Terrence Higgins Trust

Disturbing Symptoms 7

How commissioners managed sexual health and HIV in 2008 and how specialist clinicians viewed their progress.

A Research Report

May 2009

British HIV Association BHIVA

BASHH

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Disturbing Symptoms 7

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1. Executive Summary

1.1 This is the seventh edition of the *Disturbing Symptoms* collaborative research series. The report is based on analysis of responses from commissioners and specialist clinicians to two short surveys distributed in early 2009. The surveys aim to build a picture of the impact of national health policies on sexual health and HIV services. For the first time, the 2008-09 survey was sent to all four UK countries and was conducted entirely online.

1.2 Last year's report highlighted that despite rising rates of HIV and STIs, national targets and support have enabled progress. We speculated that the new era of localism might destabilise this progress. This year, both commissioners and clinics continue to report that national support and guidance provides helpful leadership. The effects of local decision-making are mixed, but some key areas for attention have emerged.

1.3 For commissioners, concerns remain around capacity and support to lead change and manage local health markets under continued pressure:

- A lack of local champions remains an issue, with a fifth of respondents overall indicating that their PCT or Health Board did not have a specific lead commissioner for sexual health and HIV. Nearly two thirds of commissioners say that local prioritisation would help them make progress.
- Needs assessment is still not consistently taking place across the UK, with almost a quarter of respondents being unable to locate any assessment that had taken place within the last four years. However, the picture is better in Scotland than elsewhere.
- Despite likely benefits to patients, joint commissioning is not taking place for sexual health or HIV services in almost a third of responding commissioning bodies. This differs between countries with higher levels of joint working across Wales but less in Scotland

1.4 Clinicians also continue to face a number of challenges. Relationships with what should be local partners are not always constructive, finances and staffing levels seem uncertain and patient and public involvement is widely lacking:

- A third of responding clinics did not indicate that they got good support from any other major partners in sexual health locally. Outside of England this rose to almost half.
- Despite being asked near the end of the financial year, a third of clinics could not say whether their drugs budget would be overspent that year. Patient activity has increased in over three quarters of clinics, while staffing levels have increased in less than a third. Over a quarter of clinics have seen staffing decrease.
- Almost half of clinics do not meet with patient representatives at all and a further fifth met so infrequently as to make meaningful engagement almost impossible.

1.5 In order to continue making progress on HIV and sexual health in the UK, it is clear that both commissioners and clinicians need to work together with each other, with local partners and with patients. In the face of an uncertain financial future and a rapidly moving policy agenda, continued national leadership to support commissioning, service redesign and partnership working will be vital to ensure all our sexual health and HIV services continue to be fit for purpose.

2. Background to the surveys

2.1 This is the seventh year that the British Association of Sexual Health and HIV (BASHH), the British HIV Association (BHIVA) and Terrence Higgins Trust (THT) have collaborated to survey commissioners and clinicians on the planning and delivery of sexual health and HIV services.

2.2 With a continuing focus on local decision-making in health service planning and the current economic climate making for uncertain financial times ahead, this year's surveys were designed to measure the impact of policy changes and investment decisions at a local level.

2.3 As always, there were separate questionnaires for commissioners and clinicians, both of which consisted of mainly closed questions with some opportunity for commentary in respondents' own words at various points. The surveys were designed collaboratively by all three organisations.

2.4 However, for the first time, the two surveys were conducted online and across the whole of the UK. Respondents were directed to a website which hosted the short questionnaires; results were collated and analysed by the Policy and Public Affairs team at Terrence Higgins Trust and the data and final report has been reviewed by officers from all three organisations.

2.5 Commissioners were alerted to the survey via an email to the English HIV Commissioners' Group (our thanks to the National AIDS Trust for facilitating this) and, as in previous years, PCT Chief Executives were alerted to the survey and asked to pass it on to the most appropriate person at the Trust, usually the sexual health or HIV lead commissioner. Commissioners at Health Boards in Scotland, Northern Ireland and Wales were contacted directly by email and asked to take part.

2.6 Clinicians across the UK were asked to take part through the electronic networks of both BHIVA and BASHH. This year, clinicians were asked to coordinate one response per clinic, rather than submitting individual responses as in previous years. This new format was designed to limit any geographical bias arising from many individuals in one area responding and to make data more robust.

2.7 For this seventh edition, the surveys were distributed later in the planning year. Responses were collected in early 2009, whereas in previous years the surveys had been distributed in late autumn. It was hoped that distributing the surveys later would allow for greater reflection on the previous year's developments.

3. Health Board and PCT Findings

3.1 Sample breakdown

Table 1: Origin of commissioner responses

England	71%
Wales	17%
Scotland	12%
Northern Ireland	0%

A total of 41 commissioners responded to this year's survey, a 20% increase on last year's response rate. At the time of the survey there were 152 English PCTs, 14 Scottish Health Boards, 22 Welsh Health Boards and four health Boards in Northern Ireland. For commissioners in England, the survey has become a regular feature over the last seven years and so it is unsurprising that there was a higher rate of response from England. In Scotland and Wales, Terrence Higgins Trust regional offices were able to contact commissioners directly and encourage them to take part. However, THT does not have a presence in Northern Ireland and so this may have contributed to the lack of responses from this country.

3.2 Commissioning Expertise

Table 2: Respondent's role

Lead commissioner for sexual health/HIV	46%
Other	17%
No response	15%
Services commissioner (inc sexual health/HIV)	12%
Public health manager/specialist	9%
Director of Public Health	0%

This year the survey was sent directly to commissioners via email in addition to the usual practice of alerting Chief Executives and asking them to cascade information down to the most appropriate staff member. This is one possible explanation for the higher number of specialist sexual health and HIV commissioners who responded this year.

In 2007, a large proportion of respondents (50%) had a public health role, whereas these respondents are very much in the minority this year. Given the differences in the way the questionnaire was distributed, it is difficult to draw any firm conclusions from this, but it is encouraging to note that nearly half of respondents were lead commissioners for sexual health and HIV. Those who answered "other" included voluntary sector managers and a practice based commissioning sexual health lead.

Table 3: Does your Board or PCT have a lead commissioner specifically for HIV and/or sexual health?

Yes	81%
No	17%
Don't know	2%

This question was changed from last year. In 2007, we asked whether the respondent was the lead commissioner for sexual health and HIV and if not, which post was. Last year, almost two thirds of respondents could not say which post included these responsibilities. This year, although this proportion had dropped, a fifth of respondents still indicated that they did not have a specific lead commissioner for these areas.

In previous years we have asked Chief Executives to nominate the most appropriate member of staff to complete the questionnaire. Responses always indicated a lack of lead commissioners. Given that this year the survey was also sent directly to commissioners and the number of lead commissioners has risen, it is possible that those in charge of PCTs were unable to identify their sexual health lead. This may indicate a worryingly low profile for sexual health and HIV services at a senior level. This year, and in previous years, respondents have indicated that a lack of commissioning capacity has been a hindrance to local work on sexual health and HIV. The lack of a specific commissioner is therefore likely to impact negatively on local work.

Table 4: If you have one, how long has that lead commissioner for HIV/sexual health been in post?

Less than 1 year	30%
1-3 years	43%
4+ years	21%
Don't know	6%

Respondents who said they "don't have one" or selected "no response" were removed from this analysis. Compared with 2007, when 24% of respondents said their commissioner had been in post for less than a year, it is likely that over half of current lead commissioners may have been working in sexual health and HIV for less than two years. The other possibility is that some areas may have an annual turnover of commissioner, which is even more concerning.

As we highlighted last year, length of service does not necessarily correlate to ability, but at a time when there is a need to strengthen the role of commissioners, having experienced staff in post can only be helpful to PCTs and Health Boards.

3.3 Sexual health planning and joint working

Table 5a: Do you actively participate in/regularly attend a planning body for your own Board or PCT for:

HIV and sexual health	81%
Sexual health only	10%
None of these	5%
Don't know/no response	2%
HIV only	2%

Last year, respondents were simply asked whether their PCT had a planning body for sexual health and HIV, whereas this year they were asked about their own participation in this body. It was encouraging that four fifths of respondents were able to say they took an active part in planning for both sexual health and HIV.

The fact that 10% only took part in sexual health planning may be attributable to the specialised commissioning arrangements that are in place for HIV services in England. However, in the interests of integrated commissioning, it would be helpful if commissioners were involved in decision-making across this area. The two respondents playing no part in planning for either area and the one respondent who was unable to say whether they participated in a planning body at all were of concern.

Table 5b: Do you jointly commission in a larger network with other PCTs/Health Boards for:

HIV and sexual health	36%
None of these	32%
HIV only	22%
Don't know/no response	5%
Sexual health only	5%

This was the first time a specific question was asked about joint commissioning arrangements, although the issue has been regularly raised in respondents' answers to free text questions in previous years. Almost a third of respondents did not take part in any joint commissioning activities. Further analysis, however, indicates disparities between the UK countries. In Scotland, four out of five respondents undertook no joint commissioning, while in Wales, six out of seven health boards jointly commission to some extent.

Given the cost and population sizes involved in HIV services, collaborative commissioning is likely to be more resource-effective for PCTs and Health Boards. Similarly, in sexual health, where patients may seek care across nominal PCT or Health Board boundaries, joint commissioning will help to provide a seamless service for the patient and reduce individual Trust or Board costs.

3.4 Needs Assessment

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

In the past year	44%
1-3 years ago	32%
4+ years ago	12%
No response	12%

This was a repeat of last year's question and proportions have remained reasonably stable. Last year 41% of respondents indicated that a specific needs assessment had taken place within the previous year, which is similar to the 44% this year. As might be expected, the proportion of respondents indicating that a needs assessment had taken place between one and three years ago has risen from 23% in 2007 to 32% this year. In Scotland, four out of five respondents had undertaken a needs assessment within the past year.

Good quality needs assessment is vital for high quality commissioning. Almost a quarter of respondents either could not say when a needs assessment had taken place, or indicated that it had taken place over four years ago. It is essential that all commissioners have access to recent needs assessment data in order to effectively plan services.

3.5 Investment in sexual health and HIV services

Table 7: Compared with 2007, has your 2008 spending on HIV and STIs:

Increased by 10% or above	42%
Don't know/no response	24%
Increased by less than 10%	17%
Stayed the same	17%
Decreased	0%

This question changed slightly from last year, when respondents were simply asked to indicate whether spending had increased with or without a cost-of-living uplift, or if spending had remained unchanged or decreased.

In total, 59% of this year's respondents indicated that spending on HIV and STIs had increased to some degree, which is significantly less than the 76% reporting an increase last year. This suggests that investment in HIV and sexual health services may be tailing off, which is worrying at a time when rates of HIV and STIs continue to rise. Although it is encouraging that no respondents reported a decrease in spending, it is surprising that almost a quarter could not say how spending levels had changed, particularly as respondents were asked to respond in the last quarter of the financial year.

It is also hard to tell what additional investment has been spent on. Given the rising rates of HIV and STIs, this extra investment could simply be increasing drug costs rather than service development, although some indication of priority areas for investment can be seen below. As finances are likely to become more constrained in the near future, it will become more important than ever for commissioners to have a good awareness of their financial situation and commission cost-efficient services.

3.6 Community-based services

Table 8: What was your priority for sexual health investment in the last year?

Community based services	66%
Primary care based services	42%
Hospital based services	15%
No investment	5%
Other	5%

This was the first time this question had been asked. Respondents could select multiple priorities, although one respondent who selected every possible option was removed from analysis on the basis that this did not constitute prioritisation. One respondent from Wales and one from England indicated they had made no investment in the previous year.

Community-based care may be delivered by a range of providers, including hospital clinics, primary care clinicians and voluntary sector providers. Adding enhanced community and primary care in sexual health and HIV to the portfolio of services will improve patient choice and could eventually free up secondary care capacity to deal with more complex cases.

3.7 Factors that influence commissioning

In the last year, what has most helped you commission sexual health and HIV services?

This question was first asked last year, when the most commonly mentioned aids were targeted funding, national prioritisation/targets and national policy guidance. Respondents were able to give free text answers to this question and a selection of this year's responses can be read below. Once again, many respondents identified national guidance, including the National Support Team, Respect and Responsibility (the Scottish national sexual health strategy) and the Welsh Annual Operating Framework as helpful. It is clear that although the focus has now shifted to local decision-making in healthcare, continued high-profile national support will help to make local prioritisation a reality. Joint working at a local and regional level was also seen as helpful.

"DH funding for contraception, national push for HIV testing, Targets for GUM, teenage pregnancy and Chlamydia keep profile high and encourage/lever funding and attention."

"Visit from the Sexual Health National Support Team and their Rapid Appraisal identifying key strengths, weaknesses and priorities for action. Conducting a Sexual Health Needs Assessment. Support from the sexual health lead director."

"Support from National Support Team. Closer working with Public Health and Informatics. Closer working across region with neighbouring NHS bodies."

"Sexual health - ongoing implementation of Scottish sexual health strategy and action plan, and of local action plan."

"Clear Welsh Assembly Government guidance with quality requirements for Sexual Health. Annual Operating Framework to focus on sexual health. Local Health Board commitment to Modernising Sexual Health services."

In the last year, what has most hindered your ability to commission sexual health and HIV services?

This was also a repeated question from last year, when respondents' top concerns included the reorganisation of PCTs and a lack of resources and commissioning capacity.

Interestingly, given the focus above on the importance of national support, respondents to this question identified a narrow focus on very specific targets as a hindrance to their commissioning work. Lack of data and issues with administration and commissioning processes were also of concern. It seems that the focus afforded to sexual health through target-setting is valued, but that more support is needed locally to make best use of these targets as a framework for broader service improvement and support quality commissioning.

"There is no specific high level national HIV target, which makes it difficult to divert funds to increased testing and social support."

"High priority of the chlamydia screening target - helped raise profile but narrow focus on achieving screening numbers with additional resources directed here."

"Prioritising chlamydia screening campaign - this seems to be a campaign which will be of little long term benefit. Better to spend the time and money on channelling young people through proper well thought out, holistic sexual health services."

"Achievement of GUM and chlamydia targets at the expense of developing community based sexual health services."

3.8 Help to improve sexual health

Table 9: What would enhance your ability to make greater progress locally in reducing the incidence of HIV/STIs?

Local prioritisation of sexual health and HIV	59%
Better information and data	54%
More funding	51%
More joint commissioning	46%
More training and support	42%
More local leadership	37%
Better local referral networks	22%
Other	17%

This was the first year that respondents were given a list of options from which to choose. The issues listed were drawn from responses to previous surveys, where these topics have been raised consistently and multiple choices were available.

Almost three fifths of respondents mentioned "local prioritisation" as a key issue. Interestingly, given the stronger national focus in Scotland and Wales, nine out of twelve Scottish and Welsh respondents wanted local prioritisation. The second most commonly cited issue generally was around information and data, which ties into the responses around needs assessment and the free-text responses to the previous question on hindrances to good commissioning. Responses under "other" included requests to train more nurses and a plea for more joined-up working with Local Authorities.

The single biggest difference we could make to sexual health and HIV services would be to support high-quality commissioning and show that sexual health and HIV are key areas of healthcare. Commissioners responding to this survey have clearly identified training and support needs and pointed to the necessity of keeping sexual health and HIV high on the local agenda. Ongoing high-profile national support for programmes such as the Chlamydia Screening Programme (England) and the maintenance of support through the National Support Team in England, Respect and Responsibility in Scotland, the Quality Improvement Scotland standards and Welsh Assembly Government guidance will help to signal to local decision-makers that sexual health and HIV remain a priority.

4. Clinic Findings

4.1 Sample breakdown

Table 10: Country origin of clinic responses

England	86%
Scotland	8%
Wales	3%
Northern Ireland	2%
No response	1%

As this was the first year that the survey was distributed online and to all four UK countries, it was unsurprising that the majority of respondents were from England and that Scotland, Wales and Northern Ireland were under-represented. One respondent was unable to indicate their country of work. A total of 102 clinics responded.

Table 11: Unit where clinician is based

GUM unit (mainly GUM)	79%
Other	16%
No response	3%
GUM unit (mainly HIV)	1%
Infectious diseases unit	1%
HIV unit	0%

Last year respondents were answering as individual clinicians, and so were asked about their own profession. This year, because respondents were asked to submit one set of answers per clinic, we asked them where they were based. This may in part explain the greater proportion of respondents indicating that they were working more generally in a GUM setting. Those who responded "other" mainly went on to describe their clinic as a GUM unit delivering an equal proportion of GUM and HIV services, rather than providing more of one service. Several respondents described their clinic as an "integrated sexual health service", indicating that service delivery models are moving away from previous norms.

4.2 Service provision

Table 12: If you are a GUM unit, do you provide both contraception and STI services?

Yes	65%
No	31%
Don't know/no response	4%

The analysis of these responses was done on the basis of the 96 respondents who had previously indicated they were based in a GUM unit. Although there is still some way to

go, more clinics are providing a combined service, with the proportion providing both contraception and STI services up from 52% in 2007 to 65% in 2008. This is likely to improve choice and convenient access to services for patients.

4.3 Access to services

Table 13: In the past year, have you had to turn people seeking initial diagnosis away without providing a service?

No	71%
Yes, occasionally	24%
Yes, often	3%
Don't know/no answer	3%

In comparison to last year's results, the proportion of those who said they did not have to turn people away has remained stable at 71%. However, the percentage turning someone away either often or occasionally has risen slightly from a total of 24% in 2007 to 27% in 2008.

4.4 Drugs budgets

Table 14: Will your unit's drugs budget be overspent by the end of the year?

Yes	36%
Don't know/ no response	34%
No	30%

Compared with 2007's responses, slightly fewer clinics thought their drugs budget would be overspent (39% in 2007, 36% in 2008). However, more respondents could not say whether or not budgets would be overspent (34%, up from 30% in 2007). In this year's survey the question was asked much later in the financial year, in January rather than September. It is therefore of concern that over a third of clinics are so unsure of their financial position so close to the end of the year.

4.5 Engagement with patients

Table 15: Does your clinic meet at least quarterly with a patient representative or patient representative group?

No, clinic does not meet with patient representatives	48%
No, meet less frequently	21%
Yes, meet quarterly or more often	17%
Don't know/ no response	14%

Patient involvement in clinics appears to have significantly deteriorated in 2008. The proportion of responding clinics not meeting at all with patient representatives has gone up from 43% to 48%. In Scotland, only two clinics out of eight who responded were able to say they met quarterly with patients. In 2008, fewer than one in five clinics

met at least every three months with patients; this was 30% in 2007. For almost half of responding clinics to have no formal patient involvement mechanisms at all is of considerable concern in terms both of national policy and local service quality.

4.6 Activity versus capacity

Table 16a: In the last year, patient activity has:

Increased by more than 10%	55%
Increased by less than 10%	21%
Stayed the same	13%
Don't know/ no response	9%
Decreased	2%

In 2007, 91% of responding clinicians said that patient activity had increased. This year, 76% of responding clinics said that patient activity had increased to some degree. In Scotland, six out of eight respondents said that patient activity had increased. Although this is a decrease in those reporting more patient activity, when viewed alongside responses about staffing levels below, there is cause for concern about the sustainability of current clinic activity.

Table 16b: In the last year clinic staffing has:

Stayed the same	39%
Decreased overall	28%
Increased, but below increase in patient activity	17%
Increased in line with patient activity or above it	13%
Don't know/no response	4%

Last year, only one in five respondents said staffing had decreased, but in 2008 this figure is up to over a quarter. Only 30% of responding clinics this year said that staffing had increased to some degree. Given that three quarters of clinics are reporting an increase in patient activity and that many areas are currently experiencing a recruitment freeze, this level of pressure on services may be difficult to sustain without more staff or further changes to service configurations.

4.7 Local prioritisation

Table 17: Are HIV and sexual health sufficiently prioritised within your local health services?

Yes	52%
No	39%
Don't know/no response	9%

In 2007, 67% of responding clinicians thought that these areas were sufficiently prioritised locally. In 2008, these figures have already dropped to just over half of respondents. Elsewhere in this year's survey, over a third of clinicians and nearly two

thirds of commissioners reported that local prioritisation would be helpful in making local progress around sexual health and HIV. It is clear that HIV and sexual health still need championing locally to ensure they do not slide off the agenda as has happened in the past.

4.8 Support from other organisations

Table 18: Do you feel your service gets good support from

Voluntary/community sector	46%
Health Board/PCT	36%
Primary care services	32%
No response	32%

This was a new question in 2008 and was designed to gauge the way services are working together to support each other locally. One in three clinics did not feel that they got good support from any of the other major players in sexual health. However, almost half have good relations with their local voluntary sector and a third with their Health Board/PCT and/or primary care services.

This section allowed free text comments and many, despite the positive tone of the question, were negative. The main issues raised were prioritisation or the lack of it, the lack of local leadership and coordination and a specific antagonism towards chlamydia screening. There was also animosity towards the voluntary sector from some English respondents in the light of competitive tendering.

"Absolutely hopeless commissioning. No idea of process therefore just destabilise current services. Public Health non-existent or counterproductive."

"GP support variable. Some very helpful. Others say sexual health is not an enhanced service and so try to avoid providing it."

"Since the Sexual Health Strategy outcomes were included in the Board's annual review we have had a great deal of attention."

"The 'voluntary' sector are bidding to take work away - who are they and what is their role?"

"Chlamydia screening is a shambles."

Sometimes the same organisation was viewed very differently. For example, "regular co-working with local THT service" was praised, but "some local agencies set(ting) up HIV/STI testing in direct competition with our service e.g. THT" was not so positively viewed.

4.9 Factors that influence service provision

In the last year, what has most helped you provide services?
81% of survey respondents answered this free text question and a representative selection of responses is given below. The main helpful themes identified by respondents included dedication of staff, better clinic accommodation, visits by NST and support from commissioners and senior management.

"Joint training (contraception and STI) with the local GUM clinicians."

"Staff worked above and beyond their job plan. Recent court ruling allowing patients ordinarily resident in the UK to have free access to the NHS."

"Moving into a completely new clinic building & amalgamating with contraception (It has taken some 9 years of political & administrative activity to get here, but we got the largest DoH building grant in 2004, found an affordable site in Sept 2006, and opened in July 2008 - total project cost £2.85 million)."

"Excellent staff. Several are contraceptive trained, and we provide an integrated young persons one stop shop. The nurse practitioners are extremely competent and can see and treat patients with complicated conditions."

"Working in the devolved NHS in Scotland. NHS QIS sexual health services standards."

As in previous years, it is clear that clinicians found a combination of local support and national leadership helpful. This was in line with commissioners' remarks about what they had found supportive and it is encouraging that both commissioners and clinicians have identified increased joint local and regional working as key to making progress.

In the last year, what has most hindered your ability to provide services?
Responses to this more negative question were often fuller than those to the previous question about what was helpful. Comments centred on poor quality commissioning, the English tendering process and on staff shortages and lack of decent premises. It was clear that many NHS service providers have been badly upset by the competitive tendering process and are hostile towards it. This has often been complicated by poor commissioning by inexperienced staff.

"The attempts to dumb down the service...The McDonalds approach doesn't address quality..."

"The PCT and its lack of leadership in commissioning sexual health services..."

"Disincentive of not receiving solid recognition of tight budgetary control...money saved on HIV drugs is not fed back to us whereas units that overspend have that overspend waived."

"Increasing patient numbers and decreasing staff levels. Inadequate space within the department in which to actually see patients - we need a bigger, better staffed unit and have done for some time."

"Commissioners that do not wish to engage in the process and who do not understand the needs of patients. Poor social care provision."

4.10 Help to improve sexual health

Table 19: What would enhance your ability to make greater progress locally in reducing the incidence of HIV and/or STIs?

Increased staffing	70%
More funding	60%
Better premises	45%
Better service networks	44%
Local prioritisation	35%
More health promotion services	35%
More community based services	31%
Other	6%
No response	6%

Similarly to the commissioners' survey, this was the first time clinic respondents had been given discrete categories from which to choose for this question. In line with previous years, staffing, funding and premises were the most regularly cited areas where support would enhance local progress. Responses in the "other" category included pleas for greater integration of services and more input to local sex and relationships education.

4.11 Payment by Results

(for English respondents only) What impact if any has the absence of Payment by Results had on your work?

This was a free text question for the 89 English respondents. Responses were very varied, illustrating both that the implementation of Payment by Results (PbR) is at different stages in different regions and that reaction to it is very mixed. Around one in five respondents (21%) said there was no effect from the absence of PbR and 30% of the English respondents chose not to respond to this question.

Of those respondents who said PbR was unhelpful, several identified administrative issues and problems with their department recouping any additional money, or said that PbR was skewing focus of their work.

"We have PbR. We bring in a shed load of money to the trust but they slap a massive overhead on us that ends up showing we operate at a loss. i.e. staffing costs are £750,000. We bring in £1.5m PbR yet we are told we are costing the trust! The same overhead goes on us as medicine or surgery, ridiculous."

"Too much emphasis on PbR over clinical needs....i.e. new to follow up ratio and obsessing with targets."

"We receive payment by results but there are no clear commissioning arrangements or Service Level Agreements. In some ways PbR has prevented services from working together because of the financial implications."

"The focus is on getting new patients in. Tariffs do not take into account complex cases or multi-disciplinary involvement. Crucially there is little emphasis on health promotion work."

"I have desperately been trying to get PbR and failed. If I could get it and have control of the budget I could develop this service rapidly for the benefit of all."

"DEVASTATING if we lost PbR. Currently our HIV work is a block contract so we make a loss - counterbalanced by the profit from STI side."

It is clear that with PbR as with other areas of the NHS agenda, the same policies are being implemented differently in different areas. This is an inevitable consequence of decentralisation and does in some cases allow for flexibility in responding to local need. It is clear however from the responses to these surveys that an element of national guidance and leadership, alongside support for implementing change, remains essential to maintaining progress.

For further information on sexual health and HIV policy and practice:

Terrence Higgins Trust website (includes many policy and practice publications including previous *Disturbing Symptoms* reports)
www.tht.org.uk

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

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

Department of Health Website
www.dh.gov.uk

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