Written evidence from SH24 Community Interest Company

Written evidence submitted by Dr Gillian Holdsworth on behalf of SH:24, a Community Interest Company providing online sexual and reproductive health services

1. Executive summary

2. Sexual health is funded by public health, which moved from the NHS to local authorities following the Health and Social Care Act 2013. Substantial cuts to the public health budget mean that funding for sexual health services has decreased significantly; in parallel demand is rising.

3. Although some of this pressure can be managed through innovation, financial pressures are forcing commissioners of sexual health services to opt for services which deliver the largest cost savings, while aspects of quality and safety (e.g. safeguarding vulnerable young people) are deprioritized.

4. Financial pressures on sexual and reproductive health services, and the associated prioritization of cost over quality is a major challenge to the development and delivery of innovative services which are safe, effective and desired by users.

5. Introduction

6. SH:24 is the leading online sexual and reproductive health service in UK. SH:24 was established as a community interest company in 2013 by a group of doctors (public health and GUM consultants) and designers working in partnership with NHS sexual health clinics. Our aim was to improve the sexual and reproductive health of the population of Lambeth and Southwark residents who had the worst rates of sexually transmitted infections (STIs) in England, with long queues at clinics and poor access to sexual health services. As a team – SH:24 believes that a significant proportion of
sexual health activity can be delivered remotely, enabling people to increasingly manage their own sexual and reproductive health with access to remote clinical support by SMS, telephone, webchat, and referral into partner clinics for specialist care as required. The scoping work we have done with services users indicates that this is what they want. Not only does SH:24 improve access for people who lead busy lives but also, for many, avoids the embarrassment and stigma of going to a clinic. However, the current financial pressures faced by local authorities translate into cost being valued above quality. This is a major barrier to innovation, as detailed below.

7. **Recent trends, demand and access**

8. Between 2013 and 2017, total attendances at sexual health services in England rose 13% to more than 3.3 million annually. There were more than 40,000 gonorrhoea infections diagnosed in 2017, including drug-resistant strains, a 22% increase relative to the previous year. Over the last 10 years syphilis diagnoses have increased by 148% (Public Health England, 2018a).

9. Approximately 200,000 Chlamydia infections were diagnosed in 2017 despite decreases in chlamydia testing. Population testing fell by 8% between 2016 and 2017, and testing in specialist sexual health clinics fell by 61%, which is likely to reflect decreases in service provision (Public Health England, 2018a).

10. The impact of sexually transmitted infections remains greatest in young people aged 15 to 24 years, black ethnic minorities and gay, bisexual and other men who have sex with men (MSM). STIs are associated with various markers of poor sexual and reproductive health.
including sub-fertility, unplanned pregnancy, teenage pregnancy and abortion. Early diagnosis of STIs is an important aspect of prevention, facilitating early treatment and preventing transmission of infections.

11. **Funding & access**

12. Sexual health services cost around £600m a year. Responsibility for commissioning and funding sexual health services largely moved from the NHS to local government, along with many other public health services, under the 2013 NHS reforms introduced in the Health and Social Care Act 2013. When public health was part of the NHS, the budget was ‘protected’. In contrast, the grant from which local authority public health teams fund sexual and reproductive health services has been significantly reduced since 2013 with a planned average reduction of 3.9% per year 2015/16 – 2020/21 (British Medical Association, 2018).

13. From 2020, the government plans to fund public health through locally retained business rates. The British Association for Sexual Health and HIV has told the health secretary that this risks compounding health inequalities in deprived areas.

14. Clinics are being closed, restricting access to services. In London there have been at least eight GUM clinic closures since January 2017 - Barnet hospital; St Ann’s hospital, Haringey; Royal Free hospital; Margaret Pyke Centre Camden; St George’s hospital; Lloyd Clinic, Riverside Clinic, Artesian Centre – at Guy’s and St Thomas’ hospital. The London e-service procurement required the e-service to ‘go live’ in May 2017 to provide an alternative point of access to STI testing in the capital. But the contract was awarded to a provider who had no e-service at the time of award and mobilization plans submitted by the lead provider post contract award detail the building of a new service from scratch – rather than the roll out of an existing service across participating boroughs (the plan submitted with their successful tender). This led to a significant delay in the roll out of the e-service when clinics had already closed and will have contributed substantially to the reduction in testing and

15. Innovation within sexual health services

16. Although there are pressures on the sexual health system there is innovation in this area, and SH:24 is the leader in the development and delivery of a gold standard, online specialist sex and reproductive health services in the UK and abroad.

17. SH:24 built the service using an agile, design led approach based on Government Digital Service principles and co-produced with users. This means we have a service which is accessible, simple to use and which service users want. Feedback from service users is incredibly positive.

“...as a full time working single mum it’s almost impossible to get to an appointment or even book an appointment so this service is truly amazing and really appreciated.”

“My life has changed overnight because of the service you provide as I was concerned about my health and didn’t have the confidence to go to a clinic in person. I can move forward knowing I’m fine thanks to you.”


“I live in an area where STI testing is otherwise only available from a clinic that’s open for 3 hours once a month. I’m physically disabled and can’t get there easily. Being able to get tested at home is so much less taxing on my health, and I appreciate it being an option.”

18. SH:24 provides online STI testing - we currently process over 120,000 tests annually, with a return rate of over 80-94% (compared to a return rate of 55% in the national HIV testing programme), remote clinical support by SMS, telephone, webchat and
email, information, education and signposting to services; and online access to oral contraception and chlamydia treatment delivered to the home of service users. We have developed the platform for photo diagnosis of genital warts and herpes, a Contraceptive Conversations platform to allow women peer to peer discussion about contraceptive options which are clinically moderated and would like to develop a ‘PrEP online service’ to help gay men manage their HIV prevention. All of our interventions have been academically evaluated and our randomised controlled trial (Wilson et al., 2017) published in 2017 has been described at the International Union of Sexually Transmitted Infections in Dublin in July 2018 as one of the most important papers to be published in the last 18 months which will change clinical practice.

19. Since 2013 SH:24 has grown the business into 18 regions across the country, have launched in Germany in collaboration with AIDS Hilfe in July 2018 and we were the catalyst for the London Sexual Health Transformation Programme and the London e-service procurement. We were awarded the BMJ Innovation team of the year in 2017, the Digital Impact Award for Health 2018 and the Queen’s award for enterprise (innovation category) in 2018.

Case study 1 - Making services accessible for people with disabilities

A 23-year-old man who was a regular user of SH:24 tested positive for Chlamydia and Gonorrhoea. He was notified of his result by SMS and advised to call his local clinic to arrange an appointment. The service user replied to our SMS and explained they are unable to use a telephone to book the appointment as they are deaf and can only communicate by SMS or email. SH:24 was able to liaise directly with the local services to arrange an appointment for treatment. This case highlights that having a range of service options increases access and may have particular benefits for people with protected characteristics.

20. Outcomes:

21. Since the launch of SH:24:
21.1 STI testing in Lambeth and Southwark has almost doubled and there has been an 8% reduction in STI rates in the two boroughs at a time when testing rates decreased across London and STI rates increased. Increased access to testing, high return rate of our test kits, rapid turnaround time in the laboratory and fast track access to treatment are likely to have contributed to this.

21.2 Access to testing has increased:

- A randomized control trial demonstrated that individuals signposted to SH:24 were almost twice as likely as those signposted to clinics to have an STI test (Wilson et al., 2017).
- Increased access is observed irrespective of characteristics such as age, ethnicity, gender and deprivation.
- One in five SH:24 services users have never attended a sexual health clinic before, approximately half of whom are over 25 years. In new users over 25 14.5% tested positive for an STI (almost double the rate seen in SH:24’s service overall). This demonstrates that SH:24 is enabling people to test who, perhaps due to fear of stigma or access issues, are not attending face-to-face clinics but should be.
21.3 **Simple (asymptomatic) STI testing has moved out of face-to-face clinics.**

This allows clinics to focus on delivering complex sexual health care. In Lambeth and Southwark asymptomatic screening fell from 16.9% to 12.3% of clinic activity while complex activity rose from 69.2% to 74.9% (Turner *et al.*, 2018).

### Case study 2 - High risk user testing for the first time

A gay man who reported a number of risks for STIs ordered his first STI test from SH:24. His results showed a reactive HIV result and a positive result for syphilis and hepatitis B. The service user was contacted by a specialist SH:24 clinician to discuss his result, at this point the service user disclosed a sexual assault 3 months previously. The SH:24 clinician gave support over the phone and agreed a plan for next steps, including identifying a face-to-face clinic which the man could attend and contacting the clinic, with the service user's consent, discussing the case and arranging a same-day appointment. The service user attended the clinic that day for further specialist input and treatment.

This case study highlights the importance of close working arrangements with partner clinics offering service users a seamless journey from online to clinic and back.

21.4 **Cost efficient:** In addition to increasing access, online services can deliver STI testing at less than half the cost of the same test in face-to-face services. This is particularly relevant given the increased in demand and the reductions in the sexual health budget described above. SH:24 also offers a significantly faster turnaround time – over 80% of SH:24 results are issued within 24 hours of samples arriving in
the laboratory, and over 98% are issued within 72 hours. This compares to a typical clinic turnaround time of 10-12 days. Access to testing with rapid results and treatment means that the length of time a person has an STI, e.g. chlamydia, is reduced and this decreases the time during which a person is capable of transmitting the infection to sexual partners. Therefore, rapid results turnaround is a fundamental aspect of breaking the cycle of STI transmission.

22. **Impact of financial pressures on delivering innovative services - Standards and the procurement process: prioritizing cost over quality**

23. Ongoing reductions in the public health budget mean that local authorities commissioning SRH services are under significant financial pressure. To ‘balance the books’ funding for public services, including SRH, is being cut. SH:24 has prioritized quality, for example through pioneering an evidence-based pathway for online safeguarding assessment of young adults and through ensuring our service and partners (e.g. laboratories) are appropriately registered with and inspected by the Care Quality Commission (CQC).

24. However, in recent years SH:24 has seen contracts awarded, based on lower cost, to online services which are not registered with the CQC and which do not carry out safeguarding assessments. This highlights how the current financial pressures on sexual health services are forcing commissioners to prioritise cost-saving over quality, which is a major challenge to delivering a truly innovative and transformative service and presents a major risk to the safety of online services.

**Case study 3 – Lincolnshire procurement for an online chlamydia screening service**

SH:24 was recently involved in a tendering process for an online chlamydia screening service in Lincolnshire. During this process the contract specifications were downgraded to facilitate commissioning of a lower cost provider. During the clarification process:

- The requirement for CQC registration was removed
- The laboratory accreditation was downgraded from ISO 15189 to ISO 17025, which falls below the standard recommended by the Royal College of Pathologists for laboratory quality assurance
25. Another core aspect of the SH:24 offer is assuring users, clinicians and commissioners of the security of data storage. This is particularly important in sexual health due to the highly sensitive nature of the information shared. SH:24 is GDPR compliant and has embedded information governance within the service, harnessing the expertise of clinicians, IG and security experts, NHS IG boards, Caldicott Guardians, industry professionals and specialist lawyers from the outset. An example of our approach is the development of scannable test kit identification codes which remove the need to include personal identifiable information on sample containers. This robust approach to information security requires appropriate levels of investment in both the technical architecture supporting the digital services as well as the hosting solutions used. SH:24 has invested to ensure that its users’ data is stored securely within the NHS N3 / HSCN network. In addition to being highly secure this approach allows clinicians in our partner clinics to access user data securely so they can manage incoming results and treatment, therefore supporting the secure communication of clinical information to support safe management of service users requiring treatment.

26. We are aware that there are providers of digital sexual health services that do not adopt the IG / security measures that SH:24 (and its partners and users) feel is commensurate to the sensitive nature of the data being stored, and to our moral and legal obligations.

27. Issues we have identified in other providers’ practice include:

- Not hosting data within N3 / HSCN datacenters or using datacentres which don’t have the equivalent quality and security controls in place
- Use of programming stacks that can be vulnerable to common web security vulnerabilities
- Lack of consultation with users, healthcare stakeholders (including NHS IT/IG teams) and industry experts during the development of products
- Sharing clinical/results information through inappropriate and potentially insecure methods. For example, we are aware of a major supplier that sends spreadsheets containing results via email as opposed to using an approved clinical system hosted in N3 / HSCN. This is problematic on several counts including making data potentially vulnerable during transmission, not meeting NHS clinical record management/audit requirements and increasing the risk of social engineering

28. Summary – Quality versus cost

29. Funding constraints on local authorities have resulted in the weighting of tenders in favour of price over quality, giving suppliers with lower cost (and lower quality) services an advantage. A lack of understanding about the required regulatory processes and registration with these bodies by those commissioning/procuring the services means that unregulated providers are able to drive down the service specification requirements – as we have recently seen in Lincolnshire. These providers invariably have a) less secure digital solutions b) the lowest possible laboratory accreditation and c) are not appropriately registered with the Care Quality Commission. This latter point is particularly important because the CQC will only inspect registered organisations, therefore there is no official regulation of unregistered online

Case study 4 – London e-sexual health service procurement

The specification for the pan-London e-sexual health service stated that the provider must provide a secure in-clinic kiosk STI ordering service. However, the contract was awarded to a provider who offer an insecure solution (which would cache sensitive information in the kiosk’s browser making it accessible to other users). Instead of insisting the provider address the security vulnerability, the commissioners withdrew the kiosks and service users are now required to register kits using their own smartphones (the alternative would have taken substantial time to develop and been associated with “high costs”). This:

- reduces access for those users who don’t have smartphones and will increase inequalities.
- highlights how the prioritization of cost over quality threatens information security.
services. This impacts on the safety, effectiveness and responsiveness of these services and creates major challenges for safe and effective online services attempting to create the disruptive innovation required to reshape sexual health services to meet increasing demand, increase efficiencies and deliver a service which users and clinicians want.

30. Conclusion

31. In summary, sexual health services are currently under significant pressure in terms of increased demand and budget reductions. National data highlight the increasing rate of various STIs, including gonorrhea and syphilis, and rising antibiotic resistance. Despite this pressure there are opportunities to rethink how sexual health services are delivered to best serve the needs service users, and there are clear examples of innovation. However, the current and proposed reductions in the public health grant, and therefore in the budget available for sexual health services, means that commissioners tend to prioritize cost over quality. This is not only a barrier to innovation but leads to the commissioning of services which are not fit for purpose and which pose genuine risks to service users in terms of safeguarding and data security. If the squeeze on public health and sexual health budgets is not reversed access to safe, effective, responsive sexual health services will continue to decrease putting young people, men and women at risk and ultimately impacting on population health through increasing transmission of STIs, unplanned pregnancy and abortions.

32. Recommendations

33. We believe that a significant proportion of sexual health activity can be delivered remotely, enabling people to manage their own sexual and reproductive health. Delivery of innovative services in sexual and reproductive health requires whole system redesign with online services not viewed as standalone services, but as part of a system which supports seamless transition of users between clinic and online services.
34. We must be able to assure the public of the safety and effectiveness of the services they use. Online services should demonstrate this by complying with the relevant guidance, regulation and/or legal requirements for safeguarding of children and adults, regulation of healthcare services, information governance and data security, and by ensuring users of online services have access to specialist clinical support as required.

35. Prioritising user experience, including through working with users in service (re)design, will reduce intervention-generated inequalities by ensuring that services are appropriate and responsive.

36. References

British Medical Association (2018) *Feeling the squeeze - The local impact of cuts to public health budgets in England.*


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