Written evidence from Specialist Advisory Committee for Genitourinary Medicine; Joint Royal College of Physicians’ Training Board

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1. **Introduction**

1.1. Our submission to this enquiry is on behalf of the Specialist Advisory Committee for Genitourinary Medicine of the Joint Royal Colleges of Physicians Training Board. We co-chair this committee which is responsible for developing the Genitourinary Medicine higher medical training curriculum (for approval by the General Medical Council), implementing this and managing recruitment into higher specialist training in Genitourinary Medicine across the UK.

1.2. Presently, recruitment to our training programmes across the UK is in crisis. Changes in commissioning and funding arrangements in England, where the vast majority of our workforce and training is delivered, has destabilised our specialty to the point that trainees no longer wish to come to train and work in it. This directly threatens the future of the specialty and of sexual health & HIV services in the UK.

1.3. This submission will describe how this situation has arisen and the serious challenges we face to sustain a senior medical workforce that is required to lead and deliver sexual health & HIV services in the future.

2. **De-stabilisation & fragmentation of sexual health services and the impact of huge funding cuts**


2.2. 90% of workplace based training of higher medical trainees in Genitourinary Medicine is delivered for the UK in England.

2.3. Different aspects of interdependent sexual health & HIV services, often delivered by the same group of staff, are commissioned by different NHS commissioners:

   2.3.1. Local Authorities: STI prevention, testing and treatment, HIV prevention and diagnosis and contraception;

   2.3.2. Local Clinical commissioning groups: Community gynaecology, genital dermatology, psycho-sexual services;

   2.3.3. NHS England specialist commissioning: HIV treatment & care.

2.4. This has resulted in:

   2.4.1. Fragmentation of service delivery in many areas;

   2.4.2. Competitive tendering of services with short term commissioning cycles that are not compatible with sustainable and longer term planning for clinical service delivery and workforce training and retention.

2.5. Dramatic cut to public health budgets for Local Authorities have followed and been passed on to services directly.  

   2.5.1. In 2015, a £200m in-year cut was made to the public health budget, and this was followed by a further 4% per annum cut within the 2017 Spending Review.

   2.5.2. In December 2017, the Government announced that its cuts to public health budgets will continue into 2018/19 and beyond, falling by 2.6% in both 2018/19 and 2019/2020.

   2.5.3. Between 2015/16 and 2019/2020, this amounts to local councils’ public health grant funding being cut by £531 million.
2.5.4. Whilst some local authorities have reported increases in their overall spend on sexual health, this varies significantly, and a quarter of localities have cut their spend in the area by 20% in the past two years.

2.5.5. In 2017/18, local councils spent £30 million less on sexual health compared to 2016/17, representing a 5% reduction in the total amount of money available for services. Over the past four years, planned spending on sexual health services has fallen by £64 million (equivalent to 10% reduction).

2.5.6. Recent analysis from the King’s Fund on future spending plans suggest that these cuts are set to deepen and that local authorities are clearly struggling to maintain spending in the face of central Government cuts.\(^5\)

2.5.7. Investigative reporters from the BBC carried out a recent Freedom of Information request of all local authorities in England to gauge future plans for public health spend - almost half plan further cuts in 2018-19 and it also found that some clinics in Suffolk, Cambridgeshire, Nottingham, Brighton, Doncaster and Norfolk will either close or have their opening hours reduced.

2.5.8. London closed clinics: Many major clinics have closed across the capital with “re-provision” at smaller satellite clinics with a different service model and target population. Furthermore, the financial disincentives to providers (marginal rates etc.) to see additional activity on the background of demand increasing 6% year on year has made developing these new service models really very difficult indeed.

2.6. These massive cuts in funding for public health and the Local Authorities are hugely different to the investment that is made into NHS services. In addition, as Local Authority commissioned services these will not see any of the investment planned for the NHS in the coming years, despite the fact that they employ NHS staff and are for NHS patients.

3. Our services are unable to provide care for those most in need & vulnerable or marginalised groups

3.1. Access data for South London & Manchester clinics indicates that >1000 individuals are turned away from our services per month due to limitations in service provision. The London data indicates that many have symptoms of a sexually transmitted infection and are aged under 24. \(^6,7\)

3.2. Limitations in service provision disproportionately affect those who are vulnerable or from marginalised groups.

3.3. Syphilis rates are the worse they’ve been since the end of World War 2: A 20% increase since 2016 & 148% increase since 2008.\(^8\)

3.4. We are seeing congenital syphilis in “low risk” individuals, the results of mothers acquiring it during pregnancy; just about the worse indicator of sexual health there is, and also an indication of fragmented health care systems.\(^9\)

3.5. Another indicator of sexual poor health is gonorrhoea rates in England are highest in decades, increasing by 22% in 2017 from the previous year.\(^8\)

3.6. Worryingly, we have also witnessed the first globally reported case of multi-drug resistant gonorrhoea in England, which follows an initial outbreak of high level azithromycin resistant gonorrhoea in England in 2015, and subsequent outbreaks across the country in 2016 and 2017.\(^10,11\)
3.7. This is all set in context against the worrying decline in chlamydia screening tests; 8% in 2016/17 due to reduction in service provision.\(^6\)

3.8. Cervical cancer is now the most common cancer amongst women under 35 and of great concern is that cervical cancer screening rates are dropping, especially in women aged 25-49 years of age, and this now 68.3%; well below the target of 80%. However, nearly all services are not commissioned to offer cervical screening when women attend for STI screening or contraception when previously this would have offered opportunistically which improved uptake rates overall.\(^12\)

4. **This has a direct effect on training of higher medical trainees**

4.1. It is well recognised that there are insufficient doctors to meet the workforce demand within the NHS in general. Thus, there are many initiatives within Health Education England and NHS hospital trusts and community services to improve intake into both specialty training and the NHS workforce in general. This involves recruitment from the UK workforce as well as international doctors and the UK Government has increased the number of undergraduate medical students by 25% including the formation of five new medical schools.

4.2. Potential entrants to higher medical training in Genitourinary Medicine evaluate the working environment, career security and opportunities in the speciality and compare that to other specialties.

4.3. All of the other medical specialities that higher medical trainees may choose to train in are commissioned by the NHS and as such are perceived as stable and secure options.

4.4. Due to the short term commissioning arrangements and consequent destabilisation of the specialty trainees struggle to identify a secure career for themselves in Genitourinary Medicine.

4.5. Today’s newly appointed consultants could be facing many tendering cycles with long term insecurity regarding their job or contracted hours so it is no surprise that other career options are more attractive.

4.6. Trainers in the specialty struggle to continue to deliver sustainable curriculum due to:

4.6.1. Training posts lost during service tendering as cost savings;

4.6.2. Reduction in training events due to insufficient doctors left to maintain them;

4.6.3. Interests of education & training not well served by the tendering process;

4.6.3.1. Fragmentation of clinical work & supervision;

4.6.3.2. Challenge to curriculum delivery: some trainees have had to move regions to gain sufficient experience to meet their training needs and progress their careers due to some specialist services not being re-commissioned post tendering, for example genital dermatology, psychosexual services etc, caps on or a reduction in numbers of symptomatic patients services have been allowed to see.

4.7. Medical trainees and newly appointed consultants report that training is rarely considered during the tendering process and has had a negative impact on their training experience.\(^13\)

5. **As a result of this applications for higher medical training have dropped hugely since the Health & Social Care Act was introduced:**
5.1. This is unique to Genitourinary Medicine within the Higher Medical Training Specialities due to de-stabilisation and fragmentation of clinical services and of the medical workforce where neither market forces nor private income that can compensate for this.

5.2. Service reconfiguration is leading to challenges in:

5.2.1. Maintaining the number of training posts;
5.2.2. Delivering scheduled training events;
5.2.3. Clinical practice & to clinical and educational supervision.

5.3. Medical and wider clinical staff have struggled with the consequences of the Health & Social Care Act and its implication for trusts and clinical services. The British Association of Sexual Health & HIV (BASHH) surveys and experience shared by medical colleagues indicate that in this new context, medical staff have experienced:

5.3.1. Extremely stressful high stakes competitive tender processes for which they are untrained and inexperienced
5.3.2. Staff diverted from clinical care to work on the tenders
5.3.3. Staff leave as a direct result of the uncertainty of the service
5.3.4. Staff recruitment paused and vacancies carried or locum rather than substantive appointments made due to service uncertainty
5.3.5. Following the tender award recruitment is often made at reduced levels to deliver the cost savings required (most contracts are of reduced value due to public health cuts passed onto them)
5.3.6. Some jobs are very unattractive and difficult to recruit to. Reasons vary but typically include frequent travel to and responsibility for a number of different sites, services that have been reduced or have aspects or sites closed down and previously integrated care being fragmented
5.3.7. There are reports of very senior staff effectively forced out of roles
5.3.8. At best a large pool of experience has been lost to the speciality and sexual health services.

5.4. Formerly recruitment rates to Genitourinary Medicine were excellent with it being a very popular choice of medical specialty for higher medical trainees. It is now the least popular. The table below indicates the numbers of higher medical training posts advertised through national recruitment in the past 5 years and the number of applications received (Health Education England data, personal communication). In 2018 less than 40% of posts advertised were filled.

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5.5. Postgraduate medical trainees, for whom many other training posts are available, perceive that Genitourinary Medicine is “a specialty in decline” with an uncertain, if any future.
6. **Steps taken by the specialty to attempt to manage and to mitigate the effects of the Health & Social Care Act**

6.1. BASHH have worked with the Local Government Association and agencies such as the King’s Fund to raise awareness of the problems faced and to constructively consider ways forward.

6.2. BASHH have supported services going through tendering and also provided a panel of experts to assist commissioners with the procurement process.

6.3. Training standards and curriculum delivery have been maintained, largely due to tenacity of the trainers.\(^{14}\) However, some changes have been required which have meant that on occasion trainees have needed to travel or move training centres.

6.4. We have been unable to address the inherent instability of the services or the problems faced due to the inability to meet demand and the pressure this places on staff. This is set to worsen with in-year cuts and short re-tendering cycles with lack of organisational memory.

6.5. Specialty training for higher medical trainees in Genitourinary Medicine will move to dual accreditation with Internal Medicine when this new curriculum becomes available.\(^{15}\) This will commence with recruitment at core training level in 2019 and for higher specialty level in 2022. This will provide a broader and more flexible training for consultant medical staff in the future, and deliver dual training in internal medicine as well as Genitourinary Medicine.

7. **Conclusions:**

7.1. The direct effect of the Health & Social Care Act has been to destabilise Sexual Health services to the extent that doctors no longer wish to train as Genitourinary Medicine Specialists due to the career instability.

7.2. We desperately need a long term stable funding plan for sexual health, whether it be via the NHS or ‘embraced by the NHS’. This would allow us to push for the stability of a long term (at least 10 years) funding regardless of whether we are in the NHS commissioning model or still within the Local Authority but with parity to the NHS.

7.3. To reverse the very damaging short term effects of tendering, the huge direct impact of the public health cuts and to give the specialty a future, our view is that this would be best served within an NHS commissioning model.

7.4. We need to urgently reverse the service and workforce fragmentation and destabilisation that this unduly complex commissioning landscape and devastating public health cuts have resulted in for Genitourinary Medicine. This will ensure:

7.4.1. Our services have access to funding opportunities that other NHS services do;

7.4.2. Stability & training opportunities for our present and future workforce;

7.4.3. Sexual health services have a future – and are not resigned to being the Cinderella service of the NHS once again!

*September 2018*
References
6. Dunne A et al. How many people do we turn away? Measuring unmet demand on sexual health services. Abstract 09: 4th Joint Conference of BHIVA and BASHH. April 2018
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