Written evidence submitted by NAT (National AIDS Trust) (PHP0083)

1. Exec summary

1. NAT (National AIDS Trust) is the UK’s HIV policy and campaigning charity. Based on the information explained in our submission of evidence NAT recommends:

2. That the Committee examine the way PHE functions within the Whitehall system and the degree of independence it in reality enjoys to make evidence-based recommendations to national and local government and to the English population.

3. That PHE is funded to commission public health interventions at a national level where this is integral to securing economies of scale, equity and effectiveness.

4. That the respective roles of national and the regional PHE centres in advising and intervening with local authorities need to be investigated and explored. This should include their standing and impact and consideration of whether PHE’s powers are adequate.

5. A new public health outcome indicator should be introduced on drug-related deaths to incentivise more effective delivery of drug treatment services and harm reduction.

6. That in order for primary HIV prevention to have a significant impact funding must increase from current and expected levels.

7. That as drug and alcohol services are frontline clinical treatment which should be universally available across England they should be mandated services.

8. That a sustainable commissioning and funding basis for cost-effective HIV support services needs to be agreed between national government, local government and the NHS to avoid the loss of an essential element of HIV treatment and care.

9. That PHE have a clearer mandate and remit from central Government to secure consistent categorisation and reporting of public health data at a local level. This will allow comparison of activity across local authorities and provide a useful national picture.

10. That the Health Committee look at sexual health and HIV as a case study for its public health inquiry.

11. Introduction

12. NAT (National AIDS Trust) is the UK’s HIV policy and campaigning charity. We welcome the opportunity to provide evidence to the Health Committee’s inquiry into public health post-2013. Our submission will focus on sexual health services, which are essential to the prevention and diagnosis of HIV, and which are now commissioned by local authorities as
part of their public health functions. We will also touch on drugs services since these also are relevant to addressing HIV-related needs amongst people who use drugs. We focus on HIV and STIs, where we have expertise, but there are broader and vitally important sexual and reproductive health services, such as contraception services, which are also relevant.

13. HIV and STI transmission rates remain high. Epidemiologists believe there has been no reduction in HIV transmission rates for more than a decade with evidence recently of an upwards trend. Last year saw the highest ever number of gay and bisexual men diagnosed with HIV. Over the past decade diagnoses of gonorrhoea, syphilis, genital warts and genital herpes have increased considerably, especially among men. Between 2013 and 2014 there was a 33% increase in infectious syphilis diagnoses and a 19% increase in gonorrhoea diagnoses. These increases can only in part be attributed to improved testing technology and are largely a result of ongoing high risk activity. Most of the STI diagnoses amongst men are found amongst men who have sex with men (MSM). Highest rates of STI diagnoses are found among people of black ethnicity. 

14. Improving our diagnosis of HIV remains the great challenge for our health services. UNAIDS has a 90:90:90 target. 90% of people with HIV diagnosed: 90% of those diagnosed on HIV treatment: and 90% of those on treatment with an undetectable viral load (the key marker of treatment success at which point risk of onwards transmission is close to zero). The UK does especially well on the latter two measures, exceeding the 90% measure on both counts, but Public Health England (PHE) states that just 83% of those with HIV are diagnosed. Furthermore, 40% of people in 2014 were diagnosed late, after the point at which they should have started treatment, with possibly serious implications for their future health and for onward HIV transmission. 

15. **Public Health England (PHE)**

16. During the Health and Social Care Bill debates, NAT and others raised concerns about the independence (enshrined in statute) of the Health Protection Agency, which would be lost in the creation of Public Health England (PHE). NAT’s experience of PHE has been that whilst it employs many dedicated public health professionals, there has been a shift of culture as PHE functions from within Government. The language and policy around drugs services and harm reduction presents an example of tension resulting from this shift. NAT and others would argue that the emphasis on exit from drug treatment as the key indication of recovery has been driven more from political pressure within Whitehall than from the evidence. As part of Government, PHE publications also appear to take longer to finalise and sign off, with influence from other Government departments linked to this. There is consequential delay to policy implementation or the initiation of programmes and we would site the Innovation Fund for HIV prevention, announced in March 2015 but not awarded until November 2015, as an example of this.

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17. **NAT recommends that the Committee examine the way PHE functions within the Whitehall system and the degree of independence it in reality enjoys to make evidence-based recommendations to national and local government and to the English population.**

18. We also have concerns about the adequacy of funding for PHE to fulfil its functions effectively. For example, staffing is very thin within the HIV and sexual health team, inevitably slowing the tender process, with knock-on effects on the continuous provision of services. Limited central funding can hinder the most effective use of total public health resources. A national HIV home sampling service has been launched in November 2015, which we welcome. However, it is co-funded between PHE and 89 participating local authorities. This means that the service is only truly national from 18 November to 31 December 2015 – from then on only residents from participating local authorities can order the kits. An online home sampling service would best be delivered on a national scale by a central organisation to increase accessibility to the tests for those with less provision in their area. But PHE did not have the funds for this approach, resulting in inequity of provision across England.

19. **NAT recommends that PHE is funded to commission public health interventions at a national level where this is integral to securing economies of scale, equity and effectiveness.**

20. In the near future we look forward to a new national HIV prevention programme going out to tender. The national programme can support innovation, develop health promotion materials, undertake research on HIV-related need, and organise events such as National HIV Testing Week, so as to support local authority activities and avoid wasteful duplication of activity. The funding for this programme however, has decreased since 2013 putting some of this important activity at risk.

21. As important an issue is the reputation and influence PHE enjoys with local authorities. Beyond the basic expectations of mandated services, PHE does not have the power to require local authorities to perform public health functions in a certain way. There is uncertainty how far PHE can go with local authorities in terms of persuasion, guidance and advice to secure consistent high-quality public health interventions.

22. **NAT recommends that the respective roles of national and the regional PHE centres in advising and intervening with local authorities need to be investigated and explored. This should include their standing and impact and consideration of whether PHE’s powers are adequate.**

23. **The delivery of public health functions**

24. The reforms introduced by the Health and Social Care Act 2012 have resulted in a complex and fragmented pattern for the commissioning of sexual health and HIV services. We believe the consequences are worth investigating in some detail if the Committee decides to look at HIV and sexual health as a case study. We mention briefly here some examples of fragmentation and the implications.
25. HIV testing is a good example of this complexity. Commissioning responsibility for HIV testing is as follows:

- HIV testing in sexual health clinics – local authorities
- HIV testing in community settings – local authorities
- HIV testing in GP settings where clinically indicated – NHS England
- HIV testing in GP settings as a public health intervention – local authorities
- HIV testing in secondary care where clinically indicated – CCGs
- HIV testing in secondary care as a public health intervention – local authorities
- HIV testing – new home-sampling test service – local authorities and Public Health England

26. Such fragmentation challenges concerted action on HIV testing in a local area. It is rare to find all commissioning parties fulfilling their responsibilities.

27. HIV treatment is commissioned by NHS England as a specialised condition to a national service specification, with specific contracts with providers managed by NHS England area teams. The majority of HIV treatment services are provided by sexual health (GU) clinics. Sexual health clinic services, other than HIV treatment and care, are commissioned by local authorities as a mandated service. The re-tendering of sexual health services by local authorities has resulted in the ‘stranding’ of some HIV treatment clinics, separating it from the sexual health service, threatening their sustainability.

28. The open access nature of sexual health services also pose challenges for local authorities unused to providing services for non-residents. The phenomenon of chemsex is one example – sexualised use of newer drugs mainly by gay and bisexual men, associated with HIV, STI and hepatitis risk as well as mental health and addiction needs. Chemsex need tends to be identified in open access sexual health services but a clinic will only be able to refer residents from their area on to local drugs services. Central London sexual health clinics with experience around chemsex are not able to refer on all patients to similar London-wide centres of excellence in addiction and drug detoxification.

29. The Public Health Outcomes Framework

30. In NAT’s experience the Public Health Outcomes Framework is a useful benchmark for local authority activity. The late HIV diagnosis indicator has focussed attention on the issue amongst local authorities. We are, however, concerned about the indicators chosen for drugs services. The substantive indicator [Indicator 2.15] is the proportion of people who successfully complete drug treatment (i.e exit treatment). This implicit hostility to people remaining in drug treatment longer-term is not evidence-based. Additionally, this indicator tells us nothing about the effectiveness of services or the proportion of people using drugs who are accessing services in the first place. Since 2013 there have been significant year-on-year rises in drug-related deaths (from 1,636 drug misuse deaths in 2012 to 2,248 in 2014\(^3\)). We note that drugs services, although clinical interventions, are not even mandated.

31. **NAT recommends a new public health outcome is introduced indicator on drug-related deaths to incentivise more effective delivery of drug treatment services and harm reduction.**

32. **Public Health Spending**

33. NAT has undertaken a survey of all local authorities in England with a high prevalence of HIV (>2 per 1,000 residents). High prevalence local authorities account for about two thirds of people living with diagnosed HIV and of new HIV diagnoses annually. We asked for information both on the services commissioned and the amount spent on primary HIV prevention and HIV testing services outside the sexual health clinic (‘out-of-GU testing’ – NICE recommends that high prevalence areas commission routine HIV testing in GP practices and in hospital general medical admissions, as well as in community settings). The key findings include:

- High prevalence local authorities spent £9.47m in 2013/14 on primary HIV prevention and out-of-GU HIV testing, and £10.32m in 2014/15 (an increase between the two years of 9%).
- Extrapolating across all local authorities at the same rate of expenditure we estimate at most £15m spent in 2014/15 on primary HIV prevention and out-of-GU HIV testing. This contrasts with £55m allocated for HIV prevention at the local level in 2001/02.
- For every £55 we spend on HIV treatment we spend just £1 on HIV prevention.
- There is no correlation between the amount spent on HIV prevention/testing by local authorities and their HIV prevalence.
- Of the 58 local authorities, in 2014/15 seven were spending nothing on HIV primary prevention or out-of-GU testing services, a further 13 were spending less than £25,000 a year and a further five less than £50,000 a year. Such levels of expenditure can purchase very little in terms of ongoing health promotion.
- National HIV testing guidelines (as described above) are not being implemented by the majority of local authorities (35 out of 58 surveyed).

34. It is important to stress that the decline in HIV prevention funding was a clear trend prior to 2013 and the slight increase in spending between 2013/14 and 2014/15 by local authorities is to be welcomed. But we must also stress how inadequate investment is whether looked at historically or in relation to current need. Every HIV transmission averted saves between £280,000 and £360,000 in lifetime treatment costs.

35. Our contention is that inadequate HIV prevention funding is itself a function of inadequate funding for public health as a whole. The contrast between the Government’s attitude to the NHS and its attitude to public health is telling. Whilst NHS spending continues to increase year on year in real terms, the public health grant was first frozen from 2014/15 to 2015/16, and then in 2015/16 subjected to an unexpected in-year cut of £200 million. The Spending review brought further news of annual cuts of an average of 3.9% over five years.

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5 For London local authorities these figures do not take account of contribution to the London HIV Prevention Programme, which is, however, meant to complement, not substitute for, prevention activity by the individual local authorities.
36. The Committee will no doubt get more direct and detailed evidence on the impact of these cuts on services, including on sexual health clinics. As one example we would mention the growing number of local authorities who are announcing they are decommissioning all community-based HIV support services, precipitated in part by the in-year £200 million cut. In recent weeks we have heard of this in Leeds, Bexley, Portsmouth and Oxfordshire and have reliable information that other councils are poised to follow suit.

37. Such HIV support services have been integral to HIV care and a vital complement to specialised clinic provision since the beginning of the epidemic. These services work to meet the significant social, sexual and mental health needs experienced by many people with HIV - for example, by providing peer support, especially when newly diagnosed, information on adherence to medication, safer sex and disclosure of status, counselling services, parenting and relationship support, signposting and social care provision. The excellent outcomes of HIV treatment are a result not just of our high quality HIV clinics but also of these support services.

38. The problem for HIV support services derives in part from lack of a clear commissioning responsibility for them following the Health and Social Care Act 2012 reforms. They span public health, social care and long-term condition management and there is no clarity as to a commissioning home for these services. This needs to be urgently addressed. The fact remains that a high proportion of these services are historically funded from what are now local authority public health budgets. The combination of cuts to public health and uncertainty on commissioning responsibility poses a profound threat to essential HIV services.

39. It has been frustrating to see the recent emphasis on increases in NHS funding (welcome though they are) whilst sexual health clinics are in all probability subject to significant spending cuts. As was shown above, sexual ill-health has increased and clinical services are not keeping up. This must at least raise the question as to whether it is right for sexual health commissioning to be outside the NHS in the long-term. It certainly underlines the importance of the mandate in ensuring sexual health clinic services are available in every local authority. We suspect given the cuts to public health that it will only be a matter of time before there is a dispute as to what constitutes the legally acceptable minimum service in a sexual health clinic to qualify as meeting the requirements of the mandate. It would be useful if there were a fuller account of service content and outcomes, perhaps as formal PHE advice, to which local councils, in law, have to have regard when interpreting the mandate. We regret that another key element in clinical treatment, drugs and alcohol services, are not mandated and therefore at significant risk.

40. **NAT recommends that in order for primary HIV prevention to have a significant impact funding must increase from current and expected levels.**

41. **NAT recommends that as drug and alcohol services are frontline clinical treatment which should be universally available across England they should be mandated services.**
42. **NAT recommends that a sustainable commissioning and funding basis for cost-effective HIV support services needs to be agreed between national government, local government and the NHS to avoid the loss of an essential element of HIV treatment and care.**

43. **The ring-fence and future consultation on public health financing**

44. NAT welcomes the retention of the ring-fence on the public health grant until 2018. The pressures on local government finances are so acute that had the ring-fence been removed funding would inevitably have been redirected to fund other services for immediate needs. We are of course immensely sympathetic to the strain on local services. But it is important to protect investment in our future health if we are to have a healthier population, a sustainable NHS and social care system, and the most cost-effective use of public monies.

45. We note that the Spending review states that ‘the government will consult on options to fully fund local authorities’ public health spending from their retained business rates receipts, as part of the move towards 100% business rate retention’ [para. 1.104 Spending review]. **We await the consultation on the future funding of public health but would mention now our concern around implications for protection of public health investment.**

46. **Categorisation and reporting of public health spending**

47. One of the challenges in analysing spending on HIV primary prevention and out-of-GU testing was the inconsistency in categorisation of HIV and sexual health expenditure. This makes it immensely difficult to compare spending across local authorities and get an overall national picture of activity and trends. That in turn has an impact on transparency and accountability. The problem is not a new one and has been noted over many years.

48. Local authorities do provide information on their public health spending to Public Health England and this is published by the DCLG. We have been told anecdotally by some Commissioners that to date there has been very inconsistent practice as to how calculations are made, what is included and what is excluded, in determining the amounts reported – and this of course has an impact on the usefulness of the data. Guidance on definitions and how to categorise expenditure is very limited and we understand the Government wants to have a ‘light touch’ approach. We appreciate the need to avoid overly burdensome or detailed reporting requirements. On the other hand, if requirements are so ‘light touch’ as to render the data useless, then the activity is wasted and so inherently burdensome.

49. **NAT recommends that PHE have a clearer mandate and remit from central Government to secure consistent categorisation and reporting of public health data at a local level. This will allow comparison of activity across local authorities and provide a useful national picture.**

50. **Sexual health/HIV as a case study**

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51. NAT recommends that the Health Committee choose sexual health and HIV as a case study for its public health inquiry:

- There is significant sexual health/HIV need with marked increases in STI rates in the last few years and also evidence of increased HIV transmission rates.
- Sexual health services include clinical treatment which is mandated – we believe it is especially important to look at public health functions which involve clinical treatment (the other being drugs and alcohol services) but which have been removed from the scope of the NHS. We also believe it is important to assess how the legal requirements of the mandate are being interpreted and implemented in practice and integrated with non-mandated elements.
- Sexual health services accounted in 2014/15 for 24% of net current expenditure by local authorities on public health.7
- Commissioning responsibility for sexual health/HIV is particularly fragmented so as a case study it will illuminate issues of whole system and integrated commissioning and the effectiveness of such bodies and processes as the Health and Well-being Board and the Joint Strategic Needs Assessment.
- Sexual health services are ‘open access’ which means people not resident in the local authority area can access the service. This raises significant challenges – of cross-charging for non-residents between local authorities in the absence of a nationally agreed payment system; and more broadly, the planning of services which meet needs over a wider geographical footprint than the local authority boundary.
- Sexual health and HIV remain stigmatised health conditions. Movement of public health responsibility to local authorities can allow for greater sensitivity to the priorities of the local population. However, the degree to which local authorities understand and respond to the needs of marginalised populations and stigmatised conditions may vary.

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