Summary

- Small reduction in numbers diagnosed with HIV infection but 17% increase in MSM diagnosed annually since 2010
- Late HIV diagnosis rates show large variations with significant reductions in MSM and in London but high rates which show little decline in heterosexuals, and outside of London
- Tendering of sexual health services continues to result in dis-integration of HIV services often at short notice without adequate planning of transition
- Fragmented and reduced commissioning of HIV prevention and testing
- Chemsex increasingly recognised as major determinant of poor sexual health outcomes
- Collaborative commissioning of sexual health, drug treatment and HIV services needed
- Major delay to commissioning decisions on public health interventions TasP by NHSE
- PrEP commissioning decision complex and delayed
- Public health cuts are likely to reduce access to STI diagnosis and treatment contributing to increased STI rates
- Commissioning of sexual health and HIV services which recognises the important interdependencies between these areas is critically important

Introduction

1. BHIVA is the leading UK association representing professionals in HIV care. Since 1995, we have been committed to providing excellent care for people living with and affected by HIV. BHIVA is a national advisory body on all aspects of HIV prevention, diagnosis and care. We provide a national platform for HIV care issues. Our representatives contribute to international, national and local committees dealing with HIV care. In addition, we promote undergraduate, postgraduate and continuing medical education within HIV care.

2. Public Health England has just published HIV surveillance data for 2014\. It is too early to assess the impact of the Health and Social Act on the numbers of new HIV infections and the proportion of individuals with HIV who are diagnosed late (CD4 < 350 cells/microL within 90 days of diagnosis). However these figures do provide the context to discuss public health aspects of HIV. Between 2010 and 2014 the annual number of new HIV diagnoses in the UK fell from 6353 to 6151. However the number of new diagnoses in men who have sex with men (MSM) increased by 17% from 2860 to 3360. It is considered most likely that the decline in diagnoses amongst heterosexuals is primarily due to changes to the migration patterns of people from sub-Saharan Africa the heterosexual group most affected by HIV.

3. There has been a decline between 2010 and 2014 in the overall proportion being diagnosed late from 50% to 40%. However looking at this more closely there are increasing differences between different communities. Late diagnosis reduced from
38% to 29% amongst MSM but only from 63%-61% in heterosexual men and 58%-52% in women. There were marked regional differences; in London late diagnosis dropped from 48%-33% with only small declines seen in the North of England (52%-48%) and the South of England (46%-44%).

**General Statement about services post 2013**

4. The Health and Social Care Act has been hugely disruptive to the delivery of HIV prevention, diagnosis and care. Prior to 2013 most HIV diagnosis and care was undertaken by integrated Genitourinary Medicine Services (Sexual Health and HIV services) Much HIV prevention was also delivered within these services encompassing both primary prevention (in HIV negative people) and secondary prevention (reducing onward transmission in people living with HIV).

5. Since 2013 the commissioning of these public health aspects of HIV has changed. Apart from a small national programme, HIV prevention is now primarily commissioned by local authorities and is delivered by a range of community and 3rd sector providers along with sexual health services. Secondary HIV prevention is more complicated. It is not entirely clear who is primarily responsible for commissioning behavioural aspects of prevention while NHS England now commission Treatment as Prevention (TasP). This is the initiation of antiretroviral treatment (ART) in people living with HIV with higher CD4 counts primarily to reduce onward transmission.

6. HIV testing is now commissioned in a variety of ways, nationally through Public Health England, by local authorities, and by Clinical Commissioning groups (CCGs).

7. The other big change that has occurred as a direct consequence of the 2013 Act is the tendering out of many sexual health services. This has resulted most commonly in the dis-integration of the sexual health and HIV services. Tendered out services have mostly been relocated out of acute Trusts; either leaving a stand-alone HIV service remaining within the Trust or adversely requiring the HIV service to be reconfigured or closed. On many occasions these changes (or cessation) to HIV services have come at very short notice.

8. Recreational drug use in MSM both diagnosed with HIV and those who are HIV negative especially in a sexual context (Chemsex) is increasingly recognised as a major determinant in the acquisition of STIs/HIV. In the ASTRA study 50% of HIV positive MSM reported recreational drug use in the preceding 3 months\(^2\).

**The delivery of public health functions**

9. Aspects of HIV prevention and testing commissioning and provision have become more fragmented and in many areas funding has been reduced. There was a very significant reduction in HIV prevention delivered through the national programme (HIV Prevention England). While this role and accompanying budget has been transferred to PHE the recent announcement of funded programmes is very limited in scope and likely impact. It is unclear whether funded programmes are expected to deliver significant public health benefit at a population level (unlikely) or whether they are innovative pilots to be evaluated and the most successful rolled out.

10. It is difficult to know what the overall impact of public health cuts on other aspects of prevention and testing has been or will be in the next five years as there is a lack of data. Anecdotally there are several examples of testing projects losing their funding – for example 56 Dean Street’s HIV testing at G-A-Y during HIV testing week. This event previously received local authority funding however this year funding was withdrawn.
11. HIV testing to reduce late diagnosis amongst heterosexuals especially from black and minority ethnic (BME) groups remains problematic. Despite clear national guidelines which prioritise opt-out testing in high prevalence areas and a growing evidence base of effective testing methodologies, commissioning and implementation of comprehensive testing programmes is inadequate. And this despite reducing late HIV diagnosis being a key outcome in the Public Health Outcomes Framework. We believe fragmented commissioning pathways post-2013 are a significant contributor to this.

12. Joined up commissioning of sexual health services and drug treatment services was one of the major advantages said to fall out of the Health and Social Care act however examples of this collaborative type of commissioning are few. There is no commissioning of either sexual health services or drug treatment services for people living with HIV directly by NHS England. With the dis-integration of sexual health services and HIV services provision the important benefits previously enjoyed relating to this integration are being lost.

13. There is increased recognition of the benefit of peer support services to assist with management of HIV as a long term condition, including maintenance of ART adherence, and retention in care. Support during pregnancy is one area identified as critical. Commissioning of HIV support services is mostly by local authorities. There are increasing reports of funding being withdrawn – the most recent being in Leeds where Peer Support services had funding discontinued.

14. Funding for community specialist HIV nursing posts has also been under threat. There is no consensus on how these posts and by whom these posts should be commissioned.

Case study – PrEP

15. The assessment of whether pre-exposure HIV prophylaxis (PrEP) should be routinely commissioned for HIV prevention in individuals at high risk for HIV is a good example of how complicated life has become post-2013. This intervention is likely to be the most effective prevention tool in 30 years of HIV prevention. The PROUD study conducted in the UK demonstrated an 86% reduction in HIV infections in a group of MSM given Truvada compared to a group in whom PrEP was deferred for 1 year. NHSE convened a group in late 2014 to write a policy proposal for consideration yet a final decision re PrEP will not be made by NHSE until June 2016. Even then this decision only relates to the commissioning of the drugs. However any PrEP programme will be delivered through sexual health clinics. This means that local authorities will need to commission the “service” aspects of a programme. They will only consider this in parallel with the NHSE process if there is no cost implication; that is PrEP can be delivered within the GU tariff currently in place. This proposal has not yet been properly tested – it is possible that providers will say this is not feasible, putting a PrEP programme at risk.

16. The other alternative is for local authorities to consider this as a new development. However under the current set up each local authority would have to do this individually. More concerning is that this process could not begin until after a positive decision by NHSE regarding funding of drugs. This would mean that PrEP would not start before April 2017.

17. The protracted time scale for NHSE to make decisions regarding interventions with significant public health benefits is not confined to PrEP. TasP is another case in point. The use of ART in people living with HIV to reduce onward transmission has been an
important part of UK (BHIVA) guidelines since 2012. This public health recommendation followed studies demonstrating a 90% reduction in HIV transmissions to HIV negative partners. Despite NHSE signalling a decision on TasP would be made by 2013 this was delayed until July 2015. Although most HIV services anticipating a positive decision began offering TasP prior to this date NHSE commissioners have been retrospectively challenging funding of this treatment.

Public health spending
18. We have major concerns about the one-off decision to cut the public health budget by 6.2% in year and especially of the decision to cut the allocation by almost 4% each year for 5 years. While we support the maintenance of ring fencing we believe this should have been for the entire 5-years not 2 years as has been announced. While the prevention aspects of public health spending are critically important and one presumes even more so taking into account The Five Year Forward View, it should be noted that this budget also includes provision for the diagnosis and treatment of sexually transmitted infections. With rates rising it is difficult to see how budget cuts can result in anything less than reduced access to care.

Effect of Health and Social Care Act on HIV services
19. While the objectives of this inquiry are to primarily examine public health functions post 2013 it is important to describe the effects of the Act on HIV services. As previously discussed many HIV services have been significantly reconfigured or in some cases closed down. BHIVA surveyed its members in Autumn 2014. Of respondents 83% worked in HIV units that were co-located with a sexual health service. Twenty-three per cent said that commissioning changes had had a detrimental effect on HIV treatment and care while 73% anticipated that treatment and care would deteriorate in the future as a result of commissioning changes.

Conclusions
20. Large numbers of people continue to be diagnosed with HIV every year. While there have been encouraging declines in late diagnosis among MSM very high rates continue to be seen in heterosexuals and outside of London. Progress in reducing new infections and late diagnosis has been restricted by fragmented commissioning, delays in decision making regarding key interventions, and funding cuts. The interdependence of STIs and HIV is well recognised but the policy response to this is being lost with the dis-integration of sexual health and HIV services.
21. We believe that integrated sexual health and HIV services are an important factor in the care-cascade which sees the UK a world leader in the proportion of people living with HIV, retained in care, on treatment and with an undetectable viral load. In public health terms these are critical markers. Finding a way to join up commissioning and provision of integrated sexual health and HIV services should remain a major objective.

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2. Daskalopoulou, Alison Rodger, Andrew N Phillip et al Recreational drug use, polydrug use, and


Sheena McCormack, David T Dunn et al Pre-exposure prophylaxis to prevent the acquisition of HIV-1 infection (PROUD): effectiveness results from the pilot phase of a pragmatic open-label randomised trial. Lancet. 2015 Sep 9 on-line