Written evidence from The Association of Directors of Public Health

Response to Health and Social Care Committee inquiry into sexual health

The Association of Directors of Public Health (ADPH) is the representative body for Directors of Public Health (DPH) in the UK. It seeks to improve and protect the health of the population through collating and presenting the views of DsPH; advising on public health policy and legislation at a local, regional, national and international level; facilitating a support network for DsPH; and providing opportunities for DsPH to develop professional practice.

The Association has a rich heritage, its origins dating back 160 years. It is a collaborative organisation working in partnership with others to maximise the voice for public health.

Summary

The ADPH welcomes the opportunity to respond to the Health and Social Care Committee’s inquiry into sexual health.

- Sexual health is about wellbeing, not just services: education, personal capacity and resilience, good relationships and preventive action are as important as the provision of high quality sexual and reproductive health services.
- A whole system approach should be adopted at both the local and national levels covering prevention, improvement, promotion and protection, spanning the three areas of sexual health, HIV and reproductive health. Attempts to tackle these issues in isolation will lead to silo working and will not be representative of people’s experiences of sexual health.
- ADPH is pleased to see that the overall prevalence of sexually transmitted infections (STI) remain stable, however the continued increases in rates of syphilis and gonorrhoea are concerning, and the persistent inequalities in sexual health outcomes, particularly amongst young people, black ethnic minorities (BME) and gay men are unacceptable. Whole system action is urgently needed to address these inequalities.
- Sexual health commissioning and services should embrace the introduction of evidence-based innovative technologies and digital services, which can increase capacity and address barriers to screening.
- DsPH are striving to manage the increasing demand and budget reductions so that they don’t impact on patient care. However, if budgets continue to reduce while demand increases, it will not be possible to maintain the same level of service.

We would welcome the opportunity to give oral evidence to the Committee.
1. Adopting a whole systems approach to sexual health

1.1. A whole systems approach needs to be taken at both the local and national levels covering prevention, improvement, promotion and protection and spanning the three areas of sexual health, HIV and reproductive health.

1.2. Sustainability and Transformation Partnerships (STPs) and Integrated Care Systems (ICS) provide an opportunity to take a whole systems approach to sexual health and work more closely together to create a more coordinated service for patients, providing links into pathways for services such as early pregnancy assessment, abortion services and health visiting.

1.3. Local authorities are well placed to commission and deliver a positive approach to sexual health. Through the range of services they provide – including early years and youth services – local authorities can develop integrated sexual health strategies. Strong links can also be made between sexual health and other key determinants of health, including alcohol and drug misuse, smoking, obesity, mental health and violence (particularly violence against women and girls), which can contribute to a reduction in health inequalities.

Recommendation: A whole system approach to sexual health should be adopted, which requires robust care pathways between sexual health services and wider services, in particular, alcohol and drug misuse services, and services for the victims of sexual violence and assault.

2. Recent trends

2.1. There have been some recent improvements in sexual health including a decrease in the rate of teenage pregnancy. The under 18s conception rate in England in 2015 was 21 conceptions per 1000 women aged 15-17. This is the lowest rate since the statistics were first recorded in 1969.¹

2.2. New diagnoses of HIV have decreased by 17% in 2017 – from 4,363 new diagnoses reported compared to 5,280 in 2016, which brings new cases down to their lowest level since 2000.² The reduction was largely driven by a decline in new HIV diagnoses among gay and bisexual men, which fell by 17% compared to 2016 and by 31% compared to 2015.

2.3. Despite these improvements there are still major advances to be made. Rates of syphilis are at their highest since 1949 and there were 7,137 diagnoses of syphilis in 2017, a 20% increase on 2016.³ There were 44,676 diagnoses of gonorrhoea reported in 2017, a 22% increase relative to the year prior; this is of concern given the recent emergence of extensively drug resistant Neisseria gonorrhoeae.⁴

2.4. Sexual health is not equally distributed within the population; the impact of STIs remains greatest in young heterosexuals 15 to 24 years, BME and gay, bisexual and other men who have sex with men (MSM). While overall prevalence of STIs remain stable, levels of transmission remain high and there are marked increases in bacterial STIs amongst these high-
risk groups. Between 2016 and 2017, there were large increases in diagnoses of gonorrhoea (21%; from 17,626 to 21,346), chlamydia (17%; from 12,626 to 14,765) and syphilis (17%; from 4,789 to 5,592) amongst MSM. Similarly, for young people, rates of gonorrhoea (27%; from 8,887 to 11,261) and syphilis (22%; from 228 to 278) continue to rise. HIV infection continues to disproportionately affect MSM and BME communities.

3. Prevention

3.1. Sexual health services account for over 25% of the entire public health expenditure of English local councils. However, only a small proportion of this expenditure is on prevention. It is necessary to establish well-funded and coordinated public health programmes and strengthen existing programmes which are focused on helping people improve their sexual health.

3.2. Health outcomes for individuals can be improved through integrated care pathways and preventative interventions targeting those most at risk. Preventative strategies such as integrating GUM, HIV and contraceptive services can help to reduce the incidence of STI contraction and transmission, and promote contraceptive choice in those accessing services.

3.3. Sexual health programmes should not just be about treating illness but also about building resilience and preventing future harm through education and health promotion. Sexual health promotion work should help people to make informed choices and should address the prejudice, stigma and discrimination that can be linked to sexual ill health. Improving the quality of individuals’ sexual experiences is important and can be achieved through ensuring that there is high quality education, good access to sexual health services, and effective preventative programmes.

3.4. The use of social media, apps and other forms of media are increasingly being used to provide clear and consistent messaging around condoms, contraception, STIs and wider health issues, as well information on how to access services. Media campaigns can be targeted to high risk groups, and can help to normalise conversations, promote behaviour change (for example, the use of contraception) and encourage people to take responsibility for their sexual health.

3.5. It is important to raise awareness of sexual health amongst local healthcare professionals, particularly those working with vulnerable groups. The approach ‘Making Every Contact Count’, provides an opportunity to appropriately raise issues related to sexual health, for example providing an HIV or chlamydia test as part of routine healthcare, regardless of whether a patient visits their GP, a sexual health clinic or another service. In addition, consensual sex and coercion, domestic and sexual abuse can also be identified through these opportunities.

3.6. ADPH welcomed the announcement of compulsory sex and relationship education (SRE) in all schools in England. This will allow vital links to be made between public health and education and will support young people to understand relationships and sexual health, understand consent and the issues around abusive relationships, and will allow them to develop the confidence to negotiate safe sexual relationships. It is important that sex and reproductive
education is coupled with timely access to confidential advice and dedicated young people’s contraceptive services.

Recommendation: Local areas should ensure that information about local services is available in a range of formats, and is widely available from a range of outlets.
Recommendation: Public campaigns should be used to help normalise conversations, promote behaviour change and encourage people to take responsibility for their sexual health. Campaigns should be directed to high risk groups.

Recommendation: Actions should be taken to put into place effective preventative strategies such as integrating GUM, HIV and contraceptive services to reduce the incidence of STI contraction and promote contraceptive choice.

Recommendation: Sexual and reproductive education should be coupled with timely access to confidential advice and dedicated young people’s contraceptive services.

4. Commissioning of sexual health services

4.1. ADPH and Public Health England recently published Sexual Health, Reproductive Health and HIV: A Review of Commissioning, which identifies the commissioning challenges faced by commissioners and providers. These range from tackling sexual and reproductive health and HIV in a co-owned strategic way to managing the complexities of multi commissioners dealing with open access services. The fragmentation and division of commissioning responsibilities is leading to services being commissioned in new silos built around the commissioning structures and not service users.

4.2. It is important that CCGs, local authorities and the NHS England work closely together to ensure that care and treatment is high quality and not fragmented. Provision must be joined up to enable seamless patient journeys across both sexual health services and other health services, including HIV and antenatal care services.

4.3. The recommendations outlined in the report need to be fully implemented. At the national level this will involve revising current commissioning guidance, facilitating sexual health networks, developing a framework for sector-led improvement (SLI) for sexual health and enhancing commissioning support tools. At the local level implementation, this will involve developing a model of ‘lead integrated commissioning’ in each locality and testing models of local delivery based on local practice.

4.4. The commissioning, planning and delivery of services should focus on delivering better sexual health outcomes across a breadth of settings and interventional approaches. It is imperative that outcomes for sexual health services cover effectiveness, safety and individual experience of care. Individuals will have diverse needs which will vary by factors such as age, gender and disability. It is important that the commissioning, planning and delivery of services caters for the needs of people of all genders and sexual orientation and at all life stages.
4.5. Residents and service users should be at the centre of co-designing services and be part of continuous feedback to and from service providers. Effective commissioning must address health inequalities and tackle the stigma associated with STIs and diseases such as HIV. The person centred, and rights-based approach needs to be balanced with the responsibilities of commissioners and planners to meet needs, promote prevention and balance budgets.

**Recommendation:** The recommendations of the Sexual Health, Reproductive Health and HIV: A Review of Commissioning report need to be fully implemented.

**Recommendation:** All providers and commissioners should work together locally to promote a whole systems approach to:
- develop models for integrated commissioning, and service provision
- seamless, affordable service pathways
- strong area-based networks and partnerships
- address barriers to primary care
- promote system led improvement

**Recommendation:** All sexual health commissioners and service planners should address health inequalities and cultural and behavioural influences on health choices such as the stigma associated with sexually transmitted infections and diseases, such as HIV.

5. **Access and demand**

5.1. There has been an increase in demand on services; in 2016, there were 2,456,779 new attendances at sexual health clinics in England compared with 1,941,801 in 2012, an increase of approximately 25%. Similarly, the total number of sexual health screens (tests for chlamydia, gonorrhoea, syphilis and HIV) increased over this time period (18%; from 1,513,288 in 2013 to 1,778,306 in 2017).

6. **Funding**

6.1. Public health funding in England will be cut by 9.7% by 2020/21, £331 million in cash terms, in addition to the £200 million in-year cut for 2015/16. Although DsPH have been acting to manage these cuts, through modernising services and introducing innovative online services, they have reached the limit of available efficiencies. While outcomes, such as STI rates have remained stable, it may not be possible to maintain the same level of service if budgets continue to reduce while demand increases.

**Recommendation:** Investment in public health must be increased. Cuts to public health budgets must be reversed and public health needs to be funded both sustainably and adequately in line with local population health need.

7. **Transformation of sexual health services**
7.1. In response to the increase in demand, DsPH are introducing innovative online services such as self-testing and postal prescribing. Online services have the potential to transform sexual health systems through increased accessed, capacity and self-management. The digitalisation and modernisation of services is similarly driven by the desire from the public, particularly young people, to access support remotely online. This helps to address the main barriers to testing, such as inconvenience, embarrassment and privacy concerns.

**Recommendation:** National bodies should prioritise support for the introduction of innovative technologies and digital services, building on successes such as self-sampling HIV testing. This will require training, funding and evaluation.

8. **PrEP**

8.1. ADPH welcomed the large scale clinical trial of PrEP, an HIV prevention tool which has the potential to transform the course of the epidemic and ensure that individuals vulnerable to HIV acquisition remain HIV negative.

8.2. However, it is important that the findings of the clinical trial are examined before the national roll out of the programme in order to learn more about the uptake of PrEP. For example, it is important to understand whether particular groups including women, BME groups and the youngest MSM are accessing PrEP, whether STI rates increase and whether inequalities persist if uptake is mainly amongst those who were already able to access PrEP privately.

8.3. NHS England/CCGs and local councils have the joint responsibility of ensuring they can deliver an integrated sexual health system. It is essential that the issue of financial burden is considered as part of any national roll out of the programme. Moving forward with the trial, it is also important to address the financial cost and additional pressure that the trial is putting on clinics, for example through increased demand and additional prescribing costs. It is important that any additional activity resulting from the PrEP trial is fully funded.

8.4. The responsibility for the cost of providing PrEP should lie with NHS England. Transferring this responsibility to local authorities would create a new and unfunded burden at a time when public health budgets are already being cut.

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6. UCL, ‘Summary of Results from The 3rd National Survey Of Sexual Attitudes And Lifestyles’ [http://www.ucl.ac.uk/news/news-


