As sexual health service providers, we welcome the HSCC Inquiry into Sexual Health (SH). We write on behalf of the London Sexual Health Providers Group. Formed in 2012, following the changes in SH funding and commissioning, the group comprises members of the multidisciplinary teams responsible for delivering SH care from the major London services.

Over the last few years we have worked alongside the London Sexual Health Transformation Programme (LSHTP), public health and local authority commissioners to remodel our services in line with the changing landscape, financial constraints and needs of the individuals we serve. We represent integrated sexual health services that deliver both STI and contraception services as well as prevention and health promotion work. We believe that open access sexual health services, with a strong focus on prevention and health promotion, are essential but are increasingly threatened by the significant budget reductions and disinvestment of recent years.

Recommendations

1. There must be an increase in public health funding to enable Local Authorities to commission effective sexual health services, with a stronger focus on prevention and sexual health promotion, alongside the delivery of STI testing and treatment and contraception care.

2. The public health ring fence for Local Authority funding should be continued indefinitely to ensure funding is protected.

3. All aspects of sexual health service provision, ranging from prevention to complex work, must be consistently commissioned and appropriately funded.

4. There should be a national strategic approach to Sexual Health provision and HIV prevention, supported by appropriate targets, that will ensure a coordinated approach across the country and prevent local variations in both funding and service provision.

5. There should be coordinated commissioning of all aspects of sexual health services across NHS England, CCGs and Local Authorities that ends the fragmented approach to sexual health service provision especially, but not restricted to, areas such as PrEP, HPV vaccination, cervical screening, HIV testing and psychosexual services.

6. There should be appropriate capacity developed in primary care services (both GP and community pharmacies) to deliver the ‘simple’ aspects of sexual health and contraception care.
Recent Trends

7. Sexual ill health remains an important public health issue throughout the UK. However, data from Public Health England (PHE) demonstrates that London’s STI rates are 83% higher than in any other region\(^1\). In 2017, 117,086 new STI diagnoses were made in Londoners, representing a rate of 1,335 diagnoses per 100,000 population. The well publicised figures documenting significant rises in both syphilis and gonorrhoea diagnoses fail to highlight that over half of these cases were diagnosed in London. Much has been made of the trend towards a decrease in overall STI rates, but a drop in STI diagnoses should always be interpreted with caution. The recent decrease in chlamydia diagnoses occurred at the same time as an 8% reduction in chlamydia tests performed: a worrying indication of the impact of disinvestment in sexual health services. If fewer tests are done, fewer infections will be detected.

8. Maintaining and improving access to high quality SH services for the most marginalised groups is essential. Young people, black and minority ethnic groups and gay, bisexual and other men who have sex with men (MSM) are all disproportionally affected by poor sexual health. London residents aged between 15 and 24 years accounted for 36% of all new STI diagnoses in 2017. Black Caribbeans have one of the highest rates of STIs (3,042 per 100,000), which is three times the rate seen in the white ethnic group. Men who have sex with men (MSM) account for 29% of London residents diagnosed with a new STI. 90% of those diagnosed with syphilis and 63% of those diagnosed with gonorrhoea are MSM. The over 50s have emerged as an increasingly vulnerable population. Without easy access to confidential open access sexual health services and high quality sexual health promotion, the rates of STIs in this group are likely to increase further due to changing sexual behaviour, reduced condom use and a paucity of knowledge about STIs and HIV.

Prevention

9. Sexual Health services play a major role in the prevention of HIV, STIs and unplanned pregnancies. The expertise of our multi-disciplinary teams focuses on health promotion, education, behavioural interventions, emergency and on-going contraception, vaccination, condom provision, pre- and post exposure prophylaxis, rapid testing, treatment and partner notification for STIs.

10. The recent steep fall in HIV diagnoses in London demonstrates the success of our prevention strategies. Graph 1 shows the decline in HIV diagnoses at 56 Dean St, one of the larger London SH services, despite the same number of HIV tests being performed. The fall in new HIV diagnoses can be attributed to increased screening, rapid diagnosis of HIV and concurrent STIs, earlier instigation of HIV antiretroviral therapy, provision of HIV Pre- and Post-exposure prophylaxis (PrEP/PEP), condom provision and health promotion and support for behaviour change. There is a wealth of health economic data reinforcing the financial importance of preventing STI acquisition/transmission. In the context of HIV, preventing just one transmission is estimated to save £380k in lifetime treatment costs alone.

Graph 1 illustrating the fall in HIV diagnoses at the central London 56 Dean St clinic. The blue line demonstrates reduced diagnoses; the yellow line shows that there was no decrease in HIV tests performed to explain the decline.

**HIV Diagnoses**

11. The disinvestment in SH services threatens to not only reverse or, at least slow down, the considerable advances we have made in HIV prevention in London in recent years, but also to prevent the work that is still needed to reduce the rates of STIs and unplanned and teenage pregnancies, especially in those vulnerable groups who are most at risk

**Commissioning and delivery of Sexual Health services**

12. The unintended consequence of the Health and Social Care Act (2012), that transferred commissioning responsibility for sexual health services to Local Authorities (LAs), has been the significant disinvestment in SH services. The public health grant to Local Authorities is being cut by £600 million between 2015/16 and 2019/20 and will have been reduced by 9.6% by 2020/21. The cuts to public health funding are directly affecting Sexual Health services as Local Authorities are forced to reduce budgets, which then results in a reduction in the number and capacity of the services they commission.

13. The response of most LAs in London has been to instigate procurement exercises and to put services out to tender. In general this has resulted in reductions in sexual health budgets of 20 – 30%. Those local authorities that did not use procurement as a means to reduce spend instigated contract negotiations with local service providers, which reduced budgets by a similar amount.

14. This has led to many services having to reduce workforce and undertake significant service redesign, with a resultant remodelling or closure of clinics.
15. Sexual Health providers are mandated to provide ‘open access’ services i.e. they should offer care to all individuals regardless of post-code, without GP referral and provide free treatment in the interest of the public health. The varying local approach to commissioning across London has led to conflicting and contrasting service models in different areas, which does not support an open access approach and puts a considerable strain on our ability to deliver the services we believe are needed.

16. Despite a London wide commissioning partnership, regional models have been created in silos and there has been a lack of coordination when deciding location, opening hours, service models and methods of access. Some boroughs have been left with no specialist sexual health services, which puts increased pressure on services in neighbouring boroughs where early closure and people being turned away is increasingly common. London services have had capacity significantly restricted without reciprocal increases in capacity in other local or online services. Some commissioners are suggesting restriction of services to non-local residents; going against the principle of open access services.

17. This huge change in service provision in London has been implemented with no up front plans for evaluation of its impact and there seems to be little ongoing oversight where specific parameters or quality outcomes are monitored.

18. The LSHTP has commissioned an ‘e-service’ for the provision of STI testing for those with the most simple needs. We are supportive of this and believe that online services have a significant role to play in the provision of convenient and cost effective sexual health services. However online services are not appropriate or acceptable for all and they should always be delivered alongside and integrated with face-to-face clinical services.

19. As a result of budget reductions the capacity to deliver face to face services across London has decreased but, as the roll out of the e-service has been delayed and is slow, this has not been replaced with the same level of capacity online, making it harder for people to access the service they need. Demand is increasingly outstripping supply and, we believe, we have now passed the ‘tipping point’ that the Local Government Association\(^2\) spoke about and have reached a crisis point.

\(^2\) Record demand on sexual health services putting system at tipping point
https://www.local.gov.uk/about/news/record-demand-sexual-health-services-putting-system-tipping-point
20. In 2015, 70% of attendees at one west London clinic were living within the local borough. By 2017, this number had reduced significantly as increasingly people from other areas of London travelled to access their service.

Figure 1 demonstrating the changing demographics of attendees of one west London SH service following the closure of services in neighbouring boroughs.

![Changing demographics of attendees](image)

**Demand and Access**

21. The central London clinic, 56 Dean Street, recently reviewed the demand for access to its service over a one-week period (Table 1). The majority (93% - 96%) of those attempting to secure an appointment were unable to do so and the provision of online testing is not at a high enough level to see those unable to access face to face services.

22. The vast majority of those attempting to secure an appointment (87%-90%) failed to access the care they need.
Table 1 The number of individuals attempting to access an appointment over a one-week period and resultant uptake of online services.

<table>
<thead>
<tr>
<th>Week beginning (2018)</th>
<th>Individuals attempting to book appointment</th>
<th>Individuals unsuccessful in booking appointment (All offered online service)</th>
<th>Number of online home test kits requests</th>
<th>Number of individuals left untested</th>
<th>% of individuals trying to access services that were left untested</th>
</tr>
</thead>
<tbody>
<tr>
<td>30th July</td>
<td>4877</td>
<td>4577 (94%)</td>
<td>321</td>
<td>4256</td>
<td>87%</td>
</tr>
<tr>
<td>6th August</td>
<td>4716</td>
<td>4416 (94%)</td>
<td>324</td>
<td>4092</td>
<td>87%</td>
</tr>
<tr>
<td>13th August</td>
<td>4849</td>
<td>4549 (96%)</td>
<td>325</td>
<td>4224</td>
<td>87%</td>
</tr>
<tr>
<td>20th August</td>
<td>4480</td>
<td>4180 (93%)</td>
<td>304</td>
<td>3876</td>
<td>87%</td>
</tr>
<tr>
<td>27th August</td>
<td>4585</td>
<td>4359 (95%)</td>
<td>312</td>
<td>4047</td>
<td>88%</td>
</tr>
<tr>
<td>3rd September</td>
<td>4716</td>
<td>4535 (96%)</td>
<td>300</td>
<td>4235</td>
<td>90%</td>
</tr>
<tr>
<td>10th September</td>
<td>4598</td>
<td>4362 (95%)</td>
<td>305</td>
<td>4057</td>
<td>88%</td>
</tr>
<tr>
<td>17th September</td>
<td>4429</td>
<td>4129 (93%)</td>
<td>292</td>
<td>3837</td>
<td>87%</td>
</tr>
</tbody>
</table>

23. Reducing access to SH services across London has led to an increasing demand and capacity mismatch. Where demand increases and capacity is restricted we increasingly have to turn people away from our services.

24. Patients are left having to attempt to access multiple services on multiple occasions which delays diagnosis and treatment for infections and restricts access to contraception thereby increasing the risk for complications, onward transmission and unplanned pregnancies.

25. In November 2017 several clinics in south London analysed their ‘turn away’ data. A survey was undertaken of people turned away from 7 sites of 3 NHS Sexual Health service providers and one 3rd Sector provider. In one month at least 1,094 people were turned away from the service they attended. This represents 7.7% of activity in the services. 284 (26%) had already been turned away from a service before. The majority of people turned away (54%) reported having symptoms, 25% wanted contraception (including LARC) and 4% needed emergency contraception. Of the 26% who had already been turned away 44% had attempted to access their GP and 42% another sexual health service³.

Funding

26. A recent BMJ investigation\(^4\) revealed that all but 33 of the 147 local authorities responding to a Freedom of Information (FOI) request had reduced spending on Sexual Health services. Most of these annual reductions in spend were between 5% and 10%, but they ranged from 0.4% to 23%. Almost two thirds of LA respondents said they had not ‘cut’ services but that they had ‘rationalised’ delivery. Chlamydia screening, prevention and health promotion have been the services most restricted along with psychosexual counselling, outreach for vulnerable populations and school drop in sessions.

27. In London, as part of the London Sexual Health Transformation Programme (LSHTP), the majority of commissioners have moved to the Integrated Sexual Health Tariff (ISHT) as the means of funding services. We support the ISHT as a method of funding services and believe that, as a model, it is an improvement on previous approaches to funding. However, there are many aspects of the tariff content and process that are inaccurate and out of date, do not recompense complex work and do not reflect current clinical practice. In addition there are a number of clinical areas that are commissioned and contracted for but are not covered by the ISHT and therefore are not being paid for.

28. The issues with the ISHT detailed above mean that much of the complex work is not fully funded, despite it being required by commissioners and detailed in our contracts and service specifications. This puts further financial strain on SH providers. In some areas, contraception delivery has been moved away from SH services, which is an unfortunate and counterproductive strategy which does not align with the principles of delivering integrated sexual and reproductive healthcare.

29. Services are being financially penalised if they do not shift contraception patients into primary care, and some out of London boroughs are refusing to pay for patients attending for contraception alone despite this being part of the service specification.

30. This is all happening in the context of increasing demand on GP services. Many GPs no longer provide simple sexual health services or the full range of contraception. Women often experience very long waits to be seen (often of many weeks) putting them at risk of unplanned pregnancy or they end up ‘bouncing around’ the system trying to find the contraception care they need. Improvements to sexual health provision needs to include primary care.

\(^4\) Sexual health services on the brink BMJ 2017;359:j5395. [https://www.bmj.com/content/359/bmj.j5395.full](https://www.bmj.com/content/359/bmj.j5395.full)
Quality and Standards

31. SH services work to national standards and guidelines published by the British Association of Sexual Health and HIV (BASHH) and the Faculty of Sexual and Reproductive Health (FSRH). Financial constraints and the current approach to commissioning are making it increasingly difficult to achieve and maintain what should be basic quality standards of sexual health care. One key quality metric that has been in place for many years is the 48-hour access target: recognition of the importance of quick and easy access to sexual health services to support early diagnoses and treatment of STIs. Services that previously met this target are now struggling to do so. One London provider that has an appointment based service reports that their first free appointment is now 8 days away. Other services are resorting to syndromic management of patients despite BASHH standards suggesting this is a substandard approach.

32. In addition, the funding restrictions inherent in the ISHT has meant that most SH services have not been able to implement new approaches to STI testing e.g. for Mycoplasma genitalium, as recommended by national BASHH guidance, due to the costs associated with implementing these new approaches and the fact that they remain unfunded by Local Authorities.

Co-commissioned services

33. Co-commissioned services within the Sexual Health setting have suffered as a result of the fragmentation in commissioning that has occurred since 2013. While local authorities are responsible for prevention and testing, NHS England and CCGs have responsibility for other aspects of sexual health commissioning which causes confusion and an inefficient approach to improving sexual and reproductive health and STI and HIV prevention. There are a number of areas where the lack of an integrated approach to commissioning and service delivery have meant significant delays in developing services or reductions in existing service provision.

34. This is evidenced in a number of examples:
   I. We still do not have a fully commissioned PrEP service on the NHS in England. PrEP is a highly effective and cost-effective HIV prevention tool but a lack of a coordinated approach to commissioning has left us with the unacceptable situation of people who are at risk of HIV acquisition in England being unable to access PrEP because there are no places on the Impact Trial.
   II. We do not have a coordinated approach to HIV testing across co-commissioned services. Rates of late diagnoses and undiagnosed HIV remain unacceptably high. HIV testing in non-sexual health settings, such as GP and Emergency departments, is essential to address this and yet this is still not commissioned in an impactful or sustainable way.
   III. Cervical screening rates in London are falling but despite this few London SH Providers are in a position to offer cervical cytology screening as there is no payment mechanism through ISHT and cervical screening is not widely commissioned or fully recompensed by NHSE in sexual health services.
IV. HPV vaccination is highly effective at preventing both HPV related cancers and genital warts, which are common and have high NHS treatment costs, and yet delays persist in rolling out HPV vaccination to MSM and young boys.

V. Commissioning of psychosexual services continues to be confused despite a huge demand from patients. Many services, despite having the expertise, are restricting or ceasing psychosexual services, leaving distressed and symptomatic patients with nowhere to go. A similar situation exists for the management of genital dermatoses.

Workforce
35. Morale is at an all time low with many from all professional backgrounds leaving sexual health, including a significant number of experienced consultants. Recruitment of specialist trainees is becoming increasingly difficult with London teaching hospitals carrying vacancies. The pool of dual trained nurses is reducing and services continue to run with vacancies and high sickness rates, which further compounds capacity issues.

Dr Michael Brady
Consultant in Sexual Health and HIV, Clinical Lead for Sexual Health, Kings College Hospital

Dr Rachael Jones
Consultant in Sexual Health and HIV, Chelsea and Westminster Hospital

Dr Liat Sarner
Consultant in Sexual Health and HIV, The Royal London Hospital

Dr Anatole Menon-Johansson
Consultant in Sexual Health and HIV, Guys and St Thomas’ Hospital

Dr Alan McOwan
Consultant in Sexual health and HIV, 56 Dean Street, Chelsea and Westminster Hospital

Dr Linda Green
Consultant in Sexual Health and HIV, St Mary’s Hospital

Dr Dawn Wilkinson
Consultant in Sexual Health and HIV, Head of Speciality Sexual Health, St Mary’s Hospital

Mr Bernard Kelly
HIV Team Lead, St George’s NHS Trust

Dr Bavithra Nathan
Consultant in Sexual Health and HIV, Kingston Hospital

Dr Sue Mitchell
Consultant and Clinical Director HIV and GUM, Lewisham and Greenwich NHS Trust

On behalf of the London Sexual Health Providers Group