1.0 Introduction

1.1 This document has been produced by the British Association for Sexual Health and HIV (BASHH) in response to a call for evidence for the Health Select Committee’s inquiry into public health post-2013. BASHH strongly believes the Committee should prioritise sexual health as a “case study” area for the inquiry. Sexual health services represent a significant portion of Public Health England’s (PHE) £2.7bn grant to local authorities - currently some £670m is allocated to sexual health. The quality, safety and future of treatment and care provision in England are currently under threat as a result of current commissioning practices and the lack of assurance over funding of these acute medical services.

1.2 This document provides an outline of the importance of including sexual health as a case study and the recommended areas and evidence the Committee could investigate as part of the inquiry.

2.0 Background

2.1 From April 2013, responsibility for the commissioning of sexual health, HIV prevention and testing was transferred from the NHS to local authorities, who are mandated to provide open access to sexual health services.

2.2 As a result of the transfer of commissioning responsibilities, frontline clinical medical services for sexual health are now subject to a price-orientated competitive tendering process in the local government contracting environment. Proposed contracts and accepted tenders are predominantly based on the expectation of achieving significant cost savings compared to existing funding levels, with increasing emphasis placed upon the inclusion of measurable but clinically irrelevant performance indicators, to the detriment of core sexual health surveillance and monitoring functions.

2.3 The most recently published data from PHE reveals that record numbers of new STIs are being diagnosed in men who have sex with men (MSM), whilst syphilis and gonorrhoea are also at their highest recorded levels in 30 years. In light of the commissioning challenges affecting the ongoing delivery of sexual health services, and with genitourinary medicine (GUM) clinic attendances having grown to almost 2 million in 2014 (representing an increase of 30% over the past four years), there are real concerns that patients are taking longer to be seen, significantly increasing the risk of even greater onward disease transmission.

2.4 At a time of projected 25-40% cuts in central funding to local authorities, the £200m ‘in year’ cut to the public health budget announced in July, coupled with the additional annual 3.9% ‘public health savings’ announced in the Chancellor’s Autumn Spending Review, places huge pressure on funding for key public health services, including those for sexual health. Whilst we welcome the commitment to extend the public health ringfence to 2017/18, the fact that sexual health commissioning falls within the remit of local authorities means that the Government pledge to protect the delivery and funding of ‘the NHS’ does not apply to these services.

2.5 Increased funding restrictions will likely lead to a further deterioration in sexual health outcomes. Estimates have suggested that a 10% reduction in sexual health spending – an amount that now looks conservative judging by the recent Spending Review - could result in an additional £8.3 billion spending due to unintended pregnancies over the next five years and an extra 72,299 sexually transmitted infection (STI) diagnoses by 2020, at a cost of £363 million. Every £1 cut from sexual health could actually generate £86 in costs for the wider health system.

2.6 In practice, these cuts leave the sexual health of English communities at serious risk through defunding, leading to service limitations, clinic closures and potential job losses, thus impinging upon the delivery of specialist, level 3 specialist GUM clinics and outcomes for patients. In light of this, there is a considerable level of interest for the Health Select Committee to explore within its inquiry the funding options for sexual health services, including an appraisal of the options for the return of
all or part of the funding and delivery of sexual health to NHS commissioners. This would create
alignment with HIV treatment and care and abortion services.

2.7 High levels of antibiotic resistance in gonorrhoea continues to represent a significant public health
risk, as evidenced by the recent and high-profile outbreak of treatment-resistant gonorrhoea across
the North of England. Significantly, the latest available PHE data shows that management of
gonorrhoea treated outside of the GUM clinic setting is increasingly likely to be inappropriate.
Prescribing of first line recommended antibiotics of GPs sampled by PHE fell from 34% in 2011 to
12% in 2014.\textsuperscript{3} Excellent public health surveillance, senior clinician supervision of advanced practice
to deliver complex medical care, behavioural interventions and prompt partner notification are all
required to combat the growth of antimicrobial resistance and all elements of this control are
threatened by the current crisis in public health.

2.8 Sexual health services hold a pivotal role in tackling child sexual exploitation and sexual violence.
Open access services screen all young people for child sexual exploitation (CSE) and offer expert
testing and treatment services to those identified as trafficked or abused of any age, providing a link
to judicial and social services. Sexual health services also offer expert care for vulnerable adults,
providing high level support in multidisciplinary care for complex co-morbidities and in challenging
patient groups such as prisoners, commercial sex workers and people living with mental health
problems or learning disability. Further disinvestment and pressure on services is likely to negatively
impact on the ability of clinics to effectively address these issues.

2.9 Treatment and care for HIV remains as a specialist service commissioned by NHS England. Abortion
and some other elements of reproductive health are the responsibility of CCGs. Although these
elements are not within public health funding, loss of sexual health services impacts upon HIV care
by limiting HIV testing at a time when one in five of all HIV infections in the UK remain undiagnosed.\textsuperscript{4}

2.10 Recent changes have created a fragmentation in the commissioning and delivery of GUM and HIV
services. The high rates of retention in care of those diagnosed HIV positive in the UK has been
crucial in containing the HIV epidemic. Ensuring those diagnosed are treated and their virus
suppressed is essential in reducing onward transmission. Most sexual health and HIV treatment and
care services have been delivered from within the same premises by the same staff. Commissioning
integrated sexual health outside the health service has meant services have been uprooted and
relocated apart from each other, increasing fragmentation to the detriment of patient access and
care. There are indications in some areas of England that the continued delivery of existing HIV
services will become untenable due to these fractures in commissioning. There also appears to be
considerable variation in the standard of commissioning across the country, with a lack of national
guidance around practices such as co-commissioning GUM/HIV services.

2.11 The impact of this fragmentation both threatens the mandated principle of providing 'open access' to
sexual health services (there are examples of some local authorities limiting access to services by
age) and also puts pressure on other parts of the health service too, particularly those areas where
effective working links have been forged, such as primary care and emergency medicine.

2.12 Commissioning challenges are also placing a greater emphasis in some areas on nurse-delivered
sexual health services. A recent BASHH Nursing Workforce Survey revealed that two thirds of
respondents had been asked to take on extra duties normally associated with a higher banding or
another healthcare provider's role.\textsuperscript{5} Nurses have a hugely valuable role in delivering fast and
effective patient care but they are not trained to carry out the full range of specialist, multi-faceted
interventions that patients presenting acutely in sexual health services often require, such as
complex medical care and ongoing management.

2.13 Consultant support is essential to take responsibility, make weighted decisions and provide expert
insight and experience. GUM consultants integrate high level public health knowledge into real time
clinical care whilst providing teaching and training into almost every interaction. Patients requiring
complex care often present on an unscheduled basis, meaning that increasing access to basic
screening and treatment services through appropriate nurse-delivered care will reveal an increased
need for on-site expert consultant supervision, as has been the experience of the NHS Sandyford-led initiative in Glasgow. Moves from some local commissioners to increasingly deliver sexual health services without adequate consultant cover, by a reduction in contracted consultant time and by failing to replace retirement posts, restricts access to the full range of treatment options, puts undue pressure on nursing staff and jeopardises patient safety.

2.14 It is significant that in other parts of the UK, which have not adopted this funding and commissioning model for sexual health, there has been a recognition that sexual health services actually need a greater number of specialist consultants, to deal with the corresponding larger volume of Level 3 complex presentations (especially linked to MSM and HIV), and new challenges that emerging issues provide, such as chemsex, LGBT support services, delivery of PrEP and HPV-related disease.

2.15 Furthermore, there are also concerns that due to this increase in fragmentation, cervical screening tests are no longer being routinely provided in local authority-commissioned sexual health services, as responsibility for national screening programmes falls under the purview of NHS England. In London for instance, the overall delivery of cervical smear tests has declined by 21% between 2012/13 and 2013/14, with the London Borough of Hillingdon experiencing a decline of 69% over this period.6 The future of the National Chlamydia Screening Programme is also under threat, which could significantly weaken the strength of nationally collected data that informs disease epidemiology service planning.

2.16 The re-configuration of clinical care services provides opportunities to experiment with innovative service improvements. We are concerned that contracts may fail to reflect this need and omit research, quality and service improvement without national oversight of accountability.

2.17 In July 2015 the APPG on Sexual and Reproductive Health (APPGSRH) published a report on the findings generated by an inquiry into the accountability of sexual health services in England. The report highlighted that there is insufficient national coordination to enable local commissioners to work together in a safe and effective way which meets the needs of service users in their area and delivers training and education to safeguard quality services into the future.

3.0 What a case study on the delivery of sexual health services could achieve

3.1 In light of these concerns and the record levels of STI diagnoses, BASHH recommends that as part of its wider review of public health, the Committee holds an evidence session into the delivery of sexual health services, to investigate both national and local funding arrangements, procurement practices and current outcomes for sexual health. This would reveal the extent to which sexual health services are becoming increasingly fragmented both from HIV services and the wider NHS, as well as the impact that issues such as reduced 48 hour access are having on the ability of services to provide essential expert, clinical care for patients.

3.2 There is also a real opportunity to drive forward the recommendations that were identified through the recent APPG on Sexual and Reproductive Health inquiry 'Breaking down the barriers; The need for accountability and integration in sexual health, reproductive health and HIV services in England' and in doing so, help improve sexual health outcomes for patients.

4.0 Scope of a case study on sexual health

4.1 In light of this, BASHH recommends that the Committee considers the following areas as part of a case study for sexual health:

4.2 Safeguarding the future of sexual health: The current funding and commissioning mechanisms for sexual health means that the delivery of expert, clinical sexual health services in coming years are at serious risk of being jeopardised by future cuts to the public health grant, wider local authority pressures and fragmentation from the NHS. It light of the deleterious impact that this would have on patients and their outcomes, there is a pressing need for a re-evaluation of the current
commissioning and funding structures. Specifically, an inquiry could evaluate the viability of returning all or part of the funding and delivery of sexual health to NHS commissioners, to create alignment with HIV treatment and care and abortion services.

4.3 **Local Authority commissioning practices:** Concerns have emerged that price-orientated commissioning practices in a number of areas has impinged upon the ability of sexual health services to carry out their clinical functions. Short-term service contracts do not allow effective longer-term planning to be put in place, increasingly taking clinical time away from patients, in order to meet the heavy administrative burden tendering requires.

4.4 **Impact on the quality and standards of care for patients:** Despite the best efforts of staff, pressures on sexual health services are likely to lead to deterioration in the level of care that patients receive, particularly in terms of restrictions in treatment options.

4.5 **Impact on access to services:** There are evidence-based studies and reports demonstrating that patient access to sexual health services in a number of areas has worsened since the transfer of commissioning responsibility, which is likely to lead to poorer sexual health outcomes. At-risk groups have been particularly exposed to this impact, with the inadequate commissioning of dedicated chemsex services one such example of this.

4.6 **Impact on workforce education and training:** In the past, local authorities bought in trained medical opinion through public health, and all medical trainees were effectively free, since Health Education England funded such posts. Sexual health trainees are now only 50% funded, and many clinicians undertake undergraduate, postgraduate and refresher training for other healthcare professionals outside the specialty. Current commissioning practice is in many cases not fully recognising the important role of specialist workforce education and training, which is likely to have significantly negative impacts on training the whole health care community in coming years. Due in part to ongoing concerns around the future of commissioning and service delivery, a significant number of junior training posts for sexual health have not been filled, threatening the very future of the specialty, its ability to be self-sustaining and jeopardising the provision of expert, clinical sexual health care for patients.

4.7 **The role of the wider system:** Concerns remain around the role and responsibility of organisations such as Public Health England. When issues arise at a local level concerning sexual health commissioning and service delivery, there appears to be a worrying lack of national oversight and measures that they are able to take to enable their resolution. There is often a feeling that things have to go ‘wrong’ before statutory involvement is invoked, to the detriment of patient safety and care.

4.8 **Sexual health in London:** The future of sexual health care in London is currently being consulted on through the London Sexual Health Transformation Project. There are significant concerns that high-level strategic decisions on the future of sexual health care in London are being made with insufficiently robust interrogation of the scientific evidence base. The latest plans indicate that there will be a wholesale reorganisation of partner notification services, as well as a reduction in the number of level 3 GUM services in London, with commissioners increasingly hesitant to fund face-face consultations – instead, a much greater emphasis will be placed on the delivery of online-based asymptomatic screening. This will likely lead to the loss of key risk-identification opportunities for patients with complex conditions, and the marginalisation of at-risk groups.

4.9 The findings of a Committee case study into sexual health could lead to a significantly improved understanding of the key issues affecting the delivery of specialist sexual health services and ultimately help to sustain patient outcomes in this challenging commissioning environment.
5.0 Suggested evidence/ Proposed witnesses

5.1 BASHH propose that the following witnesses should be called upon to provide evidence for the inquiry in the first instance.

**Government**

**Department of Health** – Ms Jane Ellison MP, Ms Andrea Duncan  
**NHS England** – Dr Ian Williams, Ms Tracey Palmer  
**Public Health England** – Professor Jane Anderson, Professor Noel Gill  
**Health Education England** – Professor Wendy Reid, Professor Simon Gregory

**Local Government**

**Local Government Association** – Mr Paul Ogden, Cllr Jonathan McShane  
**Association of Directors of Public Health** – Dr Andrew Furber

**Professional Organisations**

**British Association for Sexual Health and HIV** – Dr Jan Clarke, Dr Elizabeth Carlin  
**Royal College of Physicians** – Professor Jane Dacre, Professor Margaret Johnson  
**British HIV Association** – Dr David Asboe  
**Faculty of Sexual and Reproductive Healthcare** – Dr Chris Wilkinson  
**Faculty of Public Health** – Professor John Ashton  
**Joint Royal College of Physicians Training Board** – Dr Rak Nandwani

*BASHH can also provide individual clinicians as witnesses, to provide examples of frontline sexual health service delivery*

**Patient advocacy/third sector**

**Brook** – Ms Eve Martin  
**Herpes virus association** – Ms Marian Nicholson  
**NAZ** – Ms Marion Wadibia  
**Terrence Higgins Trust** – Dr Shaun Griffin  
**Healthwatch** – Dr Katherine Rake  
**National AIDS Trust** – Deborah Gold/Yusef Azad

**About BASHH**

- The British Association for Sexual Health and HIV is the lead professional representative body for those managing STIs and HIV in the UK. It seeks to innovate and deliver excellent tailored education and training to healthcare professionals, trainers and trainees in the UK, and to determine, monitor and maintain standards of governance in the provision of sexual health and HIV care.  

**References**


5 – British Association for Sexual Health and HIV. Survey of Nursing Workforce in GUM/Sexual Health. 2015.


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