Written evidence from Lambeth, Southwark and Lewisham local authority public health departments

Executive summary

The populations of Lambeth, Southwark and Lewisham (LSL) face some of the greatest sexual health challenges in England, including high rates of HIV, STIs, emergency contraception use and abortions. Importantly, there are inequalities in the distribution of these sexual health issues among our populations. Poor sexual and reproductive health is a major contributor to health inequalities.

We are operating within the context of extreme pressure on local government budgets, which is getting worse. Whilst sexual health services are largely funded through the reducing Public Health Grant (the future of which is unclear) many of the wider support programmes for young people around teenage pregnancy have been eroded by years of austerity impacting on schools funding for these activities as well as core local authority funding. In Lambeth, Southwark and Lewisham we have continued to innovate to meet increasing demand despite reducing budgets. This includes introducing online self-sampling testing services, and implementing the integrated sexual health tariff. However, despite this innovation, services in LSL are regularly at capacity, we face on-going challenges, and anticipate this to become more challenging with further cuts to public health budgets. We make a number of recommendations for ways in which national policy-makers could take action to support local services to continue to deliver high quality services (detailed below), and in particular that the public health funds are protected in line with NHS funding.

1. Introduction and reason for submitting evidence

1.1 The populations of Lambeth, Southwark and Lewisham (LSL) face some of the greatest sexual health challenges in England, including high rates of HIV, STIs, emergency contraception use and abortions. We have young, mobile and diverse populations, and our local sexual health services are modern and popular. Proportionately (in relation to the Public Health Grant) and in real terms, we spend a significant sum on sexual and reproductive health services to meet both the needs and demands of our populations. We therefore believe that our understanding of the sexual health needs of this population, and our experiences in planning and commissioning services to meet these needs will be of use to the Health and Social Care Committee in its inquiry into sexual health.

2. Recent Trends

2.1 Rates of STIs are considerably higher in LSL than in England and London. Diagnosis rates for some STIs are decreasing, but others are increasing. Importantly, significant inequalities exist in the distribution of STIs among different population groups.

2.2 Testing rates across LSL are consistently and considerably above levels in London and England. Lambeth had the highest rate of new STI diagnoses in England in 2017, followed by Southwark (3rd) and Lewisham (11th). In recent years there has been a downward trend in the rate of new STIs overall. Re-infection with an STI is a marker of persistent risky behaviour. The proportion of people with a re-infection in LSL is much higher than the rest of England. Rates of new STIs are considerably higher in men than women.
2.3 Chlamydia is the most common STI in LSL with rates at least double that of London, although rates are decreasing in LSL. Chlamydia diagnosis rates are particularly high in young people aged 20-24.

2.4 After a decrease in 2016, gonorrhoea increased again in 2017 across LSL and London.
2.5 Across LSL, gonorrhoea diagnosis rates vary by ethnicity, with people from other ethnic groups having the highest diagnosis rates in Lambeth and Southwark, and those from a mixed ethnic background having the highest rates in Lewisham. Men have considerably higher rates of gonorrhoea, across all ethnicities.

2.6 Syphilis rates in Lambeth and Southwark are very high compared to London and are increasing.

Figure 3. Rates of gonorrhoea diagnosis per 100,000 population in LSL, London and England, 2012-17

2.7 By contrast to other STIs which are commonly seen in young adults, syphilis is most common among those aged 35-44 and has been growing in this age group over time in LSL. Rates of syphilis vary by ethnic group and are highest amongst those from other ethnic groups.

2.8 LSL has amongst the highest rate of diagnosed prevalence of HIV in England. Rates of new diagnoses among residents of LSL continue to trend above both national and London rates.

Figure 4. Rates of syphilis diagnosis per 100,000 population in LSL, London and England, 2012-17

Figure 5. HIV diagnosed prevalence rate per 1,000 aged 15-59 LSL, London and England, 2012-16
2.9 As with other STIs, there are inequalities in HIV rates in LSL, with certain population groups more likely to be affected by HIV, namely MSM and people identifying as black African. New diagnoses in heterosexual women and Black African men also remain disproportionately high. By understanding the profile of those diagnosed, we can target ongoing efforts to tackle HIV through combination prevention approaches – for example through commissioning community-focused services targeted to black African and Caribbean communities and MSM across LSL.

2.10 Abortion rates in LSL have been considerably higher than rates for England since 2012, and local analysis suggests that these rates were highest among women from Black African and Caribbean ethnic backgrounds. Abortion rates may be considered as an indicator of a lack of access to appropriate contraception services, so this inequality may suggest that women from these backgrounds experience particular difficulty in accessing or using contraception services, and this inequality needs to be addressed. Women from Black African and Caribbean ethnic backgrounds are also over-represented among women having more than one abortion in a year in LSL.

2.11 The time immediately following abortion is an important period for contraceptive intervention, particularly LARC methods. Long Acting Reversible Contraception (LARC) uptake within abortion services has fallen to around 20% locally. This may be due to the increase in women choosing early medical abortions (EMAs, under 10 weeks), as opposed to surgical abortion or a later medical abortion. EMAs do not require clinical follow-up and therefore these women may miss out on the opportunity to discuss LARC methods post-abortion. In 2017-18, local clinic data for LSL women indicate that 61% of abortions at BPAS and 64% of abortions at MSI were EMAs, slightly higher than the national rate (60%), and trends indicate that EMA uptake rates are expected to increase.

3. Prevention

3.1 Early detection and treatment of STIs can reduce long-term consequences, such as onward transmission, infertility and ectopic pregnancy. These issues, if undetected and untreated can result in significant distress for individuals, as well as being costly for the health service. As STIs are often asymptomatic, frequent testing, particularly in higher risk groups is crucial in early detection and treatment. It is therefore important to maintain preventive activity despite reducing budgets, something which is particularly challenging in the current financial climate.

3.2 HIV testing, including frequent testing among those most at risk of HIV, continues to be one of the most important preventative interventions to identify infection and prevent onward transmission of HIV. Late diagnosis of HIV infection is associated with increased morbidity
and mortality, increased costs to healthcare services, reduced response to antiretroviral treatment and increased risk of onward transmission of HIV. People diagnosed late have a ten-fold risk of death compared to those diagnosed promptly. Reducing late diagnosis is therefore a critical target. In 2016, some groups in LSL had a higher proportion of people with late diagnosis, including those aged 50-64, those identifying as black African, those identifying as ‘other’ ethnicity, those whose route of transmission was through heterosexual contact, and women.

3.3 Widespread use of combination prevention approaches has contributed towards the decline in HIV rates. In the UK, combination prevention has included encouraging condom use, promoting the use of PrEP, promoting expanded HIV testing and diagnosis, advocating for self-sampling kits and ensuring prompt treatment when people are diagnosed with HIV and other STIs. Antiretroviral therapy (ART) is now so effective that those on treatment who maintain an undetectable viral load (<200 copies) have effectively no risk of sexually transmitting the virus.

3.4 As an example of successful joint commissioning to achieve strong prevention activities, Lambeth proudly hosts and manages the London HIV Prevention Programme (LHPP). This is a successful programme of joint commissioning of strong HIV prevention services across most London councils. As well as a city-wide Do It London campaign, the LHPP also provides a free condom distribution, outreach and rapid HIV testing service for men who have sex with men (MSM) and commissions online sexual health outreach and advice via websites and apps.

3.5 The success of the London HIV Prevention Programme and of local sexual health promotion work has successfully raised awareness of the importance of regular STI testing. This has driven increased demand for services and meant that there is still unmet need within the system, which we are working closely to better understand and meet.

3.6 Sexual health services in LSL are taking part in the national PrEP Impact Trial (HIV Pre-exposure Prophylaxis trial). This is an important trial to answer a number of questions relating to the potential use of PrEP, in which the public health departments of LSL are pleased to participate. Study participants are required to attend the clinic for regular routine tests, the costs of which are not covered by the study, but by the local authority sexual health budget. The trial has the potential to put additional cost pressures on sexual health commissioning services in LSL. Commissioners are closely monitoring testing activity trends at our services.

3.7 Following a successful pilot, HPV vaccination in men who have sex with men up to the age of 45 is currently being rolled out across LSL through sexual health clinics.

3.8 LSL public health recognise the importance and value of preventive public health actions, and welcomes the introduction of statutory provision of SRE in schools from 2020. We would like to do more preventive work in sexual health, to reduce demand and need for acute services, and to reduce costs (preventing one UK-acquired HIV infection is estimated to save £0.36m in undiscounted lifetime treatment and clinical care costs \(^1\) however are restricted by the diminishing public health budget.

4. Commissioning and Delivery of sexual health services

Co-commissioned services

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4.1 LSL has a strong history of successfully co-commissioning sexual health services. LSL faces some of the greatest sexual health challenges in England, including high rates of HIV, STIs, emergency contraception use and abortions. We have young, mobile and diverse populations, and our local sexual health services are modern and popular. As the challenges we face are similar, LSL are better able to meet the needs of our populations through collaborating on sexual health commissioning and strategy. Through this approach, we are able to effectively pool both financial and human resources to maximise our impact in many areas, and Lambeth council commissions sexual health services on behalf of Lambeth, Southwark and Lewisham. However, there remain areas where we commission separately to meet the differing requirements of our boroughs.

4.2 Lambeth, Southwark and Lewisham have played an important part in the work of the London Sexual Health Programme (previously the London Sexual Health Transformation Programme). This is a partnership of London boroughs who have worked together over the last three years to deliver a new collaborative commissioning model for open access sexual and reproductive health services. The programme was set up to lead the transformation of the service model to deliver improved public health outcomes, meet the increasing demand and deliver better cost effectiveness. As a result of this programme of work, clinics across London provide integrated sexual health services, bringing together services for infections and for contraception. As well as being popular with service users, especially young people and young adults, providing these services in an integrated way is efficient and therefore helps make better use of resources. A further significant change resulting from the work of the programme is that clinics across London now provide online (self-sampling) services in addition to in-person clinics, increasing access to sexual health services in a cost-effective way.

4.3 LSL commission integrated sexual health and substance misuse services for young people.

Demand

4.4 Services in LSL are regularly at full capacity. Wider system pressures on general practice have meant that it has been increasingly difficult for many people to access their practice, which has had an impact on GPs being able to meet residents' urgent or ongoing reproductive health needs (e.g. repeat prescriptions, LARC, or emergency contraception). More recently, there have been similar pressures on sexual health services, with demand outstripping the number of appointments and walk-in spaces available.

4.5 Local surveys have shown that there is considerable demand for sexual health services, with patients being turned away from busy clinics, and online services also regularly at capacity. As may be expected, demand for emergency contraception is high and the rate of abortion in LSL (despite a declining trend) remains high and is above the national average.

4.6 In LSL, as elsewhere we have felt the impact of the cuts to local government and the public health grant. Despite this we continue to innovate to meet increasing demand. To improve access to reproductive health services, we have moved to provide support in new and innovative ways. New models of practice include leveraging the accessibility, ease, and anonymity of pharmacies, and increasingly incorporating an online aspect to our services. The condom distribution scheme Come Correct has been popular locally and has capitalised on non-traditional settings (e.g. leisure centres and libraries) to distribute contraception to young people. Despite making these innovative changes to the ways in which services are delivered, it is highly challenging to meet the sexual health needs of the population, within
the budgets. Local authorities have worked hard to control costs whilst maintaining open access clinics however continuing Public Health Grant reductions make this increasing difficult. Any future reductions to public health, and specifically sexual health, budgets are expected to have an impact on the extent to which services are provided.

4.7 Of particular concern is the need to address inequalities in outcomes, something that is also a concern for the Department of Health and Secretary of State, who has a legal duty to have regard to health inequalities.

4.8 In order to better understand the extent of demand for services, LSL has conducted two turnaway audits, results of which are yet to be published, and which will provide information about the numbers and characteristics of people who attend clinics but are not able to be seen due to excess demand.

Access

4.9 To increase access to sexual health services and better meet local needs, Lambeth and Southwark introduced an online STI self-sampling service in 2015, with Lewisham joining in 2017. In 2018, LSL has joined the London e-service, commissioned through the London Sexual Health Programme. There are plans for this programme to be evaluated to assess its impact on access to services and on inequalities, and should it be found to be successful in increasing access to services, this model should be replicated more widely.

4.10 One area in which access is particularly challenging, is in access to contraception, particularly LARC, which may result from insufficient numbers of trained LARC fitters in primary care. We are currently looking at ways to address this gap locally.

Funding

4.11 We are operating within the constraints of reducing public health grants, but in LSL we have continued to innovate to meet increasing demand despite reducing budgets, as described previously.

4.12 The integrated sexual health tariff (ISHT), a more accurate way of paying for sexual health services was introduced throughout 17/18 as part of a London-wide Transformation Programme.

4.13 The introduction of the new integrated sexual health tariff during 17/18 means that councils now pay for the actual activity undertaken in each appointment in clinic, rather than a flat fee per attendance. This has contributed to price reductions and savings. LSL public health departments were instrumental in introducing the integrated sexual health tariff across sexual health services

4.14 Sexual health services are funded from local authority budgets and therefore subject to the same reductions as the general public health grant. However, sexual health services differ in that they are largely delivered through NHS services (NHS services are not subject to these same reductions), and specific legal requirements exist to ensure the provision of certain services.

Governance

4.15 LSL has a strong history of working in partnership around sexual health services. Local authority public health specialists and commissioners work collaboratively with CCGs and provider Trusts to understand need, and to plan, commission and deliver effective services. Lambeth council leads on the commissioning process on behalf of Lambeth, Southwark and Lewisham. The governance structure to support this model of working consists of a joint
sexual health commissioning board which monitors progress; a south east London transformation steering group; and a Clinical Advisory Group (CAG) to provide clinical oversight.

**Workforce issues**

4.16 A key workforce challenge locally is ensuring that sufficient numbers of primary care staff are adequately trained, particularly in LARC fitting, and that they are able to maintain their skills. Providers report challenges in the recruitment and training of staff.

**5. Recommendations for action**

**Funding**

5.1 We recommend that the public health grant from which sexual health is funded is protected from further reductions. This is because most delivery is through NHS services which have not be subject to similar cuts, and it is not possible to retain the levels of access and outcomes within a diminishing resource in the medium to long term.

**Commissioning and general recommendations**

5.2 We recommend a review of the way that data is collected from clinics. Data is currently available on the number of episodes of care, rather than the number of individuals accessing services. Useful insight could be gained from analysing data by numbers of individuals as well as by episodes, which could increase local understanding of the people using services, and therefore enable us to better plan services to meet need, an identify and address inequalities.

5.3 We recommend reviewing the complexity of the commissioning environment (local authorities, CCGs and NHSE all being responsible for commissioning different parts) to make it easier to take a system-wide and population view of sexual and reproductive health.

5.4 We recommend that contraception provision is built into the routine maternity and health visiting pathway, to increase uptake or contraception, particularly LARC.

5.5 We recommend that contraception is made more readily available via community pharmacy, to improve access, and reduce inequalities in access to contraception, and contribute to reductions in abortion rates and inequalities in abortion rates, particularly subsequent abortions.

5.6 We recommend that oral contraception is changed from a prescription only medication to being available from a pharmacist or even over the counter to enable women to have free access and choice to control their own fertility without having to seek a prescription. It defies logic that the emergency contraception can be obtained through a pharmacy without a prescription but more reliable forms of contraception cannot.