

3<sup>rd</sup> October 2001

Jonathon Fraser  
Department of Health  
Skipton House  
80 London Road,  
London, SE1 6LH

Dear Mr Fraser

**Re: Response from Department of Genitourinary Medicine, Newcastle upon Tyne, to the National Strategy for Sexual Health and HIV**

This initiative and document are warmly welcomed. It is felt that the predominant focus on sexually transmitted infections and HIV are appropriate and overdue as other promotions, such as teenage pregnancies, have been of little benefit to Genitourinary Medicine (GUM) services. Before dealing with the document in more detail we should like to make the following general points:-

- The document does not fully address or appear to appreciate the wide range of conditions and concerns presenting to GUM clinics not all necessarily related to infection and putting considerable pressure on the service.
- Although the state of some clinics and the number of hours available are problems in some areas our main concern is the enormous demand by the public on the service. We certainly have no problems in attracting patients and cannot boost expectation that we can see any more as we have insufficient resources to deal with the current demand. It would be helpful to have larger premises with more consulting and examination rooms but we urgently need more personnel to staff our current clinics as they stand.
- The concept of extending the role of the nurse, especially in GUM clinics is greatly welcomed. This is a fundamental shift in thinking and prior guidance with the involvement of trained nurses in the assessment and management of new patients working under protocol. The acquisition of these skills, experience and level of service commitment must be formally recognised and acknowledged in the grading allocated to such staff. This will have resource implications but is essential to protect and enhance the quality of the service. It is essential that we recruit and retain highly skilled nurses able to deal with new patients as well as reviews, provide a core level of on site health advising input, be involved in teaching, training and research and also participate in relevant outreach work.
- Similarly this will also apply to health advisers, especially if they are taking on a new role with additional responsibility in the community. Some clear guidance and recommendations will be most important. A greater clarity is required of their core roles in the specialist setting of the GUM clinic as well as in the community. The requirement of other groups, such as youth workers, as detailed in the document, to be trained, including the desire to acquire the health adviser certificate, must also be recognised. This will immediately impact on health adviser workload although ultimately will provide a larger pool of workers able to facilitate the Strategy. We welcome the recommendation that their numbers be increased and a national formula is needed to adequately assess health adviser levels for any given service/population.
- The document fails to identify the enormous increase in people, including health care providers and other professionals, telephoning for general information and advice on sexually transmitted infections (as well as obtaining test results). This is fuelled by changing public attitudes where, in general, telephone advice and information is much more readily accessible. It is also exacerbated by NHS Direct who are not in a position to give a full range of detailed advice on sexual health issues and refer on to us. The creation of special telephone only clinics or special generic local sexual health advice telephone systems should be considered to avoid pressures on standard clinics and staff serving them.

It is essential that this issue is properly identified, as its enormous growth is a new development and it must be resourced appropriately.

- The £47.5m over 2 years identified is miserly but presumably is included to help achieve the specific targets proposed and fund the projects and pilots described. It will certainly have little impact on routine over-stretched services and their accessibility. The issue of resourcing needs to be addressed and where local funding is expected clear guidance given to local commissioners by the Department of Health to ensure that is correctly directed. This should also include other agencies who receive funding which may be relevant in this Strategy. We will remember the misdirection of specific HIV/AIDS money in the early stages of the epidemic.
- The principle of the Department of Health producing and monitoring standards and targets for care and abrogating the responsibility for funding to local commissioners is of great concern. If a local commissioner prioritises sexual health at a lower level than an adjacent service the resources received will be inequitable but both services are expected to meet the same targets. This is clearly unacceptable.

## **STI targets**

### **Increasing HIV testing and improving uptake**

Currently there is reluctance by many GPs to be involved. They are concerned about the concept of 'pre-test counselling', the potential for problems with life insurance companies, despite reassurance from the Department of Health and Association of British Insurers and dealing with a positive result. In this department, in principle, we endorse and support the general principle of routine HIV testing (as with syphilis) to reduce the load of unrecognised infection which should achieve the target. However this requires extensive public and professional education campaigns to alter thinking about HIV testing and destigmatize the test. A substantial proportion of GUM clinic attendees decline to have HIV testing when offered and to achieve the 90% uptake target will need considerable efforts to educate the public and convince GUM clinic attendees of the value of routine testing. For this proposal to work and the targets to be achieved the Department of Health requires to:-

1. Ensure that overtly or covertly insurance companies do not routinely ask about previous HIV negative tests.
2. Inform and convince the public of the benefits of HIV testing.
3. Dispose of the concept of 'pre-test counselling', except for those highly at risk or with major psychological problems, and replace it with 'informed consent'.
4. Change the KC60 code P1a (indicating pre-test counselling with HIV testing to just HIV testing with consent). Additional codes may be helpful to define a patient at risk who is tested and another for someone at risk who refuses testing for easy monitoring in GUM clinics.
5. Change thinking and encourage professionals to give HIV test results by telephone. Still most professionals insist that the person must return to the clinic for a test result.
6. Recognise that new cases will be detected, potentially putting an immediate pressure on the funding of treatment. The impact on funding bodies, such as consortia, must be identified.
7. Ensure that clinics have resources to deal with the additional likely demand.
8. Ensure that with the increased quantity of testing for HIV both in GUM clinics and the community there is no compromise to the quality of the service.
9. Explain how resources will be provided to help achieve these targets and what penalties, if any, will be imposed for failure?

### **Hepatitis B vaccination**

Currently this department provides hepatitis B vaccination for immuno-naïve homosexual men and sex workers but not injecting drug misusers as other local community and specialist services are available to them who can provide vaccination. We have no funding to extend this further. It does not seem appropriate to extend vaccination to drug misusers and we note that they are excluded from the targets. We therefore recommend that they are not included or else new resources are identified or transferred from existing services to fund this initiative.

In principle we support the targets and principles behind them but have the following comments.

1. Currently we screen all those with relevant sexual risks contemplating vaccination for naturally acquired hepatitis antibodies prior to offering vaccination. We believe this to be best practice as it saves

unnecessary vaccination and provides useful epidemiological data. We would wish to continue this practice but this is not compatible with the target. It should therefore be revised to reflect that the target only refers to immuno-naïve patients following screening.

2. Monitoring could be difficult and time consuming. It might be worth considering the introduction of new KC60 codes to reflect this. This applies to the targets for first and third vaccinations.
3. Compliance of drug misusers is poor and while the targets for first and third vaccination may be reasonable for gay men and sex workers they will not be achievable for drug misusers.
4. The media campaign should provide information and advice on vaccination to the targeted groups including the importance of completing the full course of vaccination.
5. How will resources be provided to help achieve these targets and what penalties, if any, will be imposed for failure?

### **Chlamydia screening.**

Again the concept of chlamydia screening, especially in the community, is welcomed. However the following concerns are expressed.

1. Still most GUM clinics, including Newcastle, are limited to providing EIA based testing for chlamydia. This is cheaper than the modern PCR/LCR tests but misses up to 30-40% of infections. Increasingly community screening has access to the newer PCR and LCR tests. These are not only more sensitive but can be used on urine and blind vulvo-vaginal swabs. It is invidious that the specialist services have to make do with an inferior test and urgent action must be taken to ensure that GUM clinics can provide the state of the art test for chlamydia.
2. If all women having a first smear along with others are screened this is going to reveal a massive amount of infection. These women require treatment (either via the GP or GUM clinic), screening for other STIs (normally by referral to GUM) and partner notification PN. This, in itself, will produce a great deal of extra work by identifying male partners needing screening and treatment normally provided in GUM. Resources must be found and put in place in GUM clinics to allow for this increase in workload when screening for chlamydia is extended.
3. The increased publicity and public awareness is already increasing specific requests for chlamydia testing. This will inevitably increase with the introduction of the Strategy and resourcing, irrespective of what test is used, must be identified.
4. The increased detection of chlamydia infection will immediately increase drug costs. This will disproportionately impinge on GUM services as many patients diagnosed elsewhere are referred for treatment as well as further STI screening and partner notification.

### **Three Levels of service**

The concept of increasing the workforce to deal with the enormous unmet need in Sexual Health is endorsed and the concept of skilling-up Primary Care Teams to provide part of this service at levels 1 and 2 approved. However the following concerns and comments are made.

1. General Practitioners are already inundated by new work, protocols, guidelines etc from other specialties and are unlikely to respond favourably to an increase in their burden. Again this is likely to have resource implications.
2. All Primary Care Teams are expected to designate a lead person in sexual health who could be a doctor or nurse. At a minimum all of these leads will require training on the new Sexually Transmitted Infection Foundation course just for Level One services. Additional training will be required for Level Two work and it is likely that more than one person per practice will require training. The costs of this must be identified and resourced.
3. It seems that Primary Care Teams can opt out. This could put a disproportionately large burden on local GUM clinics serving such a population and create inequalities in care which this Strategy is supposed to address.
4. There is a perceived ambiguity of the role of GUM at Level Three especially for people living distant from GUM clinics. Will there be an expectation, with the associated cost implications, that GUM staff will travel out to deal with patients requiring such a service or can skilled-up GPs working under the direct guidance of central services be able to fulfil this role?
5. The importance of linkages between different aspects of sexual health service is important. However the arrangements to co-ordinate this needs to be clarified especially for specialist referrals to gynaecology, urology and psychosexual medicine where a 2 year wait currently exists.

## **Implications of increased GUM work in the community**

Although this concept is endorsed certain important points have not been addressed in this document.

1. How will standards be maintained and who will be responsible? It should be the specialist service but this could cause logistical problems in view of the large volume of work.
2. How will this new community intervention be audited and by whom?
3. How will new and updated information and advice be provided to those working at Levels One and Two?
4. How will appropriate levels of confidentiality be maintained in Primary Care in line with the National STD Regulations?
5. How will data on new infections be collected to ensure it is accurate and not duplicated if infected patients subsequently attend GUM clinics? We suggest that this should probably directly involve laboratories who can collect cumulative data from Primary care Teams or Groups.
6. How will good two-way communications be facilitated between GUM and Primary Care? This will need investment and updating in Information Technology and a well-informed and maintained web-site for information. Improved IT between laboratories and GUM clinics essential to provide fast electronic test results. Investment in IT could also resolve the first three items in this section.
7. The increased burden on laboratory services has not apparently been recognised and in itself will have considerable resource implications.
8. The role of health advisers will be crucial to ensure partner notification. There is no point detecting and treating new infections unless sexual contacts are also screened and treated. They will also be the most likely staff group to co-ordinate and deliver training to community staff, which will require funding. Links with academic institutions will need to be strengthened.

## **Human Resources**

In general the main costs arising from Sexual Health Services arise from personnel rather than expensive treatments or investigations. It is sad that the document does not tackle this except for stating that 'detailed workforce plans are expected by 2002' however we do welcome the need to address and prioritise this issue. The following comments are made:-

1. The need for an increase in health advisers is supported, especially in view of the enormous amount of work being created in the community. However this would inevitably have knock-on effects for local service as the promotion of secondary prevention would lead to increased demands for screening resulting in additional pressures on GUM services. This would therefore have to be matched with an increase in clinic staff, medical, nursing and clerical.
2. Altered roles should be considered to help free up existing health adviser time. This should include skilling-up GUM nurses to act as health advisers at a level where they can collect contact information, advise accordingly and provide contact slips as well as giving other sexual health advice (eg contraception) and HIV test information. This helps to integrate the GUM service and allows time for health advisers to deal with more complex problems and community work.
3. To our knowledge there has never been any attempt by 'Local Medical Advisory Groups' to advise on staffing and training issues and we were unaware of its presence. We are sceptical that any new 'local confederations' will be any more active unless specifically directed from the Centre.

## **Targeted Groups**

The concept of targeting resources and services at certain high risk or vulnerable groups is endorsed. However the important group of asylum seekers has been omitted and we very strongly feel that it must be included and resourced as a new development. Over the past two years there has been a large increase in demand for GUM services by asylum seekers who usually also require an interpreter further increasing the unresourced costs to GUM clinics.

The concept of geo-mapping origins of infection is also suggested to identify possible pockets of infection in the community. This is likely to appeal to general practitioners and helps direct services although in itself will have some resource implications. However around 15% of local GUM attenders refuse to give address information.

## **Research**

The suggested research issues are endorsed. However it is recognised that although in GUM we do try to practice evidence based medicine evidence is lacking in many situations and treatments used and advice given is largely based on custom and practice. These should be identified and targeted research encouraged to redress them.

## **HIV/AIDS**

There is approval for the section in the document relating to HIV/AIDS. In particular it was considered essential to emphasise and stress the importance of linkages and pathways of care. As an example health advisers, with their special skills, have little, if any, involvement with infection diagnosed outwith GUM or to patients initially seen in GUM and transferred elsewhere. As a direct consequence opportunities for partner notification and promoting safer sex are compromised.

The importance of providing HIV care within a managed service network and its destigmatisation and normalisation are endorsed. For those living distant from large centres this will have special implications which must be identified. This will include improvement in these people's local services, including the involvement of local and community pharmacists, especially important to enhance treatment adherence.

It is essential to ensure that all appropriate services are freely and equitably available to all with HIV infection irrespective of who is responsible for their care.

We have given a great deal of thought and time to in considering this document and our response to it. There is now a real chance to make an impact on the deteriorating sexual health of our community and we are very keen to embrace it given the tools. We hope that these comments and thoughts are of value and will contribute to the final document.

Yours sincerely,

**Richard Pattman**  
(Consultant Physician and Head of Service)