Written evidence from Dr Matthew Grundy-Bowers

I am a consultant nurse (HIV/Sexual Health) and senior lecture in Advanced Nursing Practice. I have worked in HIV/Sexual Health since 1994 and am passionate about the speciality. I feel compelled to contribute because of the current situation.

Summary

- The current commissioning of services is not working and has led to a reduction of services and reduction in access to services.
- The separating of different elements of service provisions creates unnecessary barriers and challenges.
- The VD regulations (and subsequent amendments) are being eroded by the commission arrangements.
- Access to services is being reduced by the commissioning arrangements, and patients are being detrimentally affected. They are having to travel miles to access services or are not able to access services near to their home or work.
- Morale is being detrimentally affected as services are being financially squeezed, reorganised, decommissioned and staff are being down banded or being made redundant.
- Because of this we are losing senior and experienced staff at a time when some serious STIs are on the increase (gonorrhoea and syphilis).
- Some conditions are no longer being treated by clinics such as thrush, bacterial vaginosis and urinary tract infections.
- PrEP works and needs to be fully funded to prevent needless HIV infections.
- Online asymptomatic STI screening works for some groups of patients, however there are many who this service is not appropriate for (e.g. those who do not want kits sent to their home).
- Advanced Clinical Practitioner and consultant nurse posts may be able to address some of the staffing issues faced in some areas of the country.
- Access to abortions should be streamlined, the requirement for two medical doctors to ‘agree it’ removed and the legislation about who can prescribe abortion drugs be expanded to include nurses.

Sexual health & HIV

The commissioning of sexual health, contraceptive and HIV services are not working as effectively as the can. Firstly, separating HIV clinical care and some contraception from sexual health, HIV prevention and other aspects of contraception has created significant issues for service as they are required to bid for, and account to different bodies for different funds to provide services, in addition, moving sexual health, HIV prevention and some contraception into local authorities makes no sense. We are providing NHS services and as such should be funded and commission through the NHS. Local authorities are facing huge financial challenges, and clinical services are suffering which ultimately affects patients. In London we have seen over the last year 7 sexual health clinics close,
and the many more contraceptive services disappear. Access to STI management and contraception is difficult, especially as some local authorities are reluctant to pay for providing services to patients outside of their area. This is a particular issue in sexual health and contraception as patients are many young and working so may want to access services near their place of work. Furthermore, many patients have to travel miles to get access to services and they are unable to get access to services in their area as they are limiting the number of patients that they see or reducing the services that they provide. This creates a potentially dangerous situation with increases in Gonorrhoea and syphilis infections.

This goes against the VD regulations of 1917, which is the principle of sexual health service provision (the centenary of which was celebrated at the Palace of Westminster last year). Which outlines that services are free at point of access, confidential (you do not have to give a name or other details), have separate clinical notes from the rest of the NHS, and you can access care anywhere in the country (not just where you reside). I feel these principles are fundamental to sexual health, contraception and HIV. For many clinicians, sexual health and HIV services are run from the same clinical space, by the same clinical staff. Separating the funding for these services has created many challenges for clinicians as in some areas of the UK services have been tendered separately to different clinical providers.

These pressures have significantly affected the moral of staff, who through recommissioning many of whom have lost their jobs, have been down banded or have had to compete against colleagues having to re-apply for their posts. There has been a reduction in junior doctors want to work in the specialities which will have an impact on the services abilities to have consultants in the future.

Nurses across the country in advanced nurse practitioner roles are being down banded, despite the level of qualification and seniority (medical consultants would never be asked to do the same job, but for registrar pay).

The funding issues have led to services rationing clinical care provision including medication. For example, many services are not treating the common conditions of vulvo-vaginal candidiasis (Thrush), bacterial vaginosis and urinary tract infections.

**PrEP**

PrEP works! We have seen significant reductions in new diagnoses in Men who have sex with men. It needs to be funded, now to prevent needless gay men acquiring HIV.

**The move to online services for asymptomatic patients**

While this initiative provides a fantastic service to many patients, especially those who have regular check-ups. There are many groups who this service is not appropriate. For example, individuals who have had an affair, would not want a test kit to be sent to their home. In addition, those who are still living at home or with conservative families would also not want a kit sent to their home. Furthermore, many patients need or want to speak with / see a clinician: those with health anxiety, requiring vaccinations, those beginning their sex lives, the young, the old to name a few. For these reasons, sexual health services should still be able to be funded to provide asymptomatic STI screening to those who want it.

**Advanced clinical practitioner and consultant practitioner roles**

One area of the work force which provides a significant contribution to service provision are advanced clinical practitioners (nurse practitioners and nurse specialists). These predominately
nurses are highly educated (many to masters or doctorate level), very experienced and knowledgeable training both doctors and more junior nurses. These roles have the potential to ease the workforce issues experienced in the medical professions, but need to be supported and encouraged. The consultant nurse body has dwindled with only a handful left in the country.

These posts have the scope to deliver excellent practice, lead services, education, and research. As such, these posts need to be protected (from being down banded or disbanded), the creation of protected training posts to ensure that trainee ACPs and consultants are trained to the appropriate level. Services should be encouraged to create consultant nurse posts and there more flexibility should be encouraged to facilitate monies for posts to recruit doctors or nurses ACP and junior doctors / registrars and consultants.

Abortion services

I think that there needs to be a revision of the legislation around abortion. I feel that the arbitrary requirements for two doctors to sign and say that a woman can have an abortion is completely unnecessary and complicates the process for women who have already had to make a very difficult decision. As such, I think that women should be able to self-refer to abortion services and not have to be referred by a clinician. In addition, medical abortions should be able to be commissioned as part of level three services to facilitate the easy access for women. In addition, I feel that there should be a change in legislation to allow nurses to be able to prescribe abortion medication. Especially with the re-focus on advanced practice roles, in particular the advanced clinical practitioner and consultant practitioner roles (HEE, 2017). The ACP roles are envisioned to be at 'ST3' which is registrar level, and in many services are on the medical or surgical rota’s. They are managing majors in the Emergency Department and undertaking surgery or being second assistant in surgical teams, and are credentialed in some specialities after following the medical curricula for trainee consultants (RCEM, 2016). In order for these roles to maximise their efficacy, gynaecological advanced clinical practitioners should be able to perform surgical abortion.

Recommendations

- The current commissioning arrangements need to be urgently reviewed and services be commissioned by the NHS and not local authorities
- The separating of different elements of service provision (HIV / sexual health) creates unnecessary barriers and challenges and should be commissioned together
- The VD regulations should be refreshed (and subsequent amendments) to ensure the principles of service provision continue to protect patients (and the wider public health)
- The amount of funding to services needs to be increased to ensure adequate provision of services and to not lose senior and experience staff when we could be facing serious sexual health challenges (resistant gonorrhoea, increases in gonorrhoea and syphilis infections, and babies being born with syphilis)
- PrEP works and needs to be fully funded NOW to prevent needless HIV infections
- Services should continue to be adequately funded to provide face to face asymptomatic STI screening to those who want/need it
- Advanced Nurse Practitioner and consultant nurse posts should be promoted and supported across the country and be appropriately remunerated
- The legislation around access to abortion needs to be reviewed to remove the requirement for two medical doctors to agree that the abortion and that nurses / advanced clinical
practitioners are able to supply abortion medications and for those ACPs in gynaecology to be able to perform surgical abortion following the appropriate level of training.