1. Executive summary

1.1. The continued reduction in spending on sexual health services since the transfer of commissioning to local authorities is clearly having an impact on sexual and reproductive health across the South West.

1.2. The main points covered within this submission and to be considered by the Health and Social Care Committee are:
   - There is a risk that the significant funding pressures being experienced could reverse the massive improvements in standards, quality and health outcomes that have been achieved in sexual and reproductive health.
   - The commissioning and organisational changes experienced within the provision of sexual health services have led to fragmentation and confusion.
   - As funding through the ring-fenced public health grant continues to be cut, sexual health services are suffering disproportionately.
   - There has been a drastic reduction in access to LARC in general practice, yet increasing the uptake of LARC will reduce the numbers of unintended pregnancies.
   - Access to contraceptive services is inequitable and currently inconsistent across local authority areas.
   - Responsibility for the oversight of the sexual health workforce is not clear and there is a risk that the workforce will not be fully trained or equipped to meet the needs of the current and future population.
   - The move to online testing and developing digital technologies is happening fast and sexual health services need to embrace and keep pace with the digital transformation.

2. The Office for Sexual Health South West

2.1. The Office for Sexual Health provides leadership and co-ordination to meet the sexual health needs of the population across the South West, on behalf of the Directors of Public Health.

2.2. The Office aims to lead improvements in sexual health in the South West through the provision of high quality evidence based recommendations. It aims to achieve reductions in sexually transmitted infections, unintended pregnancies, teenage pregnancies, stigma and discrimination, and associated health and social care complications. It facilitates improvements in access and develops guidance on the integration of sexual health commissioning and interventions.

2.3. The Office and its Board take a cross-cutting approach that considers provision for all people across the life course, mindful of high risk groups, including young people, men who have sex with men and LGBT people, people who inject drugs, people with learning disabilities, victims of sexual and domestic violence, specific black and minority ethnic groups, sex workers and homeless people.

2.4. The Board facilitates partnership working between commissioning bodies, advocating effective communication between NHS England, CCGs, PHE as well as local authorities and providers. It fulfils its role through policy and strategy formulation, bringing together the clinical expertise and multi-
agency perspective of its members to identify and provide strategic leadership in sexual health. It offers an expert resource for the South West.

3. **The issues**

3.1. The continued reduction in spending since the transfer of commissioning to LAs is clearly having an impact on sexual and reproductive health across the South West. Sexual health services are now commissioned by local authorities, sitting outside the NHS, and therefore not receiving any benefits from the NHS funding plans.

In recent years, massive improvements in standards, quality and health outcomes have been achieved in sexual and reproductive health. There is a risk that the significant funding pressures now being experienced could mean that we are now in danger of reversing the trend for these improvements (BMA, 2018). Specifically, the areas that have been identified as being at risk are:

- Teenage pregnancy rates
- Multidrug-resistant gonorrhoea – the first cases of gonorrhoea have emerged that have a high-level of resistance to both azithromycin and ceftriaxone, so not susceptible to the recommended first line dual therapy
- Syphilis incidence - congenital syphilis is being seen in the UK for the first time in many decades
- Child sexual exploitation and domestic violence, currently picked up through sexual health services

3.2. The Office for Sexual Health South West would like to submit evidence for further consideration and exploration of potential impacts on the following key issues:

1. Commissioning and delivery of sexual health services
2. Funding
3. Contraception services
4. Standards and guidance
5. Workforce
6. Digital developments

4. **Evidence and potential impact**

4.1. **Commissioning and delivery of sexual health services**

4.1.1. The commissioning arrangements following the publication of the Health and Social Care Act in 2012 have led to major changes in the way the health service is organised. The changes intended to bring commissioning closer to communities and patients, ensuring that the provision of services was based on the local population’s need. However, for sexual health these changes have led to fragmentation and confusion around service provision. For example, there are three different bodies commissioned to provide contraception – local authorities (public health) via community clinics, NHS England via GP contracts and CCGs through termination of pregnancy services. Similarly HIV testing is commissioned by all three bodies, leading to inconsistency in service provision.

4.1.2. These variances have the potential to increase the difficulty in accessing appropriate services and exacerbating health inequalities between those individuals who are able to navigate the complex system and those who are not.
4.1.3. The development of integrated sexual health services is addressing some of these inconsistencies. The model of integration aims to meet the majority of sexual health and contraceptive needs on one site, often by one health professional. However, working across the system to promote integration and inclusion is a challenge and commissioning risks have not been eliminated.

4.2. Funding

4.2.1. The current level of cuts to public health spending could result in an extra 72,299 STI diagnoses by 2020 at a cost of £363m (FPA 2015). The cuts made to the public health funded elements of sexual health provision is often felt by other parts of the system - LA driven reductions to specialist services increases the workload on general practice and other core contraceptive services (RCGP 2016).

4.2.2. Between 2016/17 and 2017/18 the local authority budgets for sexual health services reduced by £30 million nationally, a cut of 5%. In the South West the reduction in expenditure on sexual and reproductive health services by local authorities during the same period was an average of 4.28%. This was followed by a reduction between 2017/8 and 2018/19 of 3.51%. Over the last year the average spend on sexual health services per head of population across the South West was £7.30, down from £7.57 in the previous year. For the sexually active population (15-64 years) over the same period, the average spend on sexual health services was £11.79.

4.2.3. Half of local authorities reduced spending on contraceptive services in 2017/18 and nearly two thirds of local authorities made cuts to their overall sexual and reproductive health services between 2016 and 2017 (RCGP 2017). It is predicted that if the current level of cuts to public health continue over the next five years, every £1 lost to sexual and reproductive health could cost the public purse up to £86 overall (FPA 2015). In contrast, it is estimated that for every £1 spent on contraception, over £11 is saved to costs elsewhere in the NHS.

4.2.4. Around half of all pregnancies in England are unplanned, and termination of pregnancy rates amongst women over 30 years are rising, resulting in an estimated direct cost to the NHS of £240m (DH 2017).

4.2.5. The budget pressures that are being experienced within local authorities are harsh and often require authorities to make immediate financial savings. These are frequently being met through the introduction of short-term cost saving measures, which increase the risk that sexual health services retreat into the provision of test and treat services rather than focusing on prevention and sustainable improvement to population health outcomes.

4.2.6. As the ring-fenced public health grant continues to be cut, sexual health services are suffering disproportionately. The current process in place to ensure that the grant is spent appropriately is limited to an annual return. This is not proving to be useful as a meaningful audit with consequences for inappropriate spend. A revised, more rigorous audit process would help to protect the resources required to support the sexual health services.

4.2.7. In contrast, there have been uplifts to NHS funding. Specifically there have been salary increases for NHS staff, but these have not been able to be replicated for staff working in NHS sexual health services commissioned through the public health grant. This means that NHS providers are being presented with cost increases from some commissioners, but not from local authority commissioners. This is having an impact on sexual health services as increases to staffing costs still need to be paid even though there has been no passporting of additional funds from a national wage agreement.
4.3. Contraception services

4.3.1. 80% of contraceptive provision is provided by general practice and primary care remains the preferred setting for women wishing to access contraception (PHE 2018). Yet there has been a drastic reduction in access in general practice to LARC, the most effective methods of contraception, with 9% of GPs in England stating that these services had closed in the past five years (RCGP 2017). Resourcing issues are starting to impact on the timely availability of contraceptive services in primary care, with longer waiting times or shortages of qualified staff.

4.3.2. Currently, LARC provision does not form part of the GMS contract and is commissioned separately from general practice by local authorities. GPs do not need to sign up to the local authority contracts to provide LARC, despite NICE recommendations about its cost effectiveness and key role in the prevention of unplanned pregnancies (NICE 2005). As a result, LARC availability is variable and overall accessibility is reduced.

All currently available LARC methods are more cost effective than the combined oral contraceptive pill. Increasing the uptake of LARC will reduce the numbers of unintended pregnancies. Maximising access and ensuring their promotion is recommended by NICE (2015). It would therefore be logical for LARC to be included in the GMS contract as part of the standard contraceptive services to be provided by GPs. This would help ensure the availability of LARC in primary care and thus support the reduction of unplanned pregnancy.

4.3.3. Local authorities play a key role in the commissioning of contraceptive services, yet this does not seem to be recognised by the Department of Health. The indemnity scheme for general practice that was announced in November 2017 only recognises work provided under GMS, PMS or APMS contracts. Services provided under local authority contracts are not recognised and these include LARC and the contraceptive offer in primary care. As a result, insurance companies class local authority provision as ‘private, non-NHS activity’, having significant financial implications for GP providers. This may impact on their willingness to provide local authority commissioned health care services in the future.

4.4. Standards and guidance

4.4.1. National guidance sets out an expectation that payment of out of area GUM services should be met by the patient’s local authority of residence. However an increasing number of local authorities are setting maximum tariffs for GUM appointments and these may be at a level below the provider’s expected rate. This disparity risks the sustainability of some local integrated sexual health services.

4.4.2. Unlike the provision of GUM services out of area, there is no clarity in national guidance for contraception services. As a result, there are differing interpretations being applied in each local authority, with increased risk of denying access to patients when visiting out of area services.

4.4.3. In the South West there is no consistency in covering the cost of out of area contraception provision. There is an almost even split of local authorities that do not pay for out of area contraception versus those that will make the payment. Providers are making individual decisions about invoicing - some charging for GUM attendance only, some for combined GUM and contraception appointments and some for separate GUM and contraception appointments only.
4.4. The current situation of inequitable access to contraception services is increasing risks and also building a very bureaucratic system of invoicing and chasing payments. A single national approach would be welcomed, ensuring consistency, fairness and clarity.

4.5. Workforce

4.5.1. The sexual health workforce is diverse. It includes specialists (doctors and nurses in community sexual and reproductive health (CSRH), genitourinary (GU) medicine and HIV) and generalists (GPs, practice nurses, pharmacists, school teachers, school nurses and college tutors).

4.5.2. There have been recent and significant shifts in the delivery of sexual health services. The move to integrated services is resulting in changes to traditional roles and job specifications. The new models of working include an increased focus on nurse-led provision, and GU consultant roles expanding into new areas of sexual health including the provision of contraception and the management of sexual dysfunction. At the same time, the new specialty of CSRH is becoming established with consultants taking on lead roles in the integrated sexual health services.

4.5.3. The majority of the sexual health specialist workforce is employed on NHS contracts, but sexual health services are funded through local authorities. As a result, responsibility for the oversight of the full sexual health workforce is at risk of falling between organisational bodies.

4.5.4. The rapid and substantial changes to the sexual health workforce roles is causing uncertainty and uncovering significant areas of risk. These include:

- An ageing workforce
- Vacancies that are proving difficult to fill, particularly in rural areas
- Limited training budgets and provision for providing adequate professional development opportunities

4.5.5. Clear recommendations for building and sustaining a sexual health workforce that can meet the current and future population needs would be welcomed.

4.6. Digital developments

4.6.1. The way in which effective and efficient sexual health services are provided is changing. There is a move from face-to-face consultations to more online services, including the ordering of STI tests. There is the potential for online services to drastically increase the number of people being tested for STIs, but there is still a need for local services and even more need for guidance and monitoring. It is going to be vital to keep pace with the advances in online provision to ensure the quality of the services provided and the continued accuracy of data collected on service use, the STI tests offered and provided, and diagnoses.

4.6.2. The move to online testing and developing technologies is happening fast, but it is not clear if these changes are being driven by a need to reduce costs or a population need. It is likely that needs are changing and there is a demand for the ease and speed of online testing, but this has to be managed. The response to the digital transformation must be planned and adherence to standards and best practice guaranteed.

1. Recommendations for action

1.1. The exploration of the potential impact of the current funding cuts on the ability to deliver services would be welcomed.
1.2. An examination of the variability and inconsistency in services provided in different local authorities would be valuable. Are greater cuts in funding occurring in areas of high population need? It would also be helpful to identify the potential consequences of reduced service provision on the health of local populations and any associated harm. Are the changes exacerbating health inequalities or are services still being provided at an appropriate level?

1.3. There is scope for further consideration and a review of the quality of commissioning since its transfer to local authorities. Has commissioning improved or has the quality declined? How has this been reflected in the provision of sexual health services? It would also be helpful to explore the potential of the new commissioning arrangements. Are there less or more opportunities for providing cost-effective sexual health services within the new commissioning arrangements?

1.4. Are local authorities able to maintain adequate levels of sexual and reproductive health service provision or are vulnerable patients prevented from accessing the sexual and reproductive healthcare that they need? An exploration of the realities of open access to services would provide useful information about future developments.

1.5. It is recommended that the potential fragmentation and disconnect between services is assessed. For example, who has responsibility for training the sexual health workforce, HEE or the NHS? Is the future uncertainty of HIV services affecting the number of junior doctors entering the speciality?

1.6. It is recommended that changing needs in response to developing technologies are analysed. Are increases in online provision being driven by a need to reduce costs? Are online services commissioned as a complement to existing face-to-face provision? How can the response to the digital transformation be managed and how can adherence to standards and best practice be best achieved? It is recommended that an evaluation is carried out of the effectiveness of online modes of service delivery in sexual health.

Office for Sexual Health South West

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