Written evidence from the Royal College of Physicians

Executive Summary

- Sexual health services are at ‘tipping point’
- There is increased demand for sexual health services, a lack of capacity and access to services, and an unprecedented increase in specific sexually transmitted infections (STIs)
- The Health and Social Care Act 2012 has led to disparate commissioning arrangements and fragmentation of services
- There have been massive ongoing cuts to the public health budget and increasing financial constraints on sexual health services
- Tendering of sexual health services has led to uncertainty and workforce issues with recruitment, retention and training
- There is an urgent need for a long-term funding plan of at least 10 years for sexual health services, exemption from regular tendering cycles, and parity with the NHS irrespective of the commissioning organisation
- A long-term approach will allow improved service development, capacity and workforce planning as well supporting workforce stability, recruitment, retention and training so that we can provide the sexual health service we so greatly need.

Introduction

1. The Royal College of Physicians (RCP) welcomes this opportunity to submit evidence to the Health and Social Care Committee’s inquiry on sexual health. This response is based on the views of the Joint Specialty Committee (JSC) for Genitourinary Medicine (GUM), which is a specialist sexual health committee established jointly between the RCP and the British Association for Sexual Health and HIV (BASHH).

2. The RCP plays a leading role in the delivery of high quality patient care by setting standards of medical practice and promoting clinical excellence. We provide physicians in the United Kingdom and overseas with education, training and support throughout their careers. As an independent body representing 35,000 fellows and members worldwide, we advise and work with government, the public, patients and other professions to improve health and healthcare. Our primary interest is in building a health system that delivers high quality care for patients.

3. We are submitting evidence as we have serious concerns about the perilous state of sexual health and without sufficient long-term investment and planning the situation will get worse. We call for a long-term sexual health funding plan and parity with the NHS.
Recent trends in sexual health

4. Public Health England (PHE) reported that 422,147 diagnoses of STIs were made in England in 2017 this is comparable with 2016. However, certain STIs increased dramatically:

- **Syphilis** - 7,137 diagnoses reported in 2017. This is 20% higher than 2016 and 148% higher than 2008. These levels have not been seen since World War II. It is not surprising that we are now seeing cases of congenital syphilis in the babies of infected mothers, which is a sad indicator of poor sexual health.

- **Gonorrhoea** - 44,676 diagnoses reported in 2017. This is 22% higher than 2016. This is particularly concerning because of the emergence of highly drug-resistant strains of gonorrhoea.

5. PHE data shows that between 2016 and 2017 there was an 8% decline in the number of chlamydia tests. Most of the decrease took place in sexual and reproductive health services, where chlamydia testing has fallen by 61% since 2015, most likely reflecting a reduction in service provision.

6. Following the Health and Social Care Act (2012), fragmented commissioning arrangements in England have had a direct impact on sexual health and patient care. Responsibility for commissioning different elements of sexual healthcare lies with Local Authorities, NHS England and Clinical Commissioning Groups (CCGs). In many areas across England, patients are experiencing the serious adverse consequences of fragmented care, despite national guidance promoting seamless care.

7. The Health & Social Care Act also set sexual health services on course for ongoing rounds of competitive tendering and fixed-term contracts of varying length. This is standard practice for commissioning by Local Authorities. However, for sexual health services this has resulted in time which could have been spent on clinical care being used in tender preparations. Short-term commissioning cycles are not compatible with sustainable long-term planning for clinical service delivery and workforce recruitment, retention and training.

---

3. Local Authorities are responsible for: STI prevention, testing and management; HIV prevention and diagnosis; contraception provision and management. NHS England specialist commissioning is responsible for: HIV treatment and care. CCGs are responsible for: Community gynaecology, genital dermatology, psycho-sexual services).
5. Putting the pieces together: Removing the barriers to excellent patient care. RCP. 2015.
8. In 2015, a survey by BASHH of sexual health services identified that:

- Twenty three services, all outside London, had been tendered post-2012, 2 services during 2012, 14 services were going through the process or awaiting a tender/re-tender, 9 services had not been tendered. In one service the tender had been halted as all bidders had withdrawn.
- London boroughs had not been involved in tendering, this was to follow later.
- The most common contract lengths were 3-5 years. The shortest were 12-17 months.
- Significantly more negative experiences were reported with adverse effects on services.
- Overall, 38% reported decreases in their budget, rising to 48% in those who had undergone post-2012 tendering. Four services reported an increase in funding for additional responsibilities.
- There were multiple reports of staff leaving due to stress and in one service 25% of staff failed to transfer to the new provider resulting in key workforce shortages.
- Funding pressures, changes to clinic times or locations resulted in staff being spread more thinly and significant disruption.

9. In 2015, a BASHH survey of genitourinary medicine (GUM) trainees and newly appointed consultants showed that 59% felt their training was not considered and, apart from management experience, the impact on training parameters was negative.\(^5\)

10. In 2018, a BASHH members’ survey assessed how sexual health services were managing the pressures they were facing. Overall, 291 responses were received, of which 264 respondents were based in England:

- Almost a third reported that levels of care available to service users had deteriorated or significantly deteriorated. Many who had been able to maintain levels of care said staff were going ‘above and beyond’ to do so.
- Over 80% felt that staff morale had decreased in the past year, with almost half reporting that morale had ‘greatly decreased’.
- More than 9 in 10 respondents (92%) said they were worried or extremely worried about the delivery of sexual health care in England over the next year.

**Prevention**

11. Despite the evidence that prevention and early intervention is cost-effective and reduces future demand for healthcare, these services are particularly vulnerable to being reduced when there are budget cuts as the services, and their effects, are not immediately seen.

12. In 2017 the National AIDS Trust published a report based on Freedom of Information (FOI) responses from 230 commissioning bodies across the UK about their expenditure on HIV prevention in 2015/16 and 2016/17. This showed:

- A significant decrease in spending on HIV prevention across the UK.
- In areas with a high HIV prevalence, where need is highest, spending dropped by 29% and in London there was a 35% reduction.
- These reductions coincided with significant public health budget cuts in England.

13. The RCP is gravely concerned that large and sustained cuts to Local Authority public health allocations have caused serious adverse implications to the NHS and the health of the people it serves.

Commissioning and delivery of sexual health services, including contraception

Demand and access to sexual health services

14. PHE data shows that the number of individuals attending sexual health services has increased with over 2.6 million new service attenders in 2017.

15. In 2008 there was a mandatory NHS target for 48-hour access to GUM services in England. The target was subsequently removed and as services became restricted, due to financial constraints, 48-hour access was lost in many services. Mystery shopper ‘patient’ data has shown worsening 48-hour access to sexual health services in 2015 compared to 2014 for those with acute STI symptoms and it is also significantly poorer for asymptomatic women.

16. Access data for south London and Manchester has identified that over 1,000 individuals per month are turned away from sexual health services due to limitations in service provision.

---

17. In the recent BASHH members’ survey 63% of respondents said they were having to turn individuals away on a weekly basis and 19% said they turned away more than 50 people from their service every week.

18. Survey respondents were also five times more likely to report reduced outreach care for vulnerable populations (47%) compared to those reporting increased care (9%). These populations are likely to find it more difficult to access mainstream services.

19. The capacity issues in sexual health are exacerbated by the lack of available appointments in primary care for items covered under the GMS contract resulting in individuals on a daily basis seeking help at sexual health services. Women who are unable to obtain Long Acting Reversible Contraception (LARC) from primary care are also directed to attend sexual health services.

20. In recent years, online sexual health services have become available. Provision is variable but this represents an increasingly important STI testing option where appropriate. It also has the potential to increase costs to an already cash-strapped system.

**Funding**

21. There have been massive cuts to the public health budget allocated to the Local Authorities, with consequent cuts to sexual health services. In 2015/16, a £200m (6.2%) in-year cut was made to the public health budget, followed by real-terms cuts averaging 3.9% per year until 2020/21.\(^9\) At least £600 million will have been cut from the public health grant between 2015/16 and 2020/21 on top of the £200 million cut in 2015/16.\(^10\)

22. Serious financial pressures on GUM services with significant local variation have been identified by the King’s Fund. A quarter of Local Authorities reduced GUM spending by more than 20% between 2013/14 and 2015/16, while one in seven increased spending. They reported services being tendered with significantly lower budgets, which in some areas had resulted in clinic closures, reduced opening hours or being moved to less convenient locations.\(^11\)

---


23. In 2017/18 Local Authorities spent £30m less on sexual health compared to 2016/17, this is a 5% reduction in the total funding available for services. Over the past four years, planned spending on sexual health services has fallen by £64 million and the cuts appear set to deepen further.12

24. A FOI request made to Local Authorities in England to gauge future plans for public health spend identified that almost half planned further cuts in 2018/19 and several clinics across England will either close or have their opening hours reduced. In London many large clinics have closed across the capital, often being replaced by smaller satellite clinics with different service models and operating arrangements.

25. This contrasts starkly with the increased Government investment seen in NHS services.

26. The RCP strongly opposes any further funding reductions and urges the Health and Social Care Committee to call for a fair long-term funding settlement for sexual health. Investing in these services ultimately saves lives and improves long term patient outcomes. This is in addition to saving money for other healthcare areas in the NHS by reducing demand for hospital, health and social care services. The NHS faces unprecedented financial pressures, continued growth in demand, and increasingly complex patient needs. It is a false economy to impose funding reductions that will directly and adversely impact on the health service and the health of the people who rely on it.

Standards and governance

27. It is important to maintain standards and practice within a framework of national guidelines. Online sexual health services also require robust governance arrangements and new joint BASHH and Faculty of Sexual and Reproductive Health (FSRH) standards are currently out for consultation.13

Co-commissioned services

28. Many sexual health services are no longer co-located with the HIV service, which has reduced sexual health access for those living with HIV, and in some areas where the local Trust has not been awarded the sexual health tender the HIV service has been destabilised.

---


29. There is no commissioned PrEP service in England and some non-NHS provided sexual health services have been unable to participate in the PHE/NHS England PrEP Impact Trial as they do not have NHS research support. Many clinics in England now have no available MSM places and individuals are on waiting lists.

30. Cervical cytology screening rates are falling, particularly in women aged 25-49 years with current rates being 68.3%, compared to the national target of 80%. Sexual health services previously performed opportunistic cervical cytology screening but, as it is no longer commissioned from them, many have reduced provision.

31. Hepatitis A vaccination is recommended in all men who have sex with men (MSM) and HPV vaccine in those up to 45 years. This has increased the workload of sexual health clinics. In many instances this additional work will not be remunerated.

32. *Mycoplasma genitalium* is now well established as a causative organism in pelvic inflammatory disease, epididymo-orchitis and urethritis. Everyone agrees that testing for *M. genitalium* is important but the budget to support this is lacking.

### Workforce issues

33. There are major issues with sexual health recruitment and retention in all staff groups. GUM used to be one of the most popular medical specialities for higher medical trainees and recruitment rates were excellent. Now it is the least popular specialty and virtually all training schemes have some unfilled posts. This is most likely due to uncertainty about career prospects in sexual health related to cyclical tendering resulting in trainees making other career choices.

34. There is a decrease in whole time equivalents (WTE) consultants in GUM driven by a combination of the feminisation of the workforce, increased less than full time working (LTFT), job freezes during tendering cycles and an ongoing decrease of consultant hours to save money. The average WTE loss in all medical specialities is around 1% but in GUM is closer to 5%. The WTE loss in GUM is seen both in under and over 55 year olds.

35. There is an older workforce in GUM - in 2016 there were 65 (14%) consultants aged 60-65 years and 70 (16%) aged 55-59 years. It is anticipated that the age profile will be similar for specialty and associate specialist (SAS) doctors.

36. Nursing recruitment and retention has been difficult with many experienced staff leaving due to impending tenders or after the process. Almost two-thirds of

---

respondents (65%) in the BASHH members’ survey said it had become more difficult to recruit appropriate staff in the past year.

37. Additionally, when services are in the tendering phase there is often a hold on recruitment from when the tender is announced until the end of mobilisation.

38. A snapshot of GUM services in May 2018 confirmed increased numbers of consultant retirement / leaving around tendering and delays in recruitment.

- Overall, 133 responses were received from 99 clinics, 84 were from services in England and 65 (77%) had been tendered.
- In the tendered group 11 consultants retired in the 6 months before the tender and 2 moved elsewhere as a direct result; 25 consultants retired in the 12 months following a tender and 2 left as a direct result.
- Eight of the 36 retirements ‘retired and returned’ most on short-term contracts. Ten retiring / left consultants were not replaced. The other posts were on hold, had protracted recruitment delays, or recruitment was with reduced hours.

Specific population groups

39. National guidelines recommend that MSM who are at greatest risk of infection should be tested for STIs every three months. This should also encompass other groups at increased risk of STIs.

40. Less than 20% of high-risk MSM attend as regularly as recommended. If all high-risk MSM took up the offer of 3 month STI testing, services could experience up to a five-fold increase in workload.\(^\text{15}\)

Recommendations for action

41. A long-term funding plan of at least 10 years is urgently needed for sexual health that is robust, durable and fit for purpose.

42. There should be parity with the NHS regardless of whether sexual health services are commissioned by Local Authorities, ‘embraced by the NHS’, or commissioned by the NHS.

43. The disruptive and damaging effects of tendering and the destabilisation of sexual health and allied services need to be reversed as a matter of priority. Exemption for sexual health from regular tendering cycles is pivotal to this.

---

44. A long-term approach will allow for greatly improved sexual health service development, capacity and workforce planning as well as sending out a positive message about career opportunities. It will also address the crucial need for workforce stability and support recruitment, retention and training so that we can provide the sexual health service we so greatly need.