reviewed and a new service provider appointed for the Sexual Health Line (formerly the National AIDS Helpline);
- The evidence base for HIV prevention has been reviewed and the findings published by the HDA.

However, this is a long-term strategy, which involves individual's changing their behaviour. There are no "quick-fixes". The Government is committed to addressing the major public health issues highlighted in the Committee's report and working with PCTs, SHAs, local government, service providers and the voluntary sector to bring about real and measurable improvements to sexual health. It is only through this broad partnership that we can succeed in meeting the aims of the Strategy and improve the sexual health of people in England.

Investment and Resources

7. The Strategy specifies that from 2005, commissioners should ensure that women who meet the legal requirements have access to an abortion within three weeks of the first appointment with the GP or other referring doctor. In our view, three weeks is too long for people to wait in these circumstances. (Paragraph 83)

The Strategy acknowledges that currently some women have to wait more than three weeks for an abortion. This is why the Strategy sets a standard of three weeks for the **maximum** time a woman should wait from the first appointment with her GP or other referring doctor. The Government agrees that, in most circumstances, three weeks is still too long for a woman to wait. However there is evidence that many PCTs are not yet meeting the standard. We are, therefore, addressing long waiting times for abortion services in a number of ways.

The sexual health indicator in the PCT star ratings performance indicator set for 2002/03 measured the percentage of NHS-funded abortions performed up to, and including, nine weeks gestation. We consider this is a good indicator of access to services. PCTs' performance in this area, therefore, influenced their star rating which, in turn, will act as a strong incentive to make further improvements, particularly in those areas rated as below average. The Department of Health also allocated additional funding in 2002/03 and 2003/04 to selected PCTs where a high number of abortions were performed at ten weeks gestation and over. In 2002/03, £1 million was shared between 57 PCTs and in 2003/04, £4 million was allocated to 172 PCTs.

We have also provided good practice ideas and information to the PCTs and Trusts to help them improve access to services. Recommendations on modernising abortion

services by making improvements to referrals for termination of pregnancy and offering the choice of early medical abortion, which should help to further reduce waiting times, are contained in the Government funded Royal College of Obstetricians and Gynaecologists' (RCOG) evidence-based guideline *'The Care Of Women Requesting Induced Abortion'* (2000) (The Government is funding the 2003 revision of the RCOG guideline) and the Commissioning Toolkit. The RCOG recommends that, ideally, all women requesting abortion are offered an assessment appointment within five days of referral and then undergo the abortion within two weeks of the decision to proceed being agreed. Once there is clear evidence that the three week standard is being met across the country, we will revise the standard to help drive down access times further.

[See also responses to recommendations 32 and 33 in respect of access to abortion services]

8. We are concerned that there are not enough available consultant posts to be filled by appropriately trained specialist registrars. Given the shortfall of 90% in consultant numbers as against the recommendations of the Royal College of Physicians, the increase in workload and the problems of access, this is unsustainable. We recommend that the Government urgently review the staffing requirements and the need for an expansion of consultant posts in GUM. We also recommend that the Government makes clear that the additional money granted to GUM services will be given on a recurrent basis so as to encourage the creation of additional posts. (Paragraph 90)

Consultant numbers in GUM have already increased by 15% between September 1997 and March 2002 in recognition of the need for more consultants. Further growth in consultant numbers will be supported by increases in training places. For 2003/04, central funding is being distributed to support the implementation of eight additional Specialist Registrar posts in GUM. Trusts will also have the opportunity to create up to ten locally funded Specialist Registrar training opportunities. The latest workforce projections suggest that by September 2004, over a 2000 baseline, there will be up to 55 additional trained specialists available to take up consultant posts in GUM. We continually review future requirements for trained specialists as part of the NHS' new multi-disciplinary workforce planning processes. These will look at the requirements for doctors alongside other staff, focusing on the potential for new ways of working and developing new roles.

Whilst the Department of Health is no longer responsible for setting local funding priorities, we recognise that there are broader issues around service delivery which need addressing. These are being taken forward by the Department of Health in partnership with professional bodies (including the Medical Society for the Study of Venereal Diseases (MSSVD), the Royal College of Nursing (RCN) and the Society of Health Advisers in Sexually Transmitted Diseases (SHASTD)). This work will help to develop practical measures for service modernisation to increase capacity across all key professions working in clinical services, including recurrent money to increase capacity and modernise services in GUM clinics. [See also recommendation 10].

The Department of Health has already confirmed to PCTs and GUM consultants that the £5.3 million funding allocated to GUM clinics in 2002/03 will be recurring. Money for 2003/04 has already been allocated and the funding available has been increased to £8 million.

We are also taking action to support those areas across the country with little or no GUM service or services where there are limited resources to cope with current demand. The Department of Health is investing a further £2 million in 2003/04 to establish a small number of development schemes to pump-prime the establishment of new services or further develop those already in existence. This funding will be carefully targeted for maximum benefit.

At local level, it is for NHS trusts to determine how their services are configured and delivered in order to provide quality services. LDPs will identify the demand for additional GUM consultants up until 2005/06. The NHS will continue to plan, for three-year periods, its future workforce requirements and steps will be taken to address the identified need. We are ensuring through the Department's performance management measures that the creation of consultant posts is seen as a high priority.

9. It is not easy for us to judge how much recurrent funding would be needed to have a real impact on the numbers. However, we note the estimates submitted by Dr Kinghorn that, given an average cost for a completed new patient episode of £150-200, and assuming an additional 150,000 episodes per annum (allowing for increases prompted by the Government's publicity campaign) an additional revenue commitment of £22-30 million per annum will be required. (Paragraph 91)

The Government agrees that additional investment is needed to improve capacity in GUM clinics. As a result, we have prioritised funding for GUM from the sexual health and HIV budget and an additional £5 million will be allocated to PCTs this year to address capacity issues.

The central money specifically identified for sexual health only represents a pump-priming mechanism to help local Trusts re-engineer services and help bring in other resources to make further improvements.

10. While any increase in funding needs to be fully justified and accounted for, in the context of the current disastrous impact on public health of the nation's poor sexual health, these figures do not strike us as excessive. It should be stressed that there is not just a shortage of consultants: nurses with expertise and training in this area, health advisers and laboratory technicians are all needed and these should not be left behind in any increase in funding, a point we develop below. (Paragraph 91)

The work being undertaken by the Department of Health in partnership with the professional bodies, described at recommendation 8, is also allowing us to take measures to address capacity issues in these other professions. For example:

- We have produced a manual for developing the role of health advisers, to be published shortly.
- We are supporting a new framework of competencies that sexual and reproductive health nurses need to provide safe, effective and accountable care. The framework has been developed by a multi-professional, multi-organisational group of nurses and doctors with representation from MSSVD, The Genito-Urinary Nurses Association (GUNA), fpa, the National Association of Nurses for Contraception and Sexual Health (NANCSH), London Standing Conference Sexual Health Working Group, RCN Sexual Health Forum, Faculty of Family Planning and

Reproductive Health Care and other forums within the RCN. This has resulted in an integrated career and competency framework for sexual and reproductive health nurses which will be published in Autumn 2003.

- A new Professional Nursing Bodies Group has been set up to look at new roles, new ways of working and workforce issues; education, training and development, including professional leadership; nursing policy and practice development, as well as progressing a number of other related projects.
- A distance learning programme for nurses in sexual health has been commissioned from the RCN and will be published in the Autumn.
- The Commissioning Toolkit contains ideas on expanding the role of nurse and health advisers at local level, including their ability to undertake nurse prescribing courses and increase the use of nurse led clinics and patient group directives.

11. There has been evidence that money intended for HIV treatment, but not ring-fenced, has sometimes been diverted, so we would like the mechanisms to be in place to ensure that any additional funding that is granted to specialist GUM/HIV services is allocated specifically to these services. (Paragraph 92)

The additional funding allocated to GUM clinics by the Department of Health is not intended to fund HIV treatment. (The allocation formerly ringfenced for HIV treatment and care totalling £223.5 million in 2001/02 was added to NHS baselines in April 2002). The funding is to improve access to services and reduce waiting times. Clear guidance has been sent to GUM clinics and PCTs as to how this funding should be used. This includes supporting additional medical, nursing or health adviser posts or to continue to support new posts created with the funding allocated in 2002/3, and the continued development of clinical networks. This funding is not ring-fenced as greater local flexibility in allocating budgets and determining local priorities is an integral part of Shifting the Balance of Power. However, PCTs and GUM services must demonstrate to their SHA that this additional funding has been used as intended. In the first year of mainstreamed HIV funding, we carried out a survey of a representative sample of PCTs. This indicated that the majority of money was being spent as intended.

According to a 2003 audit by the British HIV Association (BHIVA) of 90 clinics, the majority of HIV treatment centres do follow BHIVA guidelines on the treatment of HIV, and there is very little indication that there are restrictions on the choice of anti-retroviral treatments available to people with HIV.

12. It is far from ideal for services to be managed by single-handed consultants. It is difficult for single-handed consultants to find a consultant locum to cover holidays and study leave. At this point we would accept that it will not be possible for every clinic to have more than one whole time equivalent consultant. However, more than one consultant can provide the service within each clinic so long as there are shared consultant appointments within clinical networks. (Paragraph 95)

Managed clinical networks are a key tool which can add value to service provision and help solve a range of difficult clinical issues, including the sharing of resources for improved service delivery. There is also significant potential for breaking down the traditional barriers between primary, secondary and tertiary care and between health and social care.

As part of the broader work on developing standards for HIV, the Department of Health commissioned the Medical Foundation for AIDS and Sexual Health (MedFASH) to develop a specific standard for the development of managed networks, and a series of 5 events were held around England in March/April 2003 to consult widely on the development of this standard. The HIV standards will be published in October 2003.

Modernisation and improvement of sexual health services

2. Given the stigma around sexual problems, and given that those groups most affected by sexual ill health tend to be those whose voices are not heard in society as a whole, we can appreciate why patients might feel reluctant or even unable to complain. PCTs need to make themselves aware of the patient's experience of sexual health services and work to improve this experience. Patient forums may be a route through which this could be undertaken. (Paragraph 27)

The Government recognises the need for PCTs to be fully aware of all the groups affected by sexual ill-health, especially those who may, for whatever reason, not have a strong voice in ensuring they get the best service. This forms part of the overall drive to increasingly involve patients in the planning and delivery of services as set out in the NHS Plan.

However, there are inherent difficulties for sexual health services in involving patients, due to the stigma and discrimination which patients may experience. A patient with an STI or an unintended pregnancy will often just want access to treatment, for example an abortion and/or counselling. Unlike other conditions such as Coronary Heart Disease or cancer, patients may understandably not welcome the opportunity to describe their experiences within a formal setting, such as a patient forum.

Nevertheless, HIV services have an excellent track record in involving service users and patients in service planning and delivery. Many clinics have patient advocates involving patients throughout their treatment. The Teenage Pregnancy Strategy has also helped to increase the role of young people in the planning and delivery of sexual health services at local level. Examples of good practice in this area are disseminated through the Teenage Pregnancy Unit's website.

The Sexual Health Commissioning Toolkit offers good practice information on new mechanisms for service user and community involvement, including ideas on how to best incorporate patient views within planning work. Many sexual health services are now working closely with health promotion, voluntary and community organisations to increase the awareness of patient experiences and to involve those who are willing in service planning. In addition, in Autumn 2003 the Department of Health will host a conference for HIV service users in partnership with the UK Coalition of People living with HIV and AIDS. The conference will aim to enhance the Positive People's Partnership (HIV voluntary organisations working with service users).

3. We recommend that the Army Medical Services forwards to the Public Health Laboratory Services its figures for STIs. We also recommend that the PHLS looks at how a more comprehensive surveillance system can be developed to cover all areas of sexual health and possible service providers. This will give a more complete picture of trends, prevalence and service utilisation. (Paragraph 50)

The Surgeon General believes it is important that information on STIs from all three branches of the Armed Forces is provided to the PHLS (now the HPA). He has therefore put things in hand to ensure that this starts as soon as possible. Inclusion of the army medical services returns on STIs will help to provide a more complete picture of the epidemiology and burden of morbidity of STIs in the UK and UK nationals.

In addition, HPA is in the process of implementing, and developing additional proposals for, more comprehensive surveillance systems for sexual health.

4. We welcome the recognition of the importance of research and evidence with regard to the provision of HIV/STI prevention. We recommend that the Government continues to support the Health Development Agency in developing an evidence base in the long term and that the Department ask the Medical Research Council to commission further research in this area of sexual health. (Paragraph 62)

The Government will continue to support the HDA in developing an evidence base for HIV and sexual health promotion. In March 2003 the HDA published a major evidence briefing on HIV prevention. Also, the Department of Health is working with the HDA to disseminate its findings and develop further work, particularly around putting evidence into practice (for example in commissioning of services) and in evaluating other types of evidence. The HIV briefing identifies gaps in primary and review level research, makes recommendations for research methodology and suggests implications for policy and research.

The Government is supporting HDA's review of the evidence base on STI prevention and sexual health promotion which HDA will complete this year. We will agree with them how best to disseminate this and what follow-up work is needed.

The Government continues to support the Medical Research Council's (MRC) research programme, and has made explicit that future research will contribute to the evidence base for the Strategy. This will prioritise research such as: studies of evidence into practice; the impact of new technologies on sexual health outcomes; research on innovative strategies to address clinical need in community and clinic settings; studies of the prevention of STIs/HIV; research on and means of reducing stigma, discrimination, and the impact of deprivation and other socio-economic factors on inequalities in sexual health and in fertility control; and, studies of effectiveness and cost effectiveness of treatments and interventions to improve sexual health.

5. In respect of the monitoring of trends in both STIs and HIV/AIDS we would like to pay tribute to the work of the Public Health Laboratory Service. Their monitoring ensures that the UK has the best data in the world, and this in turn gives great credibility to their research. It would be most regrettable if the absorption of the PHLS within the new Health Protection Agency were in any way adversely to affect its work. In particular, we would be alarmed if the close networks developed between the regional and local laboratories and clinicians and epidemiologists were to be impaired as a consequence of the move to NHS management of the laboratories (Paragraph 63)

The HPA was established to strengthen local, regional and national capacities in health protection, including the surveillance of all infectious diseases. We too would be very concerned if the creation of the HPA in any way impaired surveillance data reporting or collaborative working in respect of sexual health. Indeed the vision of the HPA is to build on and further develop the world class reputation of the PHLS.

14. We note the very poor condition of many of the premises in which genito-urinary medicine is being carried out. Many strike us as being of an unacceptable standard and significantly below the general standard within the health service, as a consequence of the low status of this branch of medicine over the years. We believe that the very condition of the buildings makes them less attractive to patients and staff, less efficient, and less conducive to the necessary levels of privacy. Below we make recommendations about extending the range of settings in which GUM should take place, drawing particular attention to the advantages of the creation of a network of school-based clinics. However, we would urge the Minister to ensure trusts give due priority to the demands of GUM to compensate for the historic levels of under-investment. Unless sexual health is given higher priority within the health service we see no immediate prospects of widespread improvement. (Paragraph 116)

Although it is not explicit, GUM clinics are included in the NHS Plan target which requires the reduction of national backlog maintenance costs by 25% by 2004 from the £3.1 billion value in 2000. This has been converted to a PPF target requiring each SHA to contribute a 25% reduction in backlog maintenance costs by 2004. Also, one of the focus performance indicators to be used in the determination of Trust star ratings for 2002/03 assesses fire safety and health & safety backlog for all Trust types. A further PPF target requires that 40% of the NHS estate, by value, should be less than 15 years old by 2010, thereby encouraging investment in the modernisation of all the NHS estate including GUM clinics. Many NHS Trusts will have produced an Estates Development Strategy (*PCTs: A Strategic Service Development Plan*) which sets out a Trust's strategic plan for capital investment that will see improved performance in both clinical and non-clinical terms over short, medium and long timescales. This is cited in the NHS Estates' documents *Sold on Health, Estatecode*, and *Developing an estate strategy*.

There is, therefore, now significant impetus for PCTs to improve the condition of the whole of their estate, including GUM clinics, and ensure that they meet the appropriate condition standards (i.e. Estatecode condition B), are modern, safe, and fit for purpose.

Testing for Chlamydia and other STIs

15. We do not think that it is necessary to wait for the results of the reinfection study before introducing nationally the chlamydia screening programme. Any additional information that the reinfection study provides is, in our view, likely only to lead to modifications in the programme rather than fundamental reforms. Accordingly we recommend that the NHS must, as a matter of urgency, move to provide such screening in all family planning clinics, infertility clinics, termination of pregnancy clinics and GUM clinics and for women having their first cervical smears. We also believe that GPs should routinely offer testing to those aged under 25 years without attempting to second-guess patients' sexual behaviour. (Paragraph 123)

The Government agrees that it is unnecessary to await the results of the ongoing chlamydia re-infection study before introducing a screening programme. We are already rolling out a chlamydia screening programme, and indeed are one of the first countries in Europe to do so. We expect that the re-infection study will provide useful information on the frequency and intervals necessary for screening, but not to put in doubt the underlying rationale of having a chlamydia screening programme.

The Department of Health invested £1.5 million in 2002/03 to pump-prime ten geographical areas (population coverage from 300,000 to 700,000) involving 30 PCTs and 400 individual testing sites, to develop specific, locally-targeted screening programmes within a standard framework. Each of these areas will receive further full funding to support their programmes, plus additional funding for 10 new sites which will be added to the programme, totalling £5.5 million for 2003/04 and £6.5 million for 2004/05. The long-term continuation of the programme will depend upon the availability of sustainable funding locally, and the Department of Health has received written undertakings from the PCTs involved to continue funding once central support ends.

Expressions of interest for inclusion in the second phase of the screening programme were sought in June 2003. As in the first phase, similar area and population coverage is being sought through bids from consortium of PCTs.

To increase access to chlamydia screening, we are encouraging involvement from primary care and GPs in this phase of the programme, as well as non-traditional health care settings. These include prisons and Young Offenders Institutions, which have, for example, been included within Hull's locally targeted screening programme.

In addition to the screening programme, chlamydia testing is currently offered widely in all GUM clinics and some community contraception clinics and GP practices. We agree that the screening for chlamydia should be fully introduced in the settings recommended by the committee. However there are a number of challenges to achieving this immediately. First, screening should only be undertaken using NAATs. We are taking action to ensure that NAATs testing is available in every region (see Recommendation 17). However laboratory staff will require support and training on the use of this technology. Clear protocols to prevent cross-contamination of samples will also need to be developed. PCTs must also consider the capacity of already busy services to undertake chlamydia screening. The Government therefore considers that phased introduction of screening across England, in line with the national screening programme, is the most appropriate way of ensuring that chlamydia screening is

successfully introduced in all these areas. It is vitally important that the programme is rolled out within a co-ordinated framework and encompasses the issues of treatment for individuals who have tested positive for chlamydia, partner notification and contact tracing and not only the offer of the testing.

16. We recommend that the Department explores the possibility of offering screening and advice on STIs, including chlamydia, to men outside traditional health service settings. Imaginative solutions will be needed if the male population is to be engaged. School based services such as that offered by the Tic Tac project offer one possible avenue for advice, testing and referral (see below, paragraph 312). We would also like screening to be offered via community outreach schemes, for example targeting night clubs or sports clubs, especially in areas where high prevalence rates are recorded. We also recommend that the Government should assess the possibility of a much wider screening campaign, including a national screening day or series of regional screening days, promoted through a campaign of hard-hitting messages. Such a campaign should be introduced in an attempt to have a real impact on chlamydia in the wider population. (Paragraph 125)

The Government is actively considering how we can better reach men, who do not traditionally use health services, to be screened for chlamydia. In December 2002, the Department of Health commissioned the Men's Health Forum to fund the 'Men and Chlamydia Project'. This project will increase men's awareness of chlamydia, promote the adoption of safer sex practices and encourage men to seek screening and treatment where appropriate.

The Department of Health has also been encouraging testing in non-traditional settings and entirely agree with the committee's views on this. For example, as part of York's Chlamydia Screening Programme, chlamydia screening tests will be offered within secondary schools. The YORSCREEN Health Advisers will be working closely with the Trust's Teenage Nurse Adviser and School Health Nurses, to provide this service within existing weekly 'drop-in' sessions held in school. School Nurses, working with the Teenage Nurse Adviser, have recently introduced an emergency contraception service in two schools – one rural and one inner city. We hope that the chlamydia screening programme will be introduced as part of this sexual health service for young people in the area.

An outreach component is being included in several of the locally targeted chlamydia screening programmes. For example, in Cornwall, they intend to hold non-invasive screening in the form of 'Pee in a Pot' days. This would involve members of the screening team arranging one-off sessions at local colleges, occupational health departments of large local employers and screening at armed force bases. They have arranged with the medical centres at RAF St Mawgan and RNAS Culdrose to have access to their units once a month to provide a regular, easily accessible service for their personnel. For those testing positive for Chlamydia infection, treatment, advice and contact tracing would then be available through regular testing sites or at the next attendance at the base.

Local areas will be evaluating these initiatives. The Department of Health will disseminate results, and if successful will advocate their introduction in other areas.

In terms of campaigns, building on the 'Sex Lottery' campaign which addresses chlamydia and to ensure campaigns are targeted locally, the Department of Health has produced specific chlamydia screening publicity entitled 'How do you know you don't have chlamydia?', comprising of posters and leaflets. Each of the first 10 areas in the programme have received 30,000 free leaflets. Local programmes are being encouraged to adapt campaign materials to local needs and the publicity has, for example, been adapted to 'back-of-bus' advertisements on the Wirral. By including NHS branding, and as the screening programme rolls out, national recognition should develop.

We recognise the importance of providing both contraception and sexual health advice in all young people's services, including those provided in the school setting. This is reflected in the *Teenage Pregnancy Strategy Best Practice Guidance on the Provision of Effective Contraception and Advice Services for Young People* (2000) which recommends that, wherever possible, chlamydia testing and treatment with partner notification is undertaken in collaboration with local STI services. Where this is not possible, services should provide verbal and written information about STI screening and treatment, and support young people to access relevant services. We are keen to explore the feasibility and cost effectiveness of school-based services providing STI screening as part of a commissioned network of provision.

17. We believe it is scandalous that a sub-optimal test, with an accuracy rate markedly below the best tests, is still widely in use in England for the detection of chlamydia. Indeed, we believe that health providers would be highly vulnerable to damages claims made by patients who had received a false negative diagnosis and had thus not had treatment for chlamydia infection. We believe that the Department of Health should issue firm guidance to the effect that the sub-optimal EIA test should be withdrawn in favour of the molecular amplification test as soon as possible. In some cases we realise that laboratory services would not be able to cope with sudden transition to these types of tests. Nevertheless, the examples of the Netherlands and Sweden, which we visited and which had long since abandoned EIA testing, convince us that it must be possible to move to the optimal test and we believe this should be an urgent priority. (Paragraph 129)

In-vitro medical devices, including these chlamydia tests, are regulated by the Medical Devices Regulations 2002, and the number of adverse incidents involving chlamydia tests notified to the Medicines and Healthcare products Regulatory Agency (MHRA) is very small. Nevertheless, the Government accepts and recognises that there is an urgent need to address the method of testing offered for chlamydia diagnosis. We are, therefore, now investing an additional £5 million, making a total of £8 million this year to accelerate the conversion of NHS laboratories to NAATs. This is pump-priming money and PCTs will be expected to provide a commitment to continue funding for the use of NAATs in the future. CMO has written to Strategic Health Authorities highlighting our concerns around the continuing use of EIA tests for chlamydia. In particular, he drew attention to the overall clinical and financial arguments for using NAATs as soon as possible. He has highlighted the money available centrally to fund laboratories to switch to NAATs. This funding should ensure that all major laboratories in each region of England use NAATs to enable equity of access across the country.

The Department of Health has specified that all areas involved in the roll out of the screening programme must use NAATs. We have supported this through the provision of pump-priming monies. This will continue to be a requirement for inclusion in the chlamydia screening programme.

As well as £8 million in support, the Department of Health will continue, through its regular dialogues with SHAs and PCTs, to draw attention to the overall clinical, and effectiveness arguments for all professionals to be using the new NAATs as soon as possible.

We are also aware that the capacity of laboratories to offer NAATs may be a further barrier to the widest possible introduction of this technology. To help address this, we are therefore also exploring regional networks of laboratories where chlamydia screening may be centralised.

HIV and AIDS

18. We are concerned by the trends in HIV and support the Government in its aim to reduce the prevalence of undiagnosed HIV and in turn to safeguard public health. Early diagnosis of HIV not only reduces the chances of it spreading within the community but it also greatly improves outcomes for those infected. On the basis of the evidence we have heard, however, we do not believe mandatory testing of asylum seekers, refugees, immigrants, visitors newly arrived in this country, and returning residents, to be an effective way of achieving the Government's aim. We recommend that HIV testing for newly arrived people should be voluntary, but should have as its clear objective the promotion of full disclosure of any relevant medical history and should also aim to facilitate appropriate and culturally-sensitive counselling before and after testing for HIV. (Paragraph 144)

The Cabinet Office is currently co-ordinating work between relevant Government Departments to review immigration and infectious diseases (including HIV) and access to NHS services. This review aims to establish the facts about health and public expenditure impacts and propose solutions should action be required. The review is ongoing and no decisions have been taken yet.

19. We recognise that the field of HIV therapy is one which develops quickly and we appreciate that any guidelines on the use of HIV drugs might require frequent revision. However, we recommend that the National Institute for Clinical Excellence (NICE) should undertake an appraisal of treatments for HIV patients so that service providers and commissioners can collaborate and plan to make available the most effective treatment. (Paragraph 148)

Since 2000 BHIVA has produced detailed evidence based national treatment guidelines, including when to start treatment and optimal drug combinations for improved patient outcomes. BHIVA updates these as new evidence becomes available and use of the guidelines by clinicians and commissioners is regularly audited. The Department of Health endorses the use of the BHIVA guidelines and refers to them in the Sexual Health Commissioning Toolkit.

Appraisal by NICE is generally sought where new and novel treatments are being considered whose effectiveness and applicability for the majority of people with a specified medical condition is unclear. Combination anti-retroviral drug treatments for people with HIV, which were introduced in 1996, are well tolerated and have proved effective for a majority of patients. There is also abundant evidence that NHS commissioners are using the BHIVA guidelines as a benchmark for prescribing. Clinicians and other experts do not therefore see the necessity for a NICE appraisal for HIV therapy.

20. Adequate funding for HIV drug therapy constitutes the only means of ensuring that HIV patients have access to the most appropriate drugs and that the other aspects of the sexual health service can be maintained and developed according to patients' needs. (Paragraph 149)

For 2001/02, the last year of special allocations, the Department of Health allocated £223.5 million for HIV treatment (and £55 million for HIV prevention)[2].

From 1985 to April 2002 funding for HIV treatment and prevention were treated by the Department of Health as special allocations with funding top-sliced from main NHS budgets and allocated centrally. In line with Shifting the Balance of Power, these allocations were added to main NHS allocations from 2002/03 and they are no longer separately identified. However, careful account is taken of the distribution of HIV cases when NHS allocations are calculated.

Despite the increase in HIV patient numbers, a recent audit by BHIVA of 90 clinics indicated that there was no evidence that treatment costs are affecting the prescription of optimum anti-retroviral treatment regimens for those with a clinical need. We believe that clinical need is, and should, continue to be the rationale on which HIV drugs are prescribed.

21. Now that funding for HIV services has been mainstreamed, and that commissioning is PCT-led, sexual health and HIV should be a priority at local level on grounds of public health. However, sexual health and HIV service providers have told us that they need help to persuade commissioners to allocate resources to an area which remains stigmatised, particularly in rural areas where prevalence of HIV is low. We are not convinced that the current arrangements will ensure that sexual health will be treated as a sufficiently urgent priority. Given that sexual health has no National Service Framework, and until NICE guidelines are introduced, we recommend that sexual health and HIV be included in Local Delivery Plans. (Paragraph 158)

When considering the question of the overall priority of sexual health and in particular the scope of introducing sexual health into LDPs, we think it is important to see this in the full context of the recently agreed 3 year PPF

Re-opening the local delivery plans and/or the PPF which are bound closely together now would undermine NHS organisations' faith in the new system of 3-year plans and allocations when it has barely got off the ground. In our discussions with SHAs and other NHS organisations we have argued strongly for something that would give

2 Note that these are the correct figures, rather than the £165 million as mentioned in paragraph 147 of the Health Select Committee's report.

the NHS greater local discretion and stability to plan investment over the next few years. A key element of this has been our commitment not to introduce new targets in mid-stream.

It would also create major practical problems. A lot of work has gone into LDPs at local level. Financial plans have been developed to underpin this. The service already faces a big challenge to achieve these targets.

However, we do think that whilst the PPF and LDPs cannot be re-opened at this stage, there are nonetheless important things which we can and shall do to raise the priority the delivery of sexual health and HIV services:

- Work with SHAs to see what other ways there may to be raise the priority level of sexual health within PCTs without re-opening the current PPF and LDPs.
- Through the performance assessment of SHAs, it will be important when the Department's Delivery Unit is assessing LDPs on health inequalities, to ensure that PCTs have paid particular attention to the capacity assumptions (and access) to sexual health services.

A number of SHAs have already provided information to the Department of Health on their plans for implementation of the Strategy at local level, and from this information we know that at least 79% have included sexual health in LDPs, with some, such as Manchester, establishing it as a high priority. Examples of work highlighted by SHAs include the formation of local multi-disciplinary implementation groups to oversee the implementation of local plans, special fast-track GU services for young people in Greenwich, South East London, the creation of dedicated, nurse led testing and counselling services, such as those introduced in Bexley, for areas without a GUM/HIV clinic and piloting the provision of sexual health services in primary care (for example, in Lewisham). Sexual health is already included in many LDPs and a variety of effective models for consortia and clinical networks are being created around the country.

22. We recognise that GPs and other primary care providers have an important role to play in the diagnosis and support of people with HIV as well as in their general medical treatment. HIV is a chronic condition. Dealing with chronic conditions is traditionally an area of strength for primary care. We therefore welcome moves to give primary care more of a role in the management of HIV/AIDS. However we are not convinced that the rebalancing of care provision is being sufficiently well supported. Accordingly, we recommend that these service providers be supported through training and through involvement in service networks. We also believe that it is crucial that the expertise currently residing within GUM is not diluted as a consequence of any move to primary care. So we would encourage any measures which promote close interaction between the expertise now found in secondary and tertiary services and that in primary care. (Paragraph 167)

The increasing emphasis on the role of primary care is an important element for successful implementation of the Strategy. We recently funded the Royal College of General Practitioners (RCGP) to run a conference on the education and training needs for GPs and other members of primary care teams, which was evaluated and judged successful.

The HIV standards make explicit the increasing role that primary care can have in sexual health service delivery. This role can be enhanced by increased training of GPs with a special interest in sexual health and greater involvement of nurses and health advisers in primary care settings.

The Strategy action plan made clear that we do not expect all "level 1" elements of care, including HIV testing, to be provided straight away by all general practices. The aim over time is to develop and modernise sexual health services in primary care and general practices will need to negotiate a pace of change with PCTs to aim towards providing the full range of level 1 elements. This role can be enhanced by increased training of GPs with a special interest in sexual health and greater involvement of nurses and health advisers in primary care settings.

There is evidence of increased interest among GPs wishing to train in GUM. For example, in Newcastle four GPs work within the GUM clinic in return for receiving specific GUM training which can then be taken back to their general practice. In addition, one of the models the Department of Health is evaluating, as a one-stop shop sexual health service, is a primary care service. The general practice selected for evaluation is the Lee Bank surgery in Birmingham. All the doctors and nurses in the practice offer HIV tests and the doctors are skilled at clinical diagnosis of HIV. For example, five new cases of HIV were diagnosed in the first half of 2002 through a combination of pro-active testing and clinical diagnosis). We will be widely disseminating findings from the one-stop evaluation on a regular basis. (See also recommendation 30).

23. We recommend that the Government should support the co-ordination of training for all social workers who have contact with those living with and affected by HIV, and also support the creation of posts for specialist social workers, who we believe could play an important role in developing and maintaining HIV service networks in high- and low-prevalence areas. (Paragraph 172)

Providers of the new social work degree are required, from 2003, to ensure that all student social workers undertake specific learning and assessment in the areas of human growth, development, mental health and disability. It would be expected that this would include broad coverage of issues relating to HIV and AIDS.

The post qualifying framework for social work education is currently reviewed by the General Social Work Council. Following this review it is anticipated that there will be revision of the individual awards within the framework, including the Post Qualifying Child Care Award. Such revision could be used to ensure the inclusion of specific input on HIV and AIDS.

24. We welcome the Government's acknowledgement of the voluntary sector contribution to HIV services. We have received a great deal of evidence to suggest that the voluntary sector can reach many HIV-positive people who will not access statutory services. We recommend that the Government reciprocate the support it receives from voluntary groups in terms of practical work and policy guidance by supporting voluntary work at both national and local level. It would be counter-productive if the Strategy led to any diminution in the funding given to these bodies. Some

HIV services (such as targeted prevention work) can only be provided by organisations which are very closely in touch with their communities and these services must be adequately resourced. (Paragraph 178)

The Government believes that the role of the voluntary sector and community organisations is a very important element of service delivery. Indeed they are often the first point of access for many people affected by HIV and sexual ill-health, particularly for marginalised populations such as gay men and Black and Minority Ethnic groups.

The Department of Health funds a number of national voluntary sector organisations to support wider HIV prevention programmes and projects. This includes the Terrence Higgins Trust (THT) to co-ordinate the Community HIV and AIDS Prevention Strategy (CHAPS), the National AIDS Trust and the African HIV Policy Network. For 2003/04, the Department of Health will allocate an extra £400,000 for HIV health promotion for gay men and African communities. This will include promoting the benefits of testing and evaluating models of HIV testing in community settings. Whilst the number of children with HIV is relatively low a significant number affected are from African communities. The Department is continuing to fund the National Children's Bureau's HIV forum for Children and Young People. The Sexual Health Commissioning Toolkit gives specific help on the role and functions of voluntary and community organisations emphasising the importance of their role at local and national level. We believe that it is very important to sustain the Government's support to maintain the roles of these organisations in helping to improve sexual health. The Department of Health ran two commissioning conferences in May 2003 and invited THT to run a workshop at both events to support commissioners in developing the role of the voluntary sector at local level. It is for PCTs to determine the levels of funding and contributions required from voluntary organisations locally.

Commissioning of Services

25. We recommend that commissioners participate in sexual health service networks, and that they should be accountable to service providers through transparent commissioning processes. Consortia are essential to the establishment of comprehensive service networks, particularly in rural areas. We believe that the Department must require Strategic Health Authorities to ensure that preliminary development of consortia is taking place, based on regional commissioning groups such as are in place for cancer services, so as to give a definite impetus to the development of networks. (Paragraph 188)

[See recommendation 26 below]

26. We welcome the guidance provided by the Department of Health in issuing the Commissioning Toolkit and also recommend that the standards developed by MEDFASH and The Specialty Societies in Genito-urinary medicine should be used by Strategic Health Authorities in managing the performance of trusts. (Paragraph 190)

The Sexual Health Commissioning Toolkit provides a range of information to help the development of local commissioning plans and/or consortia arrangements which can be tailored to local needs. We have also delivered two major conferences for PCTs and Commissioners to support the use of the toolkit and to identify further concerns

from the field which will enable us to build on this work and develop further materials over the Strategy's lifetime.

The aim of the Commissioning Toolkit is to address variations in commissioning practice by providing strategic direction, and to enable commissioners to negotiate formal agreements for local service planning and delivery. A number of commissioning models are suggested which can be tailored to accommodate local situations. We explicitly encourage the use of consortia arrangements in partnership with local authorities and the voluntary sector to ensure that resources are maximised and implementation of the Strategy is achievable. One suggestion is to identify a lead commissioning role to co ordinate the consortia's work and lead the development, implementation and monitoring of national and local action planning arrangements with a multi agency planning group. It is for PCTs and LAs to decide on how the development of consortia arrangements are planned, in agreement with SHAs.

We believe that the recommended standards for HIV treatment will be of practical use at local level. They have been developed with the aim of promoting quality services for the treatment and care of people living with HIV and AIDS in England, regardless of whether they live in high or low HIV prevalence areas. They will be a useful tool for commissioners, service providers and people with HIV to help plan, develop, deliver and audit HIV services.

Primary Care and Access to Services

27. We remain concerned that patient choice with regard to HIV and sexual health services will be limited should PCTs decide against paying for patients to use services outside the PCT area. We recommend that the Government, after consultation with commissioners and service providers, should issue further guidance and ensure funding arrangements which enable patients to access sexual health services away from their home PCT area if they wish, in line with the recommendations of the Monks Report. (Paragraph 191)

Guidance in the Commissioning Toolkit already makes explicit the primacy of self-referral and open-access to specific elements of clinical care including a range of contraceptive services and GUM services. The Toolkit recommends that for patients with HIV/AIDs that PCTs and SHAs agree an equitable method to meet the validated cost pressures for treatment of their residents living with HIV/AIDS, irrespective of where they attend for treatment, providing that treatment is in line with national BHIVA Guidelines. Similar arrangements should also be in place for people attending services for contraception or STI treatment outside their PCT area.

The Department of Health will be conducting a consultation exercise in Autumn 2003 which will consider how patient choice and service responsiveness can be extended beyond elective care. We will consider how sexual health can be included in this work.

28. We recognise that the delivery of some sexual health services through primary care has considerable potential in terms of access and continuity of care. However, we have not been assured that General Practitioners will receive sufficient training and support to deliver services effectively, nor that PCTs will provide sufficient encouragement to GPs to offer improved sexual

health services. These may be matters which could be addressed through the new GP contract. (Paragraph 195)

The GMS contract will address these issues by facilitating the introduction of a new career structure for GPs – providing a modular approach to skills development, special interest development and clinical leadership. It will also support the introduction of protected time for GPs learning and personal development. We also see practice nurses as having a key role to play in implementing the Strategy at primary care level and the contract will support the development of practice staff including nurses, by extending their roles and responsibilities and by facilitating a mix of skills.

30. If General Practitioners are to deliver Level 1 and Level 2 services to a high standard, the Government must ensure that the GP contract addresses issues of quality in relation to provision of contraceptive and other sexual health services, as well as giving GPs incentives to undergo further training in this area. The Government should also work with the relevant bodies to ensure that sexual health is given appropriate emphasis both in undergraduate medical training and in postgraduate education for trainee GPs. (Paragraph 217)

The new General Medical Services (GMS) contract includes a new Patient Services Guarantee to ensure patients have full access to the range of services, including sexual health. Patients will, therefore, not only continue to receive contraceptive services and screening for STIs where appropriate, but PCTs will also be able to commission more specialised sexual health services that deliver services in line with the Strategy.

PCTs will be responsible for ensuring that a Patient Service Guarantee is delivered. This guarantee states that 'patients will continue to be offered at least the range of services that they currently enjoy under the existing contract'. But we expect that the quality of services will improve and we will see an expansion of enhanced primary care services because of new investment. Also, for the first time, patient experience will form part of the contract and be used to offer a balanced approach to quality and service improvements.

All practices will provide essential services which include the management of patients who are ill or believe themselves to be ill, for example, screening for STIs. Contraceptive services will be delivered as an additional service which practices have a preferential right to provide, and will normally do so. Resources will be provided in practices' global sum allocations and quality care will be incentivised through a Quality and Outcomes Framework. Practices wishing to, or unable to, provide these services will be able to opt out in accordance with fixed UK rules including a deduction of an 'opt-out price' from the funding practices receive. PCTs will be responsible for re-commissioning such services and may even provide these services themselves.

More specialised sexual health services and Intra-Uterine Contraceptive Device (IUCD) fitting will be provided as a nationally enhanced service which PCTs will commission using nationally agreed minimum specifications and benchmark pricing.

On training, individual university medical schools determine their own undergraduate medical curriculum in the light of recommendations from the General Medical

Council's (GMC) Education Committee. Within the broad boundaries set by the GMC, medical schools are free to strike the most appropriate balance between the competing needs from all areas of medicine. They need to take into account issues of where and when subjects are most effectively dealt with in education terms so that service delivery is best served.

The Committee's most recent recommendations on undergraduate medical education are contained in "*Tomorrow's Doctors*" which was published in July 2002. This is not a complete guide. However, it does state that graduates:

- must have a knowledge and understanding of the clinical and basic sciences. They must also understand relevant parts of the behavioural and social sciences, and be able to integrate and critically evaluate evidence from all these sources to provide a firm foundation for medical practice
- They must know about and understand normal and abnormal structure and function, including the natural history of human diseases, the body's defence mechanisms, disease presentation and responses to illnesses. This will include an understanding of the genetic, social and environmental factors that determine disease and the response to treatment
- Graduates must understand the social and cultural environment in which medicine is practised in the UK. They must understand human development and areas of psychology and sociology relevant to medicine, including reproduction and child, adolescent and adult development
- Graduates must understand the issues and techniques involved in studying the effect of diseases on communities and individuals, including:
  - assessing community needs in relation to how services are provided
  - genetic, environmental and social causes of, and influences on the prevention of, illness and disease; and
  - the principles of promoting health and preventing disease, including surveillance and screening

Responsibility for specifying the content of the GP training curriculum rests with the Joint Committee on Postgraduate Training for General Practice (JCPTGP), an independent professional body.

GPs are expected to learn in training the skills needed to deal with all their patients. As sexual health issues are relatively common, GP Registrars would be often exposed, while training, to the issues in assessing, managing, and monitoring patients with sexual health problems.

Contraceptive Services and Termination of Pregnancy

29. According to the Government, the prevention of unplanned pregnancy by NHS contraception services probably saves the NHS over £2.5 billion a year already. Despite this, we have received compelling accounts of disinvestment in these vital services, and the fact that contraceptive services are not even included within the Strategy's five aims is further evidence of

this creeping deprioritisation. We recommend that the Government takes immediate steps to rectify this priority imbalance. (Paragraph 211)

The Government agrees that the provision of contraception is an essential health care service which contributes to better maternal and child health and to the stability of family life. Although contraception is not explicitly mentioned, one of the Strategy's five key aims is to reduce unintended pregnancy rates. Provision of good quality contraception services will play a major role in achieving this aim. The Strategy highlighted that accessibility to a range of contraceptive methods and services was important, but that access around the country was variable. We share the committee's concerns about any reported disinvestment in contraceptive services at local level in some areas, particularly as the contribution of community contraceptive and reproductive health services relieves pressure on hospital-based STI and abortion services. The Commissioning Toolkit gave clear guidance on minimum elements of service and best practice guidelines for contraceptive services, acknowledging the roles of both primary and specialist provision and the importance of providing quality services to achieving the strategic goals.

PCTs are responsible for ensuring that there are a range of contraceptive services across levels 1, 2 and 3 (in primary and specialist care settings) and have been issued guidance on how to commission those services.

The Department of Health has convened a group of key experts including representatives from the Faculty of Family Planning and Reproductive Healthcare, the Royal College of General Practitioners (RCGP) and the *fpa* to define and implement a specific work-plan to support the improvement of contraception services at PCT level. This group will also advise on evidence on the extent of any dis-investment in services.

We shall be making £1 million available to help improve contraceptive services this year, which will be targeted at improving access to services.

31. Many memoranda also point out that there is a serious shortage of national information currently available about the organisation and provision of contraceptive services. According to Dr Smith, a review of contraceptive services was carried out by the Department at a regional level ten years ago, but the results were never analysed or used to obtain a national picture due to lack of Department of Health capacity. Very little data are available about GP provision of contraceptive services. We recognise the importance of the collection of relevant information for the planning and delivery of services. We therefore recommend that steps are taken to standardise information collection in the field of sexual health, both for specialist service providers and general practitioners. (Paragraph 218)

The Sexual Health Services Data Group, which has representation from providers of sexual health services, the HPA and the Department of Health, has already drawn up a specification for a minimum data set for sexual health services. This will include information both on contraception services and on the diagnosis and treatment of STIs. It will also apply to the three levels of service identified in the Strategy and will therefore include services provided by primary care. The specification is being submitted to the NHS Information Standards Board for approval. When fully

implemented, the data set will provide integrated and standardised information across the range of sexual health services.

As an interim step, we aim to implement the minimum data set in community contraceptive services, so as to give a better picture of local service provision. For GP provision of contraceptive services however, until the proposed Integrated Care Records are available for statistical analysis, we will continue to rely on national level information derived from regular surveys and more local information derived from prescription reporting systems and from the GP Research Database.

32. With improved access to better contraception services as part of the implementation of the Strategy, we would hope to see a reduction in the number of unwanted pregnancies, leading to a decrease in the use of the abortion service. For those women who do seek access to the service, we believe that certain improvements should be made. We recognise the difficulties that would beset attempts to reform current laws relating to abortion. However, we support the FPA's view that access targets are meaningless without attendant measures to cut through the bureaucracy surrounding referral for termination of pregnancy. We believe, therefore, that the Government should, within the current legal framework which includes the approval of two doctors, promote a model of open-access for termination of pregnancy, based within Level 3 services, and accessed through a national advice line. (Paragraph 220)

One of the Strategy's key aims is to reduce the number of unintended pregnancies and we agree that this can only be achieved through better access to contraception and contraception services. We have set out the actions we are taking in this area in response to recommendation 29. However, it should be recognised that no method of contraception is 100% effective and inevitably some women will be faced with an unintended pregnancy. For those women who choose to seek a termination of pregnancy and who meet the legal requirements we agree that in order to access an early abortion, they need prompt onward referral. The current legal framework does not prevent women from self-referring to termination of pregnancy services. Indeed, women accessing services in the independent sector already do this. The RCOG's guideline and the Commissioning Toolkit recommend that services offer arrangements which minimise delay for example, a telephone referral system and direct access from referral sources other than GPs including the women themselves. The setting up of a self-referral system was suggested in the notification letter that went to those PCTs who received extra funding in 2002/03 and 2003/04 for improvements in access to abortion services.

The Commissioning Toolkit also recommends that printed information and a telephone helpline should be available to inform women on where to go for pregnancy testing, counselling and how to access abortion services. There are already national advice lines in existence to provide advice for example, the *fpa*'s national advice line. Advice from the IAG on Sexual Health is that a national referral line would not be appropriate and that referral lines for access to specialist services should be at SHA or PCT level. As services are commissioned and provided locally, the Government considers that it would not be feasible for a national advice line to be used to book appointments for abortion services.

The Government will, however, issue further best practice guidance on referral for termination of pregnancy with examples of good practice.

33. We heard compelling evidence that for women who need to undergo an abortion, early medical abortion is a preferable option to surgery, as it carries significantly reduced risk of complications, and can be less distressing. The fact that early medical abortion does not involve any type of surgical process means that, with appropriate training and backup, it could be carried out by nurses rather than solely by doctors, and in community settings rather than solely in acute hospitals. However, at present early medical abortions constitute only a very small proportion of the total abortions carried out. We believe that allowing women access to early medical abortion in a wider range of healthcare settings would help reduce the number of late abortions which may occur as a result of long waits for surgery, and would also be a more cost-effective use of NHS resources. We therefore recommend that the Government should consider this option. (Paragraph 221)

The Government agrees that women, who have grounds for an abortion, should be offered the choice of an early medical abortion and that PCTs and abortion service providers should ensure this provision exists. The RCOG's guideline and the Commissioning Toolkit recommend that a choice of methods should be offered at each gestation band. It is disappointing to note that in 2001, only 16% of the abortions performed under 10 weeks were medical abortions. However, it is encouraging that this figure is increasing – in 1999 it was 12%. In the North East region, a large number of the abortions performed under 10 weeks are medical abortions – over 90% in some areas. The setting up of an early medical abortion service was suggested in the notification letter that went to those PCTs who received extra funding in 2002/03 and 2003/04 for improvements in access to abortion services.

In addition to the actions described at recommendations 7 and 32, we are actively considering what non-traditional settings may be suitable for medical termination. Section 1(3a) of the Abortion Act 1967, as amended gives the Secretary of State for Health the power to approve a "class of place" to perform medical abortion which could enable this method to be available in a wider range of healthcare settings. This power has not been used in England as the Government has not yet determined what would be a suitable "class of place". The Strategy Implementation Action Plan proposed that pilots be established to develop early abortion procedures, including medical abortion. Two pilots sites have now been identified the purpose of which is to enable the Government to define a "class of place". No "class of place" will be approved unless the Government is content that a woman's safety is not at risk.

We agree that nurses have an important role to play in the provision of termination of pregnancy. However one of the requirements of the Abortion Act 1967, as amended, is that a pregnancy may only be terminated by a registered medical practitioner. For medical terminations, the practitioner is not required to perform personally each and every action that is needed for the treatment but must personally decide upon and initiate the process of medical induction and take responsibility throughout. In some areas nurses are already playing a leading role in providing abortion services. However, in others, we consider there is scope, within the current legal framework, for local services to further develop the nurses' role. We will work with the RCN and other professional bodies to ensure that the nurses' role is developed appropriately.

Sexual Dysfunction

34. We fully accept that any Government has to balance competing priorities and pressures in respect of public expenditure. We do, however, find it indicative of the priority accorded to sexual health, and sexual dysfunction services in particular, that access to anti-impotence services and drugs is so restricted. Effectively, the Government is dealing with this more as a lifestyle issue than a health issue, and that seems to us to be wrong. It is simply not appropriate that so many men and women with a clear medical and psychological need are not having access to these treatments, leading to a situation where only those who can afford it are likely to use them. This seems to us contrary to the fundamental principles of the NHS. We therefore recommend that access to anti-impotence treatments should be reviewed. We also think it would be helpful if the Department commissioned research to establish the costs and benefits of a more liberal prescribing regime, given the likely savings which might accrue in areas such as the treatment of depression, infertility, and dealing with the consequences of marital breakdown. Given the lack of development of sexual dysfunction services, and the fact that social pressures are such that those suffering will often be shy and unwilling to articulate their case, we call on the Department to include sexual dysfunction within the wider sexual health strategy. (Paragraph 230)

There are currently no plans to review access to anti-impotence drugs. The Department of Health recognises that impotence can be distressing for both men and their partners. But we believe the current statutory framework accommodates the need to treat men with impotence while protecting the resources of the NHS to deal with other patients, for example, those with cancer, heart disease, mental illness and HIV/AIDS.

Expenditure on impotence drugs is currently over £30 million a year and continues to increase.

The current prescribing framework effective from July 1999 enables:

- GPs to prescribe impotence treatments on the NHS to those men who, in their clinical judgement, are suffering from impotence and have a specified medical condition
- GPs to prescribe impotence treatments to those men who were receiving a specified drug treatment for impotence on 14 September 1998
- Men not covered by the above can receive private prescriptions from their GP
- Men suffering from severe distress on account of their impotence receive treatment from specialist services.

In 2001 the Department of Health consulted widely on the 1999 regulations. Ministers carefully considered the consultation responses along with the cost implications for the NHS of removing the current prescribing restrictions. They decided to maintain the status quo. The Government has, therefore, no current plans to commission research to establish the costs and benefits of a more liberal prescribing regime.

Psychosexual services, including sexual dysfunction, are one of the areas for which the Department of Health is developing recommended service standards, in consultation with professional bodies and service users. It is for service providers to ensure that those patients who may need access to mental health services, and who may need broader support for psychosexual problems, are referred to relevant local provision. To facilitate this, the standards will include definitions of care pathways, including links with mainstream services, such as mental health.

Sexual Health Promotion

35. Sexual health promotion offers a long term solution to many of the sexual health problems which challenge society. It is clear from the evidence we have received that awareness-raising activity and information campaigns are important but they will not on their own bring about sustained behaviour change, particularly amongst those marginalised individuals, groups and communities most vulnerable to HIV and other sexually transmitted infections. We recognise the importance of targeted community-based initiatives, peer education programmes and outreach work and would urge PCTs to ensure these range of interventions are a central part of local HIV prevention and sexual health promotion programmes. (Paragraph 243)

See response to 36, overleaf.

36. We welcome the Department of Health's efforts to produce and disseminate a health promotion toolkit to support commissioners. In relation to sexual health, this should specify that all those providing services in any area of sexual health, including GPs, GUM clinics, family planning clinics, and termination of pregnancy services, should provide a full sexual health risk assessment and sexual health promotion advice to all patients, as clinically appropriate. We feel that health promotion services in the field of sexual health are absolutely vital, but are also one of the services most at risk of being marginalised and deprioritised, given that demand for preventative services is never articulated as vociferously by patients as demand for treatment, and that targeted funding which has been available over the past decade has been subsumed into mainstream allocations. There is a compelling rationale for continued investment in health promotion and prevention. If a healthier nation is to be created, sexual health promotion needs the support and capacity to make a difference. Resources need to be identified to maintain specialist health promotion services, which provide training and advice to health professionals and lead on community-based initiatives with target groups. PCTs should be held to account for the commissioning of targeted HIV prevention and sexual health promotion, both in terms of resource input and effectiveness measures. (Paragraph 250)

The Government shares the Committee's view that PCTs should ensure that targeted community based initiatives, outreach and peer education programmes are planned and delivered, and are central to local HIV prevention and health promotion programmes.

The Sexual Health Promotion Toolkit offers guidance on methods and programme plans for health promotion teams and PCTs, offering a range of interventions to support health promotion programmes.

The Commissioning Toolkit also identifies the importance of commissioning quality health promotion programmes, and for maintaining proactive HIV prevention programmes. Voluntary and community organisations are key to the successful delivery of many programmes nationally and locally, with their contributions to collaborative multi-agency partnership approaches adding value to activities specifically targeted at vulnerable and excluded communities.

The Government continues to undertake sexual health promotion activities at national level. The Department of Health's 'Sex Lottery' campaign targets the 18 to 30 age group to raise awareness of STIs and safer sex. This has been informed by a review of the research evidence into the most effective types of sexual health campaign for this group. Specially developed materials are placed in magazines, clubs, holiday resorts and student venues alongside radio adverts on local and regional radio stations. A new website, www.playingsafely.co.uk, and telephone helpline, 0800 567 123, support the campaign. The campaign provides a national back-drop for local activity – campaign materials for use in local areas will be available in the Autumn.

Sex and Relationships Education

37. Our evidence from young people, which we discuss more fully below, suggests that even basic factual knowledge about sex and sexual health cannot be assumed, and we believe that providing young people with accurate and appropriate information through school relationships and sex education programmes is an essential building block for securing improved sexual health both for this and for future generations. We see no benefit in preventative approaches based primarily around promoting abstinence. However, the fact that many young people who have not had sex believe they are in a minority, and equally that a significant proportion of them regret their first sexual experience, suggests that they would benefit from more support in deciding when is the right time for them in respect of the management of relationships, and support to resist external pressures to have sex, which is why we firmly support the location of sex education within the broader emotional and social framework of sex and relationships education (SRE). (Paragraph 267)

See response to 38, overleaf.

38. In view of the clear inadequacy of provision relating to the context in which sexual behaviour takes place, we feel that a much greater emphasis on the importance of handling relationships would contribute to an improvement in sexual health. We therefore recommend that DfES give further consideration to whether existing guidance on the relationships aspect of SRE emphasises sufficiently the importance of this area. (Paragraph 275)

The Government agrees fully with the recommendation that sex education should be located within a broader emotional and social framework. That is why we recommend that SRE should be firmly rooted in the framework for PSHE. Our guidance to schools is clear that effective sex education should not be delivered in isolation and that the objective is to help and support young people through their physical, emotional and moral development. The PSHE framework plays an important role in helping pupils deal with difficult moral and social questions; and enable them to mature, to build up their confidence and self-esteem and understand the reasons for delaying sexual activity.

Effective SRE and PSHE in schools will address the three main elements of attitudes and values; personal and social skills; and knowledge and understanding. Our guidance is very clear about what should be covered. We believe that the key to ensuring that schools address these broader themes is not through issuing further guidance, but through supporting teachers to give them the skills and confidence they need to work with young people.

From April 2003 we are rolling out an innovative professional development programme for teachers of PSHE which includes a specialist module for sex and relationship education. Up to 750 teachers will participate this year. This emphasis on PSHE rather than just SRE is designed to ensure that teachers demonstrate those generic skills of teaching and managing pupil learning which are key to working in this sensitive and challenging area. The specialist module ensures that knowledge and understanding and its application in the teaching of SRE are demonstrated.

We have established a new website for teachers of PSHE which forms part of the award winning Teachernet site. This website provides a self-assessment tool to help teachers identify their own development needs; and flags up resources, training opportunities, news and events. It includes case studies of good practice in SRE which have been drawn from surveys of what is happening across the country in a variety of schools settings. New case studies continue to be added.

39. We recommend that the Department for Education and Skills and the Department of Health work together to compile a resource for schools detailing websites with high-quality information on sexual health which should be exempted from any filters schools may apply to their I.T. systems. DfES should also consider making 'electronic babies' more widely available in schools. The possibility of a text-messaging advice service should also be investigated. (Paragraph 281)

There are a range of websites which provide information and advice to young people on relationship and health related issues. The Government-backed 'Wired for Health' site, for example, addresses issues which children may raise through each of the four key stages. The Department for Education and Skills (DfES) website for teachers of PSHE contains information about a variety of resources, including web-based ones, which teachers can access themselves or refer pupils to.

The Internet and related technologies are powerful tools for learning and the communication of information. To use these technologies effectively requires an awareness of the benefits and risks, and an understanding of their appropriate use both in and outside the classroom. All schools have a responsibility to filter both access at school and any access pupils are given as part of home-school links. Filtering systems prevent or block users' access to unsuitable material. Most schools

recognise that a blanket approach to filtering on websites which contain words such as sex might mean that some educational sites are filtered out. They are therefore encouraged to research for good educational sites that touch on topics such as sex and consider the general content of such websites before deciding whether to filter them out from the school system.

Responsibility for deciding which resources to use to deliver SRE rests with teachers. We believe they are best placed to determine what is required to meet their pupils' learning needs.

Despite widespread use of the 'electronic' babies in schools and other settings, and encouraging feedback from students, there is little evidence available of whether they have impact, or what the impact might be. There have been a small number of studies in the USA : a recent one (Somers, C and Fahlman, M, 2001) showed that use of these babies had no impact on the young person's sexual behaviour, intentions regarding childbearing, realism about the responsibility of parenting or contraceptive use. Electronic babies are expensive and their use needs to be carefully planned, and staff trained to use them. They may be a useful addition to SRE programmes, but a systematic evaluation of the outcomes is needed.

The Department of Health provides information and advice to young people (aged 11–18 years) and young adults (aged 18–30 years) about sex and relationships via its RUThinking? awareness and Sex Lottery information campaigns respectively. Both campaigns are supported by websites offering information and access to local community contraception services, specialist young people's drop-ins and GUM clinics. Information for under-18s is available at www.ruthinking.co.uk, for over-18s at www.playingsafely.co.uk. Each campaign is also supported by a separate telephone help line offering confidential support and information

It is essential that information and advice about safer sex is made available to young people in an accessible and contemporary way. In 2002, 545 million text messages were sent – by 2004, 85% of 10 to 14 year olds will own a mobile, with this figure rising to 94% young people 15 to 19 years[3]. Young people report that text message is a preferred way of receiving information. Extending the support offered by the Campaign's websites and helplines via text messaging will be investigated as part of campaign development by the Teenage Pregnancy Unit at the DfES and the Department of Health in 2004/05.

40. We strongly recommend that SRE becomes a core part of the National Curriculum, to be delivered within the broader framework of PSHE along with citizenship. We want to see education on relationships and sex given a high priority since the short and long term consequences of poor sexual health for young people, including unplanned pregnancy and parenthood as well as disease, can be so serious. (Paragraph 286)

SRE, including education about HIV/AIDS and other STIs, is now a statutory requirement for schools. The National Curriculum Science Order 2000 provides the statutory basis. In addition, the Education Act 1996 (as amended by the Learning and Skills Act 2000) places a statutory responsibility for sex education on governors and headteachers and requires them to have regard to the DfES' SRE Guidance. The

3 Source: COI/Mobile Youth 2002 Report

guidance makes clear that SRE should be delivered within the broader framework of PSHE. We have been encouraged by the efforts schools are making in this area and OFSTED will continue to inspect PSHE, including education on relationships. We have also asked OFSTED to specifically report on progress of the teaching of sex and relationship education by the end of 2004.

PSHE covers a variety of topics, including health and safety, basic aid, personal finance, legal and human rights. The non-statutory framework for PSHE sets out broadly the knowledge, skills and understanding pupils need lead healthy, confident, independent lives, but allows them the flexibility to meet the particular needs of their pupils by focusing more attention on some issues than others.

At present, we believe that the current non-statutory approach to PSHE allows teachers to progress and develop the teaching of PSHE in schools effectively. To date this has allowed a flexible approach for teachers who have carefully tailored programmes to meet pupils' needs.

Our current priority is to improve the effectiveness of what is taught by providing clear frameworks and guidance; supporting teachers' professional development; identifying and disseminating good practice etc. The DfES are working closely with the Department of Health on a range of initiatives to improve the effectiveness of teaching and will continue to do so.

Our overall aim is of course to ensure that PSHE is taught as effectively as possible. Should the evidence show that the current process is not delivering, we shall review our approach. Indeed, any future review of the National Curriculum would consider all the options including the case to make PSHE statutory.

41. While investing SRE with National Curriculum status will improve its standing, we believe that the key to improving educational standards in SRE lies in providing each school with well-trained, capable and enthusiastic SRE teachers. We recommend that the Department for Education and Skills reviews the way in which teachers are trained and SRE is managed in schools, ensuring that SRE is taught by teachers with specialist knowledge and expertise in the subject. We recognise the difficulties of scale that might attend ensuring that each primary and secondary school has a dedicated SRE teacher, but we believe that these logistical difficulties could be overcome through creative local arrangements, such as pooling a teacher or teachers across a consortium of schools within a local authority. DfES should also ensure that schools have access to, and make good use of, support from a range of individuals and agencies—such as nurses, GPs, health promotion specialists, peer educators and youth workers—when planning and teaching SRE. (Paragraph 292)

Following consultation by the TTA, new standards for ITT require all trainees to demonstrate familiarity with the framework for PSHE. The Handbook of Guidance produced by the TTA highlights SRE as one of the important elements that trainees should be familiar with. To support this, the TPU has commissioned a '*Best Practice Toolkit on PSHE*' for ITT providers. Development and drafting will take place in the summer term 2003. It will be published and disseminated to ITT institutions in the autumn term. (See also Recommendation 40).

A similar PSHE/SRE certification scheme for community nurses is being piloted and will be completed by March 2004, for roll-out from autumn 2004. This is being independently evaluated to ensure that the learning informs future roll out.

42. The Department for Education and Skills is currently engaged in work with the National Children's Bureau on guidelines specifically aimed at how to best engage boys and young men in schools-based sex education. We recommend that this guidance forms a specific plank of the National Curriculum on SRE, as clearly young men's needs have hitherto not been adequately addressed, despite the fact that they represent half the problem and half the solution to improving young people's sexual health. We were also struck by the fact that during the course of this inquiry, the vast majority of the people we met and took evidence from who were involved in sex and relationships education, and sexual health promotion for young people were female. One of the young men who came to give us evidence gave lack of specific male input as a key problem in the delivery of relationships and sex education for young men, and this is clearly a difficult problem that needs to be addressed. While we understand that it may not be practical for every school to provide both a male and a female teacher for SRE, schools must ensure that young men have access to SRE delivered by males, perhaps through using male peer educators, community workers and health professionals. (Paragraph 299)

The Government agrees that traditionally the focus has been on girls, and boys may have felt that sex education is not relevant to them; or are unable or embarrassed to ask questions about relationships and sex. Our SRE guidance to schools makes clear that programmes should focus on boys as much as girls at both primary and secondary levels.

We have already commissioned the development of practical guidance for teachers on engaging boys and young men; and are developing a dedicated site on the DfES website for teachers of PSHE. Teachers participating in the PSHE professional development programme are required to demonstrate a secure knowledge and understanding of the gender roles and how that is applied to teaching.

We have commissioned the National Children's Bureau to produce 'Best Practice PSHE in Initial Teacher Training', to support ITT providers in ensuring their students meet the standard for PSHE set by the TTA. This will include guidance on meeting the needs of boys and young men in PSHE programmes.

It is the case that teachers of SRE and PSHE are predominantly women. Just 10% of the teachers participating in the professional development programme are male. One local education authority participating in the programme has specifically targeted men and we will encourage others to do so as the programme continues to role out.

43. It is imperative that all school-based relationships and sex education gives young people the opportunity to learn and think about the broader aspects of sex and sexual health, including emotions, relationships and families, and including the existence of different family structures. It is also vital that young people have a good understanding of the facts surrounding sexual health before they need them. Current guidance states that all primary aged children need to know about how a baby is born and about

puberty before they experience the onset of physical changes; and that secondary school pupils should understand human sexuality, be aware of their own sexuality and know about contraception, sexually transmitted infections and HIV. We have seen little evidence through this inquiry that the SRE guidance is being implemented in a consistent way, especially in relation to more sensitive areas such as sexual feelings and emotions, sexual orientation and HIV and AIDS. We therefore recommend that the Department for Education and Skills establishes mechanisms (until such a time when SRE has National Curriculum status) both to monitor the implementation of the guidance and to assess the extent to which relationships and sex education, which addresses the needs of young people, is being delivered by primary and secondary schools. (Paragraph 303)

From September 2003, schools will be subject to a new inspection regime by OfSTED. Where schools are fully inspected under what is know as "Section 10" arrangements, the inspection report will include a subject paragraph on the quality of PSHE teaching and learning. This is a new requirement and we are working closely with colleagues in the Qualifications and Curriculum Authority and OfSTED to draft a PSHE inspection handbook to support these new arrangements. Where schools are judged to be providing good or better provision, future inspections will be 'light touch'.

Later this year OfSTED will be carrying out an inspection on PSHE in secondary schools which will include sex and relationship education. The findings will be available next year.

We will also, in due course, monitor the impact of the professional development programme of teachers of PSHE which rolled out from April 2003.

44. We welcome the efforts currently being undertaken by the Department of Health and the Department for Education and Skills with regard to helping parents talk to their children about sex, as we feel that this type of engagement has a vital role to play in ensuring young people receive rounded sex education. (Paragraph 305)

The Government welcomes the Committee's endorsement of its approach in supporting the role of parents in effective SRE. (See also recommendation 46).

45. We strongly support the use of peer educators, and recommend that the Department for Education and Skills and the Department of Health should work together to continue to promote this approach in all schools, although we believe this should be a supplement to rather than a replacement of formal schools-based relationships and sex education. (Paragraph 307)

The Government agrees that peer-educators can valuably complement sex and relationship education delivered in schools. Delivery of sex and relationship education is not the sole responsibility of teachers. Elements are provided by a range of people in the wider community including health professionals, social workers, youth workers and peer educators. They have much to offer at all levels of planning and delivering SRE, bringing a new perspective and offering specialist knowledge, experience and resources.

In June 2002 the Department of Health published *Involving Young People in Peer Education: A Guide to Establishing Sex and Relationships Peer Education Projects*. This guidance aims to provide information on setting up and monitoring peer-led approaches to delivering SRE, drawing on research evidence and best practice examples.

46. The Tic Tac project in Paignton, clearly an example of best practice in meeting, in a confidential manner, young people's sexual health needs, has been heavily driven by local enthusiasm and leadership, which has helped steer it through continuous funding uncertainties as well as negative publicity. It is seen as an integral part of raising educational standards in the school. However, we also heard of several examples of other schools which were keen to adopt the model, but which were obstructed by school governors. We believe that the Government should actively promote this model of joint service provision and education for young people, and make dedicated funding available to establish an appropriate number of such services within each local authority area. Although we recognise that it may not be practicable to have such a service attached to every school site, arrangements should be made between smaller schools to establish shared facilities or to devise links with dedicated clinics. We would also urge the Department to pilot a youth clinic along the lines of those we visited in Sweden: these may be more effective in reaching those not attending school. (Paragraph 312)

DfES is encouraging all schools to provide, or work with others to provide, a range of services for pupils, families and the wider community, appropriate to local needs and priorities, and to their own resources. Schools, working closely with LEAs and other bodies such as PCTs and Social Services Departments, need to consider which health and social care services might best be provided in a school setting.

DfES will support all LEAs and schools to plan, set up and manage extended services. Funding is being made available to all LEAs to develop "full service" extended schools, offering a prescribed core range of services. Health and social service provision and parenting support will form essential elements of the full service extended schools. Funding is also available to support LEA level strategic co-ordinators and school level managers to plan, develop, manage and maintain services in other schools.

The TPU commissioned the Sex Education Forum to produce a booklet 'Secondary schools and sexual health services: forging the links' which was published in May 2003. This gives guidance on improving young people's access to sexual health services in school (such as the Tic Tac model) and in the wider community.

Improving young people's access to advice services is a core part of the Teenage Pregnancy Strategy. Best Practice Guidance has been issued, setting out the criteria by which services should be commissioned and provided. These criteria are drawn from research with young people. Local Teenage Pregnancy Strategies have audited their clinic services and GP practices against the guidance to identify gaps in provision. The results of the audit have informed local action plans to improve services in mainstream and outreach settings to ensure all young people can easily access advice from a service they trust. Since the start of the Strategy there has been a 25% increase in the number of dedicated young people's services and

some excellent examples of innovative approaches to reach boys and young men and other young people who do not traditionally access mainstream services. Some of these services are one-stop health information models.

In addition the TPU is working with the RCGP on an initiative to improve young people's access to advice in general practice. The 'Getting it Right' campaign aims to remove the barriers to access and increase young people's uptake of early advice on a range of health and emotional issues, not only sexual health.

We believe that through these initiatives, local Teenage Pregnancy Strategies are making significant progress towards improving young people's access to advice. The provision of a network of youth friendly services will be enhanced by the use of the Commissioning Toolkit and through implementation in 2004 of the Children and Young People's National Service Framework.

Although there are core features that make a service accessible to young people, the experience of local Teenage Pregnancy Strategies suggests that a range of models are required to address local circumstances and needs. The Sweden youth clinic is another service model that may be successful in some communities. We are interested in exploring further the success ingredients of the youth clinics and particularly the strong links with schools and the routine visits made by pupils to familiarise them with the service.

Published by TSO (The Stationery Office) and available from:

Online
www.tsoshop.co.uk

Mail, Telephone, Fax & E-mail
TSO
PO Box 29, Norwich, NR3 1GN
Telephone orders/General enquiries: 0870 600 5522
Fax orders: 0870 600 5533
E-mail: customer.services@tso.co.uk
Textphone 0870 240 3701

TSO Shops
16 Arthur Street, Belfast BT1 4GD
028 9023 8451 Fax 028 9023 5401
71 Lothian Road, Edinburgh EH3 9AZ
0870 606 5566 Fax 0870 606 5588

TSO@Blackwell and other Accredited Agents

ISBN 0-10-159592-1

9 780101 595926