Written evidence submitted by the Terrence Higgins Trust (PHP0035)

Terrence Higgins Trust is the UK’s largest HIV and sexual health charity, with 32 service centres across the UK. We are a campaigning and membership organisation which advocates on behalf of people living with or affected by HIV or poor sexual health.

THT provides services for people living with HIV to manage their condition and access emotional and practical support. These include one-to-one counselling, peer support, health trainers and information and advice covering benefits, housing, finances, employment and immigration. We also deliver community based clinical services, such as chlamydia screening and rapid HIV testing, and health promotion campaigns and initiatives which target populations most at risk of HIV and poor sexual health.

Throughout this consultation response we make clear that in the case of local authorities we are not generalising or asserting that all local authorities act in the same way. Local authorities are not a homogenous group and we have experienced both excellent and challenging behaviour from local authorities.

1. Executive summary

1.1 The change in structure of HIV and sexual health commissioning has led to fragmentation and raises question marks over where accountability lies. With HIV rates continuing to rise in 2014, it is unclear who is ultimately accountable for the HIV response in England.
1.2 The pressure on local authority budgets is directly affecting essential HIV and sexual health services. The reduction in local public health spending in 2016/17 has already led to the scrapping of HIV services across England.

1.3 Funding for the national HIV prevention programme has halved and the budget for next year is uncertain. Any reduction in prevention activity through the national programme will need to be picked up though local authority public health budgets. With the further squeeze on local authority funds, it is unclear how this will be delivered.

1.4 Communication, clarity and consistency post-changes was not well managed. There was a lack of clarity on where new responsibilities for commissioning lay and which individuals within new organisations led on sexual health and HIV work. From a provider perspective, there was uncertainty about whether contracts would continue and a lack of information about when decisions would be made on funding.

1.5 The role of “generalist” contract managers and an increase in evaluation have put extra pressure on contract holders. Whilst sexual health and HIV expertise was maintained in some cases in the transfer of responsibilities to local authorities, in other local authorities responsibility for commissioning sexual health and HIV services has transferred to “generalist” contract managers who have no expertise in public health or social care provision. In addition, some local authorities have imposed arbitrary KPIs on service providers that do not reflect the purpose of, or intended outcomes of, the service.
1.6 Positively, the transfer of public health responsibilities to local authorities has resulted in an increased focus on the social determinants of health.

1.7 The Act resulted in reduced joint-commissioning initiatives and cross-border communication. As local authorities must commission services specifically for their own residents, joint sexual health and HIV initiatives across local authority borders are now rare. The fragmentation of responsibilities around HIV and sexual health has also led to a reduction in initiatives to bring together stakeholders. The changes introduced in 2013 have also resulted in difficulties with service provision in local authority border areas.

1.8 There is inconsistency in access to services across local authorities. This “postcode lottery” means that access to support services by people with a sexual health need and people living with HIV varies greatly depending on where they live.

2. The change in structure of HIV and sexual health commissioning has led to fragmentation and raises question marks over where accountability lies

2.1 The new structures and responsibilities brought in by the Health and Social Care Act 2012 led to the systematic fragmentation of HIV and sexual health commissioning and accountability. We are now in a situation where responsibility lies across central NHS (NHS England), local Clinical Commissioning Groups (CCGs), local authorities and Public Health England (PHE).

2.2 NHS England commissions HIV treatment and care, sexually transmitted infections (STI) testing and treatment and contraceptive services provided as part of the GP
contract, national screening and immunisation programmes (e.g. for HPV and cervical cancer). CCGs commission a smaller number of specific services e.g. contraception for gynaecological purposes. Local authorities now play a key role in commissioning STI testing and treatment, HIV testing, HIV prevention and sexual health promotion, HIV social care, community delivered contraception, chlamydia screening, and young people’s sexual health services including in schools. In addition, PHE directly commissions a national HIV prevention programme aimed at those individuals at highest risk – men who have sex with men (MSM) and the black-African community.

2.3 An additional impact of the fragmentation of commissioning leads to services that are not designed around the individual service user, but are instead focused on where the pots of funding lie.

2.4 Since the Health and Social Care Act, it is also increasingly unclear what the role of the Department of Health is in HIV and sexual health compared with Public Health England. In particular it is unclear who is responsible for identifying and sharing good practice.

2.5 This split of responsibilities has made it increasingly difficult to understand where accountability lies for the HIV and sexual health response in England. For instance, local authorities are responsible for commissioning HIV testing in their local areas. However, CCGs also deliver HIV testing when required in other services they commission and NHS England provides HIV testing when required in other NHS England-commissioned services. Local authorities need to commission HIV prevention programmes that promote and increase HIV testing, and the national HIV prevention programme (commissioned by PHE) is needed to underpin these local programmes.
2.6 The latest Public Health England figures\textsuperscript{1} show that in 2014 the number of new HIV infections continues to rise and we now have more people living with HIV than ever before. It is unclear who is ultimately responsible for the HIV response in England.

3. The pressure on local authority budgets is directly affecting essential HIV and sexual health services

3.1 Local authorities are being asked to provide more and more services locally with an ever-decreasing pot of money available. The ring-fence in place for public health spending by local authorities has indeed protected funding. However the definition of what constitutes a public health service is not consistent across local authorities with instances of public health funds being spent on leisure centres and broader children’s services.

3.2 In addition, HIV support services including counselling, provision of specialist advice and peer support are often funded from local authority social care budgets which are under considerable pressure.

3.3 Although local authorities are mandated to provide open-access sexual health services (for STIs and contraception) we are aware that some local authorities have introduced a cap on the number of HIV tests that sexual health clinics are able to provide, with punitive tariffs in place if they exceed this.

3.4 We are pleased that the local authority public health ring-fence will remain in place for another two years. However, we are extremely concerned that in 2018 when the public health ring-fence is abolished the definition of what constitutes “essential” public health

\textsuperscript{1} https://www.gov.uk/government/statistics/hiv-in-the-united-kingdom
services will result in a further down-scaling of HIV and sexual health prevention and support services.

3.5 The non ring-fenced local authority social care budget is acutely precarious. The extreme demand for social care funded services has already led to HIV services funded by social care being cut from April 2016. This includes all funding for HIV support services for the whole of Oxfordshire being lost. As the only provider of such services in Oxfordshire, it is unclear what provision will now be made for counselling, support and specialist advice for people living with HIV in the area. The contract also included HIV prevention work with high-risk groups (men who have sex with men and black-African communities). Local HIV prevention efforts are essential and must continue to be funded. We are aware of similar service cuts in Leeds and Portsmouth with proposed cuts in Lambeth and East Sussex (both areas with extremely high HIV prevalence rates).

3.6 An additional impact of the cutting of public health and social care services is the potential loss of health prevention expertise in the voluntary sector. A loss that is not easily reversed.

3.7 Whilst we fully support the protection of the NHS budget, the exclusion of public health and social care services from this protection will directly lead to increased pressures and costs on NHS services as HIV and sexual health prevention programmes are undermined and people living with HIV and poor sexual health are not able to access the support services they need to remain healthy – both mentally and physically.

4. Funding for the national HIV prevention programme has halved and the budget for next year is unclear
4.1 The PHE commissioned national HIV prevention programme (called HIV Prevention England – HPE) has been in existence since 2013. Its purpose is to complement locally commissioned HIV prevention interventions in areas of higher HIV prevalence. The programme has three aims - to increase HIV testing, to reduce undiagnosed and late diagnosed HIV; to support sustained condom use, and other behaviours which prevent HIV infection; and to tackle stigma within MSM and black-African communities and more widely.

4.2 Between 2014/15 and 2015/16 the funding for the programme was slashed by 50% - to £1.2 million. With the recent announcement in the Chancellor’s comprehensive spending review that central Public Health England funds will be severely reduced, the future of the national HIV prevention programme after March 2016 is uncertain.

4.3 Any reduction in prevention activity through the national programme will need to be picked up though local authority public health budgets. With the further squeeze on local authority funds, it is unclear how this will be delivered.

5. Communication, clarity and consistency post-changes was not well managed

5.1 The transition period from old structures of commissioning (e.g. Health Protection Agency and PCTs) to new structures as defined by the Health and Social Care Act was not managed well. There was a lack of clarity on where new responsibilities for commissioning lay and which individuals within new organisations led sexual health and HIV work. From a provider perspective, there was uncertainty about whether contracts would continue and a lack of information (and understanding of who to
gain information from) about when decisions would be made on funding.

6. The role of “generalists” and an increase in evaluation have put extra pressure on contract holders.  
6.1 We fully support measures to monitor and evaluate services to ensure that they are effective and satisfying the needs of local residents. However, there has been a visible increase in the level and volume of scrutiny of new local authority commissioned contracts for sexual health and HIV services. Whilst it is understandable that local authorities are under a lot more pressure and scrutiny by political cabinet members, it results in a disproportionate amount of time needed for reporting by service providers.

6.2 There is a huge variation in behaviours of local authorities with some working in collaboration with providers to develop key performance indicators (KPIs) that are useful and beneficial to both parties. However, some local authorities have imposed arbitrary KPIs on service providers that do not reflect the purpose of, or intended outcomes of the service. Whereas PCTs were interested in quality of interventions and services, the reporting requirements of many local authorities are now focused on quantitative targets with no interest in understanding or interpreting the numbers with regards to health outcomes, and no focus on the quality of services delivered.

6.3 The extra scrutiny local authorities are under has also resulted in requests for new information from providers at short notice and with a short turnaround time. This is not sustainable when providers, especially
third sector organisations, have limited personnel and are operating on ever decreasing budgets.

6.4 PCTs had a good level of public health expertise in their staff, who understood and engaged in good practice and innovation around sexual health and HIV. Whilst this expertise was maintained in some local authorities, in others responsibility for commissioning sexual health and HIV services has transferred to “generalist” contract managers who have no expertise in public health or social care provision.

7. Transfer of responsibilities to local authorities has resulted in more focus on social determinants of health

7.1 A positive consequence of the transfer of public health to local authorities is their understanding and focus on the social drivers and determinants of health inequality and poor sexual health. In some local areas there is a focus on addressing the underlying causes of poor sexual health and the lack of access to services.

8. The Act resulted in reduced joint-commissioning initiatives and cross-border communication

8.1 We have found that since the move of public health responsibilities to local authorities, many successful local cross-border initiatives have come to an end. Previously, some local commissioning bodies (PCTs) jointly commissioned HIV and sexual health services over an extended local area. As well as reflecting the movement of local populations, it increased communication and sharing between local areas and ensured consistency in services commissioned. As local authorities must commission services specifically for their own residents, these joint initiatives are now rare.
8.2 The fragmentation of responsibilities around HIV and sexual health has also led to a reduction in initiatives to bring together stakeholders. Whilst pre-Health and Social Care Act, there were good networks and forums that brought together local partners – commissioners, providers and service users - these are now rare. An exception is in Brent in London where a sexual health providers forum brings together partners to ensure that services are joined up and holistic.

8.3 The changes introduced in 2013 have also resulted in difficulties with service provision in border areas. For example, in one instance Terrence Higgins Trust provides outreach and engagement services with the congregation of a church that sits on the border of two local authority boundaries. It has been increasingly difficult to secure ongoing funding for the service as accountability for those who would be reached by the intervention are split between two local authorities.

9. There is inconsistency in access to services across local authorities

9.1 We support the design of local services to ensure that they meet the needs of local residents.

9.2 However, the responsibility of provision of specific services (the “what” not the “how”) to local authorities has resulted in inconsistency in the level of sexual health and HIV services provided.

9.3 This “postcode lottery” means that access to support services by people with a sexual health need and people living with HIV varies depending on where they live.

10. Conclusion
In conclusion, some local authorities have successfully embraced their new sexual health and HIV responsibilities are working with partners (including third sector organisations and those directly affected) in the design and delivery of services. However, many others are still struggling with their new responsibilities. With the ever increasing pressure on local authorities to deliver more public services with less, the future for sexual health and HIV services delivered by local authorities looks uncertain. In addition, any further cuts to the nationally funded HIV prevention initiative, not protected under the NHS budget, will directly result in local authorities having to step up funding and delivery of HIV prevention services in their areas.

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