# POLICY CONSULTATION ON CONFIDENTIALITY AND DISCLOSURE OF PATIENT INFORMATION: HIV AND SEXUALLY TRANSMITTED INFECTION (STIs)

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### 1. Introduction

1.1 The Department of Health (DH) is undertaking a consultation to clarify policy on patient confidentiality and disclosure of information on STIs including HIV. The outcome will benefit those who use services in that they will know what to expect. This paper also takes account of representations to DH from sexual health professionals seeking clarification of the circumstances when they may need to disclose confidential information, including about a patient's HIV status, both with and without the patient's consent.

1.2. This paper takes account of a recent High Court decision involving as claimants, the Health Protection Agency (HPA), an acute hospital trust and a primary care trust. The claimants were seeking a declaration relating to the common law on disclosure, the duties imposed by the European Convention on Human Rights and application of the legislation[1] on disclosure of information on sexually transmitted infection (including HIV). However, the Judge decided not to make a decision.

### 2. Consultation

2.1 The DH invites comments on the questions set out in this paper plus any other relevant issues. Additionally, Annex 3 sets out scenarios which illustrate some of the dilemmas in this area. These are included to ground some of the consultation questions in the real situations in which health care professionals from time to time find themselves. The scenarios invite responses on what you would do or how you would advise a colleague seeking professional advice from you. Comments on the scenarios also are welcome from other interested groups.

2.2 The outcome of this consultation will inform policy and any changes to the existing Regulations and Directions and new DH guidance. The deadline for comments, is **31 October 2006**. Please email comments to Sexual-Health-&-HIV@dh.gsi.gov.uk or send comments to Jonathan Fraser, Area 620, Wellington House, 133-155 Waterloo Road, London SE1 8UG. The criteria for all national consultations is set out in Annex 4.

2.3 The British HIV Association (BHIVA) has recently completed consultation on its briefing paper, *HIV transmission, the law and the work of the clinical team.* DH will consider the outcome in taking forward this consultation. The BHIVA consultation focuses on the responsibilities and duties of health care staff in the light of recent prosecutions of HIV positive people for the transmission of HIV. (see www.bhiva.org under BHIVA guidance).

[1] NHS (Venereal Diseases) Regulations 1974 and NHS Trusts and PCTs (Sexually Transmitted Diseases) Directions 2000

2.4 DH has sent this document to the organisations listed in Annex 5. Comments from interested individuals and organisations not listed are also welcome.

2.5 Since there are no anticipated cost implications as a result of this consultation, DH has not included any Regulatory Impact Assessment. DH will keep this under review.

## 3. Background

### The common law of confidence

3.1 It is a long established principle of the common law of confidence that private information provided by a patient to a medical professional is held by the medical professional in confidence[2]. The obligation of confidence means that information can be lawfully disclosed only if the patient consents or if there is a public interest of sufficient force to take precedence over the professional's duty. Whether or not there is a sufficient public interest to justify disclosure is something which must be judged by the professional (and ultimately the courts) on the facts of each case.

3.2 In assessing whether there is a sufficient public interest to justify disclosure it must be borne in mind that there is an important public interest in maintaining professional confidences, and thereby encouraging patients to divulge information which may be relevant not just to their own treatment but for the protection of public health generally.

3.3 According to the common law, the test of overriding public interest is a substantial hurdle which must be overcome before disclosure is made. It should not be equated merely with a need to show good reason for the disclosure of confidential information. Hence the key NHS publication on confidentiality - Confidentiality: NHS Code of Practice (2003) ("the Code of Practice") - sets out a very limited range of circumstances which may justify disclosure of confidential patient information in the public interest: "in order to prevent and support detection, investigation and punishment of serious crime and/or to prevent abuse or serious harm to others (page 28, para 30).

3.4 In relation to "serious crime" the Code of Practice goes on to say that there is no clear definition but murder, rape, manslaughter, treason, kidnapping, and child abuse and other cases where individuals have suffered or could suffer serious harm would all be included. Serious harm to the security of the state or public order crimes or crimes involving serious financial gain or loss are also said to justify disclosure. But the Code of Practice makes clear that there is a wide range of less serious crimes, the desire to report which would not justify overriding a patient's right to confidentiality. An extract of the Code is at Annex 1.

[2] Hunter v Mann [1974]QB 767, 772

## Human Rights Act 1998

3.5 Since October 2000 when the Human Rights Act 1998 came into force, the common law of confidentiality has been overlaid with the right to respect for private life contained in Article 8 of the European Convention on Human ("the ECHR") Rights[3]. Common law principles must now be identified and applied in line with Article 8, which reinforces the principle that private information provided to a medical professional must be kept in confidence subject to consent or an overriding public interest. That public interest must fall into one of the categories set out in Article 8(2) and any disclosure must have effects which are proportionate to the public interest which it is said to serve.

3.6 Under Article 8, as under the common law, there will be a justification for disclosing private information where that is necessary to prevent serious crime. One of the justifications under Article 8(2) is "for the prevention of disorder or crime" but it would be wrong to conclude from that wording that Article 8 will permit disclosures for the purposes of preventing *any* crime. Where a crime is not serious it would be disproportionate, and so contrary to Article 8(2) to breach the important duty of confidence in order to report it.

3.7 Proportionality will turn not only on the reasons for disclosure but also on the range of persons to whom disclosure is made, and what they do, or could reasonably be expected to do with the information. Again therefore the circumstances of each individual case must be considered before justification can be made out.

## Public Health Monitoring

3.8 The Human Tissue Act defines this as …*using population-based or epidemiological techniques to ascertain the prevalence, spread and pattern of an established disease or condition in the community, and relating its occurrence to public health programmes and activities*. Effective public health monitoring is essential for the control of STIs and HIV.

3.9 For many decades successful voluntary reporting by clinicians and microbiologists of individual cases of HIV infection and of selected STI cases, as well as aggregate data from GUM clinics has informed both local and national strategies for prevention and treatment services. It is reassuring that no breaches of confidentiality have occurred in 20 years of HIV reporting. *Getting Ahead of the Curve*: *a strategy for combating infectious diseases* (DH 2002) the Chief Medical Officer highlighted the importance of robust public health monitoring information for infectious diseases. Chapter 5 set out the main components of the existing public health monitoring systems and

[3] "(1) Everyone has the right to respect for his private and family life, his home and correspondence (2) There shall be no interference by a public authority with the exercise of this right except such as is in accordance with the law and is necessary in a democratic society in the interests of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime, for the protection of health or morals, or for the protection of the rights or freedom of others."

highlighted HIV clinician and laboratory reports, statistical returns by GUM clinics and data from unlinked anonymous surveys of HIV. Without this data it would not have been possible to track the changing UK HIV epidemic as well inform the need for prioritisation of STI prevention, diagnosis and treatment.

3.10 One of the intended outcomes of this policy review is to support the continuing need for robust public health monitoring whilst maintaining patient confidentiality. The NHS Code of Practice on Confidentiality covers disclosing and using confidential patient information in areas which do not directly support the patient's care but provide very important benefits to society. Data on STIs to support planning and improvement of services is one such area.

3.11. Clinicians and microbiologists participating in voluntary national reporting of HIV and STIs will only do so if they have confidence in the scheme's confidentiality . Likewise if information is to be accurate it must be possible to recognise reports that refer to the same individual, to avoid double counting especially for a chronic infection such as HIV. Therefore, surname "soundex"[4] code in combination with date of birth is used for HIV infection reports to eliminate double counting and to strengthen the protection of confidentiality. Additionally, reports of HIV infections and other STIs are kept in strict medical confidence and in conformity with Caldicott guidelines at local, regional and national levels within the HPA.

**Common Data Set for Sexual Health**

3.12 Work on developing a common data set for sexual health is underway with the twin objectives of helping clinicians to provide better care locally and improving surveillance and monitoring[5]. It will be implemented through the systems and structures being put in place by Connecting for Health (the National Programme for IT in the NHS) and will adhere to the guidance and procedures concerning confidentiality being adopted within the Programme.

## 4. Legislation on Disclosure of Information on STIs

4.1 In addition to the common law of confidence and the Data Protection Act 1998 ("the DPA"), there is specific legislation covering the disclosure of information about STIs, including HIV. The current legislation is the NHS (Venereal Diseases) Regulations 1974 and the NHS Trusts and PCTs (Sexually Transmitted Diseases) Directions 2000. The Regulations apply to officers of Strategic Health Authorities, all NHS Trusts, NHS Foundation Trusts and Primary Care Trusts and the Directions apply to members or employees of all NHS trusts and Primary Care Trusts. The Regulations and Directions provide that information shall not be disclosed except:

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[4] For more information about Soundex see: Mortimer JY, Salathiel JA. 'Soundex' codes of surnames provide confidentiality and accuracy in a national HIV database. *Communicable Disease Report* 1995;**15(12):**R183-186

[5] See www.cdssexualhealth.org.uk for more detail

"(a) for the purpose of communicating that information to a medical practitioner, or to a person employed under the direction of a medical practitioner in connection with the treatment of persons suffering from such disease or the prevention of the spread thereof, and

(b) for the purpose of such treatment and prevention."

## 5. Interpretation of the Regulations and Directions

5.1 Interpretation of the Regulations and Directions in a way which is compatible with the relevant articles of the European Convention on Human Rights (ECHR) has raised a number of issues for healthcare professionals. DH is aware of differing interpretations of the legislation and there is a need for the NHS to adopt a consistent approach.

5.2 Different approaches to interpreting the legislation have included:

i) Only permitting disclosure of information likely to identify a patient and their treatment if it is to a medical practitioner, or person acting under the direction of a medical practitioner, for the purpose of treatment of an STI or prevention of the spread of an STI,

ii) Permitting disclosure as in (i) above but also permitting disclosure in line with the NHS Code of Practice on Confidentiality and the GMC Guidance on Serious Communicable Disease (see Annex 2), in order to protect others from serious harm. For example, to a known sexual contact of a person with HIV, where a health care professional has reason to believe the patient has not informed that person and cannot be persuaded to do so,

iii) Permitting disclosure in circumstance (i) only or (ii) only but also where the patient consents to disclosure.

iv) Permitting disclosure in circumstance (i), (ii) or (iii) but not permitting disclosure of routine anonymised information for health surveillance purposes.

## 6. Confidentiality and sexually transmitted infections

6.1 Ensuring patient confidentiality for people using sexual health services is and must remain a key component of prevention strategies to control the spread of infection and reduce undiagnosed infections. STIs and HIV remain stigmatised health conditions.

6.2 Self-referral to NHS sexual health clinics without fear that sensitive and personal information will be disclosed wider than is needed to treat the patient concerned or to prevent the spread of the STI has successfully underpinned sexual health services in the UK for many years. Article 2 of the Public Health

(Venereal Diseases) Regulations 1916 required, amongst other things, that "all information obtained in regard to any person treated [for venereal disease] …shall be regarded as confidential". The aim of our policy remains to encourage people to use services so they can seek advice, access testing and treatment services and make any behavioural changes necessary to reduce the risk of transmission to others and safeguard their own health. Doing so without fear that health care professionals will disclose information to others, without a patient's consent, remains key to our response of controlling HIV and other STIs.

6.3 The confidentiality provided by the Regulations and Directions also encourages patients to be honest and disclose their true sexual behaviour without fear of moral judgement or embarrassment. This will include details of sexual partners who may be at risk if HIV or an STI is diagnosed. Partner notification is a key preventative intervention. The vast majority of patients raise the issue of partner notification with sexual health advisors at the time they receive a positive HIV diagnosis. If necessary, they will seek advice and support from trained health advisors on how to disclose their HIV diagnosis to their partners.

## 7. Discussion

7.1 The 1974 Regulations were agreed several years before the first reports of AIDS (and subsequently HIV). In 1974 all known STIs were treatable, and not seen as life threatening, unlike HIV which while treatable is incurable. Issues such as the reckless transmission of life threatening infections would not therefore have been considered at the time that the Regulations were drafted.

7.2 In cases where a health professional is aware that a patient's continuing behaviour may be presenting a risk of serious harm to identifiable contacts (some of whom may also be in the care of the health care professional), and the patient cannot be persuaded to disclose to the person whom they are putting at risk that they are HIV positive (or have a serious STI) there would appear to be a public interest in disclosing that information, without the patient's consent to the contact in order to protect the contact from contracting the virus or serious STI.

*i) Do you agree that where a health care professional believes their patient's sexual behaviour is putting individuals at risk of serious harm, and, the identity of those at risk is known, the health care professional should consider taking steps to inform known contacts, even if the patient does not consent, or consent cannot be obtained, and the patient cannot be persuaded to tell the individual(s) themselves?*

*ii) What might those steps be if the identity of the person at risk is known but they are not a patient of the treatment centre treating the index patient?*

*iii) Are there circumstances when a health care professional may choose not to disclose to a known partner even though that partner might be at risk?*

*iv) Where does final responsibility for decisions on disclosure rest ? For example, does responsibility lie with the Caldicott Guardian or are such decisions the duty of only the appropriate Doctor in consultation with peers if necessary (GMC Guidance annex 2)*

v) *Given the provisions of the common law of confidence and the NHS Code on Confidentiality, what additional safeguards do the current Regulations/Directions on STIs provide in practice? Are these additional safeguards necessary? Are they too restrictive?*

*vi) If you consider that disclosure to the known sexual partner is appropriate in any circumstances, do you consider it to be appropriate for the healthcare professional to inform the partner directly that they can report their partner to the police for reckless transmission of HIV or other serious STI? Would this be likely to deter people from using sexual health services?*

## 8. Disclosure to whom ?

8.1 With the exception of issues relating to child protection, and apart from the case of disclosure to known sexual contacts whom a health care professional believes to be at risk, it is not clear what public health interest would be satisfied, by disclosing to others, such as other relatives, social service departments and the police.

*vii) Do you agree? Other than for child protection in what circumstances might a health care professional, need to consider disclosure to someone other than a known sexual contact. When answering this question please consider what the recipient of the information would be expected to do, or could do, in practice in response in response to receiving such information.*

## 9. Children and Young People aged under 16

9.1 Guidance on confidential sexual health advice and treatment for young people aged under 16 (*Best practice guidance for doctors and other health professionals on the provision of advice and treatment to young people under 16 on contraception, sexual and reproductive health*) was issued by this Department in July 2004. This guidance sets out the principles of good practice for health professionals who see under 16s requesting advice and treatment for contraception or other sexual health matters. These include:

- providing the young person with the time and support to make an informed choice, including exploring whether the relationship is mutually agreed or whether there may be coercion or abuse;

- always encouraging the young person to talk to their parent, carer or another trusted adult;

- identifying any additional counselling or support needs.

9.2 The guidance does make clear however that the duty of confidentiality is not absolute. There will be instances when information should be shared without consent - where the young person is engaged in an abusive or coercive relationship, or there is another over-riding public interest to do so such as the prevention or detection of serious crime.

9.3 The Government provided clear national guidance on this issue in the revised *Working Together to Safeguard Children* document, published on 6 April 2006. This contains detailed guidance for professionals to identify and support the minority of young people who are at risk of significant harm. There should be a strong presumption of reporting for children aged under 13 who are involved in sexual activity, because sex with someone under 13 is a serious offence and indicates a risk of significant harm to the child.

9.4 The guidance also sets out a framework for safeguarding sexually active 13-15 year olds. It provides clear guidelines on how professionals should judge when to share information. The key step in the first instance is a discussion between agencies to consider concerns and what, if anything, should be done in the best interests of the child.

9.5 Effective implementation is through the development of local multi-agency protocols.

## 10. Services provided in primary care

10.1 The national strategy for sexual health and HIV and Choosing Health Public Health White Paper envisage an increasing role for primary care in sexual health services, including STI testing and screening. Individuals using primary care services should be given the same level of confidentiality as that offered by GUM services.

> *viii) Do you agree that the added confidentiality provided by the Regulations/Directions applies wherever STI services are provided ? (ie it is not limited to GUM services)? This may require sharing of information, in line with locally agreed protocols in settings providing integrated STI and contraceptive services in order to provide a seamless service to patients (eg avoid duplication of questions).*

## 11. Protection and use of sexual health information

11.1 The provision of local and national data for surveillance and monitoring enables effective and responsive service planning and feeds into preventive actions of various sorts at local, regional or national level. Work on developing a common sexual health data set is underway with the twin objectives of helping clinicians to provide better care locally and improving

surveillance and monitoring (see www.cdssexualhealth.org.uk for more detail). It will be implemented through the systems and structures being put in place by Connecting for Health (the National Programme for IT in the NHS) and will adhere to the guidance and procedures concerning confidentiality being adopted within the Programme.

11.2 In relation to surveillance and monitoring, the NHS Code of Practice on Confidentiality covers disclosing and using confidential patient information in areas which do not directly support the patient's care but provide very important benefits to society. Data on STIs to support planning and improvement of services is one such area. .

*ix) Do you agree that policy on confidentiality should not prohibit the provision of non-identifying data and information for local and national surveillance.*

## Annex 1

## Extract from NHS Code of Practice on Confidentiality

## Disclosure of confidential information in the 'public interest'

Under common law, staff are permitted to disclose personal information in order to prevent and support detection, investigation and punishment of serious crime and/or to prevent abuse or serious harm to others where they judge, on a case by case basis, that the public good that would be achieved by the disclosure outweighs both the obligation of confidentiality to the individual patient concerned and the broader public interest in the provision of a confidential service.

Whoever authorises disclosure must make a record of any such circumstances, so that there is clear evidence of the reasoning used and the circumstances prevailing. Disclosures in the public interest should also be proportionate and be limited to relevant details. It may be necessary to justify such disclosures to the courts or to regulatory bodies and a clear record of the decision making process and the advice sought is in the interest of both staff and the organisations they work in.

Wherever possible the issue of disclosure should be discussed with the individual concerned and consent sought. Where this is not forthcoming, the individual should be told of any decision to disclose against his/her wishes. This will not be possible in certain circumstances, e.g. where the likelihood of a violent response is significant or where informing a potential suspect in a criminal investigation might allow them to evade custody, destroy evidence or disrupt an investigation.

Each case must be considered on its merits. Decisions will sometimes be finely balanced and staff may find it difficult to make a judgement. It may be necessary to seek legal or other specialist advice (e.g. from professional, regulatory or indemnifying bodies) or to await or seek a court order. Staff need to know who and where to turn to for advice in such circumstances.

**Examples of Disclosure to Protect the Public**

**Serious Crime[6] and National Security**

The definition of serious crime is not entirely clear. Murder, manslaughter, rape, treason, kidnapping, child abuse or other cases where individuals have suffered serious harm may all warrant breaching confidentiality. Serious harm to the security of the state or to public order and crimes that involve substantial financial gain or loss will also generally fall within this category. In contrast, theft, fraud or damage to property where loss or damage is less substantial would generally not warrant breach of confidence.

**Risk of Harm**

Disclosures to prevent serious harm or abuse also warrant breach of confidence. The risk of child abuse or neglect, assault, a traffic accident or the spread of an infectious disease are perhaps the most common that staff may face. However, consideration of harm should also inform decisions about disclosure in relation to crime. Serious fraud or theft involving NHS resources would be likely to harm individuals waiting for treatment. A comparatively minor prescription fraud may actually be linked to serious harm if prescriptions for controlled drugs are being forged. It is also important to consider the impact of harm or neglect from the point of view of the victim(s) and to take account of psychological as well as physical damage. For example, the psychological impact of child abuse or neglect may harm siblings who know of it in addition to the child concerned.

[6] Serious crime, as defined by the GMC is "a crime that puts someone at risk of death or serious harm and would usually be crimes against the person, such as abuse of children" (GMC guidance "Confidentiality: Protecting and Providing Information paragraph 37).

## Annex 2

## General Medical Council Guidance on Serious Communicable Disease

The paragraphs 18-23 reproduced below are taken from Serious Communicable Disease produced by the General Medical Council

### Confidentiality

Informing other health care professionals

18. If you diagnose a patient as having a serious communicable disease, you should explain to the patient:
    a. The nature of the disease and its medical, social and occupational implications, as appropriate.
    b. Ways of protecting others from infection.
    c. The importance to effective care of giving the professionals who will be providing care information which they need to know about the patient's disease or condition. In particular you must make sure that patient understands that general practitioners cannot provide adequate clinical management and care without knowledge of their patients' conditions.
19. If patients still refuse to allow other health care workers to be informed, you must respect the patients' wishes except where you judge that failure to disclose the information would put a health care worker or other patient at serious risk of death or serious harm. Such situations may arise, for example, when dealing with violent patients with severe mentally illness or disability. If you are in doubt about whether disclosure is appropriate, you should seek advice from an experienced colleague. You should inform patients before disclosing information. Such occasions are likely to arise rarely and you must be prepared to justify a decision to disclose information against a patient's wishes.

### Disclosures to others

20. You must disclose information about serious communicable diseases in accordance with the law. For example, the appropriate authority must be informed where a notifiable disease is diagnosed. Where a communicable disease contributed to the cause of death, this must be recorded on the death certificate. You should also pass information about serious communicable diseases to the relevant authorities for the purpose of communicable disease control and surveillance.
21. As the GMC booklet **Confidentiality** makes clear, a patient's death does not of itself release a doctor from the obligation to maintain confidentiality. But in some circumstances disclosures can be justified because they protect other people from serious harm or because they are required by law.

### Giving information to close contacts

22. You may disclose information about a patient, whether living or dead, in order to protect a person from risk of death or serious harm. For example, you may disclose information to a known sexual contact of a patient with HIV where you have reason to

think that the patient has not informed that person, and cannot be persuaded to do so. In such circumstances you should tell the patient before you make the disclosure, and you must be prepared to justify a decision to disclose information.

23. You must not disclose information to others, for example relatives, who have not been, and are not, at risk of infection.

**Annex 3**

**Scenarios**

In the hypothetical scenarios described below, you are asked to respond as a GUM clinician or health adviser, taking account of the common law of confidentiality and article 8 of the European Convention on Human Rights. In replying, it would help to set out what underlying principles have informed your answers.

1) As the health adviser you have reason to believe that an HIV infected male patient has not told his current female sexual partner of his HIV status. You think he is not using a condom consistently and he has already infected a previous female sexual partner who is being cared for in a different clinic. His viral load is such that he is not yet on anti-retroviral medication. He has had other casual partnerships as well as the current 'steady' sexual relationship.

*What do you think you should do ?*

2) An HIV positive man who has sex with other men is asymptomatic but has a high viral load. He has so far refused treatment. He has told you (as the GUM clinician) that he has multiple sex partners in your small city and regards it as the duty of his sexual partners, and not his responsibility, to ask about condoms - otherwise he will assume they are also HIV positive. He occasionally gets paid for sex (usually the receptive partner in such sexual encounters). There is only one GU clinic in your area.

*What do you think you should do ?*

3) A male, attends the GUM clinic with a chancre on his penis and is diagnosed with primary syphilis. He thinks he was infected from sex with a sex worker a few weeks before. He has a long-term partner whom he had sex with one week before attending the GUM clinic. She is six months pregnant. He refuses to inform her or for the clinic staff to make contact as she will then realise he has had other partners. He is an aggressive man, knows his 'rights' and tells you that as this is the GUM clinic, you are not allowed to breach his confidentiality by informing his partner without his consent. You, as the GUM clinician, are very concerned because of the possibility of congenital syphilis and the need for the partner to be seen and given appropriate treatment.

*What do you think you should do ?*

4) An HIV positive man has infected two women. The first woman was his long-term partner and tested positive shortly after his HIV diagnosis. The second woman he infected was someone he had a brief relationship with

two years after he was diagnosed and she is now also a patient of yours. The second woman asks you (as her GUM clinician) when this ex-partner knew he was HIV positive as he had not told her about his diagnosis. You can see from his notes that you asked him to inform his new sexual partner (the second woman) when their relationship began two years previously (which he said he had done but in retrospect clearly had not).

*Do you tell her the information she requests? Do you tell her that she can report the matter to the police? Do you say that if she brings a case to court the evidence can be subpoenaed but you are not able to disclose to her otherwise because the information is confidential?*

5) A male, who is a well known regular attender at the GUM clinic (usually comes for treatment of his gonorrhoea) attends this time and is not at all well. He has lost some weight and has oral candidiasis. You suspect he may be HIV positive, but he refuses to have a test. You know he has a long-term regular partner and also many casual partners. You also know from his history that he says he never uses condoms. You ask him to inform his partner of your suspicion that he may be HIV positive. He refuses.

*As you suspect he is probably HIV positive, do you have a duty to inform his regular partner that she might be at risk ?*

*Do you think she could bring a legal case against you as the doctor, for not informing her of the potential HIV risk? You suspected her partner to be positive and this is documented in his notes.*

**Annex 4** - **Consultation Criteria**

This consultation follows the revised Cabinet Office code of practice which is available from the Cabinet Office website. This requires government departments to:

- Consult widely throughout the process, allowing a minimum of 12 weeks for written consultation at least once during the development of policy

- Be clear about what proposals are, who may be affected, what questions are being asked and the timescale for responses.

- Ensure that consultations are clear, concise and widely accessible.

- Give feedback regarding the responses received and how the consultation process influenced the policy.

- Monitor their effectiveness at consultation, including through the use of a designated consultation co-ordinator.

- Ensure consultations follow better regulation best practice, including carrying out a regulatory Impact Assessment if appropriate.

The Code also invites respondents to "comment on the extent to which the criteria have been adhered to and to suggest ways of further improving the consultation process". For DH consultation, comments or complaints (but not your response to this consultation) should be sent to:

Steve Wells
Consultations Coordinator
Department of Health
Skipton House
80 London Road
London SE1 6LD (steve.wells@dh.gsi.gov.uk)

Information provided in response to this consultation, including personal information, may be published or disclosed in accordance with the access to information regimes (these are primarily the Freedom of Information Act 2000 (FOIA), the Data Protection Act 1998 (DPA) and the Environmental Information Regulations 2004).

If you want the information that you provide to be treated as confidential, please be aware that, under the FOIA, there is a statutory Code of Practice with which public authorities must comply and which deals, amongst other things, with obligations of confidence. In view of this it would be helpful if you could explain to us why you regard the information you have provided as confidential. If we receive a request for disclosure of the information we will take full account of your explanation, but we cannot give an assurance that confidentiality can be maintained in all circumstances. An automatic confidentiality disclaimer generated by your IT system will not, of itself, be regarded as binding on the Department.

The Department will process your personal data in accordance with the DPA and in the majority of circumstances; this will mean that your personal data will not be disclosed to third parties.

**Annex 5 – Organisations consulted**

The Department has invited comments from the following organisations. We also welcome comments from others.

African HIV Policy Network
All Party Parliamentary Group on AIDS
Birkbeck School of Law
British Association for Sexual Health and HIV
British HIV Association
British Medical Association
British Social Care Council
Brook
Crown Prosecution Service
Department for International Development
Expert Advisory Group on AIDS
Faculty of Family Planning and Reproductive Health Care
Faculty of Public Health
Fpa
General Medical Council
George House Trust
Greater London Authority
GU Nurses Association
Health Protection Agency (HPA) Sexual Health Programme Board
Home Office
Independent Advisory Group on Sexual Health and HIV
Keele University School of Law
London Metropolitan University
Medical Foundation for AIDS and Sexual Health
Monitor
National AIDS Manual
National AIDS Trust
NAZ
National Association of NHS Providers of AIDS Care and Treatment
National Association of Nurses for Contraception and Sexual Health
National HIV Nurses Association
Open Door Brighton
Patient Information Advisory Group
Positively Women
Release
Ribbon Centre Southampton
Royal College of General Practitioners
Royal College of Midwives
Royal College of Nursing
Royal College of Obstetricians and Gynaecologists
Royal College of Physicians
Royal Society of Medicine
Shield Sheffield
Sigma Research
Society for Sexual Health Advisers
Terrence Higgins Trust
UK Coalition of People living with HIV
UK Law and HIV/AIDS Project
UK Network of Sex Work Projects