1. Introduction

1. NAT (National AIDS Trust) is the UK’s HIV policy and campaigning charity. We welcome the opportunity to submit evidence to this important and timely inquiry on sexual health.

2. The conclusions of the Committee’s 2016 inquiry on public health post-2013 are also highly relevant to this inquiry. The warnings issued by the Committee at that time have not been heeded. Continued steep cuts to public health funding mean that the current system is chronically under-resourced. Despite the purported intentions of the Five Year Forward View, ambitions to put prevention at the heart of the NHS are not coming to fruition. As evidenced by the lack of local authority and public health involvement in the development of the 10-year plan for the NHS, investment and planning in the NHS is increasingly divorced from discussions around public health. We are now seeing an impact on service quality and outcomes in sexual health.

NAT recommends: That NHS England include public health stakeholders in the development of the 10-year plan for the NHS and ensure that public health services form a part of this plan as a vital component of the health and care system.

2. The context of sexual health services in England

2.1 Funding challenges

3. Whilst NHS funding has been protected and at times increased, those health services commissioned through the public health grant have been subject to significant cuts. The local authority public health grant, from which most sexual health services are funded, was reduced by approximately 7% in 2015/16 and a further 3.9% year on year thereafter.\(^1\) The funding context exacerbates all other issues within the system. Ultimately our sexual health services are under-resourced and as a result service design is driven not by innovation or need, but by cost. This was the conclusion of the British Medical Association (BMA) in their review of public health activity\(^2\) and was clearly indicated by NAT’s research on local authority spending on HIV prevention, which showed no relationship between investment decisions and prevalence of HIV.\(^3\)

NAT recommends: That funding to the local authority public health grant is urgently increased.

2.2 The legal framework

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\(^1\) *Spending Review and Autumn Statement 2015*, HM Treasury, 2015

\(^2\) *Feeling the squeeze: The local impact of cuts to public health budgets in England*, BMA, 2018 (data sourced from Department for Communities and Local Government)

\(^3\) *UK investment in HIV prevention 2015/16 and 2016/17*, NAT (2017)
4. Under the current framework there are some public health activities that are mandated to be provided, including open access sexual health services. It is, however, intended that regulations give commissioners flexibility and ‘...do not impose any requirements about how and where this testing and treatment should be offered, how quickly appointments should be offered, or which providers should be commissioned...’. The loose definition of ‘open access sexual health services’ has resulted in variation in service accessibility and quality.

5. The Government plans to remove the public health ring fence in 2020 and it is proposed that the grant will be replaced by funding from locally retained business rates. Public health will then have to compete with other local authority priorities - it is highly likely that sexual health funding will be cut further to fund other cash-starved services. Greater clarity will be needed as to the responsibilities of local authorities and the Secretary of State to ensure appropriate sexual health provision, integrated into the wider health system. Accountability around public health services must also be ensured through transparent and consistent reporting of local spending.

6. An important Government call for evidence on the future of the legal and regulatory framework for public health closed in April 2018 but the Government is yet to report back.

NAT recommends: That the regulations for public health activity are strengthened and that open access sexual health services are better defined to ensure high quality services are equally accessible to all.

NAT recommends: That the Government urgently publish a response to submissions made to its April 2018 call for evidence on the legal and regulatory framework for public health.

2.3 Trends in Sexual health

7. In England in 2017 there was a 20% increase in syphilis diagnoses and a 22% increase in gonorrhoea diagnoses from 2016, continuing a trend of rapid increases over a number of years. Having STIs also increases risk of HIV transmission and acquisition. There are significant inequalities in sexual health. NAT focusses here on the disproportionate impact on Black, Asian and Minority Ethnic (BAME) groups; and men who have sex with men.

8. In 2017 people of black Ethnicity had the highest rates of diagnosed STIs in England. Rates of STIs such as chlamydia, gonorrhoea and genital warts are higher among black Caribbean people and black people who do not identify as Caribbean or African, whereas black African people are more likely to be affected by HIV – in 2016 one in 29 black African heterosexual women and one in 43 black African heterosexual men were living with HIV.

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4 Commissioning Sexual Health services and interventions, Department of Health, 2013
5 Local authority prescribed public health activity: a call for evidence, closed 17 April 2018, submission from NAT available on request.
6 Sexual and reproductive health sector join forces in call to strengthen public health regulations, Open letter to Secretary of State for Health, 19 April 2018
7 Sexually transmitted infections and screening for chlamydia in England, 2017, PHE 2018
9. The sexual and reproductive health needs of women are not met equally for all. As well as experiencing disproportionate rates of STIs relative to other women, black women in England are more likely to experience more than one abortion than others accessing abortion services.

10. The inequality in BAME communities is interlinked with the high burden of STIs on migrants. In 2016 55% of those accessing HIV care and 55% of those newly diagnosed with HIV in the UK, were migrants. Late diagnosis, which means risk of mortality is ten times higher in the first year after diagnosis, is significantly higher amongst migrants (53% compared with 43% overall). This is not solely a problem of people migrating to the UK already having HIV, for example, 60-70% of Eastern and Southern African MSM living with HIV, acquired it in the UK.

11. MSM are also disproportionately affected by STIs. More than half of HIV diagnoses each year continue to be amongst MSM. And, despite decreases in HIV diagnoses, there were large increases in diagnoses of gonorrhoea (21%), chlamydia (17%) and syphilis (17%) amongst MSM in 2017. There is an especially high incidence of STIs among HIV positive MSM, underlining the need for effective integration of sexual health and HIV treatment services.

12. Sexual health inequalities are linked to broader issues of marginalisation and deprivation that limit access to sexual health information, wider physical and psychological wellbeing and health seeking behaviours. These inequalities call for urgent action, but the services that go beyond the sexual health clinic, that might reach these populations the best, are where dis-investment is steepest (discussed below).

3. Deterioration in sexual health services

3.1 Open access sexual health clinic services

13. Spending on sexual health clinic services decreased by 5% between 2016/17 and 2017/18 but demand is increasing; attendances to sexual health clinics increased from 1.6 million in 2011 to 2.1 million in 2015, and rates of some STIs such as syphilis and gonorrhoea have increased much faster. Almost a third (31%) of sexual health clinicians in the recent British Association for Sexual Health and HIV (BASHH) survey, said they felt that care had deteriorated or significantly deteriorated in the past year.

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9 Sexually transmitted infections and screening for chlamydia in England, 2017, PHE 2018
10 Abortion statistics, England and Wales: 2017, PHE 2018
11 Data provided by PHE to NAT upon request in 2018
12 Ibid.
13 Trends in new HIV diagnoses and people receiving HIV-related care in the United Kingdom: data to the end of December 2017, PHE 2018
14 Sexually transmitted infections and screening for chlamydia in England, 2017, PHE 2018
15 Gwenda Hughes and Nigel Field ‘The epidemiology of sexually transmitted infections in the UK: impact of behaviour, services and interventions’ Future Microbiol. 2015 10(1), 35-51
17 Feeling the squeeze: The local impact of cuts to public health budgets in England, BMA, 2018 (data sourced from Department for Communities and Local Government)
14. Many areas are finding efficiencies through reducing the number of clinic sites. In London seven clinics have closed and there have been efforts to achieve efficiencies using an online service. But remaining clinics cannot meet demand; 56 Dean St this year reported that they had 1,500 patients a day vying for only 300 appointments. 63% of clinicians in the BASHH survey said they were now turning away patients weekly, with 19% turning away more than 50 a week. There are declines in clinic attendances and testing in East Midlands, North East and South West PHE regions. This, combined with high numbers being turned away, will inevitably mean increased STI transmissions as STIs go undiagnosed and untreated.

‘Walk in appointments no longer available. Each time I have tried [to book]...I’m told all the slots have been taken...It seems as if it will be impossible for me to complete my course of HPV vaccination.’ Patient in London describing a recent experience to NAT

15. NAT’s review of local authority spending on non-mandated STI and HIV prevention services similarly demonstrated that commissioners were streamlining sexual health services, consolidating and combining prevention and treatment contracts.

16. Concerns have also been raised about a reduction in consultant input and what this may mean for patient safety and equality of access. Consistency could be enhanced by compelling local authorities to provide services that have regard to national standards, as set out by the Faculty for Sexual and Reproductive Health (FSRH) and BASHH. NAT recommends: That the regulations are amended to achieve greater consistency in service provision across the country by specifying that services need to be delivered to clinically agreed standards.

3.2 Non-mandated services

17. NAT’s research, using Freedom of Information submissions to all local authorities in England, showed spending on non-mandated sexual health and HIV prevention and testing in areas with a high prevalence of HIV (>2 per 1,000), decreased by nearly a third (29%) in two years to April 2017.

18. Specialist, targeted prevention services for MSM and BAME groups were a significant casualty. Funding for BAME targeted sexual health promotion dropped more than 50% in London alone. These findings are further backed up by sexual health clinicians, 47% of whom said that outreach to vulnerable populations decreased in their area this year; clinicians also say that non-mandated aspects of reproductive and psychosexual health services have been significantly

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22 PHE ‘Sexually transmitted infections and screening for chlamydia in England, 2017’ June 2018
23 ‘UK investment in HIV prevention’, NAT 2017
26 Ibid.
impacted by reductions in funding.\textsuperscript{27,28} There has also been a decrease in funding for national prevention programmes that can support local activity, such as HIV Prevention England.\textsuperscript{29} 

19. The cuts have had a knock-on effect on the quality and range of our sexual health services; on outcomes such as safer sex behaviours, testing and STI incidence; and on the inequalities described above.

**NAT recommends:** That the Government, in determining increases to the public health grant, take account of the vital importance of non-mandated sexual health services and consults strategically with local authorities and other key stakeholders around appropriate provision.

**NAT recommends:** That the Government and Public Health England expand further such national prevention initiatives as HIV Prevention England and Sexwise\textsuperscript{30} to support local services.

4. **Severing sexual health and aspects of the HIV pathway from the NHS**

4.1 **A closer look at HIV**

20. HIV diagnoses decreased by 28\% in two years from 2015 to 2017.\textsuperscript{31} This is a result of combination HIV prevention, with increased testing amongst MSM, particularly in London, and immediate access to treatment being key components (97\% of people on HIV treatment have an undetectable viral load and cannot pass HIV on\textsuperscript{32}), as well as people accessing Pre-Exposure Prophylaxis (PrEP).\textsuperscript{33} But, the reduction in diagnoses now are in part related to reducing acquisitions in previous years, and those services that have achieved this success are under threat.

21. There is a very real risk that the success we have seen will not be sustained and that the increased STIs amongst MSM are a warning sign.

22. Late diagnosis of HIV remained stable at 43\% showing that although acquisitions have decreased, when people do acquire HIV they are not necessarily being diagnosed faster.\textsuperscript{34} England is also yet to achieve the first 90 of the UN 90-90-90 targets, that 90\% of people living with HIV are aware of their HIV status. In the WHO West sub-region, the UK is performing behind eight other countries (Israel, Denmark, Portugal, Switzerland, Sweden, Austria, Greece and the Netherlands) in relation to ‘the first 90’.\textsuperscript{35}

\textsuperscript{27} British Association for Sexual Health HIV. Member Survey. September 2018. Data available on file. 
\textsuperscript{28} Cuts to contraceptive care deepen as new data reveal half of councils closed sites providing contraception since 2015, Advisory Group on Contraception, 2018 
\textsuperscript{29} Azad, Y. National HIV Prevention – Grateful for small mercies? blog for NAT 2016 
\textsuperscript{30} National sexual health programme https://sexwise.fpa.org.uk/
\textsuperscript{31} PHE 2018 
\textsuperscript{32} Trends in new HIV diagnoses and people receiving HIV-related care in the United Kingdom: data to the end of December 2017, PHE 2018 
\textsuperscript{34} Trends in new HIV diagnoses and people receiving HIV-related care in the United Kingdom: data to the end of December 2017, PHE 2018 
\textsuperscript{35} Noori, T (2018) ‘Overview of the HIV continuum of care in Europe and Central Asia’, presented at AIDS 2018,
23. The mixed picture in STIs and HIV trends, and the disparity between the international policy commitments and actual investment in services, is indicative of a lack of strategic approach to sexual health and HIV. The recent commitment to the elimination of Hepatitis C in England by 2025 has renewed focus and energy in that sector. The UK is already signed up in theory to the UN Sustainable Development Goal of elimination of HIV as a public health threat by 2030. We have the skills to do this. Political leadership, strategy and investment are needed to make this a reality.

**NAT recommends:** That the Government commit explicitly to the UN Sustainable Development Goal of eliminating new HIV transmissions in England by 2030. This should be backed up by a comprehensive strategy for sexual health and HIV that links up stakeholders across the system.

### 4.2 HIV care

24. Complicated commissioning structures have meant fragmentation of the health and care system. This is especially acute in the HIV and sexual health sector where prevention, diagnosis, treatment and support have been separated out for commissioning purposes, and in some instances still lack a commissioning ‘home’.  

25. There is no commissioner clearly responsible for HIV support services or Clinical Nurse Specialists both of which are crucial in supporting healthcare engagement and adherence to medication for many. As a result, these services have often been cut or decommissioned entirely. Good HIV care is not only important for the individual, but also for public health because of the preventive effect of treatment. But overall more than three quarters (76%) of HIV clinicians feel that HIV care had worsened since 2013.

26. Co-location of HIV and sexual health clinical services has been a standard approach, supporting access to sexual health care and streamlining the pathway from diagnosis to treatment. But these services are being de-coupled following tenders as they are commissioned from different parts of the system that don’t talk to each other. More than 40% of HIV clinicians have reported reduced access to sexual health screening for people living with HIV through their service.

### 4.3 PrEP

27. PrEP, and the battle to make it available in England, illustrates the complexities of current sexual health arrangements. Despite its stated commitment to prevention, in 2016 NHS England attempted to avoid a decision on PrEP by claiming they did not have the legal power to commission it. NAT successfully challenged this in the courts.

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36 *The future of HIV services in England: shaping the response to changing needs*, King’s Fund 2017

37 *HIV in the future NHS*, NAT 2016

38 *Why we need HIV support services*, NAT 2017

39 *HIV support services: The state of the nations*, NAT 2017


41 Ibid.

42 *Five Year Forward View*, NHS England, October 2014

28. The subsequent decision was to commission PrEP but in the first instance via a large-scale implementation study, the PrEP IMPACT trial, which now has 13,000 places over three-years.\(^{44}\) One year in and many of the clinics most used by those at risk of HIV have used or are nearing their full allocation. It cannot be acceptable for these clinics not to provide PrEP for a further two years. Many people will inevitably acquire HIV were that to happen.

29. NAT and 35 other organisations have signed a community statement calling for a national PrEP programme from April 2019.\(^{45}\) While there may be increased (but surely welcome) engagement with sexual health clinics for those accessing PrEP through a national programme, the main cost is the drug – and a recent court judgment has removed its patent protection. Whilst there will probably be an appeal, it is likely that in the next financial year it will be possible to routinely commission PrEP at a fraction of the patented cost.

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<tr>
<th>NAT recommends: That in light of their legal duty to promote integration of healthcare, NHS England and local authorities agree the joint commissioning of HIV and sexual health services as their default model of provision.</th>
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<td>NAT recommends: That commissioning responsibility is ascribed for HIV support services and Clinical Nurse Specialists.</td>
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NAT (National AIDS Trust)

October 2018

\(^{44}\) [https://www.prepimpacttrial.org.uk/](https://www.prepimpacttrial.org.uk/)